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2 BEFORE THE KANSAS INSURANCE DEPARTMENT

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4 PUBLIC HEARING RE:

5 HEALTH REFORM PROVISION

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11 TRANSCRIPT OF

12 PROCEEDINGS,

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14 .

15 beginning at 1:00 p.m. on the 14th day of March,

16 2011, at the Law Capitol Plaza Hotel, Maner

17 Conference Center, 1717 Southwest Topeka

18 Boulevard, in the City of Topeka, County of

19 Shawnee, and State of Kansas, before Lora J.

20 Appino, RPR-RMR, Certified Shorthand Reporter.

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1 APPEARANCES

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4 ON BEHALF OF THE INSURANCE DEPARTMENT:

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1                   COMMISSIONER PRAEGER: Good afternoon.  
2     It's just, what, a week away from spring, and as  
3     our headline in our paper this morning said,  
4     winter makes a last ditch-effort, but fortunately  
5     it's not sticking. It doesn't look too bad out  
6     there.

7                   Well, for those of you who don't know who I  
8     am, I am Sandy Praeger, the Kansas Insurance  
9     Commissioner, and I want to formally call to order  
10    this public fact-finding hearing that is being  
11    convened by the Kansas Insurance Department and  
12    really thank all of you for taking the time to be  
13    here.

14                  Let me introduce the folks that are here with  
15    me. Ken Abitz, who is the head of our Financial  
16    Surveillance Division; Zac Anshutz, who is our  
17    chief legal counsel; and Linda Sheppard, who is  
18    the head of our Accident and Health Licensing  
19    Division, but is also our in-house chief of our  
20    health implementation, the Affordable Care Act  
21    implementation team. So, Linda is really doing a  
22    lot of the heavy lifting on the various meetings  
23    and opportunities for getting public input that we  
24    are trying to create as we go through this  
25    process.



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1           So as you all know, under the provisions of  
2 the Affordable Care Act, beginning with the  
3 current 2011 plan year, the year we are in right  
4 now, insurance companies must meet a minimum loss  
5 ratio of 80 percent in the individual and the  
6 small group health insurance market. Health  
7 insurance that do not meet the standard in 2012  
8 will have to begin paying rebates or refunds back  
9 to their insureds.

10           And as the Insurance Commissioner for Kansas,  
11 I really am concerned about the impact of the new  
12 standard on insurance companies that are operating  
13 in Kansas and any potential disruption of the  
14 market as a whole. And ultimately, our duty is to  
15 protect the consumers, and ultimately market  
16 disruption affects consumers as well.

17           So on January 14th, 2011, this year, I issued  
18 a Notice of Hearing to solicit testimony about the  
19 potential for disruption in the individual market  
20 resulting from the implementation of the 80  
21 percent MLR standard, and that -- looking at the  
22 standard, not just for this year but going forward  
23 up until full implementation in 2014, the  
24 Affordable Care Act states that the medical loss  
25 calculation has three components: The



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1 reimbursements for medical services. So that's  
2 easy. You pay a doctor, you pay a hospital,  
3 that's medical service. The cost per activities  
4 that are envisioned to improve health care  
5 quality, and the cost of all other non claims  
6 costs, excluding taxes and fees, commonly referred  
7 to as the administrative cost of health care. So  
8 take out the taxes and fees and other -- and other  
9 non claims costs and that's the administrative  
10 side of the equation.

11 The National Association of Insurance  
12 Commissioners, NAIC, through the accident and  
13 health working group, which is part of the life  
14 and health -- or the life and health actuarial  
15 task force, which now is just the life task force  
16 - we have divided it into two separate working  
17 groups - spent hours meeting in person and through  
18 conference calls to develop a recommendation for  
19 the methodology to be used for the -- for the --  
20 for computing the MLR. And the recommendation was  
21 submitted to U.S. Department of Health and Human  
22 Services, and HHS issued its final regulation on  
23 MLR in December, largely based on the NAIC's  
24 recommendations. They made a few changes, but the  
25 law actually said the NAIC shall develop the



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1 methodology and the Secretary shall certify. So  
2 there wasn't a lot of latitude there.

3 So the specific issue that we are going to  
4 hear about today regards the impact of the minimum  
5 loss ratio standard on the Kansas health insurance  
6 market, and in particular the individual market.

7 The Secretary of HHS has established a  
8 process by which a state may request an adjustment  
9 to the MLR standard that is based on evidence that  
10 the application of the 80 percent MLR will  
11 destabilize the states' individual market. And I  
12 would just point out that last week the first  
13 waiver to a state was granted in the State of  
14 Maine, which, from an individual market  
15 standpoint, is very stressed. They have very few,  
16 very few carriers writing. So they received a  
17 waiver of 65 percent over three years. The first  
18 two years 65 percent, the third year they are  
19 going to have to justify if they stay at the 65  
20 percent.

21 So we will begin our public hearing process,  
22 and I just want to remind those that are  
23 testifying, speak directly into the microphone.  
24 Are you able to hear me okay? And then, yes, turn  
25 off cell phones, like this. You know, you take it



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1 out of your pocket or your purse and you push  
2 power end. It's embarrassing to be the one giving  
3 the instructions to do it and then have mine ring,  
4 which has happened to me.

5 Okay. I'll turn things over to Director of  
6 Accident and Health, Linda Sheppard.

7 MS. SHEPPARD: Good afternoon. Thank  
8 you, Commissioner.

9 My name is Linda Sheppard and I am Director  
10 of the Accident and Health Division and project  
11 manager for the Department's implementation of the  
12 Affordable Care Act.

13 As Commissioner Praeger stated, today's  
14 hearing is being held in order to focus on  
15 gathering testimony regarding the potential impact  
16 of the new 80 percent MLR requirement on the  
17 Kansas individual health insurance market.

18 In addition, although the HHS regulations  
19 currently limit the opportunity for a waiver or an  
20 adjustment to the MLR in the individual market, we  
21 are willing to accept testimony during this  
22 hearing regarding the potential impact of the new  
23 MLR standard on the small group market, as that  
24 information may be requested at some future date.

25 We ask the persons testifying and members of



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1 the public who may want to comment to please limit  
2 their comments only to those two issues. For this  
3 hearing, we will not entertain comments on the  
4 merits or problems with the federal legislation,  
5 whether the legislation will be around in the  
6 future, or anything other than the potential  
7 impact of the new MLR requirement on the stability  
8 of the Kansas health insurance market.

9 This is the procedure we will follow: As of  
10 right this moment, we have seven individuals who  
11 have previously requested an opportunity to  
12 testify today. This testimony is being recorded  
13 by the court reporter, whose name is Lora. Thank  
14 you, Lora. And the statements will be made under  
15 oath and all persons testifying will be sworn in  
16 by Lora. And when you -- when you come up to  
17 testify, if you have a business card that you can  
18 give to her, that would be great. Otherwise, if  
19 you would just spell your name for her when you  
20 come up, that will help her get it -- make sure  
21 she gets it properly in the record.

22 After each witness completes their testimony,  
23 the Commissioner may, at her discretion, ask  
24 questions of the witness or seek clarification of  
25 statements made during the testimony. This



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1 process will be completed with each subsequent  
2 witness.

3 Once all witnesses have completed their  
4 testimony, the hearing portion of the meeting will  
5 be closed and the meeting will be open to comments  
6 from the public. Members of the public commenting  
7 will not be sworn in. If you wish to be heard,  
8 you need to fill out a form, and I think each of  
9 you was given a form that you could fill out if  
10 you wanted to speak. And if you -- if you want to  
11 speak, just fill out the form and bring it up with  
12 you when you come up. If you need a form, let Bob  
13 know and he'll bring one for you, and just fill  
14 out the form and bring it up to the microphone  
15 with you when you come up to speak.

16 And to go ahead and begin, our first speaker  
17 this afternoon is Robert Richey.

18 ROBERT RICHEY,  
19 presented as a witness, was sworn and testified as  
20 follows:

21 MR. RICHEY: I'm Robert Richey, an  
22 independent agent from Wichita, Kansas, and -

23 COMMISSIONER PRAEGER: Do you want to  
24 pull the mic up just a little. Oh, you might  
25 actually check to make sure it's on. The other



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1 one. Yeah. There you go. There we go.

2 MR. RICHEY: I'm Robert Richey, an  
3 independent agent from Wichita, Kansas, and I'm  
4 here to talk about the impact that the insurance  
5 agent's commission being as part of the  
6 administrative fees may cause carriers that are  
7 trying to stay competitive and solvent to not be  
8 able to continue paying agents. They may try to do  
9 their business direct, maybe through a point and  
10 click system on the Internet, like you buy a  
11 travel ticket. And so I'm trying to bring to you  
12 a personal story that may be able to help you  
13 understand the role of an agent and why it's  
14 important to keep agents involved.

15 I insure a group in Halstead, Kansas, that  
16 back in March of 2007 had a employee's spouse that  
17 was diagnosed with cancer. This spouse was  
18 needing to get treatment, and the recommended  
19 treatment for her at that time was using a Gamma  
20 Knife treatment center up in Kansas City. Her  
21 carrier had declined the coverage for that  
22 treatment because they said at the time it was not  
23 considered proper treatment for her particular  
24 type of cancer; that she would need to go through  
25 a radical surgery rather than trying to use the



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1 Gamma Knife system.

2 They appealed that process and were again  
3 denied, and so then it went to a third party  
4 appeal. And this is -- this takes time to do  
5 those. So it was July of 2007 that they had  
6 applied to the State Insurance Commissioner's  
7 office through the third party appeal. That's the  
8 process that we have in place in Kansas. And the  
9 issue that they ran into was that their appeal was  
10 being delayed because there was not an available  
11 doctor in the State of Kansas to review her  
12 appeal. Under state law, they have to have a  
13 doctor in the State of Kansas certified to do the  
14 type of procedure that they are reviewing.

15 At that time they finally went to their  
16 employer. The employer contacted me and asked me  
17 for help with this claim situation. As their  
18 agent, immediately I contacted the carrier, found  
19 out the situation, contacted the Kansas Insurance  
20 Department and realized that under state law there  
21 was nowhere for this to go at the moment. So I  
22 contacted Catholic Charities in Wichita to see if  
23 they could help with the cost of this because we  
24 couldn't get insurance to go one way or the other  
25 at this point. We needed to go a different route.



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1 Catholic Charities had agreed to pay for the  
2 surgery if it could be done, and their medical  
3 director agreed that it would help their  
4 situation.

5 After the medical director reviewed the files  
6 that I was able to obtain, after getting the  
7 proper HIPAA authorization form and getting the  
8 medical records to them, they came back and said,  
9 no, we really don't think that we can help, but I  
10 have already accomplished one thing for this  
11 insured at this moment. It's no longer a matter  
12 of payment. We now have someone willing to pay  
13 for their services. So they are already feeling a  
14 little better knowing that someone cares, they are  
15 willing to pay for it.

16 Now, I went another step further. When I  
17 talked to the medical director at Catholic  
18 Charities or Via Christi where they have a Gamma  
19 Knife center, they recommend that I contact M.D.  
20 Anderson down in Houston to see if they could get  
21 this particular patient in for treatment using  
22 their proton beam accelerator. They have four of  
23 these in the United States, and it's something  
24 that they felt could possibly work under her  
25 circumstance with the information they had at the



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1 time.

2 So I sent those medical records down to M.D.  
3 Anderson, and this is all within the confines of  
4 about a two-week period from when I was contacted.  
5 They looked at it and said we need to have a new  
6 MRI to make sure that this cancer hasn't advanced  
7 and that it's something that we can do, but they  
8 contacted me back within 24 hours of me sending  
9 them the medical records. So it was very, very  
10 quick.

11 When I got the phone call back within two  
12 days after them reviewing the medical records and  
13 the new MRI that they had received, they said, no,  
14 there is nothing we can do for this patient. This  
15 patient needs to get in hospice care immediately.  
16 So I asked them, are you going to contact this  
17 patient or her doctor to let them know that there  
18 is nothing that could be done. They said, well,  
19 based on the HIPAA laws, we - we don't think that  
20 we have the ability to do that. She's not  
21 actually a patient of ours at the moment. So I  
22 had to make the phone call and tell them, you  
23 know, we have sent this to M.D. Anderson, there is  
24 nothing they can do.

25 When I did that, the patient then let me know



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1 that they had started coughing up blood the  
2 morning before. They knew it had gotten into  
3 their lungs, it was terminal. We got them on  
4 hospice immediately. The patient died just about  
5 two weeks later. So there was very little time  
6 after that, but we accomplished a second thing for  
7 this patient. Not only did we find funding  
8 available for them outside insurance, but we also  
9 got their files in front of the medical director  
10 at Via Christi and we got their files in front of  
11 M.D. Anderson, one of the best cancer centers in  
12 the United States. So they were also able to  
13 understand that someone also cared not just about  
14 paying for it, but cared to have the best medical  
15 minds look at their files, and there was nothing  
16 that could be done at this point.

17 This was all done because they had an agent.  
18 Without having an agent involved, it's going to be  
19 a point and click system and you're not going to  
20 get that. So I just wanted to share this story  
21 with you. This is why we need to keep agents  
22 involved. I did submit this in writing to the  
23 Department, as I wasn't sure I was going to be  
24 able to be here today. So you do have this in  
25 case you need it. Thank you.



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1 COMMISSIONER PRAEGER: Thank you, Robert.

2 Do you have any questions?

3 I think you make a very clear case for the  
4 value that the agent brings to the process and  
5 appreciate your good work.

6 MR. RICHEY: Thank you.

7 MS. SHEPPARD: Our next speaker this  
8 afternoon is Tom Bryan. Okay. Then Terry, that  
9 brings you up, Terry Dressman.

10 TERRY DRESSMAN,  
11 presented as a witness, was sworn and testified as  
12 follows:

13 MR. DRESSMAN: Good afternoon, folks. My  
14 name is Terry Dressman. I am the president of the  
15 Greater Kansas City Association of Health  
16 Underwriters. And like Robert, too, I'm an  
17 insurance agent. I do sell health insurance and  
18 my clients have relied upon that for over 20  
19 years.

20 His story is not unlike every one of the  
21 agents that I represent in Kansas City, which we  
22 have 200 active members. We represent over 1,200  
23 just on the Kansas side of the metropolitan area.  
24 I know that there is probably 4,000 here in the  
25 State of Kansas that are actively trying to

1 provide, you know, health insurance for the  
2 individuals here in Kansas.

3 The biggest problem that I see with this MLR,  
4 and having developed products back in the '80s,  
5 Sandy, I don't know if you know this, but my past  
6 life was I worked in insurance companies and  
7 worked in and consulting actuarial companies  
8 developing products trying to determine, you know,  
9 what the rates should be based upon meeting a loss  
10 ratio that we had to meet back in the '80s. So my  
11 job was, you know, in developing products was to  
12 file it with the state insurance departments and  
13 then, obviously, to try to maintain those blocks  
14 of business. So I'm rather -- I'm rather educated  
15 on the idea of what this MLR will do. And the  
16 insurance companies in January sent me some Dear  
17 John letters and said your commissions are now  
18 going to be cut in half, and those commissions are  
19 my livelihood. I don't have an extra job. I'm  
20 not selling Amway on the side. This is a  
21 full-time job. And the agents that I represent as  
22 the president there in Kansas City, they have the  
23 same exact M-O. And we have been working in this  
24 industry to improve the livelihoods of Kansans.  
25 And Rob Richey's story, and many that I can tell



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1 you that have already submitted, are the -- going  
2 beyond and above what you would normally expect an  
3 agent to do, but that's what we are paid to do.  
4 Our job is to make sure that these people get the  
5 services that they expect underneath their  
6 policies. And when you take and essentially pull  
7 a rug out from underneath that agent and say that,  
8 you know what, we are not going to be able to pay  
9 you anymore, because we are not independently  
10 wealthy people, we have -- we have a need to be  
11 able to choose what we can do in order to continue  
12 to survive as an agent. And this particular move  
13 was, in my opinion an insurance company's  
14 survival, too. Their underwriting has tightened  
15 up significantly, and so just writing an  
16 application today is no guarantee that they are  
17 going to be able to see a policy in a couple of  
18 weeks. If they can run a couple of marathons in a  
19 month, then they are going to be able to get a  
20 policy, but I have already written at least a  
21 dozen apps in the last six weeks and they have all  
22 been declined, declined because of medical  
23 history.

24 My objective in this particular meeting is to  
25 let you know that we have been harmed already and



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1 it's disrupted this market considerably and we are  
2 two years out. Am I empathizing for Blue Cross  
3 Blue Shield of Kansas? Absolutely not. I'm  
4 empathizing for the insurance agent. I'm here to  
5 try to provide the manpower, the people that are  
6 going to be able to educate the people out there  
7 in the State of Kansas that there are products  
8 that can help serve their needs, but they may be  
9 very expensive, because I had a symposium last  
10 Wednesday and in that symposium over in Kansas  
11 City we had 170 people attend and we provided  
12 evidence of what the Massachusetts connector is  
13 already charging. I'm a little bit older than  
14 most people, so my family with four people would  
15 be charged \$2,545 a month. I'm 55, folks, and  
16 that's a month. And if you make over 63,000, you  
17 don't get any subsidies in the State of  
18 Massachusetts. So that's a little bit of a tough  
19 nut to crack here in Kansas. You just generally  
20 don't have two -- two incomes that can meet the  
21 70-some thousand dollars.

22 And so what I'm trying to leave with this  
23 particular hearing is that the agents have already  
24 been harmed. Our incomes have been devastated and  
25 we are trying to -- we are trying to wade through



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1 these meetings in establishing this exchange for  
2 the benefit of Kansans, but, obviously, for our  
3 own livelihood. We are trying to provide a  
4 program that's going to help sustain the health  
5 care needs here for these people in the State of  
6 Kansas. And I do appreciate the opportunity to  
7 testify, Sandy.

8 COMMISSIONER PRAEGER: Thank you, Terry.  
9 Are you -- you say -- I mean, you are already  
10 hearing from some of the companies that - that  
11 you represent that they are -- and your colleagues  
12 that you work with are doing the same. Have you  
13 seen people move to another line of work in this  
14 really great job market?

15 MR. DRESSMAN: Last year we had 275  
16 people attend that symposium. This year we had  
17 170, and about 25 of those people were new  
18 members. And we have been -- I would say that we  
19 have already lost 10 percent of our employee base.  
20 They have already fled. And do I have that number  
21 exact? Well, 170 from 270 is a pretty telling  
22 story.

23 COMMISSIONER PRAEGER: You know, Terry,  
24 we asked -- when all of this was being discussed  
25 and I wanted to take some information back to our



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1 NAIC, could you just kind of run through the list  
2 of some -- we have heard the personal story from  
3 Robert, and you've talked a little bit about what  
4 you do, but just some of the additional services  
5 that go beyond just selling a product.

6 MR. DRESSMAN: And I appreciate this  
7 opportunity because, you know, typically we are in  
8 a small group market. So, Linda, this is really  
9 going to address more of the small group market  
10 than the individual market.

11 A lot of small employers -- the majority of  
12 my business is small employers, and the average  
13 size in the State of Kansas is probably six or  
14 seven lives.

15 You know, we actually help them with a lot of  
16 their human resources work. You know, they can't  
17 afford to farm it out. It's generally the owner  
18 of the company that's trying to wear three  
19 different hats. And our job is to make sure that  
20 they, you know, they educate their employees on  
21 what the benefits are to make sure that those  
22 employees are constantly served.

23 I carry a cell phone, it is on stun, and I  
24 don't want anybody to think that I'm inaccessible.  
25 People can call me on the weekends, they can talk



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1 to me, and I do have, I do have people call me and  
2 ask me, you know, how do we -- you know, how do we  
3 handle this particular issue? And there is a lot  
4 of hand-holding, because as I sit down with  
5 particular clients, I run into cases like the  
6 following: I had a gentleman who was working with  
7 a trucking company and he has been struggling to  
8 try to, you know, provide a benefit that, you  
9 know, is decent for his employees. We came in  
10 with a good company product and we sat down and we  
11 worked through every single employee on an  
12 individual basis and told them what their benefits  
13 were. Well, this gentleman is like 60 years of  
14 age, he comes in and he starts looking at these  
15 benefits. You know, there are several options, we  
16 picked one of the options for him, and he says, I  
17 really don't have a lot of money, and I can see  
18 his glasses are, you know, are taped in the  
19 middle. You know, he needs a new pair of glasses.  
20 We've got a vision plan in place. We've got a  
21 dental plan in place. I can see that his teeth  
22 are not coming together right. I'm talking about  
23 what we do as a whole. Before I left that  
24 meeting, I had him set up so that he could be in a  
25 new pair of glasses and a new set of dentures.



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1 And within about 35 days from getting that policy  
2 in place, those were in place. He said he hadn't  
3 had his glasses or his teeth changed since he got  
4 out of prison about eight years ago.

5 That's a commitment that we make as  
6 individuals to, you know, humble ourselves to  
7 their situation because we wear a lot of suits and  
8 ties, we can be rather intimidating, but for the  
9 most part it may be the only people that they see  
10 that comes in their house and talks about the very  
11 serious nature of incidents that they face on a  
12 livelihood.

13 The idea of going beyond and above, I have  
14 clients that don't get that service on a click and  
15 run basis. They come back to us and ask us, now,  
16 what did I get into here? If I went through  
17 another 20 stories, because I think I sent you  
18 five of them, and I ripped those off in about  
19 seven minutes, folks, because they are just coming  
20 off that quickly. You can run into these  
21 situations every single day.

22 And, you know, I actually went to KU and I  
23 taught graduate students over there. I taught  
24 math. You know, we had this gentleman come in on  
25 Wednesday and we talked about literacy levels in



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1 the State of -- in the State of Missouri, in the  
2 nation as a whole. You know, people are reading  
3 at about maybe a seventh or an eighth grade level.  
4 If you don't have somebody who knows on a  
5 face-to-face basis how to ask the questions to  
6 help them understand their policy, this could be a  
7 nightmare.

8 This plan in Kansas, to make it work, is  
9 going to need professionals on the ground who are  
10 pen ready to make this work. Thank you.

11 MS. SHEPPARD: Thank you, Terry. Scott  
12 Day? Scott, I don't think you were in the room  
13 when we said it. If you have a business card you  
14 could give to the court reporter and we'll make  
15 sure she gets your name included correctly. Thank  
16 you.

17 SCOTT DAY,  
18 presented as a witness, was sworn and testified as  
19 follows:

20 MR. DAY: My name is Scott Day. Some of  
21 you will recognize me. I advertise myself. I'm a  
22 board member of the Kansas Association of Health  
23 Underwriters serving as the treasurer, but I am  
24 not here testifying today on behalf of the Health  
25 Underwriters, I'm testifying on behalf of Day



1 Insurance Solutions. We are a health and life  
2 insurance agency located here in Topeka, Kansas.  
3 Okay?

4 Sandy, to answer an earlier question, I am  
5 currently working looking for another line of  
6 business. Okay? We do 95 percent health  
7 insurance. MLR, PPACA is not going to do anything  
8 to lower health insurance premiums. It just got a  
9 whole heck of a lot harder to sell health  
10 insurance, to keep small businesses into health  
11 insurance, to do all of that. It's gotten a whole  
12 lot harder.

13 And to second or reaffirm Terry Dressman's  
14 comments, our commissions are being cut. So I'm  
15 going to do just as much work, probably more due  
16 to health care reform, yet I'm paid less. Okay?  
17 I don't expect anybody to feel sorry for us. I  
18 don't feel sorry for us. This is what's dealt for  
19 us, this is where we're going. So I am looking  
20 for other lines of business. But health care  
21 reform always opens new opportunities. There is  
22 always something to do.

23 Day Insurance Solutions is going to do just  
24 fine under health care reform. I'm not worried a  
25 lick about it. I'm not going to be chasing



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1 promoting health insurance sales near like I was.  
2 We are shifting away from that. That's the  
3 reality of this scenario. We are moving as  
4 quickly away from health insurance sales as I  
5 possibly can.

6 And right now, today, small groups are  
7 dropping health insurance. Today they can't  
8 afford health insurance. I mean, we are  
9 struggling every day to keep them into health  
10 insurance. We are raising deductibles to \$5,000.  
11 We're carving out RX plans. We're doing everything  
12 we can to keep the small business owner insured.  
13 Yet, everything we are doing today is outlawed  
14 under this scenario. And then you take medical  
15 loss ratios, I mean, I have talked to a couple of  
16 my companies. They immediately cut commissions to  
17 try to meet the medical loss ratios. They  
18 couldn't do it before. I mean, services from  
19 insurance companies are being cut. I mean, no  
20 more fancy brochures showing how their plan works,  
21 no more sales marketing teams explaining the  
22 products to the agents. All that stuff is being  
23 cut. So the insurance industry is -- is under  
24 dire jeopardy.

25 Well, if all those services are being cut,



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1 who is doing the customer service on these plans  
2 in exchange? Who is going to do that? MLR rips  
3 away services, who is going to do that? Well, I'm  
4 going to tell you right now we also sell Medicare,  
5 and the average time for a Medicare client concern  
6 is about an hour and a half in our office. That's  
7 the average length of time to do customer service  
8 on one of our clients, on one. And why is it so  
9 difficult? Because they call their insurance  
10 company who has the med supp plan or the Medicare  
11 advantage plan, whatever it is. And it's always,  
12 oh, that's a problem on the Medicare side. So  
13 then you've got to call Medicare. I don't know if  
14 any of you have ever tried to call Medicare. It's  
15 45 minutes getting to the right department. And  
16 once you get there, then you're calling back your  
17 insurance company rep who just told you it's  
18 Medicare's fault and you're making that  
19 connection. That's how we handle Medicare  
20 customer service. It's a three-way call because  
21 one side says the other, and this is where this  
22 stuff is going.

23 You call a big insurance company today and  
24 you get Joe Snow insurance agent account rep. You  
25 call back the next time, it's somebody else. You



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1 never get the same -- you don't get the commitment  
2 to the customer service. So we see this stuff  
3 going to that model. It's going to be customer  
4 service is -- is not going to be provided. That's  
5 something that we do. We take care and protect  
6 our clients.

7 I mentioned small employer groups are  
8 dropping health insurance today, and everything we  
9 are trying to do to keep them in is going to be  
10 outlawed.

11 There is a new way that we are attacking this  
12 problem today, and some of this is -- even the  
13 broker world don't like some of the things that we  
14 are doing to keep employers insured, but you're  
15 going to see a new dawn and a new rise in products  
16 and it's coming in the form of limited plans.  
17 You're going to see surgical plans coming back.  
18 You're going to see plans that just address major  
19 need parts of the component, and they are going to  
20 be outside of this exchange world. So there is  
21 still going to be a product. I already see them.  
22 We are already installing them. You put in a  
23 limited plan that maybe has good surgical  
24 benefits, and you don't have chemo and you don't  
25 have this type of things provided in that plan.



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1 But you know what this reform does? I don't care.  
2 If somebody on that plan gets sick today and needs  
3 chemo, I've got a guaranteed issue PPACA plan.  
4 The PCIP, guaranteed issue, it's pretty  
5 affordable. You just stick them on there and they  
6 are covered. It's totally shifting the need for  
7 people to buy health insurance.

8 If it's all guaranteed issue, there is no  
9 need, and we already are seeing this. Employers  
10 are going to lower cost plans providing basic  
11 services and they have the umbrella of PCIP to  
12 cover their employees in case they really get  
13 sick, and that's how it's going to be under the  
14 exchange. And brokers will take care of  
15 themselves. We'll still make money helping  
16 people, it's just a different way to attack the  
17 problem. And MLR, PPACA has done all that. It's  
18 just -- employers still want to provide, they want  
19 to do the right thing, it's just nobody can afford  
20 it today, and it's really going to be unaffordable  
21 tomorrow. Thank you.

22 COMMISSIONER PRAEGER: Scott, could you  
23 -- since the waiver that we are, you know,  
24 potentially trying to gather information to  
25 potentially apply for really relates only to the



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1 individual market, can you -- what kind of  
2 experience have you had in your agency with  
3 companies that you write for selling an individual  
4 product? Have you seen the same kind of reduction  
5 in commissions?

6 MR. DAY: Underwriting has gotten a whole  
7 heck of a lot harder to place. Okay. Stuff that  
8 used to be ridered can no longer be ridered. So  
9 getting people onto health insurance has gotten a  
10 whole lot tougher. We just don't have the  
11 options.

12 The children piece, you know, we used to do a  
13 ton of writing children. We would pull them off  
14 expensive group plans and put them on a really  
15 affordable low-cost 40 to \$60 a month plans and we  
16 could save families tons of money. Well, that got  
17 taken away. I mean, carriers are not insuring  
18 children because of the guaranteed issue  
19 component. So we have seen those two big things.

20 We have seen a huge up-tick in the limited  
21 plans. People are looking at the high-risk pool,  
22 which is way too expensive. They have a six-month  
23 wait to go onto the PCIP plan, so they are taking  
24 some of these plans that aren't even considered  
25 major medical. They don't count against the six



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1 months PCIP waiting period, and they are running  
2 the game right now of I've got a surgery table.  
3 If I do get sick, I can go under the PCIP and pay  
4 the higher premium there later. So we are seeing  
5 a huge uptake in people gaming the system. They  
6 are taking the limited plans. We have the  
7 protection of PCIP after six months. We are just  
8 seeing a lot of that taking place in the  
9 individual market.

10 COMMISSIONER PRAEGER: And have you seen  
11 from the companies in the individual market,  
12 you're seeing the reduction in -- in commission as  
13 well?

14 MR. DAY: Yes. I mean, two of our -- we  
15 write three carriers heavily, and I'm not going to  
16 mention them by name, but one kept the commissions  
17 the same. They were pretty much lower than  
18 everybody else anyway, and then two of our other  
19 carriers have -- have -- one has knocked it 50  
20 percent, the other one is at least 40 percent off.  
21 They were our second and third -- I mean, it's a  
22 hit to us, but it's not -- to other producers who  
23 are million dollar producers of those companies,  
24 it would be devastating. I mean, to us, they were  
25 out second and third. We usually went to them



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1 because they had easier underwriting guides, stuff  
2 like that. You always had a place for a company.  
3 One company would write this and, you know, they  
4 would write this disease or this one wouldn't, so  
5 we always had this game where we are shifting back  
6 and forth between carriers trying to find the best  
7 fit.

8 But, no, we have seen the commission drops on  
9 that side. It's the small group market that I'm  
10 worried about, too. I mean, I think that one is  
11 in dire straits.

12 COMMISSIONER PRAEGER: And, of course,  
13 the waiver opportunity isn't there for the -- for  
14 the small group market, unfortunately.

15 MR. DAY: Yeah, and then we were also  
16 doing a lot of trying to shift small employers to  
17 individual insurance, and, you know, it would have  
18 been really nice if employers could contribute to  
19 individual policies, but we -- it's just gotten a  
20 whole lot harder to write some of this up, not  
21 perfectly healthy cases.

22 COMMISSIONER PRAEGER: Okay. Thank you.

23 MR. DAY: Thank you.

24 MS. SHEPPARD: Next speaker, Diane  
25 Thornton. No? Okay. Brenden Long? All right.



1 employees in the state, I want to express our  
2 appreciation again for the department, as well as  
3 Sandy and the staff, for giving us a chance to  
4 talk about this very important topic.

5 Coventry is a significant provider of health  
6 insurance in the state, and we currently provide  
7 insurance coverage to 230,000 Kansans, a little  
8 more than 12,000 individual members across the  
9 State of Kansas.

10 My comments will be brief. Coventry will  
11 follow with more detailed written testimony for  
12 the record. However, in my statement today, I  
13 want to leave the Department with three main  
14 points.

15 The first, Coventry supports the decision by  
16 the KID to apply for federal adjustment to the 80  
17 percent MLR requirement for the individual market.  
18 We also ask that the KID seek an orderly  
19 transition period until 2014. Our specific  
20 request is that we have a 65 percent MLR in 2011,  
21 and gradually and systematically increase that in  
22 subsequent years. Our recommendation is to go to  
23 70 percent in 2012 and 75 percent in 2013.

24 We believe this approach will provide the  
25 best conditions to allow carriers to make the



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1 necessary adjustments to their business and  
2 contracts, given the disconnect that we have today  
3 between the short time to comply with the new  
4 federal requirements issue -- and the rules issued  
5 in late 2010 and the longer lead time necessary to  
6 implement changes to our operations.

7 Most important, it will ensure a continued  
8 competitive environment and promote stable access  
9 by consumers to new and existing individual health  
10 plans.

11 Second point, without a federal adjustment,  
12 we believe there is a reasonable likelihood that  
13 the application of the 80 percent MLR requirement  
14 will destabilize the individual market in Kansas,  
15 some of which we have already heard about, which  
16 is the standard identified for granting an  
17 adjustment under Section 2718 of the Affordable  
18 Care Act and subsequent regulations from the U.S.  
19 Department of Health and Human Services.

20 As a relative newcomer to the individual  
21 market in Kansas, Coventry has a much newer block,  
22 compared to most established plans. As a result,  
23 our MLRs run today considerably below the 80  
24 percent mandate. Application of the 80 percent  
25 standard will result in unsustainable losses for



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1 Coventry's individual health plan business and  
2 raise major concerns about our ability to continue  
3 operating this segment of business in the State of  
4 Kansas.

5 The third point, our fellow Kansans will feel  
6 the ultimate harm if an adjustment is not  
7 provided. We've heard a little bit about this  
8 already. It will reduce the coverage choices  
9 available to the individuals and families who need  
10 to turn to the individual market for coverage  
11 before 2014. It will reduce the level of  
12 competition and lead to higher premiums, which  
13 will make coverage less affordable and potentially  
14 increase the number of uninsured.

15 It will harm our partners in the broker and  
16 producer community who are not able to continue  
17 playing a valuable role in assisting consumers to  
18 make the best plan choice for them.

19 Finally, it will cause carriers who are required  
20 to scale back their operations in this market  
21 space to reduce jobs.

22 Again, we encourage and support the decision  
23 by the KID to seek a federal adjustment and  
24 orderly transition to the 80 percent MLR standard  
25 to avoid a reasonable likelihood of market



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1 destabilization and subsequent harm to the  
2 residents of Kansas.  
3 Once again, I appreciate the opportunity to  
4 provide our comments and the efforts by the KID to  
5 ensure continued and stable access by Kansans to  
6 the individual health plan market. That's my  
7 official statement.

8 COMMISSIONER PRAEGER: Mike, would you  
9 clarify your comment about that you have a newer  
10 block of business and, therefore, you are below  
11 the -- would have trouble meeting the 80 percent?

12 MR. MURPHY: We have, in relative terms  
13 in the market, I'm not sure how all the different  
14 carriers rank in terms of volume, but ours as an  
15 individual block is relatively small, which means  
16 two things. One, it's much more volatile. MLRs  
17 jump all over the place. They can go from 50  
18 percent to 90 percent from one year to the next  
19 depending on what happens, particularly with large  
20 cases.

21 The other is there are people who actually  
22 depend on individual insurance as their primary  
23 insurance over a long period of time because they  
24 are in business for themselves or something of  
25 that nature, versus somebody just buying a gap

1 policy because they are between jobs or something  
2 like that.

3 So the larger your block, the more of those  
4 people who are more stable. And the longer  
5 somebody is in insurance coverage, typically the  
6 cost of caring for them goes up over time as we  
7 all age. So a larger block indicates that it's a  
8 larger portion of essentially long-term individual  
9 policyholders, but you're generally going to have  
10 a higher MLR as a group. Does that make sense?

11 COMMISSIONER PRAEGER: Yeah, it's sort of  
12 counter-intuitive. But if you have a younger,  
13 healthier group, for example, you might not be  
14 paying out as much in medical claims but your  
15 administrative costs are still there, making it  
16 more difficult to meet the -

17 MR. MURPHY: Right.

18 COMMISSIONER PRAEGER: -- MLR.

19 MR. MURPHY: Yeah. I don't -- I'm just  
20 reflecting what our block currently shows. We can  
21 certainly provide some factual  
22 actuarially-supported documentation to back that  
23 up.

24 I think one of the comments that was made  
25 earlier, which, to your point exactly, the

1 legislation as it's written is a little bit --  
2 does exactly the opposite of what we would like to  
3 see it do in some regards. Certainly we are  
4 looking for more coverage for more people and  
5 making it more affordable, but what happens is it  
6 takes the least costly premium plans essentially  
7 out of the market for like benefits.

8 As an example, if it costs us, to make the  
9 math simple, if it costs me \$50 a year to  
10 administer an insurance policy for an individual,  
11 which is less than \$5 a month, and you add that  
12 onto a policy that costs \$85, so you're charging  
13 them 120, if by raising the MLR we'll have to  
14 spend a bigger -- bigger percentage of those  
15 dollars delivering health care, there is not \$50  
16 left over to cover my costs. So in order to get  
17 to a percentage, it gives me the same \$50, the  
18 overall premium has to go up in price.

19 So what we're doing is we're eliminating the  
20 low-end low-cost premiums that most, whether  
21 you're a college student or somebody just looking  
22 for a catastrophic coverage or something of that  
23 nature, is willing to pay for or willing to -- and  
24 then they can afford and they want to be in the  
25 marketplace, those are essentially going to



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1 disappear. You may end up with some sort of  
2 specialty type plans that were talked about  
3 earlier, but they certainly don't provide the  
4 comprehensive coverage that people need to have  
5 and should have and prefer to have.

6 COMMISSIONER PRAEGER: Okay. Thank you.

7 MR. MURPHY: Thank you.

8 LOU SMITH,

9 presented as a witness, was sworn and testified as  
10 follows:

11 MR. SMITH: My name is Lou Smith. I'm an  
12 independent agent in Wichita, Kansas, with  
13 Harrington Health, and I'd like to add some  
14 comments to some of those made this morning -- or  
15 this afternoon already regarding some stories. I  
16 want to relate a story to you as it relates to the  
17 MLR.

18 If we recognize those of us in the business  
19 that MLRs are going to put pressure on agent's  
20 commission, reducing them, and indeed one  
21 commercial carrier, for example, has removed  
22 commissions entirely from employer groups from two  
23 employees up to 50. This particular large  
24 commercial carrier sent out notices to remove  
25 commissions entirely, and that's going to put

1 pressure on the involvement of the trusted agent  
2 or trusted advisor for many, many employers, and I  
3 want to relate a story to you that can perhaps put  
4 some flesh on that story. And all of us have  
5 these kinds of stories, by the way.

6 This story goes back about three years ago  
7 working with an employer group who had struggled  
8 over time with their rates clicking along at  
9 double digit increases every year. And they were  
10 debating the issue of should they pass along the  
11 cost to the employer group, should they raise  
12 deductibles, should they increase their  
13 out-of-pocket, should they reduce benefits, what  
14 could they do?

15 And so working with -- with our office, we  
16 put together an overall comprehensive plan to  
17 encourage their employees to take better health.  
18 Well, how do you do that? Well, one notion is to  
19 raise deductibles to force the employees to pay  
20 more out of their pocket, maybe be more careful  
21 perhaps in how they spend their dollars.

22 Another way might be to encourage employees  
23 to just simply take better care of themselves.  
24 What a novel thought. And indeed, in any -- all  
25 of this national health initiatives that we see

1 coming down the pike, there is really nothing in  
2 that to encourage us as consumers to take better  
3 care of our health. Because after all, health  
4 care costs are related to what expenses we incur  
5 as a result of our diseases and injuries.

6 This particular employer put together a plan  
7 to encourage their employees to not smoke. They  
8 put a premium differential in the first year for  
9 employees that smoked to encourage them not to  
10 smoke. They put a premium differential in to  
11 encourage their employees to have their wellness  
12 exams. Now, mind you, this was an employer who  
13 already had 100 percent coverage for wellness. A  
14 review of the data reflected less than 15 percent  
15 of their employees were taking advantage of that  
16 100 percent wellness. I'm talking about  
17 mammograms, pap smears, PSAs, the wellness exams  
18 for kids. Fifteen percent or less were taking  
19 advantage of that.

20 So how do you encourage, how do you ask  
21 employees to take full advantage of their health  
22 insurance and maybe forestall some unwanted health  
23 instances down the road? Well, they put an  
24 incentive in if you did not appear for a health  
25 fair annually, you and your spouse, you had to pay

1 a financial penalty if you did not appear. If you  
2 appeared, not only did you get all your blood work  
3 and lab work all covered at 100 percent, you get a  
4 full report back to you, the employee or spouse,  
5 to take to your physician and discuss with them.  
6 But if you did not appear, you had to pay a  
7 financial penalty to not appear and not take those  
8 tests.

9 The third thing they did was ask their  
10 employees to work with a lifestyle coach. What's  
11 a lifestyle coach? That's someone who is going to  
12 look over all this data and fill out a health  
13 questionnaire about their health history. It's  
14 called a health risk appraisal. And then the  
15 coach reviews this health risk appraisal and looks  
16 at things like do you smoke? What's your weight?  
17 What's your height? Do you wear a seat belt?  
18 What's your diet? Do you eat salads? Just basic  
19 dietary information, but also discuss your BMI.

20 This health coach would call you at home and  
21 ask you what do you want to work on to improve  
22 your health. Well, most of us, we already know  
23 what we need to work on for -- to improve our  
24 health, most of us already have a good idea. And  
25 so the coach would work with that individual to



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1 work with them in identifying some health need,  
2 and then through the course of maybe six or eight  
3 phone calls encourage them to do that. But -- so  
4 the employer put that incentive in place. So the  
5 smoking incentive, they go do the lab work, and do  
6 the health risk appraisal incentive, and also work  
7 with a health coach. They had three incentives.  
8 To do all that, it would take less than an hour a  
9 year, less than an hour. And you might expect the  
10 employer had a lot of noise. A lot of employees  
11 resisted that. Why are you asking -- why are you  
12 interfering with that. So the employer, for the  
13 first year, put that in effect.

14 The second year they did it again. They had  
15 a little bit more noise, but not quite as much,  
16 but we did it again for the second year.

17 Beginning on the third year, the manager of  
18 this particular employer wanted to make a  
19 presentation to all of his employees, very much in  
20 a room like this. He said, I want to tell you a  
21 story. He introduced the whole health fair  
22 discussion by this story and I want to relate it  
23 to you because it makes the point I think. He  
24 indicated that he embraced this whole program  
25 somewhat reluctantly because he did not understand



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1 why encouraging your employees to do these things  
2 might help lower their health care costs, but he  
3 did it anyway because he was a manager and he felt  
4 the need to support management's decision and did  
5 it.

6 And so the first year he had his PSA and it  
7 was, as I recall, it was like 2.6. The second  
8 year he had his PSA, and this gentleman is in his  
9 50 -- is 52 years old, as I recall, he had his PSA  
10 and it elevated to over five, his PSA. And so  
11 when he got his lab results back, he took that to  
12 his physician and the physician says, you know,  
13 it's more than doubled, it's something we ought to  
14 take a look at. They did a test on him and  
15 further tests and decided to do a biopsy. They  
16 found a very severe case of -- and I'm not  
17 familiar with all the types of prostate cancers,  
18 but this particular one was very aggressive, it  
19 grows very fast.

20 As a result of that, he was referred then out  
21 of state and had some prostate surgery, and he  
22 related this story to his employees that day. And  
23 you have to, I guess, value that someone is  
24 willing to stand up in front of their employees  
25 and tell this kind of story, personal story. But

1 he married late in life, in his mid to late  
2 thirties, and had some young children. As he  
3 related this story, he said had he not had those  
4 PSA exams, had he not done those tests, his doctor  
5 had told him that this particular type of  
6 aggressive cancer was such that it would have been  
7 asymptomatic. He wouldn't have had any symptoms  
8 until it would have been too late for him to be  
9 helped in any fashion.

10 He -- as he told the story, he began to cry  
11 and he said how valuable it was for him now to be  
12 around to see his daughter's marriage and  
13 graduation, his son's graduation from college, and  
14 he interspersed that story with that. But his  
15 point about that was were it not for that health  
16 fair that he reluctantly embraced, he would not  
17 have had that kind of story to relate to his  
18 employees. That year we had not one complaint  
19 from his employees about the health fair and the  
20 tests they had to go through.

21 And there are other stories, people who have  
22 lost weight, people who have quit smoking, all  
23 those kinds of stories. Now, all that grew out of  
24 the advice and counsel they received from their  
25 agent, their broker, because heretofore their

1 coverage, their insurance coverage covered 100  
2 percent of those services, but no one was taking  
3 advantage of it. So was it not for the counsel to  
4 put in incentives, you know how we consumers are,  
5 we don't do very much without hitting your  
6 pocketbook anyway, but were it not for those  
7 incentives, they would not have encouraged him to  
8 do what he did.

9 And by the way, that particular group has had  
10 two years of back-to-back now of zero percent  
11 change in their insurance premiums. Can I take  
12 responsibility for that? No. I wish I could, but  
13 I think it's more than coincidence that prior to  
14 the implementation of these programs they were  
15 suffering through double digit increases and now  
16 they've seen back-to-back zero changes in their  
17 health insurance premium.

18 So I relay that story to you to tell you that  
19 I think the role of the insurance agent working  
20 with employers is very, very valuable, and I  
21 think, as -- everything I read and hear coming  
22 down the road is going to damage that  
23 relationship. You have already heard testimony  
24 earlier about what impact that's going to have. I  
25 think it will damage that, and it's unfortunate

1 because I think more and more employers are going  
2 to be looking for financial relief through this to  
3 help lower their cost, and this is just one story  
4 that I think brings that home. Thank you.

5 COMMISSIONER PRAEGER: Thank you.

6 MS. SHEPPARD: Do we have anyone else?  
7 And I'll give you your option. Do you just want  
8 to make public comment or do you actually want to  
9 it have it on the record?

10 MS. OCHSNER: Oh, I can just make a  
11 comment.

12 MS. SHEPPARD: Okay.

13 MS. OCHSNER: I'm Gina Ochsner from  
14 Century Health Solutions -

15 MS. SHEPPARD: Oh, you're certainly  
16 welcome to come up.

17 MS. OCHSNER: Oh, okay.

18 MS. SHEPPARD: Yeah. We'll go ahead and  
19 close the formal portion of the hearing, unless  
20 there is someone else who wants to talk.

21 MS. OCHSNER: Gina Ochsner with Century  
22 Health Solutions. We are a company here in  
23 Topeka, and we do have two separate divisions of  
24 our company. Of course, one is our independent  
25 insurance agency, and so I certainly concur with

1 all the comments here today regarding declining  
2 commissions and the impact to the agent/broker  
3 community.

4 The other side of our business, however, is  
5 also being impacted by the MRL (sic) that is not  
6 being discussed a lot, and that's the opportunity  
7 to maintain provider networks. Many carriers, of  
8 course, own and operate and maintain their own  
9 provider networks, but I think I can speak for  
10 them as well. That administrative cost component  
11 is being reduced, as well as other administrative  
12 areas.

13 There are also companies that contract  
14 directly to someone like Century. We are an  
15 independent PPO and we are available for lease and  
16 contract with many insurance companies. So, in  
17 essence, we work in partnership with them to  
18 provide a local comprehensive provider network  
19 when they are not in the business of doing that  
20 provider contracting themselves.

21 Regarding the individual market specifically,  
22 you know, I do think back to a number of years ago  
23 where we maybe had a handful of individual  
24 carriers who used our provider network. Today we  
25 have one. I think it's a fairly strong carrier,



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1 but they already contacted me months ago and  
2 basically said that they are slashing their  
3 provider network relationships throughout the  
4 country. Kansas specifically was a target. And  
5 unless I was able to renegotiate our network fees,  
6 that they would no longer be able to use our  
7 provider network and may have to consider  
8 withdrawing from this service area. So, of  
9 course, this is an important carrier in the  
10 market. I think it's important to the consumers  
11 in this area. They are certainly an important  
12 carrier to our livelihood, so we did renegotiate  
13 our network access fees. We are probably now  
14 providing services to them at a loss, but that was  
15 necessary on their behalf to meet the new  
16 requirements of the MLR.

17 And likewise, again, the carriers who also  
18 maintain and operate their own networks. I have  
19 talked with many of them. You know, they are  
20 cutting their staff in network contracting, they  
21 are cutting their staff in provider relations.  
22 And I think that not only will consumers be hurt  
23 by those efforts, but there is also the provider  
24 industry that's going to hurt from the reduction  
25 of those administrative costs, as well.



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1 COMMISSIONER PRAEGER: Thank you.

2 Now, there are a number of things included in  
3 the administrative fees. Anti-fraud efforts, for  
4 example, that the case has been made there ought  
5 to be some recognition of that helping from a  
6 quality standpoint, and that case has been made.

7 MR. GROSS: I'd like to make some  
8 comments.

9 COMMISSIONER PRAEGER: Sure -- do you --  
10 yeah. Do you have a business card, just so -

11 MR. GROSS: Sure.

12 COMMISSIONER PRAEGER: We're just trying  
13 to make sure the court reporter has correct names.  
14 Okay. Thank you.

15 MR. GROSS: My name is Mike Gross. I'm  
16 an independent agent and I have been in the  
17 business for decades, anyway, and being a little  
18 older I have spent -- I spent about 15 years as a  
19 carrier manager and now I've got time again back  
20 on the independent agent side. And I think  
21 probably one of the most valuable components of  
22 what agents and brokers provide is for the  
23 understanding of claims, how claims are handled,  
24 why the customer got paid a certain amount. And  
25 quite frankly, it's not that the carrier doesn't



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1 try to do a good job, they do. I think they've  
2 got to protect themselves. And if you start  
3 explaining something and you use too many words or  
4 you try to use an example, then the carrier  
5 individual finds themselves in this circle that  
6 goes around for 30 or 40 or 50 minutes, and it can  
7 take up a lot of time and they still really don't  
8 get the job done.

9 I think because we sell a policy, because we  
10 explained it to that customer initially, we  
11 understand exactly the way it's supposed to work  
12 and we understand what parts should be covered,  
13 what parts shouldn't. And as we can go back  
14 through the whole process of that claim and where  
15 they went, they were in network, out of network,  
16 we can -- we can sort through the whole thing, but  
17 I think a real important component in this is we  
18 deal with the end user all day every day.

19 And just like Terry said last Wednesday in  
20 the symposium, we learned about health literacy,  
21 and it's a big deal. There are a lot of people  
22 out there that function at about a sixth grade  
23 level. I think about that every day when somebody  
24 has a claim problem. I break it down to the  
25 smallest level, the easiest way to understand it,



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1 and I don't let go until that person understands  
2 why that claim was paid in that fashion. If I  
3 don't, then they'll call me back next week and  
4 we'll do it all over again.

5 So I think -- I think the claim is a very  
6 important component. And like I said, I'm kind of  
7 old, it seems to me like back in the early  
8 nineties in California, the State of California  
9 decided that they were going to let their -- let  
10 all those insurance buyers take a break. You  
11 could either buy the insurance policy without an  
12 agent and save six percent or you could elect to  
13 have an agent. And if my memory serves, 93  
14 percent of the people buying insurance in the  
15 State of California decided to have an agent  
16 because nobody else was going to help them  
17 otherwise. So I think it's a big deal.

18 COMMISSIONER PRAEGER: I actually think  
19 it was even higher than 93.

20 MR. GROSS: Pardon me?

21 COMMISSIONER PRAEGER: I said I think it  
22 might have even been higher than 93 percent.

23 MR. GROSS: Okay, okay. That's good.

24 MS. SHEPPARD: Anybody else who would  
25 like to comment? Okay. Then closing comments.



1                   COMMISSIONER PRAEGER: Let me just thank  
2 everyone, of course, and remind everyone that the  
3 waiver opportunity is just in the -- for the  
4 individual market, so being able to demonstrate  
5 disruption, and we have received written comments  
6 from -- from a number of companies. We did ask  
7 the companies to submit data that will be specific  
8 to the questions that we have to respond to from  
9 HHS to be able to submit a waiver request.

10                  You know, I think it was good to hear the  
11 existing problems in the small group market  
12 because I don't think there is a lot of -- a lot  
13 of difference. Obviously, selling to an  
14 individual is a little bit more time intensive  
15 than selling in a small group, but it still, in  
16 both cases, labor intensive and very service  
17 oriented from the -- from the agent's -- agent's  
18 standpoint.

19                  So we will continue to have our dialogue  
20 through our national association with HHS. We  
21 have an executive level committee that is working  
22 with HHS. We have actually drafted a model that  
23 should the bill, the law, get opened up again for  
24 amendments, and there has been some expression of  
25 interest in doing that, then that would be an



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1 opportunity for us to ask that the agent  
2 commission just be pulled out and treated much the  
3 same way that state and federal taxes are treated,  
4 but that remains to be seen whether or not they  
5 will even open it up for any additional changes.

6 There is a strong interest right now, I would  
7 point out, in opening up the law and changing the  
8 flexibility which now states can apply for general  
9 waivers if they can demonstrate that they are  
10 going to still cover the same number of people for  
11 the same price and, you know, a lot of -- you have  
12 to demonstrate a lot of maintenance of effort  
13 kinds of things, but that's not available until  
14 2017. And I think they realized that that really  
15 is a problem, and there is a bipartisan group that  
16 -- in Congress that has suggested that the law be  
17 changed, opened up and that that be looked at  
18 because you don't -- we are working on our  
19 exchange implementation right now. That's --  
20 that's going to be a very IT and expensive process  
21 to get it up and running, and states don't -- if  
22 they think they might want a waiver from the --  
23 some of the requirements aren't going to want to  
24 spend that money to develop their exchanges to be  
25 up and running in 2014 and then in 2017 apply for



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1 some flexibility.

2 So the flexibility opportunity, I think there  
3 are many in Congress, and -- and the president has  
4 even said that he'd like to see that -- that moved  
5 up to 2014. So, but that would require -- and I  
6 think that's less controversial than -- than some  
7 of the other issues. That would require opening  
8 up the law. And once the law is opened up for an  
9 amendment, then the agent commission issue could  
10 be dealt with as well. So I guess we'll see what  
11 happens.

12 I think they are -- they have demonstrated  
13 with Maine that they are -- if a good case can be  
14 made, that they are interested in looking at  
15 waivers. Now, I'll point out that in Maine they  
16 have their state system, Dirigo, and they have two  
17 other plans writing in the individual market. So  
18 they really don't have much in the way of a  
19 competitive individual market in Maine. So we --  
20 we'd have to demonstrate the same thing. Right  
21 now, I mean, I hope we -- I hope we don't get to  
22 a situation where we just have a couple of  
23 companies writing. Maine's problem has been  
24 around for a long time. It's not because of the  
25 new health reform law. But that -- those are the



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1 kinds of -- they have looked at the Maine example,  
2 they've granted a waiver.

3 If we file a waiver in the individual market,  
4 we are going to have to make a strong case that we  
5 also will have market disruption. So that's what  
6 we'll be -- that's what we will be taking under  
7 advisement and looking at the data that companies  
8 have submitted.

9 We appreciate you being here today, all of  
10 you. Scott?

11 MR. DAY: I would dare to say that we  
12 don't have that big of a market in Kansas. I  
13 mean, there is just very few select carriers we  
14 can place business with that are competitive.

15 COMMISSIONER PRAEGER: Well, that's --  
16 and that's the kind of data that we are  
17 collecting, so -- and it's -- I know when we talk  
18 about how many health insurance companies do we  
19 have licensed in the state, that number is much  
20 larger than the number of health insurance  
21 companies actually enrolling folks. So it's -- it  
22 is -- it is a smaller market than - yeah. Thank  
23 you.

24 MR. RICHEY: Just to comment on that,  
25 according to the HHS website where they have the



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1 healthcare.gov.

2 COMMISSIONER PRAEGER: Yes.

3 MR. RICHEY: The individuals -

4 THE REPORTER: I'm sorry, I can barely  
5 hear you.

6 COMMISSIONER PRAEGER: Yes.

7 MR. RICHEY: According to the HHS  
8 website, the options available in Kansas, when you  
9 put in a specific zip code to see what carriers  
10 are available, when I'm putting in a Wichita zip  
11 code it comes up with eight carriers as an option.  
12 Of course, two of those are -- (inaudible.) So we  
13 really have seven carriers to choose from at this  
14 point.

15 COMMISSIONER PRAEGER: Right, and it is  
16 important. I mean, there are a number of plans  
17 that are out there offered under different  
18 corporate names, but it is the same -- the same  
19 entity. Yes.

20 UNIDENTIFIED SPEAKER: If I may ask  
21 timeline on applying for a waiver, is this  
22 something that we're looking at trying to get a  
23 handle on within the next 60 days, 90 days?

24 COMMISSIONER PRAEGER: Well, we need to  
25 get -- companies need to know what the rules are



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1 going to be because if they're not -- if they are  
2 -- if we have to enforce the medical loss ratio  
3 requirements, it will be for 2012. So the sooner  
4 we can get that sorted out, the better. I mean, I  
5 think we would like to get something filed, if  
6 we're going to file. If we feel like we have  
7 sufficient information -- and I think these were  
8 available?

9 MS. SHEPPARD: Yes.

10 COMMISSIONER PRAEGER: Yeah, you should  
11 have gotten a copy of the specific questions that  
12 we sent to the companies and asked for feedback  
13 on. So we're not going to -- I mean, we're going  
14 to try to get something dealt with here in the  
15 next -- as soon as we can.

16 MS. SHEPPARD: We have on the -- I mean  
17 as far as collecting the information, we have --  
18 we had given folks up until a week from today, so  
19 the 21st, to get all information submitted, any  
20 written information that was going to be submitted  
21 as of next week, and then, you know, we'll begin  
22 the process to start looking at what we -- at what  
23 we have at that point and making a decision  
24 whether or not we have sufficient evidence to  
25 support the application.

1 UNIDENTIFIED SPEAKER: Is there an HHS  
2 deadline on filing the waiver?

3 COMMISSIONER PRAEGER: No. No. It's  
4 more -- the deadline is from a company standpoint  
5 that if -- if it looks like there are going to be  
6 issues around MLR, we'll - we need to know before  
7 2012 when the companies would have to begin  
8 sending rebates.

9 You know, the rebate, I haven't heard a lot  
10 of discussion around the rebate, but to me it  
11 seems like a paperwork nightmare for the  
12 companies, but what do I know.

13 UNIDENTIFIED SPEAKER: That's an accurate  
14 assessment.

15 UNIDENTIFIED SPEAKER: Particularly on  
16 the group side because you have to split the  
17 rebate between the employer and the employee-based  
18 contribution rate.

19 COMMISSIONER PRAEGER: That's -- yeah.  
20 Oh, yeah.

21 UNIDENTIFIED SPEAKER: And most of us  
22 don't capture that information today.

23 COMMISSIONER PRAEGER: Yeah. It's --  
24 it's, yeah, it's a nightmare.

25 UNIDENTIFIED SPEAKER: If an individual

1 is with a carrier and a plan that end up having to  
2 pay a rebate back and that individual was  
3 receiving a federal subsidy, where does the rebate  
4 go?

5 COMMISSIONER PRAEGER: Well, they won't  
6 be getting the federal subsidy until 2014.

7 MR. RICHEY: Right, on the exchange.

8 COMMISSIONER PRAEGER: Yeah, right.

9 MR. RICHEY: So does that rebate go back  
10 to the exchange to divide back out? Does that  
11 rebate go to the individual, the employer and back  
12 to the feds?

13 COMMISSIONER PRAEGER: Those are all good  
14 questions and to be determined.

15 MR. RICHEY: If I'm a subsidized  
16 individual, if they keep paying my commissions, I  
17 may be.

18 COMMISSIONER PRAEGER: Here's -- yeah.

19 MR. RICHEY: And I find out there is a  
20 plan that's overcharging, I may want to go under  
21 that one so I can get my hands on a rebate check a  
22 year from now.

23 COMMISSIONER PRAEGER: The -- one of the  
24 issues, one of the concerns around the people  
25 receiving financial assistance through the subsidy

1 is that if -- and we have had these discussions  
2 and I think, again, the jury is still out, but if  
3 a person's economic status changes during that  
4 year and they have a plan for a plan year with a  
5 subsidy that is -- that they are receiving, first  
6 of all, they are getting the subsidy based on last  
7 year's income tax return. So it's already old  
8 information.

9 I'm glad I'm in Kansas, let me just say that,  
10 not having to deal with some of these  
11 implementation issues at the federal level because  
12 there are a lot of -- there's a lot of questions  
13 like that that are still up in the air, and we  
14 want to encourage people to be able to buy a plan  
15 and stay on that plan for the whole year. You  
16 don't want people having to -- the churning  
17 process. And so we have been making those  
18 statements, as well, that it -- there needs to be  
19 some ability for somebody to be able to receive  
20 the subsidy for the -- for that year, regardless  
21 of what happens with their status. But the way  
22 the law is written, it doesn't appear that that's  
23 going to be the case.

24 So again, we'll have to sort through. That  
25 will be another area we have to sort through, but



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1 we are violating my rules about going way beyond  
2 the medical loss waiver in the individual and  
3 small group market, but it all does kind of  
4 relate.

5 So I just, I guess, the message for all of  
6 you who were willing to show up today and offer  
7 your advice and counsel, just know that through  
8 our national association insurance regulators are  
9 still at the table. They are still seeking our  
10 advice and counsel, and so we -- and I -- and they  
11 are listening, so that's a good thing. And there  
12 is still some time to fix some of these things,  
13 although the MLR needs to get fixed quickly, if  
14 there is a fix, an available fix out there, we  
15 need to -- we need to identify it and work with  
16 Congress to try to get it implemented.

17 So if there is nothing else, thank you all again.  
18 If you have written comment, we'll be receiving  
19 written comments until the 21st, so you can send  
20 that in. As I said, we have already received  
21 comment from a number of our companies. Okay. We  
22 are adjourned.

23 (THEREUPON, the public hearing concluded  
24 at 02:20 p.m.)  
25 .



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3 ss:

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5 I, Lora J. Appino, a Certified Shorthand  
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 7 Supreme Court of the State of Kansas, and  
 8 authorized to take depositions and  
 9 administer oaths within said State pursuant  
 10 to K.S.A. 60-228, certify that the foregoing  
 11 was reported by stenographic means, which  
 12 matter was held on the date, and the time  
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 15 and accurate transcript of the same.

16 I further certify that I am not related  
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 20 financial interest in the outcome of this  
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22 Given under my hand and seal this  
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24 \_\_\_\_\_  
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