Approved 3/30/90
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

The meeting was called to order by SENATOR RICHARD L. BOND
Chairperson
at 9:00 a.m./~~p.m.~~ on MONDAY, MARCH 26, 19 90 in room 529-S of the Capitol.

All members ~~were~~ present~~except:~~
Senators Karr, Kerr, McClure, Parrish, Reilly, Salisbury, Strick, and Yost.

Committee staff present:
Bill Edds, Revisors Office
Bill Wolff, Research Department
Louise Bobo, Committee Secretary

Conferees appearing before the committee:
Representative Jim Braden
Representative Dale Sprague
Rich Huncker, Kansas Insurance Department
Donald R. Lynn, Blue Cross Blue Shield
Bill Sneed, Health Insurance Association of America

Chairman Bond called the meeting to order at 9:13 a.m.

HB 3012 - Insurance: accident & sickness rates.

Representative Jim Braden addressed the committee in support of this bill which he requested to be introduced. Representative Braden explained that he originally requested the bill in order to give the same authority to the Commissioner over other health insurance companies that he now has over Blue Cross and Blue Shield. Representative Braden advised that, in its present form, the bill gives the Commissioner authority to approve policy forms and rates and prohibits breaking up large pools and squeezing people out. The bill further requires that all groups of 25 or less be combined with other groups of 25 or less issued by the same company. Representative Braden also stated that he approved of the amendments to the bill prepared by the Insurance Department.

Representative Dale Sprague addressed the committee for the purpose of advising the committee about the four major topics of study resulting from the Joint Meeting of the House and Senate Committees the end of January. Representative Sprague concluded his remarks by advising that there was agreement that competition is the "spurring factor" causing premium rates to soar and further advised that if a level playing field was not forthcoming, the competition would freeze more people out. His advice was not to delay action by sending these bills to interim study. (Attachment 1)

Rich Huncker, Kansas Insurance Department, informed the committee that the Insurance Department believe this bill, as amended, would provide the most certain means for preventing the rate variations created by tier rating and the greatly reduced use of community rates. (Attachment 2)

Mr. Huncker explained the amendments to the bill, as developed by the House committee. One amendment to the bill would require that rate regulatory requirements and prohibitions cover Kansas residents or employees regardless of where the policy is issued. Another amendment would correct the problem some people face because of tier rating. Amendments to the bill would also address the classification problem and also represent another effort to restore the concept of group insurance to its original form. (Attachment 3)

Donald R. Lynn, Blue Cross Blue Shield, told the committee that his organization was in support of the bill if it is uniformly applicable to all carriers in the state. He listed some major concerns with the bill, however, that he said needed to be studied and revisions made before HB 3012 is passed and enacted. (Attachment 4)

Bill Sneed, Health Insurance Association of America, addressed the committee in

opposition to this proposal. According to Mr. Sneed, this bill will not lower health costs and, in addition, will place additional regulations on insurance companies. Mr. Sneed concluded by strongly urging the committee to recommend HB 3012, along with other health issues, to an interim study committee. (Attachment 5)

No action was taken on HB 3012 and the hearing and possible action will continue later this week.

Minutes of the March 21, 22, and 23 meetings were approved on a motion by Senator Reilly with Senator Salisbury adding the second. The motion carried.

Chairman Bond announced the meeting adjourned at 10:08 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Mon. Mar 26, '90

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Rich Hancker	420 SW 9th	Kansas Ins. Dept.
Bill Sneed	TOPEKA	HIRA
Norm Wilks	TOPEKA	KASB
Don Lynn	Topeka	Blue Cross & Bs of Ks
Dale Sprague	McPherson	Representative

DALE M. SPRAGUE
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STATE CAPITOL
ROOM 330-N
TOPEKA, KANSAS 66612
913) 296-7695
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STATE OF KANSAS

SPEAKER PRO TEM

A G E N D A

Committee on Insurance

3:30 p.m.
Room 531-N

Monday, February 12, 1990
Topic Briefings on:

Kansas Mandated Health Insurance Coverages
Insurance Dept. Overview
Interested Groups

Tuesday, February 13, 1990
Health Care Presentation
Blue Cross/Blue Shield

Wednesday, February 14, 1990
Topic Briefings on:

Delivery Systems Concepts for Health Insurance
HIAA -- Washington Staff

Thursday, February 15, 1990
Committee Discussion of Topic Briefings
Bill Requests by Committee Members

Friday, February 16, 1990
No meeting scheduled

Anyone wishing to appear before the Committee should contact the committee secretary, Patti Kruggel at 296-7695 prior to the meeting. Conferees are required to provide 20 copies of written testimony.

Attachment 1
H I + I
3/26/90

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STATE OF KANSAS

SPEAKER PRO TEM

REVISED AGENDA

Committee on Insurance

3:30 p.m.
Room 531-N

Monday, February 5, 1990
No meeting scheduled

Tuesday, February 6, 1990
Hearings on:

HB 2676 -- health maintenance organizations; contractual provisions
HB 2701 -- health maintenance organizations; deposit requirements
HB 2722 -- continuing education for agents

Wednesday, February 7, 1990
Topic Briefing on:

Health Care Insurance Kansas Marketplace

Thursday, February 8, 1990
Topical Briefing on:

Rate Regulation and Pricing Concepts

Friday, February 9, 1990
No meeting scheduled

Anyone wishing to appear before the Committee should contact the committee secretary, Patti Kruggel at 296-7695 prior to the meeting. Conferees are required to provide 20 copies of written testimony.

Kansas Insurance Department
Testimony Before the
Senate Committee on Financial Institutions and Insurance
on House Bill No. 3012
Presented by Rich Huncker

House Bill No. 3012 is a natural and appropriate response to some of the increases that have taken place recently in connection with accident and sickness insurance. It proposes a prior approval type of rate regulation for individual and group policies issued by traditional insurance companies that is similar or identical to that which currently applies to mutual nonprofit hospital and medical service corporations and health maintenance organizations.

As the sponsor noted when he requested the House Insurance Committee to introduce this bill, he was very surprised to discover that such rate regulatory authority was not an existing law. You should be aware; however, that legislative consideration has been given to general accident and sickness insurance rate regulation before, but has obviously not been enacted. Those were, of course, somewhat different days when health insurance costs and availability had not yet achieved the priority status they occupy today. So the fact that this legislation has not been enacted despite previous opportunities to do so does not necessarily mean it is without merit or that public policy needs don't change. Nevertheless, the previous lack of legislative enthusiasm is an obvious indication that some negative considerations were also present.

I can recall a couple of problems raised by opponents at previous hearings. One was the fact that it is not unusual for a group accident and health policy to be issued to a non-resident policyholder and be governed by the laws of the policyholder's state of residence even though the coverage may extend to a number of Kansas residents and/or employees. Thus, the fact that Kansas might have a rate regulation law does not necessarily mean the rates for accident and sickness insurance covering all Kansans would be regulated.

Attachment 2
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3/26/90

The House Committee amendments address this problem by the inclusion of New Section 2 appearing in lines 20 through 25 on page 3 of the bill. This is an extra-territorial provision adapted from existing K.S.A. 40-2,103 which simply provides that the rate regulatory requirements and prohibitions contained in House Bill No. 3012 will apply to all accident and sickness insurance policies to the extent they cover Kansas residents or employees regardless of where the policy is issued.

Another argument raised by opponents was the fact that accident and sickness insurance is often a subject of negotiations between labor and management. In such situations, negotiators are placed in an untenable position. Either the rates and forms to be used are already filed with and approved by the Commissioner, in which case there is little to negotiate or the negotiators don't know from one offer to the next whether it will be approved by the regulator. On the other hand, the regulator is probably not oblivious to the havoc he or she can cause by disapproving a "done deal". House Bill No. 3012 as passed by the House does not address this problem.

However, there was another shortcoming in the original bill which was much more serious, and that was the bill wouldn't have corrected the problems some people face because of tier rating. Tier rating is nothing more than a system of risk classification where subclassifications are established within a group based on health condition or some other rating criteria. Varying rates are established for each of these subclassifications so what really exists is one group for coverage purposes but several small groups for rating purposes. This is a product of the fragmentation of the group concept you heard several express concerns about during the course of your joint hearing on January 30. However, there is nothing in current law to prevent it and, more important, there was nothing in the original version of House Bill No. 3012 to prevent it either unless the risk classifications proposed were clearly and demonstrably unfairly discriminatory.

Another potential problem with the bill, or at least with any expectations that the Insurance Department might be able to utilize its provisions to disapprove rating classifications that result in very significant, even traumatic rate increases for some members of a group, is caused by a 1980 decision of the Kansas Supreme Court. The portion of the decision you need to be aware of is a sentence which reads as follows: "The Commissioner should not substitute his judgment for that of the directors of Blue Cross and Blue Shield of Kansas when it comes to grouping and classifying risks for the purpose of establishing rates on individual policies or on group policies." This decision incorporated a number of other reasons for overturning our disapproval of a rate increase submitted by Blue Cross and Blue Shield of Kansas (BCBSK), but the language of the rate regulation act applicable to that organization is nearly identical to House Bill No. 3012 in its original form -- not word for word but the substance is the same. The fact that BCBSK is a creation of the legislature and is a nonprofit entity may have had a bearing on the Court's decision, but I wouldn't rely on this possibility.

We believe the House Committee amendments address the classification problem and the Supreme Court's finding by the language appearing in lines 11 through 17 on page 2. This language is intended to prohibit insurers from singling out individuals for some kind of specific rating treatment and also prohibits the establishment of rating classifications within the group other than as might be necessary to reflect different rating treatment based on marital status or dependents coverage. This same prohibition has been added to the rate regulation act applicable to Blue Cross and Blue Shield in Section 3.

Finally, the House amendment appearing in lines 37 through 43 on page 2 and continuing in the first 2 lines of the next page represent another effort to restore the concept of group insurance to its original form. Specifically, this amendment requires groups of 25 or less members or member units to be community rated. As a result insurers would no longer be able to rate small groups of 8 to 10 or so persons largely on the basis of their own experience but rather would require the experience of

all similar groups to be combined for ratemaking purposes. This should add some much needed stability to this segment of the insured population. This amendment has also been added to the Blue Cross and Blue Shield law by the language appearing in lines 27 through 35 on page 4.

While House Bill No. 3012 as amended is, we believe, the most certain means of preventing the rate variations that have been created by tier rating and the greatly reduced use of community rates. It must be remembered, however, that these rating devices are used by insurers as a means of retaining as many "insurable" risks in a group as possible. We believe that, when such prohibitions are in place and applicable to all insurers, the competitive pressures that have been responsible for the introduction and increasing use of these rating techniques will largely disappear. At least from a rating perspective, insurers will be competing on a more level playing field. But there is one danger. While House Bill No. 3012 will effectively stop the rating practices it will not prevent insurers from underwriting out individuals or groups of individuals whose absence would permit an insurer to quote a more competitive rate. We frankly don't know if this will happen or not. In addition, the rating restrictions included in House Bill No. 3012 are probably among the most stringent in the country -- we don't know this but neither do we know of any other jurisdiction that has done this. As a result, we have no way of gauging the insurance market's reaction. Obviously, insurers don't happily embrace new regulatory requirements and if there are good, sound reasons for not enacting this bill, we haven't heard them. Nevertheless, the insurance marketplace has yet to be heard from and I would hope some reaction from this sector could be obtained before final action is taken. In this regard, I would note, however, that Blue Cross and Blue Shield of Kansas have been aware of this bill and the amendments. At least publicly that organization has been silent. If the bill was abhorrent I would think we would have heard from this organization because, unlike the traditional insurers, it can't simply stop doing business in Kansas and write business elsewhere.

As Amended by House Committee

Session of 1990

HOUSE BILL No. 3012

By Committee on Insurance

2-16

AN ACT relating to insurance; concerning accident and sickness insurance and the regulation of the rates thereof by the commissioner of insurance; amending K.S.A. 1989 Supp. 40-19c07 and 40-2215 and repealing the existing ~~section~~ sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1989 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

(b) No group or blanket *policy of accident and sickness insurance ~~providing medical, surgical or hospital expense coverage~~ shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof ~~and of the classification of risks and the premium rates pertaining thereto have~~ has been filed with the commissioner of insurance. ~~This section shall not apply to disability income, hospital confinement indemnity, specified disease or accident only coverage.~~*

~~(b)~~ *(c)* No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.

~~(c)~~ *(d)* The commissioner may, within 30 days after the filing of any ~~such~~ form required to be filed pursuant to subsection (a) of this section, disapprove such form: ~~(1) If the benefits provided therein are unreasonable in relation to the premium charged;~~ (1) If the benefits provided therein are unreasonable in relation to the premium charged; or ~~(2)~~ (2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. If the commissioner notifies the insurer which has filed any such form that it does not comply with the provisions of

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Explanation:
This amendment removes the requirement for filing rates and classifications but makes it clear that all forms used in connection with group or blanket insurance are to be filed.

Explanation:
This restores the previous language and requirements with regard to individual policies.

Attachment 3
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3/26/90

this section or K.S.A. 40-2202 and 40-2203, and amendments thereto, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

(e) (1) Any ~~filing of~~ risk classifications, premium rates ~~or~~ rating formulae ~~shall be approved by the commissioner unless the commissioner finds that such filing does not meet the requirements of this act or,~~ establishes an unreasonable, excessive or unfairly discriminatory rate or, with respect to group or blanket policies issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, ~~discriminates~~ against any individuals eligible for participation in a group, or ~~establishes~~ rating classifications within a group except those based on criteria solely and directly relevant to recognition of rating differences attributable to the marital status of a group's members and person eligible for dependents' benefits. ~~As soon as reasonably possible after the filing has been made, the commissioner shall in writing approve or disapprove the filing. Any filing shall be deemed approved unless disapproved within 30 days after receipt of such filing or supporting information in connection therewith. In the event the commissioner disapproves a filing, the commissioner shall specify in what respect such filing does not meet the requirements of this section or other provisions of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto, and shall state that a hearing will be granted within 20 days after receipt of such request in writing by such corporation.~~

(2) All rates, ~~filed pursuant to this section,~~ shall be made in accordance with the following provisions: (A) Due consideration shall be given to: (i) Past and prospective loss experience; (ii) past and prospective expenses; (iii) adequate contingency reserves; and (iv) all other relevant factors within and without the state;

(B) risks may be grouped by classifications for the establishment of rates for individual, group or blanket policies; ~~and~~

(C) rates shall be reasonable, not excessive and not unfairly discriminatory; and

(D) rates for group and blanket policies covering 25 or fewer members or member units shall be based on the aggregate loss and expense experience, contingency reserves and other factors required to be considered in making rates to which this act applies. Such rates shall apply ~~equally~~ to all members and member units of all groups comprised of 25 or fewer members insured in this state by the insurance company ~~filing~~ the rates on a per person

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, and all modifications of either applicable to Kansas residents shall not

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for accident and sickness insurance covering Kansas residents

Explanation:
The above amendments remove the prior approval requirements relating to group and blanket rates but imposes standards such rates must meet when applied to Kansas residents.

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basis but may vary with the number of persons in a family or the primary occupation of the group's members or both.

(3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act.

~~(d)~~ *(f)* The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the insurer, withdraw approval of any ~~such~~ form ~~on any of the grounds stated in this section or rate in the event the commissioner finds such filing no longer meets the requirements of this section or of article 22 of chapter 40 of the Kansas Statute Annotated, and amendments thereto.~~ It shall be unlawful for the insurer to issue such form or use it ~~or any rate~~ in connection with any policy after the effective date of such withdrawal of approval.

~~(e)~~ ~~(g)~~ Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

New Sec. 2. The requirements and restrictions imposed by K.S.A. 40-19c07 and 40-2215, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides ~~or is employed~~ in this state.

Sec. 3. K.S.A. 1989 Supp. 40-19c07 is hereby amended to read as follows: 40-19c07. (a) Every such corporation shall file with the commissioner a copy of all subscription agreement forms and rates pertaining thereto and all modifications of either that it proposes to use. Every such filing shall indicate the character and extent of the coverage contemplated by such rates, the plan of operation contemplated and shall be accompanied by the information upon which such corporation supports the filing.

(b) Any filing made pursuant to this section shall be approved by the commissioner unless such filing does not meet the requirements of this act or establishes an unreasonable, excessive or unfairly discriminatory rate *or, with respect to group or blanket policies issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminates against any individuals eligible for participation in a group, or establishes rating classifications within a group except those based on criteria solely and directly relevant to recognition of rating differences attributable to the marital status of a group's members and persons eligible for dependents' benefits.* As

Policies issued or renewed after the effective date of this act may utilize rates for specific groups that also vary from the community rates by no more than 50% if issued or renewed prior to January 1, 1992; 30% if issued or renewed prior to January 1, 1993; 20% if issued or renewed prior to January 1, 1994; and 10% on policies issued or renewed thereafter.

Explanation:
This amendment will provide for a transition period that will alleviate the same kind of premium changes in the reversion to community rating that occurred when community rating was discontinued. The permanent 10% variation permitted by this amendment would allow insurers some latitude to recognize geographic or other reasonable rating distinctions.

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on any of the grounds

stated in subsection (d) of this section

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Explanation:
This amendment restores the due process requirements relating to disapproval of forms.

(g) Violations of subsection (e) of this section shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 1989 Supp. 40-2407 and 40-2411.

(h)

Explanation:
Since group and blanket rates are no longer subject to prior approval, this amendment would permit the use of the penalties provided under the Unfair Trade Practices Act as an enforcement tool.

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Explanation:
This amendment would limit application of the extra-territorial provision to Kansas residents only.

soon as reasonably possible after the filing has been made, the commissioner shall in writing approve or disapprove it. Any filing shall be deemed approved unless disapproved within 30 days after receipt of such filing or supporting information connected therewith. In the event the commissioner disapproves a filing, the commissioner shall specify in what respect such filing does not meet the requirements of this section and shall state that a hearing will be granted within 20 days after receipt of such request in writing by such corporation.

(c) The commissioner may at any time after a hearing, of which not less than 20 days' written notice shall have been given, withdraw approval of any such subscription agreement or rate in the event the commissioner finds such filing no longer meets the requirements of the nonprofit medical and hospital service corporation act.

(d) All rates, filed pursuant to this section, shall be made in accordance with the following provisions:

(1) Due consideration shall be given to (A) past and prospective loss experience; (B) past and prospective expenses; (C) adequate contingency reserves; (D) the provisions of contracts between such corporation and participating physicians and hospitals; and (E) all other relevant factors within and without the state;

(2) risks may be grouped by classifications for the establishment of rates for individual subscription agreements or for group subscription agreements; ~~and~~

(3) rates shall be reasonable, not excessive and not unfairly discriminatory~~;~~ *and*

(4) rates for group and blanket policies covering 25 or fewer members or member units shall be based on the aggregate loss and expense experience, contingency reserves and other factors required to be considered in making rates to which this act applies. Such rates shall apply ~~equally~~ to all members and member units of all groups comprised of 25 or fewer members insured in this state by the insurance company filing the rates on a per person or per family basis but may vary with the number of persons in a family or the primary occupation of the group's members or both.

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(e) Nothing in the nonprofit medical and hospital service corporation act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with the nonprofit medical and hospital service corporation act.

(f) Premiums shall be payable in cash and no subscription agree-

Policies issued or renewed after the effective date of this act may utilize rates for specific groups that also vary from the community rates by no more than 50% if issued or renewed prior to January 1, 1992; 30% if issued or renewed prior to January 1, 1993; 20% if issued or renewed prior to January 1, 1994; and 10% on policies issued or renewed thereafter.

Explanation:
This amendment will provide for a transition period that will alleviate the same kind of premium changes in the reversion to community rating that occurred when community rating was discontinued. The permanent 10% variation permitted by this amendment would allow insurers some latitude to recognize geographic or other reasonable rating distinctions.

4-23

ment issued by such corporation shall provide for any assessment or contingent premiums.

(g) Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 2 4. K.S.A. 1989 Supp. 40-19c07 and 40-2215 ~~is~~ are hereby repealed.

Sec. 3 5. This act shall take effect and be in force from and after January 1, 1991, and its publication in the statute book.

TESTIMONY ON HOUSE BILL 3012
BY DONALD R. LYNN
VICE PRESIDENT, FINANCE
BLUE CROSS AND BLUE SHIELD OF KANSAS

FINANCIAL, INSTITUTIONAL AND INSURANCE COMMITTEE
Monday, March 26, 1990

Blue Cross and Blue Shield of Kansas supports the move back to a Community rating approach for the small groups of less than 25 contracts. We support this approach in order to give these small groups a more stable rate and a long-term method of financing their health insurance coverage. We do have some concerns however as it relates to the way that this particular bill is drafted. We think there may need to be some review and changes made in order for the implementation of this Community rating method to be less of a hardship and disruption on some of the groups that would be involved. Below are a list of some of our concerns that we feel need to have attention given and possible study and revisions made before this Bill is passed and enacted.

1. The Bill currently states that it applies to policies covering "25 or fewer members or member units". We would suggest this be changed to state that it applies to groups that have "less than 25 employees or member units covered by the health insurance coverage".

2. Insurance companies must be able to review the risk of new groups wishing to enroll in this Community pool and have the ability to reject an entire group that will have an extreme detrimental impact upon the rates of that particular pool. If this right is not made available to the insurance companies, this Community pool could become the coverage for the State's uninsurables and the rates would become unaffordable for the groups it was intended to help. We think this Bill allows for these actions.

3. The insurance companies must have the right to set and enforce reasonable underwriting regulations that require the participation of the eligible employees within a group to allow for coverage being extended to a cross section of risk and not just the individuals with the highest medical risks within these small groups. If this were not allowed by the insurance companies, then larger groups could segment out 25 or fewer of their employees that are of high medical risk and enroll them in these Community pools. This, we feel, is not the intent of the Bill. We think this Bill allows for these actions.

Attachment 4
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4. It does not appear that this Bill applies to HMOs. We feel that HMOs should also come under this Bill to eliminate any opportunities for adverse selection because of the experience rating that HMOs are beginning to utilize. If HMOs were not under this Bill, then they would have an advantage of attracting the healthier and better risk groups away from this Community pool rating that is required of the other insurance companies.

5. This Bill must require that METs and other insurers that have rejected individuals within a group because of medical conditions from having coverage, be required to accept those individuals into the group in which they work. If this Bill only applies to future enrollments on or after the effective date of the Bill, then the companies that have selectively underwritten the healthier individuals out of groups will have an unfair competitive advantage as it relates to the rates that they need to charge to maintain their existing Community pool.

6. Blue Cross and Blue Shield of Kansas rate changes the small groups on anniversary dates that are spread throughout the year. Some of these small groups have their rate change on January 1st. Other groups have their rate change on February 1st, etc. If this Bill were passed, we question whether all groups would change their rates to the Community pool rates on January 1st regardless of their anniversary date. If this is the intent, you would have to recognize that some groups may have experienced a rate adjustment in November or December and then would experience another rate adjustment that may be favorable or unfavorable to them on January 1st.

7. Blue Cross and Blue Shield of Kansas has approximately 30,000 contracts insured in our small groups of less than 25 contracts. This experience pool may be considerably larger than some of the other insurers doing business in Kansas. We recognize that it may take a higher rate to maintain the medical risk of our existing contracts covered within our Community pool for groups of less than 25 than another insuror with limited current enrollment in this size category. Other insurers may be able to have a more favorable rate because of their more stringent review of the risk of groups they accept into their Community pool.

8. The rating methodologies that have been utilized over the past years have resulted in wide rate variations between individual groups of less than 25 contracts. By going to a Community rate, we will be adversely affecting the rates of approximately half of the groups and beneficially impacting the rates on the other half of the groups. Pulling all groups' rates back to an average Community rate will be a major rate adjustment for some groups which is a concern to us. Those groups that receive a rate reduction because of going to a Community rate will more than likely accept this new rating method and continue coverage through the pool. It is not as likely that groups that are having a sizeable rate increase to their existing rates in order to get to the Community rate level will accept this change and join the Community pool. These groups will seek alternative methods of providing coverage to their employees which will include disbanding the group program and having their employees seek individual coverage through an age-rated and medically underwritten non-group product. The results of these actions by the various groups will have an adverse impact on the rates for the second and future years of the Community pool. Consideration should be given to allow for adjustments over five years to allow insurance companies to adjust individual group's rates towards the Community pool rate that we wish to have and maintain in the future. This change to a Community pool rate would be too extreme of a change to implement in one rate change cycle. We would suggest that these changes be made over five years.

9. By having a requirement of Community rating without any ability to vary the rates according to the average ages of the employees covered in a particular group will result in insurance companies being unable to compete with non-group products that are currently age-rated and medically underwritten. This inability to compete with non-group products that are age-rated will force insurance carriers to discontinue offering group coverage to some, if not all, of the small group market that this Bill is attempting to help. We think it is inappropriate to restrict variations in rates to the "primary occupation of the group's members". The purpose of this Bill should be the restriction on how much above the Community Rate an insurer can charge a high use group. The insurance companies should have the ability to select the methods of varying the rates for individual groups as long as they do not exceed the maximum rates established by this Bill.

In conclusion, Blue Cross and Blue Shield of Kansas supports the concept of trying to get to a Community rating approach for the small groups of less than 25 contracts. But we feel this is a very major step that requires a great deal of review and consideration of all aspects of this type of change in rating methodology for the Kansans that would be affected. We urge your review of the concerns we have identified and the consideration of the attached proposed amendment. We appreciate your consideration of the these points. Thanks.

DL/pw

As Amended by House Committee

Session of 1990

HOUSE BILL No. 3012

By Committee on Insurance

2-16

AN ACT relating to insurance; concerning accident and sickness insurance and the regulation of the rates thereof by the commissioner of insurance; amending K.S.A. 1989 Supp. 40-19c07 and 40-2215 and repealing the existing ~~section~~ sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1989 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

(b) No group or blanket *policy of accident and sickness insurance providing medical, surgical or hospital expense coverage shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the commissioner of insurance. This section shall not apply to disability income, hospital confinement indemnity, specified disease or accident only coverage.*

~~(b)~~ *(c)* No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.

~~(c)~~ *(d)* The commissioner may, within 30 days after the filing of any such form, disapprove such form: ~~(1) If the benefits provided therein are unreasonable in relation to the premium charged; or (2)~~ if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. If the commissioner notifies the insurer which has filed any such form that it does not comply with the provisions of

this section or K.S.A. 40-2202 and 40-2203, and amendments thereto, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

(e) (1) Any filing of risk classifications, premium rates or rating formulae shall be approved by the commissioner unless the commissioner finds that such filing does not meet the requirements of this act ~~or~~, establishes an unreasonable, excessive or unfairly discriminatory rate or, with respect to group or blanket policies issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminates against any individuals eligible for participation in a group, or establishes rating classifications within a group except those based on criteria solely and directly relevant to recognition of rating differences attributable to the marital status of a group's members and person eligible for dependents' benefits. *As soon as reasonably possible after the filing has been made, the commissioner shall in writing approve or disapprove the filing. Any filing shall be deemed approved unless disapproved within 30 days after receipt of such filing or supporting information in connection therewith. In the event the commissioner disapproves a filing, the commissioner shall specify in what respect such filing does not meet the requirements of this section or other provisions of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto, and shall state that a hearing will be granted within 20 days after receipt of such request in writing by such corporation.*

(2) All rates, filed pursuant to this section, shall be made in accordance with the following provisions: (A) Due consideration shall be given to: (i) Past and prospective loss experience; (ii) past and prospective expenses; (iii) adequate contingency reserves; and (iv) all other relevant factors within and without the state;

(B) risks may be grouped by classifications for the establishment of rates for individual, group or blanket policies; ~~and~~

(C) rates shall be reasonable, not excessive and not unfairly discriminatory~~;~~ and

~~(D) rates for group and blanket policies covering 25 or fewer members or member units shall be based on the aggregate loss and expense experience, contingency reserves and other factors required to be considered in making rates to which this act applies. Such rates shall apply equally to all members and member units of all groups comprised of 25 or fewer members insured in this state by the insurance company filing the rates on a per person~~ rates for group and blanket policies covering 25 or fewer employees of an employer, and any rate under a contract issued to a trust or an association applicable to an employer of 25 or fewer employees, must be developed based upon the loss experience, expenses, reserves, and other factors of all such policies covering persons who reside in or are employed within this state by the insurance company filing the rates. Such rates may vary from an average or community rate per person only:

(a) with the number of persons in a family, and

(b) based on actuarially reasonable factors, a group's rates may be no higher than:

(i) in 1991, 150% of the average or community rate;

(ii) in 1992, 140% of the average or community rate;

(iii) in 1993, 130% of the average or community rate;

(iv) in 1994, 120% of the average or community rate; and

(v) thereafter, 110% of the average or community rate.

such rates may be implemented on the anniversary date or normal rate change date of the contract.

~~basis but may vary with the number of persons in a family or the primary occupation of the group's members or both.~~

(3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act.

~~(d)~~ *(f)* The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the insurer, withdraw approval of any such form ~~on any of the grounds stated in this section~~ *or rate in the event the commissioner finds such filing no longer meets the requirements of this section or of article 22 of chapter 40 of the Kansas Statute Annotated, and amendments thereto*. It shall be unlawful for the insurer to issue such form or use it *or any rate* in connection with any policy after the effective date of such withdrawal of approval.

~~(e)~~ *(g)* Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

New Sec. 2. The requirements and restrictions imposed by K.S.A. 40-19c07 and 40-2215, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 3. K.S.A. 1989 Supp. 40-19c07 is hereby amended to read as follows: 40-19c07. (a) Every such corporation shall file with the commissioner a copy of all subscription agreement forms and rates pertaining thereto and all modifications of either that it proposes to use. Every such filing shall indicate the character and extent of the coverage contemplated by such rates, the plan of operation contemplated and shall be accompanied by the information upon which such corporation supports the filing.

(b) Any filing made pursuant to this section shall be approved by the commissioner unless such filing does not meet the requirements of this act or establishes an unreasonable, excessive or unfairly discriminatory rate *or, with respect to group or blanket policies issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminates against any individuals eligible for participation in a group, or establishes rating classifications within a group except those based on criteria solely and directly relevant to recognition of rating differences attributable to the marital status of a group's members and persons eligible for dependents' benefits*. As

soon as reasonably possible after the filing has been made, the commissioner shall in writing approve or disapprove it. Any filing shall be deemed approved unless disapproved within 30 days after receipt of such filing or supporting information connected therewith. In the event the commissioner disapproves a filing, the commissioner shall specify in what respect such filing does not meet the requirements of this section and shall state that a hearing will be granted within 20 days after receipt of such request in writing by such corporation.

(c) The commissioner may at any time after a hearing, of which not less than 20 days' written notice shall have been given, withdraw approval of any such subscription agreement or rate in the event the commissioner finds such filing no longer meets the requirements of the nonprofit medical and hospital service corporation act.

(d) All rates, filed pursuant to this section, shall be made in accordance with the following provisions:

(1) Due consideration shall be given to (A) past and prospective loss experience; (B) past and prospective expenses; (C) adequate contingency reserves; (D) the provisions of contracts between such corporation and participating physicians and hospitals; and (E) all other relevant factors within and without the state;

(2) risks may be grouped by classifications for the establishment of rates for individual subscription agreements or for group subscription agreements; and

(3) rates shall be reasonable, not excessive and not unfairly discriminatory.; *and*

(4) ~~rates for group and blanket policies covering 25 or fewer members or member units shall be based on the aggregate loss and expense experience, contingency reserves and other factors required to be considered in making rates to which this act applies. Such rates shall apply equally to all members and member units of all groups comprised of 25 or fewer members insured in this state by the insurance company filing the rates on a per person or per family basis but may vary with the number of persons in a family or the primary occupation of the group's members or both.~~

rates for group and blanket policies covering 25 or fewer employees of an employer, and any rate under a contract issued to a trust or an association applicable to an employer of 25 or fewer employees, must be developed based upon the loss experience, expenses, reserves, and other factors of all such policies covering persons who reside in or are employed within this state by the insurance company filing the rates. Such rates may vary from an average or community rate per person only:

(a) with the number of persons in a family, and

(b) based on actuarially reasonable factors, a group's rates may be no higher than:

(i) in 1991, 150% of the average or community rate;

(ii) in 1992, 140% of the average or community rate;

(iii) in 1993, 130% of the average or community rate;

(iv) in 1994, 120% of the average or community rate; and

(v) thereafter, 110% of the average or community rate.

such rates may be implemented on the anniversary date or normal rate change date of the contract.

(e) Nothing in the nonprofit medical and hospital service corporation act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with the nonprofit medical and hospital service corporation act.

(f) Premiums shall be payable in cash and no subscription agree-

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ment issued by such corporation shall provide for any assessment or contingent premiums.

(g) Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 2 4. K.S.A. 1989 Supp. 40-19c07 and 40-2215 is are hereby repealed.

Sec. 3 5. This act shall take effect and be in force from and after January 1, 1991, and its publication in the statute book.

Section 4. K.S.A. 40-3210 is hereby amended to read as follows: 40-3210. Rates; health maintenance contracts. (a) Any health maintenance organization issued a certificate and otherwise in compliance with this act may enter into contracts in this state to provide an agreed upon set of health care services to enrollees or groups of enrollees in exchange for a prepaid per capita or prepaid aggregate fixed sum. ~~(b) The rates charged by any health maintenance organization to its enrollees shall not be unreasonable, inadequate or unfairly discriminatory. The commissioner may define by rule and regulation what constitutes unreasonable, inadequate or unfairly discriminatory rates and may require whatever information he deems necessary to determine that a rate or proposed rate meets the requirements of this subsection. (c) If a health maintenance organization desires to amend any contract with its enrolees or desires to change any rate charged therefore 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~~. (b) No contract shall be issued or delivered to any person in this state by a health maintenance organization, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the commissioner of insurance. (c) No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof. (d) The commissioner may, within 30 days after the filing of any such form, disapprove such form: if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. If the commissioner notifies the health maintenance organization which has filed any such form that it does not comply with the provisions of this section, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for disapproval and state that a hearing will be g d within 20 days after request in writing by the insurer.

Continued

(e)(1) Any filing of risk classifications, premium rates or rating formulae shall be approved by the commissioner unless the commissioner finds that such filing does not meet the requirements of this act or, establishes an unreasonable, excessive or unfairly discriminatory rate or discriminates against any individuals eligible for participation in a group, or establishes rating classifications within a group except those based on criteria solely and directly relevant to recognition of rating differences attributable to the marital status of a group's members and person eligible for dependents' benefits. As soon as reasonably possible after the filing has been made, the commissioner shall in writing approve or disapprove the filing. Any filing shall be deemed approved unless disapproved within 30 days after receipt of such filing or supporting information in connection therewith . In the event the commissioner disapproves a filing, the commissioner shall specify in what respect such filing does not meet the requirements of this section of the Kansas Statutes Annotated, and amendments thereto, and shall state that a hearing will be granted within 20 days after receipt of such request in writing by such corporation. (2) All rates, filed pursuant to this section, shall be made in accordance with the following provisions: (A) Due consideration shall be given to: (i) Past and prospective loss experience; (ii) past and prospective expenses; (iii) adequate contingency reserves; and (iv) all other relevant factors within and without the state; (B) risks may be grouped by classifications for the establishment of rates for individual, group or blanket policies; (C) rates shall be reasonable, not excessive and not unfairly discriminatory; and (D) rates for group and blanket policies covering 25 or fewer employees of an employer, and any rate under a contract issued to a trust or an association applicable to an employer of 25 or fewer employees, must be developed based upon the loss experience, expenses, reserves, and other factors of all such policies covering persons who reside in or are employed within this state by the insurance company filing the rates. Such rates may vary from an average or community rate per person only: (a) with the number of persons in a family, and (b) based on actuarially reasonable factors a group's rates may be no higher than: (i) in 1991, 150% the average or community rate; (ii) in 1992, 140% the average c community rate; (iii) in 1992, 130% the average or communi rate; (iv) in 1994, 120% the average or community rate; and

continued

(v) thereafter, 110% the average or community rate. such may be implemented on the anniversary date or normal rate change date of the contract. (3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act. (f) The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the health maintenance organization, withdraw approval of any such form or rate in the event the commissioner finds such filing no longer meets the requirements of this section. It shall be unlawful for the health maintenance organization to issue such form or use it or any rate in connection with any policy after the effective date of such withdrawal of approval. (g) Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

ment issued by such corporation shall provide for any assessment or contingent premiums.

(g) Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

~~Sec. 3 4.~~ ~~K.S.A. 1989 Supp. 40-19c07 and 40-2215 is are hereby repealed.~~

~~Sec. 3 5.~~ This act shall take effect and be in force from and after January 1, 1991, and its publication in the statute book.

5. K.S.A. 1989 Supp. 40-19c07 and 40-2215 and K.S.A. 40-3210 are hereby repealed.

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4-12

MEMORANDUM

TO : Senator Richard Bond
Chairman, Senate Financial Institutions and Insurance Committee

FROM : William W. Sneed
Legislative Counsel - HIAA

DATE : March 26, 1990

RE : House Bill 3012

Mr. Chairman and members of the Committee: my name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of American ("HIAA"). The HIAA is a health insurance trade association consisting of over 325 insurance companies that write over 85% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to House Bill 3012 and its potential effect within the health insurance marketplace in the State of Kansas.

The HIAA shares the concerns of the Kansas Legislature, employers, and consumers concerning the high cost of health care in the United States. Also, we share the concern over the problem the small employers have in obtaining and retaining reasonable health care benefits at an affordable price. As you are aware, insurance company premiums reflect the charges made by hospitals, health care practitioners, claims administration costs, premium tax, and, of course, hopefully a profit. However, we must point out that this is just the beginning of everyone's work in regard

Attachment 5
III
3/26/90

to addressing this problem. Any problem of this complexity must be handled deftly and with caution.

We also acknowledge the major concerns that Speaker Braden is attempting to address in House Bill 3012. However, we believe that the best approach the Kansas Legislature can take, and in essence, assure employers and consumers within the State of Kansas the best results, is that House Bill 3012 should be referred to an interim committee study.

House Bill 3012 will not lower overall health insurance premiums, but will in effect place additional regulations on health insurance companies. Insurance lives within a world of regulation, and my client is not opposed to regulations per se. However, we believe it is of utmost importance to point out to the Legislature situations in which additional regulation will not effect the ultimate goal addressed by the piece of legislation, and in many instances, the proposed regulation may in fact create more problems than the proposed piece of legislation will solve.

House Bill 3012 in effect will provide a mechanism where every employer will be able to file a complaint with the Kansas Insurance Department if they are dissatisfied with the initial bid for their new business, or every time there is a renewal. While this sounds good, in reality it will become an administrative nightmare for the Kansas Insurance Department, as well as insurance companies. Everyone is unhappy with rate increases.

We also contend that the bill would also require employers to subsidize other employers' health care costs.

Certainly this sounds like a reasonable objective and one found within the general principles of insurance of sharing the risk. However, this is not practical because of the following reasons.

A. Employers who have low risk occupations, a healthy working environment, safety programs, and/or wellness programs, could be faced with a situation of having no incentive to spend additional funds in order to effect their health care costs. In other words, many may find themselves in a situation of considering why they should spend money for those types of programs when their rates will be the same as everyone else's, or at least close enough not to warrant the additional expenditure of funds.

B. Additionally, urban resident costs could potentially be subsidized by rural residents. For example, medical costs are normally higher in urban areas and lower in rural areas. Why? Salaries, cost of living, etc. are different. With this proposal, all will pay the same. Thus, the natural differentials in costs would be abandoned and could potentially create a disparity within the marketplace.

C. This bill does not increase competition or availability. In its truest sense, all this bill really does is increase problems and requirements for insurance companies in order to do business in Kansas. In order to solve the problems attempted to be addressed in this bill, certain issues must be kept in consideration, and that includes competition and the ability to define potential losses so that a fair and equitable price can be established. Certainly, some companies will always be in Kansas

and attempt to market health insurance products. Thus, this bill certainly will have a dramatic effect on small and medium insurance companies to either stay within the market or enter the market. Again, when such a bill is prepared, it must be crafted so that, in addition to protecting and/or promoting the availability of the insurance, it must create an atmosphere which the companies can enter into with some certainty. We all are aware that there are too many companies leaving this line of business already, and as such we must move cautiously.

I have attached to this testimony a copy of the HIAA proposal. I believe the proposal is self-explanatory, but there are some highlights.

1. The program is a voluntary effort by my client to address many of the problems that the State of Kansas, and all states, are now faced with in the health insurance marketplace. As you can see by the date of the memorandum, this proposal was finally drafted after many months of work in February of 1990. Thus, this is not simply a reaction to the bill in front of you, but a demonstration of my client's long-standing commitment to meet problems head-on and to attempt to find voluntary solutions.

2. This proposal, although not complete, will go further than House Bill 3012. We believe that it was demonstrated during the joint hearings that the health care insurance availability is a complex problem, and although our proposal does not at this time address all of the problems, it does go further than House Bill 3012.

3. Finally, the types of programs that the HIAA enumerates within this proposal show our commitment to not only work on this problem, but to see that the appropriate laws and regulations are implemented.

Thus, on behalf of my client, we respectfully request that House Bill 3012 not be acted upon by this Committee, and that this Committee request that this bill, along with several other issues, be directed for an interim study. Since House Bill 3012 has an effective date of January 1, 1991, we believe that by allowing all of the interested parties to work on this project during the summer, we will be able to bring to the table a more comprehensive plan to the Kansas Legislature, and that the only true loss there might be is a pushing back of the effective date of the proposals of no more than an additional six months. We believe that these problems must be looked at quickly, but not in haste. Thus, we respectfully request your consideration of referring this bill to an interim study. I am available for discussion on this matter at your convenience.

Respectfully submitted,

William W. Sneed

FOR IMMEDIATE RELEASE

HIAA

Health Insurance Association of America

Contact: Don White
202/223-7782

Mr. Joe Peel

NEWS RELEASE

HEALTH INSURANCE INDUSTRY PROPOSES MAJOR REFORM OF SMALL EMPLOYER MARKET

Washington, D.C., February 26, 1990 -- Leaders of the country's major health insurance companies have approved a plan that would make health care coverage available to all small employers and help contain the cost of that coverage.

The plan, which represents a major reform of the small employer market, was adopted by the Board of Directors of the Health Insurance Association of America (HIAA) at its meeting last week. It is one part of an overall plan proposed by the industry to increase access to health care coverage for those Americans without it.

Dr. Louis W. Sullivan, Secretary of the Department of Health and Human Services, attended the meeting and applauded the Association's efforts to address the problems facing small employers in providing health insurance for their employees.

"The insurance industry has taken the lead in seeking to assure that small employers and their employees have access to health insurance coverage," said Carl J. Schramm, HIAA president. "This plan represents a fundamental change in the way our industry does business," he added.

Under the plan, employers with 25 or fewer employees who seek to purchase health insurance for their employees would not be

- more -

denied coverage even if one or more of their employees might otherwise be a high risk or uninsurable in today's market. Once insured, neither the group nor an individual in the group would be denied continued coverage because the group's or an individual's health deteriorates. Further, when an employer changes insurance companies or an employee changes jobs, individuals would generally not have to meet any new pre-existing condition restrictions. There also would be limits on how much the premium and annual premium increase could vary for similar groups. The plan calls for a system to be funded by the private sector through which high risk individuals could be reinsured.

The reinsurance system also would ensure that if for some reason an employer group was unable to obtain coverage, they could purchase basic coverage for 150 percent of the average premium for similar groups. Losses from the reinsurance system would be borne equitably by the health benefit market.

Legislation at the state and federal levels would be necessary to obtain market-wide compliance with the reforms, to allow the reinsurer to fund its losses, and to preempt state provider and benefit mandates.

Because rising health care costs have a direct impact on the small employer market and all aspects of insurance, the Board also adopted a report on health care cost containment that relies heavily on the increased development of managed care programs. Those programs include channelling patients to efficient providers; improving the productivity and efficiency of providers by identifying and encouraging providers to adopt appropriate and efficient methods for delivering care under specific circumstances; promoting the use of economic incentives for consumers to be cost conscious in making choices to utilize medical services and in selecting providers; and promoting efforts

- more -

to improve the general health status of the population through support for wellness programs, illness prevention activities and consumer education efforts.

There also were cost containment recommendations for government actions which include establishing policies that will encourage the development of managed care systems, and that will match supplies of medical resources with needs, changes to reduce the occurrence of malpractice and to reform the malpractice liability system, and activities related to data collection and analysis.

The recommendations on small employer market reform and cost containment will be incorporated into HIAA's four-point plan to increase access to health care coverage through a joint public/private approach.

HIAA is a trade association of 320 commercial insurance carriers who provide health insurance protection for approximately 90 million Americans.

# # #

HIAA

February 23, 1990

HEALTH INSURANCE ASSOCIATION OF AMERICA
PROPOSAL FOR FINANCING HEALTH CARE FOR AMERICANS

SUMMARY

I. The problem is complex because of the heterogeneous nature of the population without health insurance.

A. Thirty percent are below the federal poverty level; 30 percent are near poor, between 100 percent and 200 percent of the poverty level; and 40 percent are above 200 percent of the poverty level.

B. Eleven percent are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

II. HIAA proposes a four point plan:

A. Reform and expand Medicaid to cover all those below the federal poverty level, regardless of family structure, age or employment status.

1. Eliminate categorical restrictions.

2. Uncouple eligibility for Medicaid from eligibility for welfare cash payment.

3. Low-income individuals above the poverty level should be able to "buy into" an income-related package of primary and preventive care.

4. "Spend-down" program should be required in all states for the medically needy.

5. For those Medicaid-eligible people who are working, optional "buy-out" program should allow state to pay the employee share of employer group insurance and to provide transition coverage for those coming off Medicaid.

B. Allow insurers to offer more affordable coverage:

1. Extend ERISA preemption of state mandated benefits given to self-insured plans to insured employee plans.

2. Allow insurers to market lower-cost prototype plans.

C. Provide tax assistance to make private coverage more affordable.

1. Help small businesses afford coverage by allowing a 100 percent tax deduction for the self-employed as long as they provide equal coverage for their employees.

2. New tax subsidies should be targeted to financially vulnerable groups. Subsidies could be directed at: financially fragile employers, low income individuals offered employer sponsored coverage and low income individuals not offered employee sponsored coverage.

D. Guarantee availability of private health insurance:

1. For high risk groups, a private reinsurance mechanism should be established, with losses spread equitably through the private sector.

2. For uninsurable individual, state pools with losses financed by state general revenues or other broad-based funding should be established; if a state does not act, HHS should set up a pool in that state with losses paid with federal funds that HHS would otherwise spend in that state.

III. HIAA also believes that quality and cost of care are essential components of any health care financing proposal, and we encourage the creation of an environment that promotes low-cost insurance and managed care benefits, not subject to state mandates or other restrictions.

HIAA

Health Insurance Association of America

PROPOSAL FOR SMALL EMPLOYER MARKET REFORM

The Health Insurance Association of America has developed a fair and equitable proposal to assure that all small employers can avail themselves of relatively affordable health insurance coverage. The HIAA plan would:

1. guarantee that employers with fewer than twenty-five employees who seek to purchase health insurance for their employees will not be denied such health insurance coverage even if one or more employee might otherwise to either uninsurable or a high risk in today's world;

2. provide that once insured, neither the group nor an individual in the group may be denied continued coverage because the group's or the individual's health deteriorates;

3. limit the rate of year-to-year premium increases relative to other groups insured by the same carrier, and limit how much a carrier's overall rates can vary among similar groups;

4. permit medical underwriting only for the purpose of determining the level of risk, and thus anticipated health claims;

5. not deny coverage or apply new preexisting condition restrictions to a group changing insurance carriers or to an insured individual changing employers;

6. establish a privately funded and administered reinsurance mechanism through which insurers could reinsure high risk persons;

7. assure that any group would pay no more than 150 percent of the average cost of similar groups for basic coverage.

February 23, 1990

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

DRAFT

February 22, 1990

REINSURANCE AND SMALL EMPLOYER MARKET REFORM RECOMMENDATIONS

Approved by the HIAA Board of Directors
February 21, 1990

The reinsurance approach was developed by HIAA as part of a range of proposals to better meet the health coverage needs of the American public. Reinsurance and related market reforms are directed at making relatively affordable health coverage available on an ongoing basis to all small employers. Listed below are the specific precepts for market reform and reinsurance that the HIAA recommends for the small employer health benefits market. We emphasize that these market reforms should be pursued only in conjunction with a workable reinsurance structure. Elimination of any component of our recommendations weakens the proposed approach as a solution to current marketplace problems and may undermine the market's viability.

PRECEPTS FOR THE SMALL EMPLOYER HEALTH BENEFIT[1] MARKET

I. WHOLE GROUPS - Coverage would have to be available to entire employer groups. Neither employers nor small group carriers[2] may exclude from coverage individuals within a group because of their high expected health risk.

Rationale: Excluding individuals from coverage within an employer group due to their expected health risk: (a) acts to deny coverage to persons who need coverage the most and (b) may be contrary to the public's perception of group insurance.

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[1] The term "small employer health benefit" market is intended to be as inclusive as possible, encompassing any benefits administrator in the small case market (including: Commercial, Blues, HMO, METs, association groups, Taft Hartley plans, discretionary groups, and employment based individual coverage (applicability to individual policies is subject to further discussion). In addition, the intent would be to sweep in "insured," partially insured, and "self insured" variants of the above small employer market administrative entities). The Committee recommends that "small employer" be defined as an employer with 25 or fewer eligible (for example permanent) employees.

[2] We use the term "carrier" hereafter as a surrogate for the range of small employer health benefit entities described in footnote 1.

II. CONTINUITY OF COVERAGE - Once in the health system, persons should be allowed to maintain a continuous source of health coverage. Hence, when an employer changes plans or employee changes jobs, persons should not have to face a new set of preexisting condition limitations with the change in coverage. More specifically, persons who have satisfied all or part of their previous plan's preexisting condition clause may count this towards meeting the new plan's preexisting condition provisions.

However, for persons first entering the insurance system, preexisting condition limitations are an important element of benefit plan design. (This is necessary to encourage people to obtain coverage before they are sick.)

Rationale: Even for those individuals who in good faith have maintained their coverage, a change in jobs or an employer's change in carriers can lead to an unexpected absence of coverage (for their most costly conditions). Persons covered through the small case market are particularly apt to face recurring preexisting condition limitations due to (a) the frequency with which small employers change carriers and (b) the frequency with which employees in small firms change jobs.

III. RISK ASSESSMENT AND CLASSIFICATION - Individual medical underwriting should be retained as a device to establish rates and assess risk. In addition, carriers must be allowed to continue to establish rates based on customary factors such as geography, demographics, industry and plan design.

IV. RENEWABILITY OF COVERAGE - When the health risk of a group deteriorates, the group should be assured that coverage will be continued. Further, individuals within a group should be assured that they can continue coverage in the event that their own health deteriorates.[3] However, there are reasons unrelated to health risk that would permit a carrier to rescind or not renew coverage. These reasons include: fraud, material misrepresentation, failure to pay premiums, failure to meet group enrollment requirements (such as minimum participation) and the decision of a carrier to exit the market.

Rationale: Some have maintained that certain carriers may fail to renew coverage of a group or individual because their

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[3] These recommendations in no way suggest that an insurer would be obligated to continue coverage for persons once they cease to be part of a group (beyond complying with state continuation requirements for group policies and the federal COBRA requirements for employers with more than 20 employees).

health deteriorates. There have been reports of some small group competitors effectively cancelling certain small groups through extraordinarily large rate increases, particularly if the groups' claims experience is less than favorable. There is a perception that post claims underwriting (in the form of periodically reunderwriting and excluding certain individuals from coverage with the group) has left many unsuspecting individuals without coverage, however, the number of such cases, if any, is small. Employer groups and their employees should have the assurance that a carrier will continue to provide coverage regardless of claims experience.

V. RELATIVE PRICING LIMITS - There should be meaningful limits on the degree to which rates vary for groups that are similar with respect to their plan design, geography, demographic composition and industry.[4] The price of health coverage offered by the reinsurer in its role as the "insurer of last resort" would act as a price ceiling on what any small group would have to pay for basic benefits. Beyond this, there should be limits on: (a) the degree to which a carrier's rate levels vary for groups that are similar with respect to plan design, geography, demographic composition and industry: and (b) percentage increase in a carrier's renewal rate levels. More specifically, a carrier's highest rate level could not exceed some multiple of their lowest new issue rate level for groups that are similar with respect to their plan design, geography, demographic composition and industry. Renewal rate increases could not exceed the annual increase(s) in a carrier's lowest new business rate level(s) plus an additional specified percentage allowance over this amount.

VI. MARKET VIABILITY - Any reforms in the small employer health benefit market should help to ensure a viable private marketplace over the long term.

Rationale: It is recognized that if certain policy actions are not taken, the viability of the small employer health benefits marketplace will be called into question. However, overly simplistic policy interventions may themselves jeopardize the long term functioning of the marketplace. Therefore, any actions taken should promote and ensure private sector participation in the small employer health benefit market over the long term.

The precepts above are achievable with the establishment of a reinsurance mechanism which allows carriers to "reinsure" high risks in exchange for a reinsurance premium. Claims incurred by

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[4] HIAA will develop further specifications on appropriate and acceptable industry categories.

reinsured claims costs would be covered by the reinsurer. (This would encourage carriers to accept risks that they might not normally accept since they are protected by the marketplace at large from the costs of accumulating a disproportionate number of high risk cases.) The reinsurance mechanism would also assure that if for some reason a group was unable to obtain coverage, they could purchase basic coverage for 150% of the average premium for groups that are similar with respect to their geography, demographic characteristics and industry.[5] Private carriers would offer this coverage and the reinsurer would make group reinsurance available to these carriers. HIAA is refining more specific proposals to assure that both efficiency and access objectives are achieved. Aside from this function, however, reinsurance would generally be available for carriers to reinsure for the cost of high-risk individual employees and their dependents.

GENERAL REINSURANCE STRUCTURE

I. REINSURANCE AVAILABILITY AND PRICE - Carriers could cede to the reinsurer the costs of high risk individuals from small employer groups. In general, the HIAA recommends that for existing members of already insured groups, reinsurance availability should be limited. Furthermore, when an employer group switches carriers, the new carrier should not be granted more favorable reinsurance terms. This would assure a level playing field and avoid new incentives for churning. However, it will be important to allow carriers to reinsure new entrants to a group.

A. Carriers would be allowed to reinsure members of previously uninsured groups at a price of 150% of average market costs for similar individuals. Carriers could also reinsure previously uninsured individuals who are new entrants to existing (already covered) groups at 150%.

The 150% reinsurance price is to allow carriers to market affordable coverage to currently uninsured groups. However, to discourage gaming (e.g., existing groups reconfiguring as new groups) all reinsurance at 150% would require that carriers impose a 12 month restriction on coverage of pre-existing conditions.

B. For existing members of already insured groups, carriers could purchase reinsurance at 500% of average market costs for similar individuals.

C. Reinsurance of individuals (whether initially at 150% or 500%) would generally be on a three year basis. Initial placement of individuals from groups would be for three year periods. For new entrants to the group, reinsurance would be available for the remainder of the

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5 See footnote 4.

group's existing three year contract period. Existing members of the group that are not initially reinsured could not be subsequently reinsured until the group's third anniversary.

D. To help assure a level playing field and to preclude gaming, entities found to be "gaming" reinsurance rules (e.g., by swapping cases to gain earlier entry to or exit from reinsurance for individuals) would no longer be eligible for reinsurance. However, they would continue to be assessed for reinsurance losses based on their share of nonreinsured small case business.

II. INCENTIVES FOR EFFICIENCY IN REINSURING INDIVIDUALS

A. Arrangements for ceding costs of high risk individuals to the reinsurer should include incentives for effective and efficient management of claims costs. Carriers would be required to apply to reinsured cases their typical cost management techniques used for fully insured cases (such as high cost case management). Third party audits would be used to assure compliance with the requirements. Strong action could be taken against carriers failing to comply with these reinsurance requirements, including possible loss of the right to reinsure.

B. The reinsurance mechanism would make available:

- An option for preferential reinsurance prices if a carrier meets managed care performance requirements specified by the reinsurer.

- An option for lower reinsurance prices if a carrier chooses to share a portion of the risk for reinsured cases through copayments or deductibles. The lower price would reflect: 1) expected lower <u>total</u> claims costs for reinsured cases due to cost sharing incentives and 2) the reduced proportion of costs borne by the reinsurer.

- An option for carriers to cede 100% of the claims of reinsured individuals in exchange for an established reinsurance price.

Carriers would choose options for their entire book of small case business (i.e. they would not be allowed to select reinsurance options on a case-by-case basis.). This is to reduce the reinsurer's administrative costs and to prevent gaming.

III. FINANCING OF REINSURANCE LOSSES - Legislation should give the (private not-for-profit) reinsurer's governing Board of Directors[6] the authority to cover or offset reinsurer losses in the following way(s):

- First, all carriers in the small employer market would pay a contribution of up to 4% of total small case market premium.
- Losses above those funded by the first tier should be financed through a contribution across total (small and large employer) market premium and premium equivalent, not to exceed 1%.[7]
- If losses exceed a level which can be funded by the first and second tiers, broad-based public funding should be made available to cover these excess losses.

IV. LEGISLATIVE CONSTRUCT - HIAA will continue to pursue reinsurance and related small employer market reform at the state level (e.g., in California and Connecticut). This will include work with the NAIC on complex technical issues such as rating reforms. At the Federal level, HIAA will recommend legislation to give states authority, where needed to include all health benefit competitors in the reinsurance assessment base and to assure universal compliance with small employer market and rating reforms.

In addition, HIAA will continue to recommend legislation to obtain a federal preemption from state provider and benefit mandates.

VII. PHASE-IN - Any legislation pursuing the recommended reinsurance and small employer market reforms would need to include an appropriate phase-in period. HIAA will develop such phase-in recommendations.

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[6] The membership of the Board of Directors shall be composed of representatives of entities participating in the financing of losses, including: commercial insurance plans, nonprofit services plans and HMOs.

[7] The dollar ceiling for tier 1 and tier 2 are approximately equal. (One percent of total health insurance market premium is about equal to 4% of small case premium.)