Approved: 3-30-09
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:38 p.m. on February 17, 2009, in Room 784 of the Docking State Office Building.

Committee members: All members were present except Representative Siegfreid. excused.

Committee staff present:
Norm Furse, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Reed Holwegner, Kansas Legislative Research Department
Janet Grace, Committee Assistant

Conferees appearing before the Committee:
Linda Sheppard, Kansas Insurance Department (Attachments 5, 6)

Others attending:
See attached list.

Chairman Landwehr called the meeting to order.

Discussion and action on **HB 2287 - Health reimbursement arrangements**. Representative Crum provided an amendment for the committee to begin working the bill. The amendment encourages small businesses not offering health insurance the ability to contribute to the premium of an eligible individual health insurance plan for their employees. The bill will have a sunset clause on July 1, 2014. Representative Crum moved the motion to accept the amendment. Representative Morrison seconded the motion.

Discussion among the committee included terminology, sunset date rationale, not wanting to compromise the small employer market, deleting the portion on small group requirements and providing protection for small groups. Cindy Hermes from the Kansas Insurance Department was available to answer questions from the committee pertaining to insurance issues. Representative Crum closed on the amendment. The amendment passed.

Representative Ward provided the committee with an article from the *New York Times* (Attachment 1) describing how women pay more for their health insurance than men. This is a discrimination issue. Representative Ward made an amendment (addressing the discrimination issue) to **HB 2287** as a motion. Representative Flaharty seconded the motion. The committee discussed the amendment. There are several states looking at the issue of women paying more than men for health insurance.

The Kansas Insurance Department is not considering this concept in Kansas. The insurance rates are based on gender, age, morbidity, and expense tables. Statute does not allow unfair discrimination. Women's health costs are higher due to child bearing years being more costly than for mens health issues at that time. Concern that this bill may undermine the bill and insurance companies and their processes. The Insurance Department provided an actuary to answer other committee questions. He concurred that there are rate differences with age and gender particularly with women in their child bearing age. The insurance company already has checks and balances in place that coincide with this amendment's wording.

Representative Ward closed his amendment. There was a division vote called, 7 were in favor, 10 opposed. The motion failed.

Representative Schwab made the motion to pass the bill out favorably. There was not a second to the motion.

Representative Ward handed out articles that explain the four additional amendments he would like to propose to the committee. Some are legitimate, others are not. HealthNet and Anaheim Blue Cross were being sued for removing people from their insurance policy who filed substantial insurance claims, then show up on the Medicaid and Medicare roles. (Attachments 2, 3, 4) Amendment 3: The insurance carrier can only exercise their refusal if they fail to disclose a condition diagnosed by a physician. Representative Ward made a motion to accept the amendments. It was seconded by Representative Slattery. Three out of ten policies come under the jurisdiction of the Kansas Insurance Department. The others are divided between Medicare

and Medicaid. There are a lot of people in Kansas that rely on individual policies. There are very few individual policies rescinded in Kansas. Representative Crum spoke in opposition to the amendment, stating he believes there are already protections in place to not warrant the amendment.

Linda Sheppard discussed deductibles and groups. (Attachments 5, 6) The committee reviewed her handouts that discussed rates and how groups/individual policy increases.

Representative Schwab made a substitute motion to move **HB 2287** out favorably. Representative Otto seconded the motion. Division was called for the vote, 9 in favor, 8 opposed. The motion carried.

The hearing on **HB 2287** was closed.

HB 2259 - Health care act providing for a medicaid waiver to offer health opportunity accounts and a pilot premium assistance plan program for small employers. This bill was worked by the committee. Representative Crum made a motion to amend **HB 2259**, which strikes Section 2 in the bill. Representative Mast provided the seconded for the amendment motion. There was discussion on the reason Section 2 was pulled due to placing an unreasonable burden on Kansas Health Policy. The motion carried.

The discussion topics included HSA's, HOS, Medicaid, who pays the premiums, who subsidizes the account, and what happens to those that are below the poverty line.

Representative Crum made a motion to pass the bill as amended. Representative Mast seconded the motion. There was a division called on the vote, 8 were in favor, 8 opposed. Chairman Landwehr voted in favor of the motion to pass favorably as amended. The motion carried.

The next meeting is scheduled for February 25, 2009.

The meeting was adjourned at 2:45 p.m.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

HOUSE HEALTH & HUMAN SERVICES COMMITTEE

DATE: 2-17-09

NAME	REPRESENTING
Linda Sheppard	KID
Cindy Hermes	KID
Dan Morin	KS Medical Society
Deborah Stern	KHA
Effie Swanson	KHPA
Patrick Vogelsberg	Kearney and Assoc
Bill Sneed	AHIP
Julie Holmes	KID
Barbara Torkelson	KID.
Mark McCleaf	KID
Craig Van Aalst	KID
Bruce Witt	PHS
Berend Koops	Hein Law Firm
Laurel Forbes	VHG
Kerri Spielman	KAIA

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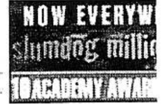
The New York Times



October 30, 2008

Women Buying Health Policies Pay a Penalty

By ROBERT PEAR

WASHINGTON — Striking new evidence has emerged of a widespread gap in the cost of health insurance, as women pay much more than men of the same age for individual insurance policies providing identical coverage, according to new data from insurance companies and online brokers.

Some insurance executives expressed surprise at the size and prevalence of the disparities, which can make a woman's insurance cost hundreds of dollars a year more than a man's. Women's advocacy groups have raised concerns about the differences, and members of Congress have begun to question the justification for them.

The new findings, which are not easily explained away, come amid anxiety about the declining economy. More and more people are shopping for individual health insurance policies because they have lost jobs that provided coverage. Politicians of both parties have offered proposals that would expand the role of the individual market, giving people tax credits or other assistance to buy coverage on their own.

"Women often fare worse than men in the individual insurance market," said Senator Max Baucus, Democrat of Montana and chairman of the Finance Committee.

Insurers say they have a sound reason for charging different premiums: Women ages 19 to 55 tend to cost more than men because they typically use more health care, especially in the childbearing years.

But women still pay more than men for insurance that does not cover maternity care. In the individual market, maternity coverage may be offered as an optional benefit, or rider, for a hefty additional premium.

Crystal D. Kilpatrick, a healthy 33-year-old real estate agent in Austin, Tex., said: "I've delayed having a baby because my insurance policy does not cover maternity care. If I have a baby, I'll have to pay at least $8,000 out of pocket."

In general, insurers say, they charge women more than men of the same age because claims experience shows that women use more health care services. They are more likely to visit doctors, to get regular checkups, to take prescription medications and to have certain chronic illnesses.

Marcia D. Greenberger, co-president of the National Women's Law Center, an advocacy group that has examined hundreds of individual policies, said: "The wide variation in premiums could not possibly be justified by actuarial principles. We should not tolerate women having to pay more for health insurance, just as we do not tolerate the practice of using race as a factor in setting rates."

Without substantial changes in the individual market, Ms. Greenberger said, tax credits for the purchase of insurance will be worth less to women because they face higher premiums.

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The disparities are evident in premiums charged by major insurers like Humana, UnitedHealth, Aetna and Anthem, a unit of WellPoint; in prices quoted by eHealth, a leading online source of health insurance; and in rate tables published by state high-risk pools, which offer coverage to people who cannot obtain private insurance.

Humana, for example, says its Portrait plan offers "ideal coverage for people who want benefits like those provided by big employers." For a Portrait plan with a $2,500 deductible, a 30-year-old woman pays 31 percent more than a man of the same age in Denver or Chicago and 32 percent more in Tallahassee, Fla.

In Columbus, Ohio, a 30-year-old woman pays 49 percent more than a man of the same age for Anthem's Blue Access Economy plan. The woman's monthly premium is $92.87, while a man pays $62.30. At age 40, the gap is somewhat smaller, with Anthem charging women 38 percent more than men for that policy.

Todd A. Siesky, a spokesman for WellPoint, declined to comment on the Anthem rates.

Thomas T. Noland Jr., a senior vice president of Humana, said: "Premiums for our individual health insurance plans reflect claims experience — the use of medical services — which varies by gender and age. Females use more medical services than males, and this difference is most pronounced in young adults."

In addition, Mr. Noland said, "Bearing children increases other health risks later in life, such as urinary incontinence, which may require treatment with medication or surgery."

Most state insurance pools, for high-risk individuals, also use sex as a factor in setting rates.

Thus, for example, in Dallas or Houston, women ages 25 to 29 pay 39 percent more than men of the same age when they buy coverage from the Texas Health Insurance Risk Pool.

In Nebraska, a 35-year-old woman pays 32 percent more than a man of the same age for coverage from the state insurance pool.

Representative Xavier Becerra, Democrat of California, said that "if men could have kids," such disparities would probably not exist.

Elizabeth J. Leif, a health insurance actuary in Denver who helps calculate rates for Nebraska and other states, said: "Under the age of 55, women tend to be higher utilizers of health care than men. I am more conscious of my health than my husband, who will avoid going to the doctor at all costs."

"Many state insurance laws require insurance policies to cover complications of pregnancy, even if they do not cover maternity care," Ms. Leif said. Insurers say those complications generate significant costs.

Representative Lloyd Doggett, Democrat of Texas, asked, "How can insurers in the individual market claim to meet the needs of women if maternity coverage is so difficult to get, so inadequate and expensive?"

Cecil D. Bykerk, president of the Society of Actuaries, a professional organization, said that if male and female premiums were equalized, women would pay less but "rates for men would go up."

Mr. Bykerk, a former executive vice president of Mutual of Omaha, said, "If maternity care is included as a benefit, it drives up rates for everybody, making the whole policy less affordable."

The individual insurance market is notoriously unstable. Adults often find it difficult or impossible to get

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affordable coverage in this market. In most states, insurers can charge higher premiums or deny coverage to people with health problems.

In job-based coverage, civil rights laws prohibit sex discrimination. The Equal Employment Opportunity Commission says employers cannot charge higher premiums to women than to men for the same benefits, even if women as a class are more expensive. Some states, including Maine, Montana and New York, have also prohibited sex-based rates in the individual insurance market.

Mila Kofman, the insurance superintendent in Maine, said: "There's a strong public policy reason to prohibit gender-based rates. Only women can bear children. There's an expense to that. But having babies benefits communities and society as a whole. Women should not have to bear the entire expense."

And that expense can be substantial.

In Iowa, a 30-year-old woman pays $49 a month more than a man of the same age for one of Wellmark's Select Enhanced plans. Her premium, at $151, is 48 percent higher than the man's.

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Big jump in Blue Cross premiums sparks outrage

Victoria Colliver, Chronicle Staff Writer
Wednesday, February 11, 2009

(02-10) 19:16 PST --

Anthem Blue Cross, which plans to raise premiums for about four-fifths of the health insurer's individual policyholders effective March 1, has outraged members, many of whom have been hit with price increases of more than 30 percent.

San Francisco resident and cafe owner Jesse Fink, who has had Blue Cross coverage for at least 30 years, has gotten used to regular premium increases. But he wasn't prepared for a letter telling him the cost to cover himself and his family would jump by 31 percent on March 1.

"How could they just charge a 31 percent increase?" said Fink, 55, who already has raised his annual deductibles from $2,500 to $5,000 per family member. He said his 23-year-old son, who is on a separate policy, got a 40 percent increase.

"This is pushing the need for health care reform," he said. "When someone gets, God forbid, cancer or something, are we supposed to go broke?"

Anthem Blue Cross, formerly Blue Cross of California, covers about 800,000 individual policyholders in California, more individual members than any other insurer in the state. Individual policies are typically purchased by people who do not have access to a group policy through an employer.

Anthem officials confirmed the company will raise rates March 1 for about 80 percent of its individual members.

Higher costs blamed

In a statement, the insurer blamed the increase in health costs for the higher premiums, in particular "the increasing need for medical services, the use of new, expensive prescription drugs and advanced technologies."

"We have seen double-digit premium increases. This year seems higher, and there's a large block, a majority, who are seeing double-digit increases, and some are clearly higher than others," said Anthem Blue Cross spokesman Ben Singer. Singer said some plans have been repriced. "The new rates reflect both the current medical costs that that product has seen with individual members, as

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well as projections," he said, adding that members also may see increases due to their age.

The insurer's response did little to assuage customers like Alla Marinow, a Berkeley resident and small-business owner who received a 31 percent premium increase for herself and her husband. Coverage will cost the couple $855 a month starting March 1.

Marinow, 57, filed a grievance and has asked Anthem Blue Cross' chief financial officer for a detailed financial explanation of the increase. "We'll see what happens. I'll probably get nothing, but it makes me feel better," she said.

Marinow, who is working with a broker to find more affordable health coverage, was already told by a Blue Shield of California representative that she would not be considered because she has a pacemaker.

More than the mortgage

Once the premium increase takes effect, Mary McNamara, 55, of San Rafael figured she and her husband will be paying more for health insurance each month than they do in mortgage payments for their home.

"We are absolutely trapped in this plan," said McNamara, who will be paying about $1,200 a month for coverage.

Kevin Blakeman, 53, of Campbell, received a letter telling him his premiums would increase to $345 a month, a 43 percent hike.

"I find it quite ironic that in the second paragraph it says, 'We know that lowering health care costs is important to you,' " he said.

The number to call

Anthem Blue Cross members concerned about upcoming premium increases are advised to call the toll-free number on the back of their membership card to reach a customer service representative. Licensed health plan advisers are available to discuss other plan options.

Company officials acknowledged receiving higher-than-expected call volumes this week and said customer service representatives have been added to handle the calls. The call center is open 8 a.m. to 7 p.m., Monday through Friday.

Source: Anthem Blue Cross.

E-mail Victoria Colliver at vcolliver@sfchronicle.com.

http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/02/11/BU2F15I06K.DTL

This article appeared on page **C - 1** of the San Francisco Chronicle

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Los Angeles Times

http://www.latimes.com/business/la-fi-bluecross11-2009feb11,0,5019817.story

From the Los Angeles Times

HEALTHCARE

Anthem Blue Cross agrees to take back clients, pay $1-million fine

As part of a deal with California regulators, the state's largest health insurer will offer new coverage to 2,330 people it dropped after they submitted bills for expensive medical care.

By Lisa Girion

February 11, 2009

Anthem Blue Cross, the state's largest for-profit health insurer, has agreed to pay a $1-million fine and offer new coverage -- no questions asked -- to 2,330 people it dropped after they submitted bills for expensive medical care.

As part of a deal that the California Department of Insurance is set to announce today, Anthem also will offer to reimburse those people for medical expenses that they paid out of pocket after they were dropped. The company, a subsidiary of Indianapolis-based WellPoint Inc., estimated that those reimbursements could reach $14 million.

In exchange, the state agreed to drop its prosecution of its accusation that the company broke state laws in the way it rescinded members in preferred provider organization (PPO) policies between 2004 and 2008.

The settlement follows Anthem's agreement last year to pay a $10-million fine to settle similar charges involving 1,770 members in HMO-type policies overseen by the Department of Managed Health Care, another state regulator.

In both cases, Anthem agreed to make substantial changes in the way it sells and manages individual insurance coverage in California. Those changes, which include simplifying coverage applications, are expected to reduce the number of people who lose coverage through rescission.

The Anthem deal is the latest in a two-year effort by regulators to crack down on health insurers for dropping sick members on dubious grounds. It brings the last state rescission investigation to a close.

But insurers Anthem, Blue Shield of California and Health Net Inc. all remain targets of individual and class-action lawsuits alleging that they gamed insurance laws to dump sick people and avoid the costs of their care.

The only case to go to trial so far involved Health Net's rescission of a woman suffering from breast cancer. In that case, an arbitration judge awarded $9 million to Patsy Bates, a Gardena hair salon owner, after hearing her recount the fear she felt when she lost insurance and had to stop chemotherapy treatments.

"I am pleased that through this settlement, we have guaranteed reimbursement and restoration of coverage for the more than 2,300 people whose healthcare insurance was terminated without their consent," state Insurance Commissioner Steve Poizner said about the Anthem deal. "The settlement is a significant step towards ending rescission practices that can devastate consumers already weakened in their battle against illness."

Leslie A. Margolin, president of Anthem Blue Cross Life, the unit involved in the deal, said she too was pleased.

Margolin said the company would be contacting consumers over the course of the next 90 days and sending them information on how to participate in this settlement.

"Under the terms of the settlement, Anthem Blue Cross Life will invite these consumers to purchase coverage on a go-forward basis, regardless of past or present medical conditions," she said. "Additionally, these consumers will be eligible to receive reimbursement of prior out-of-pocket medical expenses."

Under the deals with regulators, rescinded patients can accept new coverage without forfeiting any legal rights. But they must waive their right to sue insurers in order to make claims for out-of-pocket medical expenses.

Critics say medical expenses often are only the beginning of the losses. In some cases, they say, patients were unable to get care because they couldn't pay for it, causing health conditions to worsen. In others, mounting medical bills damaged their credit and led to financial calamity.

Then there are the less tangible consequences. Bates, for instance, was awarded about $700,000 for pain and suffering.

"You have to give everything else up just to get your medical bills paid," said William Shernoff, Bates' lawyer. "I'm all for getting medical bills paid, but this is coercive. That's the real bad part of this settlement and the other ones too."

Jerry Flanagan, a patient advocate with Consumer Watchdog in Santa Monica, said Anthem's $1-million fine was "an insult to the people of California, especially those who have lived under the financial destruction caused by rescission."

The fine, he said, pales in comparison to what Anthem must have saved by rescinding policies for years. Anthem has never said what costs it avoided through rescission. But Health Net, in documents produced for the Bates trial, said it avoided $35.5 million by canceling 1,600 policies.

"A low fine encourages the company to rescind more policies because the company saves far more money on the policies it does not get caught rescinding," Flanagan said.

Darrel Ng, a spokesman for Poizner, said the commissioner's top priorities were winning back coverage and medical reimbursements for rescinded patients. Another goal was to close the door on improper rescissions by persuading Anthem to agree to changes in the way it does business and the threshold it uses for dropping coverage.

The fine was a lower priority than the 2,330 people affected, Ng said. "In our mind it was more important to take care of these people who had their insurance policies canceled than to continue negotiating for something that wouldn't directly help these people."

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Los Angeles Times

http://www.latimes.com/features/health/la-fi-settle12-2009feb12,0,2086863.story
From the Los Angeles Times
INSURANCE

Health Net agrees to settle rescission lawsuits

The Woodland Hills insurer will pay as much as $14 million to close the books on litigation over the canceling of health policies.
By Lisa Girion

February 12, 2009

Woodland Hills insurer Health Net has agreed to pay as much as $14 million to settle a pair of lawsuits brought on behalf of 800 former policyholders whose coverage was dropped after they submitted substantial medical bills.

Under the deal, which won preliminary court approval Wednesday, individuals whose health insurance policies were canceled since 2004 are eligible for payments of up to $218,000. The average payment is expected to be $7,836.

The settlement would resolve a class-action lawsuit filed by Claremont lawyer William Shernoff, as well as a suit filed by Los Angeles City Atty. Rocky Delgadillo.

In addition to the payments to customers, it requires Health Net to pay a fine of $2 million to the city attorney and to contribute $500,000 to charities. Shernoff's firm will earn $2.1 million.

It follows a two-year crackdown by state regulators on the widespread and controversial practice known as rescission. In deals with regulators, insurance providers Health Net, Anthem Blue Cross and Blue Shield all have agreed to make substantial changes in the way they sell individual coverage in an effort to reduce the number of rescissions.

In all, Health Net has agreed to pay more than $40 million to resolve the regulatory actions and litigation over rescission.

Health Net is the only company that has been forced to defend rescission at trial. Nearly a year ago, an arbitration judge awarded $9 million to Patsy Bates, a Gardena hair salon owner whose coverage Health Net dropped after she was diagnosed with breast cancer. The rescission forced her to suspend her chemotherapy treatments for several months.

That was one of 1,600 rescissions that helped Health Net save $35.5 million over several years, according to trial documents. The trial also revealed that Health Net paid bonuses to an employee based in part on how many rescissions she carried out.

Health Net stopped those bonuses and, under the settlement, agreed not to reinstate them.

"This case proved that no matter how much money these organizations make, they are not above the law," said Invia Betjoseph, a San Jose family therapist who served as the lead class member in the suit against Health Net.

Betjoseph was left with about $8,000 in medical bills and went for more than a year without health insurance when Health Net rescinded his coverage three years ago. He said Health Net accused him of lying on his application for coverage.

Specifically, he said, Health Net alleged that he knew beforehand, but didn't divulge in his application, that he had a benign mass, which he had surgically removed shortly after his policy took effect.

But Betjoseph said doctors didn't discover the mass until after he had signed up with Health Net. His doctor wrote Health Net a letter in an effort to get his coverage restored.

"It said, 'Mr. Betjoseph didn't know about the mass because I, his surgeon, didn't know,' " Betjoseph said.

The letter apparently was ignored, he said: "You work hard all your life, follow the rules and do the right thing, and, when you need them, they abandon you."

Health Net said it was simplifying its coverage application and would do a better job of checking applicants' health history in the future. It also said it was committed to broad-based insurance reforms that would end the practice of rescissions.

"Health Net believes all Americans should have access to high-quality and affordable healthcare," it said in a statement. "To that end, we have been working with our regulators and the Legislature to reform the entire system in support of guaranteed issue and an individual mandate, which would make rescissions obsolete."

Health Net's class-action settlement is the first of its kind. Shernoff, the lawyer representing rescinded policyholders, said it was unusual in that it makes payments to class members without requiring them to submit claims.

Typically, he said, class-action settlements that require claims result in a very small number of actual payouts. He said class members would have the option of forfeiting the payout and filing a suit on their own.

Anthem and Blue Shield also face class-action suits alleging they gamed state insurance laws so they could cancel people's coverage after they got sick and thereby avoid paying their medical expenses.

Delgadillo also has enforcement actions pending against the other insurers and said he hoped the Health Net settlement would "serve as a model for other companies which stand accused of engaging in unlawful rescission practices."

The Health Net agreement includes provisions that parallel earlier settlements with regulators, including an offer to extend coverage to the affected consumers without regard to preexisting conditions.

It also requires Health Net to reimburse medical expenses paid out of pocket by former policyholders after they were rescinded.

In addition, Health Net agreed to extend its self-imposed moratorium on rescissions until lawmakers or regulators establish standards for them -- or until the company establishes a third-party review process that is acceptable to the judge overseeing the case.

lisa.girion@latimes.com

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HEALTH AND HUMAN SERVICES
DATE: 02/17/09
ATTACHMENT: 4

From: Linda Sheppard
To: jill@jillquigley.com
Date: 2/16/2009 1:07 PM
Subject: HB 2287
Attachments: Linda Sheppard.vcf

Rep. Quigley, thank you for the opportunity to provide you with additional information regarding testimony presented with regard to HB 2287.

The three largest insurers who provide coverage in the small group market have advised us that they require participation of 75 to 90% for groups of 10 or less. We are not sure what the basis is for Mr. Day's comment referring to "75%/50%" as there is no Kansas statute or regulation that requires those numbers. The participation requirement is established by the insurance companies, at their discretion, depending on the number of people in the group.

Mr. Day has provided no information regarding the basis for his comments about the impact of the Missouri HRA legislation. However, please be advised that the Missouri legislation only permits the employer to pay for individual coverage that an employee already has in place BEFORE they become eligible for participation in their employer's health plan. Therefore, if an employee already has an individual policy and he goes to work for a small employer, the employer can contribute to that employee's premium for the policy he already has but this would not permit an employer to drop group coverage and then tell his employees to go out and get individual coverage. The language in HB 2287 is different from the Missouri language and does not contain the same limitation as the Missouri law. In addition, we have previously provided information to the Committee regarding the responses we have obtained from various other states expressing their similar concerns regarding the impact this type of legislation would have on the small group market.

Mr. Day states that young people are waiving employer sponsored insurance and going uninsured due to high premium rates. However, very affordable individual coverage for young people is already available in Kansas but has drawn very little interest.

We certainly understand the Legislature's interest in trying to find ways to provide coverage for as many individuals as possible. However, we reiterate our concerns that removing the young and/or healthy people, who can obtain affordable health coverage in the individual market, potentially leaves the remaining employees without coverage or with coverage that is cost prohibitive for the employer and/or the employees. In a report prepared by AHIP in 2005, the following premium rate information was presented:

* Nationwide, annual premiums averaged $2,268 for single coverage and $4,424 for a family plan in 2004. For single policies, annual premiums ranged from $1,170 for a person aged 18-24 to $4,185 for a person aged 60-64. For family policies, premiums ranged from $1,832 for policies covering only children under age 18 to $7,248 for families headed by a person aged 60-64.

If an employer were to choose to pay a dollar amount or percentage amount of the premiums for its employees this premium assistance would have a very different impact on the employees depending on their age, marital status, and number of dependents and those employees with higher premiums would then be left to pay the balance of the premium. For those individuals who already have health conditions, coverage in the individual market may not be available. It was suggested that those individuals could obtain coverage in the high risk pool. However, the premiums for coverage in the pool are significantly higher than those in the individual market. By statute the rates may be up to 150% greater than the rates in the private individual market but they are currently at 128%. Current rates for different age groups are provided below for your information. These rates are for a policy with a $1,500 deductible.

Child under the age of 17 - $237/month
25 year old male - $243/month
25 year old female - $691/month
40 year old male - $370/month
40 year old female - $568/month
60 year old male - $897/month
60 year old female - $829/month

Please let us know if we can provide you with additional information.

Linda

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DATE: 02/17/09
ATTACHMENT: 5

(6)

From: Linda Sheppard
To: Melissa Calderwood
Date: 2/13/2009 12:32 PM
Subject: Re: HB 2287
Attachments: Linda Sheppard.vcf

Melissa, I think there was some confusion yesterday during the hearing and it wasn't clear to us which question was being asked so we thought we would just provide you with a general explanation of how this would work for both small group insurance and individual insurance.

If a person in a small employer group has been healthy but subsequently gets diagnosed and treated for cancer, the premium rates for that small employer group would be affected by the claims that person incurs, along with everyone else in the group. Premium rates for small employer groups are determined by three factors, one of which is the total dollar amount of claims paid for the group. The total benefits paid by the insurance company for the individuals in that group, divided by the total amount of premium received from that group creates a "loss ratio" that is used to determine if a rate increase is necessary. Under Kansas law the rate increase caused by claims experience is capped at 15% annually, so that is the most that the rate would increase each year for that group, as it relates to claims experience. However, as you can see, the more healthy people in the group the better because their combined premium dollars help keep the loss ratio down, which subsequently keeps the claims experience rate increase down.

For individual coverage, if the policyholder gets diagnosed and treated for cancer, he or she cannot have his or her premium rates increased based solely on their claims alone. All policyholders covered by the same type of policy, which is referred to as a "book" or "block" of business, receive the same premium rate increase based on the claims experience of all the individuals participating in that book of business. The loss ratio for that entire book of business is used to determine the need for a premium rate increase. Therefore, the claims paid for the policyholder with cancer are pooled with the claims of every other policyholder in that book of business to determine the need for a premium rate increase. The individual policyholder with cancer won't have a premium rate increase as a "direct" result of his or her claims but will experience a rate increase because his or her claims will impact the loss ratio for that entire book of business along with the claims of everyone else in that book. If a book of business has a lot of healthy people in it, the rate increase will be less. But if that book has unhealthy people in it, the rates for everyone will go up.

Thank you for the opportunity to provide some additional information. I hope this helps but let me know if you have any other questions.

Linda

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