

ABCs of Insurance

A primer for understanding terminology, regulation and available resources



Kansas Insurance Department

Sandy Praeger • Commissioner of Insurance

ABCs of Insurance

Kansas Insurance Department

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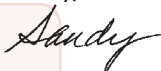
Dear Kansas consumer,

As you know, insurance can be a complicated and confusing subject. It's also an essential part of daily life and financial security. This primer is designed to help you make sense of the terminology and to provide you direction in how to find answers to your insurance questions.

This guide is divided into sections that represent the three-pronged mission of the Kansas Insurance Department: (1) to regulate the industry, (2) to educate consumers and (3) to advocate for consumers. We hope you'll find it to be a useful tool.

As always, feel free to call our in-state hotline if you have any questions: 800-432-2484.

Sincerely,



Sandy Praeger,
Commissioner of Insurance



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Annual limit	Limited benefit plans
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Assigned risk plans	Medical loss ratio
Balance billing	Mine subsidence coverage
Captive agent	Mortgage guarantee insurance
Children's Health Insurance Program (CHIP)	Mortgage insurance
Coinsurance	Mutual insurance company
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	Network
Copayment	Non-preferred provider
Cost-sharing	Open enrollment
Credit scoring	Out-of-network provider
Deductible	Out-of-pocket limit
Domestic insurance company	Patient Protection and Affordable Care Act (PPACA)
Employee Retirement Income Security Act of 1974	Point of service plan
Errors and omissions coverage	Preauthorization
Excess lines	Pre-existing condition
Excluded services	Preferred provider organization
External review	Premium
Flex rating	Premium tax
Gramm-Leach-Bliley Act	Preventive benefits
Guaranteed renewability	Provider network
Guaranteed replacement cost coverage	Rate review
Health Insurance Portability and Accountability Act (HIPAA)	Rescission
Health maintenance organization	Reserves
Health savings account	Risk-based capital
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About us

Kansas Insurance Dept.

The Kansas Insurance Department (KID), established in 1871, assists and educates consumers, regulates and reviews companies, and licenses agents selling insurance products in the state. In 2009, more than \$15 billion in premium was written in Kansas. The state is second nationally in the number of out-of-state insurance companies doing business here. More competition means more competitive rates for Kansas consumers.

KID has approximately 130 full-time employees in the following divisions: Accident & Health, Property & Casualty, Life, Anti-Fraud, Consumer Assistance & Market Conduct, Financial Surveillance, Producers (Licensing), Government & Public Affairs, Legal, Administration and Administrative Services.

In fiscal year 2010, KID collected \$120.8 million in premium tax. Premium tax money is deposited in the state's general fund.

By phone: 800-432-2484 (toll-free in Kansas)
785-296-3071

Online: www.ksinsurance.org

Email: commissioner@ksinsurance.org

Commissioner Praeger

Sandy Praeger was elected Kansas' 24th Commissioner of Insurance in 2002 and was re-elected again in 2006 and 2010. She served as the 2008 president of the National Association of Insurance Commissioners.

Prior to her work at the Kansas Insurance Department, Commissioner Praeger was elected to the Kansas Senate in 1992, 1996 and 2000 and to the state House of Representatives in 1990. She also served on the Lawrence City Commission from 1985 to 1989 and was mayor of Lawrence from 1986 to 1987.

Regulate

What we do regulate

Companies

KID regulates and reviews the companies that sell policies in the state to make sure they are solvent and comply with insurance laws and regulations. In 2011, approximately 2,527 companies sold policies in the state, and 66 were headquartered (domiciled) in Kansas.

Agents

As of November 2010, approximately 22,000 resident agent-producers and 72,500 nonresident agent-producers were licensed in Kansas to sell insurance products. The Kansas Insurance Department also requires agents to meet ongoing continuing education requirements.

Firefighter Relief Fund

This fund, which is administered by the insurance department, is used to assist firefighters and their families when accidents or deaths occur in the line of duty. It is generated by a 2% tax imposed on insurance companies writing fire insurance coverage in Kansas. The tax is collected, placed in a special fund and distributed to approximately 580 cities, counties, townships and fire districts. The 2010 distribution of the fund totaled nearly \$9.7 million, \$500,000 more than the 2009 total.

Regulate

Policies

The Kansas Insurance Department is responsible for regulating the following types of insurance policies:

Fully-insured plans: Most insurance policies purchased through a local agent or agency are fully insured. Fully-insured policies are plans that insurance companies are 100% financially responsible for. The following types of plans fall under this category:

Automobile/vehicular: As long as the insurance company is licensed to do business in Kansas, KID has some authority over automobile and other vehicular insurance. In some rare cases, coverage for a vehicle is obtained through an excess lines carrier (see pg. 21 for more on excess lines). In these cases, KID may not have any authority.

Homeowners/renters: As with automobile insurance, KID regulates a majority of homeowners insurance and similar coverage (renters, dwellers, farm, etc.).

Health: All *individual* health insurance policies are fully insured. *Group health plans* (such as those through an employer) can be either fully-insured or self-insured. KID has regulatory authority over all fully-insured health plans.

Medicare supplement insurance: KID does not regulate Medicare but does have authority over Medicare supplement plans.

Long-Term Care insurance: KID regulates all long-term care insurance sold by licensed companies in Kansas.

Other types of insurance:

Travel

Life

Disability

Regulate

What we don't regulate

COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA gives workers and their families who lose their health benefits the right to choose to continue their group health benefits for limited periods of time when they leave their jobs or during other life events. Qualified individuals are required to pay the entire premium for coverage up to 102% of the cost to the plan. COBRA is regulated by the U.S. Department of Labor.

By phone: 866-4-USA-DOL
816-285-1800 – Kansas City, Mo., office

Online: www.dol.gov/ebsa/COBRA.html

HHealthWave

HealthWave is a Kansas program that enables families with children who are eligible for Medicaid and the state's Children's Health Insurance Program (CHIP) to have the same health plan and provider for all family members. HealthWave is administered by the Kansas Department of Health and Environment. See also *Medicaid and Children's Health Insurance Program* on Pages 5 and 7.

By phone: 800-792-4884

Online: www.kansashealthwave.org

Regulate

What we don't regulate

NFIP

(National Flood Insurance Program)

The Federal Emergency Management Agency (FEMA) oversees flood insurance, which is sold through independent agents.

Homeowners insurance policies don't cover flood damage losses. The availability of flood insurance depends on your community's participation in the NFIP.

If you live in a floodplain, your mortgage lender will require you to have flood insurance. Contact the NFIP to learn about agents in your area who sell flood insurance.

By phone: 888-379-9531

Online: www.floodsmart.gov

Medicaid

Medicaid is a partnership between the federal government and state governments, which share funding and administration. It provides health and long-term care coverage to low-income children and their parents, seniors and individuals with disabilities. Participants must meet income criteria, including possible asset tests. See also *HealthWave* on Page 4.

By phone: 800-792-4884

Online: www.cms.hhs.gov/home/medicaid.asp
or www.khpa.ks.gov/medical_assistance/default.htm

Regulate

What we don't regulate

Medicare

Medicare is a health insurance program for people 65 and older or those with certain disabilities or End-Stage Renal Disease. It provides medical care coverage, but there are many costs it doesn't cover. For example, it provides very limited long-term care. Medicare has the following parts:

Part A – Hospital insurance

Part B – Medical insurance

Part C – Medicare Advantage plans, run by private companies but regulated by the Centers for Medicare and Medicaid Services

Part D – Prescription drug coverage - see also SHICK on pg. 8

Medicare is regulated by the federal government. Medicare supplement insurance is regulated by the Kansas Insurance Department.

By phone: 800-MEDICARE

Online: www.medicare.gov
or www.cms.hhs.gov/home/medicare.asp

Multi-Peril Crop Insurance

The U.S. Department of Agriculture's Risk Management Agency oversees crop insurance, which is sold through independent agents.

By phone: 785-228-5512 – Topeka regional office

Online: www.rma.usda.gov

Regulate

What we don't regulate

CHIP

(Children's Health Insurance Program)

CHIP was created by Congress in 1997 as an option for states to cover low-income children who don't qualify for Medicaid. Kansas' program, HealthWave CHIP, serves children up to 200% of the federal poverty level. See also *HealthWave* on Page 4.

Online: www.khpa.ks.gov/healthwave/

Self-insured health plans

Many large companies self-insure their health plans. Self-insured plans have their own appeals process. Consumers should refer to their employer's summary plan booklet to learn about the appeals process.

Out of any 10 health plans in Kansas:

- 3 are regulated by KID.
- 4 are self-funded plans under the Employee Retirement Income Security Act of 1974 (ERISA).
- 3 are Medicare or Medicaid.

State of Kansas employees' health plans are self-insured.

Also called *self-funded*. See also *Employee Retirement Income Security Act of 1974* on Page 20.

Regulate

What we don't regulate

SHICK (Senior Health Insurance Counseling for Kansas)

SHICK is a free program offering older Kansans an opportunity to talk with trained community volunteers and get answers to questions about Medicare and other issues, like Medicare supplement insurance, long-term care and Part D of Medicare. SHICK is a Kansas Department on Aging program.

By phone: 800-860-5260

Online: www.agingkansas.org/SHICK/shick_index.html

Workers' compensation

The Kansas Department of Labor is the primary state agency charged with the oversight of workers' compensation in Kansas. KID's responsibilities with workers' compensation are limited to approval of rates, oversight of the high-risk plan, the administration of the Workers' Compensation Fund (previously known as the second injury fund) and the investigation and prosecution of fraud and abuse by insurance companies in the payment of workers' compensation claims.

By phone: 785-296-2996

Online: www.dol.ks.gov/wc/about.html

Other

KID also does not have regulatory oversight regarding physicians, 401(k) plans, flexible spending accounts and other payroll deduction issues.

Regulate

Related organizations

Guaranty associations

Funds in these associations protect resident policyholders in the event an insurance company becomes insolvent (cannot pay policyholder's claims). All insurers are members of the guaranty association for their line of insurance, and the association covers claims (within limits) against companies that fail.

The Kansas Insurance Guaranty Association contracts with Western Guaranty Fund Services to administer property and casualty claims should an insolvency occur. The Kansas Life & Health Insurance Guaranty Association is composed of all insurers licensed to sell life insurance, health insurance and annuities in Kansas.

Western Guaranty Fund Services:

By Phone: 303-759-5066 or 800-303-7565

Online: www.wgfs.org

Kansas Life & Health Insurance Guaranty Association:

By Phone: 785-271-1199

Online: www.kslifega.org

Kansas FAIR Plan

Short for "Fair Access to Insurance Requirements," the Kansas FAIR Plan was created by the Kansas Legislature to insure property that insurance companies refuse to cover. To be eligible for consideration under the FAIR Plan, property coverage must first be declined by three insurance companies. To apply for coverage under the plan, contact any agent who sells property insurance. The FAIR Plan agent will inspect the

Regulate

Related organizations

property to determine whether the plan will offer coverage. Approval in the plan is not guaranteed.

By phone: 785-271-2300

Online: www.ksfairplan.com

KAIP

(Kansas Automobile Insurance Plan)

This plan provides coverage for drivers who are unable to purchase automobile insurance in the private market. To be eligible for consideration under the Kansas Automobile Insurance Plan, the driver's coverage must have been rejected by three insurance companies. To apply for coverage under the plan, contact any agent who sells personal auto insurance.

KHIA

(Kansas Health Insurance Association)

Sometimes referred to as the state high-risk pool, KHIA was created by the Kansas Legislature to provide coverage to consumers who are unable to buy health insurance from an insurance company. If you have been a resident of Kansas for at least six months and you meet one of the following criteria, you are eligible to buy coverage through KHIA:

- Your previous health insurance coverage was involuntarily terminated for any reason other than nonpayment of premium.
- You have been turned down by two insurance companies because of health conditions.
- You have applied for health insurance and have been quoted a premium rate that is in excess of the KHIA rate.

Regulate

Related organizations

- You have been accepted for health insurance but the policy contains a permanent rider excluding a pre-existing condition.

If you leave a group health plan, have exhausted group continuation coverage and had previous health coverage for at least 18 months, you are exempt from the six-month residency requirement.

By phone: 800-362-9290

Online: www.khiastatepool.com

P **PCIP-KS** (Pre-existing Condition Insurance Plan - Kansas)

As part of the Patient Protection and Affordable Care Act of 2010, the PCIP - KS was created to provide coverage for individuals who are unable to purchase health insurance in the private market due to a pre-existing condition.

To be eligible for the PCIP-KS plan, the individual must be a legal resident of the United States and Kansas, have been uninsured for at least 6 months prior to applying for coverage and have a pre-existing condition.

To apply for coverage, contact the Kansas Health Insurance Association either by phone or online.

Under the health reform law, this program will be discontinued in 2014 when all individuals will be eligible for health insurance regardless of health status.

By Phone: 877-505-0511

Online: www.khiastatepool.com

Regulate

Related organizations

NAIC (National Association of Insurance Commissioners)

Headquartered in Kansas City, Mo., the National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and five U.S. territories. The NAIC's overriding objective is to assist state insurance regulators in protecting consumers and helping maintain the financial stability of the insurance industry by offering financial, actuarial, legal, computer, research, market conduct and economic expertise. Formed in 1871, it is the oldest association of state officials.

In 2010, state insurance departments employed approximately 11,600 personnel to regulate 7,863 domestic insurers. During that same year, states received more than 304,000 official complaints and 2.1 million inquiries. Of these amounts, Kansas received 3,764 complaints and 1,527 inquiries.

Online: www.naic.org

Educate

Tips and tools

Request a speaker

KID employees speak at dozens of conferences, meetings and other engagements throughout the state annually. On the top right of the KID homepage, under the “Quick Links” tab, click on “Speaking Engagements” to request a speaker. Also, by clicking on the link on the right of that page, you can see upcoming engagements listed and a map showing recently visited counties.

Online speaker request form:

www.ksinsurance.org/about/speaker.htm

Publications from KID

To educate consumers about insurance, KID publishes booklets, rate guides and brochures on many kinds of insurance coverage. The following publications can be requested online or by phone, or they can be printed from the KID website:

Life and health

- “Long-Term Care Insurance & Shopper’s Guide”
- “Medicare Supplement Insurance Shopper’s Guide”
- “Health Insurance in Kansas”
- “Life Insurance and Annuity Basics”

Property and casualty

- “Auto Insurance and Shopper’s Guide”
- “Homeowners and Renters Insurance & Shopper’s Guide”
- “Personal Home Inventory”

General

- “Consumer Complaint Ratio Report” (annual)
- “Annual Report”
- “ABCs of Insurance”

Educate

Complaint ratio

A complaint ratio is a statistic that shows the number of closed complaints for every \$1 million of premium a company sold in Kansas during each calendar year. For example, if a company has a complaint ratio of 1.58, it means the company had 1.58 complaints for every \$1 million of premium sold in Kansas. The lower the number of complaints per million, the better. A company with a complaint ratio of 1.58 has a better complaint ratio than a company with a 3.58 ratio. If a company has a zero (0) ratio, no complaints were filed against that company. You can find these ratios in the most recent edition of KID's "Consumer Complaint Ratio Report."

Home inventory

A home inventory is a document that anyone with homeowners or renters insurance should maintain to ensure appropriate coverage on the contents of the dwelling. A home inventory is also a valuable resource should a home be burglarized or damaged in a disaster.

KID's "Personal Home Inventory" booklet — which can be printed from the KID website or ordered via web or phone — offers tips for recording the contents of a home, as well as tips for photographing or video recording contents. The booklet's charts focus on different areas of a home and include recommendations about the types of items to include.

Auto insurance/coverage

A basic personal automobile insurance policy requires four types of coverage:

- Bodily injury liability
- Property damage liability
- Personal injury protection (PIP)/Kansas no-fault
- Uninsured/underinsured motorist protection

Educate

A consumer may also want to purchase collision or comprehensive coverage, which aren't required by Kansas law but may be required by a lender or bank until the vehicle is paid off. Collision provides coverage for the repairs or actual cash value of your own vehicle in a motor vehicle collision or rollover. Comprehensive provides coverage for damage to your own vehicle caused by fire, theft, windstorm, hail or other losses.

Auto insurance/ratings

Details about you and your driving record help decide how an auto insurance company rates you as a driver. Companies use three categories:

Preferred – Drivers usually have had no moving traffic violations and/or chargeable accidents in the past three to five years. These drivers pay the lowest premium rates.

Standard – Moderate-risk drivers who have a reasonably clean driving record with no more than one moving traffic violation and no chargeable accidents in the past three to five years.

Nonstandard – Drivers considered to be high-risk. These drivers may be young, have less driving experience, have had moving traffic violations and/or chargeable accidents in the last three to five years, have poor payment history or have had convictions for driving under the influence of alcohol or drugs. These drivers pay the highest premium rates.

See also *Kansas Automobile Insurance Plan* on Page 10.

Educate

Shopping for individual health

When shopping for an individual health insurance policy, it is important to make sure you are buying the health care plan you want and can afford. You should make a list of your needs to compare with the benefits offered by a plan you are considering. Listed below are some questions you should ask when shopping for health insurance.

Questions about coverage

- What does the plan pay for, and what does it exclude?
- What are the pre-existing medical condition limits?
- Will the plan pay for preventive care, immunizations, well-baby care, substance abuse, organ transplants, vision care, dental care, infertility treatment, durable medical equipment or chiropractic care?
- Will the plan pay for prescriptions?
- What mental health benefits are available under the plan?
- Will the plan pay for long-term physical therapy?
- Are my providers in the network?
- Is pregnancy care covered?

Questions about premiums

- Do rates increase as you age?
- How often can a company change rates?
- How much do you have to pay when you receive health care services (copayments, coinsurance and deductibles)?
- What is the limit on how much you must pay for health care services you receive (out-of-pocket maximums)?

Questions about customer service

- Has the company had an unusually high number of consumer complaints?
- What happens when you call the company's customer service number?

Educate

- How long does it take to reach a real person?
- Does the company have an easy-to-use website that is helpful?

A health insurance company isn't required to accept you as a client, but it is required to explain to you or your physician why it turned down your application.

nsure U

The Insure U curriculum teaches consumers about insurance in an informal, online program. Participants can research the topics that affect them, then take quizzes to test their knowledge. Consumers learn about auto, home, health and life insurance decisions that often depend on their stage in life. Information is geared toward young singles, young families, established families, seniors, domestic partners, single parents, grandparents raising grandchildren and military members. There's also a segment for small-business owners.



Insure U was developed by the National Association of Insurance Commissioners.

Online: www.insureuonline.org

Educate

Key terms

Actual cash value v. replacement value – Replacement value is the amount needed to buy a comparable new item. Actual cash value means a policy will pay damages equal to the replacement value minus depreciation. In both cases, your deductible still applies.

Adverse selection – People with illnesses or who are at high risk to develop illnesses are more likely than healthier people to seek health insurance. Health insurance companies strive to keep their risk pools balanced by including both healthy and unhealthy individuals. Adverse selection occurs when a disproportionate number of unhealthy people enroll in a health plan, which can cause health insurance premiums to rise.

Allowed amount – Maximum amount on which payment is based for covered health services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing)

Annual limit - Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year.

Annuity – A life insurance product that pays income benefits for a specific period or for the consumer’s life. Deferred annuities let assets grow tax deferred before they’re converted to payments. Immediate annuities can begin payments after a single premium is paid.

Assigned risk plans – Plans through which a consumer can buy insurance if they have been denied coverage in the regular market because they are considered too great of a risk. The term is most often applied to auto insurance. Every insurer licensed in the state must participate in these plans.

Educate

Balance billing – When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may *not* balance bill you.

Captive agent – An agent who represents only one insurance company.

Children’s Health Insurance Program (CHIP) - Provides coverage to low- and moderate-income children. Like Medicaid, it is jointly funded and administered by the states and the federal government. It was originally called the State Children’s Health Insurance Program (SCHIP).

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is \$100 and you’ve met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Commercial lines – Products for businesses. For example: directors and officers liability, fire and allied lines, medical malpractice liability, and workers’ compensation are commercial lines.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – Congress passed the COBRA health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have “mini-COBRA” laws that apply to the employees of employers with less than 20 employees.

Educate

Copayment – A fixed amount (for example, \$25) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-sharing - Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance and copayments. Balance-billing charges from out-of-network physicians are not considered cost-sharing.

Credit scoring – Insurers commonly review the credit history of consumers to produce an insurance score that is used in underwriting and rating insurance policies.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Domestic insurance company – A company incorporated in Kansas.

Employee Retirement Income Security Act of 1974 (ERISA)

– A comprehensive and complex statute that federalizes the law of employee benefits. ERISA pre-empts state insurance law from regulating employer self-funded benefit plans. It also sets minimum standards for private health benefit plans and pensions. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits, which are called employee welfare benefit plans.

Errors and omissions coverage (E&O) – Coverage agents and brokers can purchase to protect against negligent acts and omissions that may harm clients. E&O coverage is not required in Kansas.

Educate

Excess lines – Property and casualty coverage that — because of the nature of the risk — isn't readily available in the standard marketplace (from an admitted carrier). Also called *nonadmitted*, *substandard* or *surplus lines*.

Excluded services - Health care services that your health insurance or plan doesn't pay for or cover.

External review - The review of a health plan's determination that a requested or provided health care service or treatment is not or was not medically necessary by a person or entity with no affiliation or connection to the health plan.

Flex rating – Flex rating bands allow property and casualty companies to raise or lower rates within a band (in Kansas, the band is 12%) without approval from the insurance department.

Gramm-Leach-Bliley Act – Federal legislation that enables insurance companies, banks and securities firms to engage in each others' activities and own one another.

Guaranteed renewability - A requirement that health insurers renew coverage under a health plan except in cases of failure to pay premium or fraud. HIPAA requires that all health insurance be guaranteed renewable.

Guaranteed replacement cost coverage – A homeowners insurance policy that pays to replace or repair a home even if the cost exceeds the policy limit.

Health Insurance Portability and Accountability Act (HIPAA) – The federal law enacted in 1996 which eased the “job lock” problem by making it easier for individuals to move from job-to-job without the risk of being unable to obtain health insurance or having to wait for coverage due to pre-existing medical conditions.

Health maintenance organization (HMO) – A type of managed care organization (health plan) that provides health

Educate

care coverage through a network of hospitals, doctors and other health care providers. Typically, the HMO only pays for care that is provided from an in-network provider. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan. See also *Point of service plans* on Page 24 and *Preferred provider organization* on Page 25.

Health savings account (HSA) – The Medicare bill signed by President George W. Bush on Dec. 8, 2003 created HSAs. Individuals covered by a qualified high-deductible health plan (HDHP) (and have no other first dollar coverage) are able to open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses. Additional information about HSAs can be found on the US Treasury website: <http://www.treasury.gov/resource-center/tax-policy/Pages/Health-Savings-Accounts.aspx>

High-risk pool - A state-subsidized health plan that provides coverage for individuals with pre-existing health care conditions who cannot purchase it in the private market (see pgs. 10-11).

In-network provider - A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee.

Internal review - The review of the health plan's determination that a requested or provided health care service or treatment health care service is not or was not medically necessary by an individual(s) associated with the health plan.

Limited benefit plans - A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or

Educate

treatments for a certain amount during a specified period.

Major medical – Insurance that covers a much broader range of medical expenses than standard health insurance. It generally has higher individual benefits and policy maximum limits.

McCarran-Ferguson Act – Federal legislation that declared states could continue to regulate insurance companies and agents.

Medical loss ratio - The percentage of health insurance premiums that are spent by the insurance company on health care services.

Mine subsidence coverage – A rider to homeowners insurance policies that covers losses caused when the land under property collapses into a mine shaft.

Mortgage guarantee insurance – Coverage required by a lender in case the mortgage holder defaults on a loan. Also called *private mortgage insurance*.

Mortgage insurance – Term insurance that covers the life of the person taking out a mortgage to pay the mortgage if that person dies. The coverage amount decreases as the mortgage is paid off.

Mutual insurance company – A company that is owned by its policyholders, who receive dividends.

Network – The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-preferred provider – A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Educate

Open enrollment period - A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

Out-of-network provider - A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an HMO or PPO). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

Out-of-pocket limit – The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Patient Protection and Affordable Care Act (PPACA)

- Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the "Affordable Care Act", "ACA" or "the health reform law".

Point of service plan – A managed care plan that gives members the option of seeking care from a specialist without a referral from a primary-care physician. Such services are subject to a higher deductible and/or coinsurance. See also *health maintenance organization* on pages 21-22 and *preferred provider organization* on page 25.

Preauthorization – A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes call prior authorization, prior approval or precertification. Your health insurance or plan may require

Educate

preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Pre-existing condition – A condition for which a reasonably prudent person sought and received medical treatment prior to the effective date of a company's coverage.

Preferred provider organization (PPO) – A type of managed care organization (health plan) that provides health care coverage through a network of providers. Typically the PPO requires the policyholder to pay higher costs when they seek care from an out-of-network provider. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan. See also *Health maintenance organization* on pages 21-22 and *Point of service plan* on page 24.

Premium – The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Premium tax – A state tax on consumer premiums, collected by insurance companies and deposited in the state's general fund, where it is appropriated by the legislature.

Preventive benefits - Covered services that are intended to prevent disease or to identify disease while it is more easily treatable.

Provider network – The group of doctors and specialists with which an insurance company contracts. The copayment to see a network provider is generally less than to see an out-of-network provider.

Rate review - KID reviews the premium rates set by insurance companies to make sure that they comply with insurance laws. This review is a safeguard to make sure that the company will be able to pay all necessary claims to its policyholders.

Educate

Rescission - The process of voiding a health plan from its inception based on the grounds of fraud or intentional misrepresentation of a relevant fact.

Reserves – Money collected by companies from premiums and set aside to pay claims.

Risk-based capital – The need by insurance companies to maintain capital relative to the risk of the types of insurance they sell. Higher risk types of insurance require higher amounts of capital.

Self-insured – Group health plans may be self-insured or fully-insured. A plan is self-insured when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully-insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurer. Self-insured plans are exempt from state regulation but may be subject to ERISA plans. Also called “self-funded.”

Solvency – The ability of an insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all insurance plans and require corrective action if a plan’s financial situation becomes hazardous. In extreme circumstances, a state may seize control of a plan that is in danger of insolvency.

Third-party administrator – A business that processes claims for an insurance company.

Viatical settlement – The sale of a life insurance policy for more than the cost of premiums but less than the death benefit. Policyholders are often terminally ill. Also called “life settlement.”

Waiting period - A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. Premiums are not collected during this period.

Advocate

Consumer assistance

KID's consumer assistance representatives recovered more than \$10.1 million for consumers in 2010. They handled 3,802 complaints and 1,535 inquiries.

Consumers with questions or concerns are encouraged to call the Consumer Assistance Hotline. See also *Filing a complaint* below.

Consumer Assistance Hotline: 800-432-2484

Filing a complaint

If consumers have tried unsuccessfully to resolve a claim dispute with their company or agent, we encourage them to contact KID. Often companies resolve the matter after the department intervenes.

Consumers may file a complaint online through the KID website, but we recommend they also call because we may be able to provide immediate assistance.

If a consumer does need to file a formal written complaint, we require the following information:

- Name.
- Address.
- Daytime telephone number.
- The name of the insurance company, agent or adjuster.
- The type of insurance involved (automobile, homeowners, health, life, etc.).
- The policy number.
- A clear, concise written explanation of the complaint — this can be sent by mail or filed through our website.
- Copies of supporting letters, police reports, notes, etc.
- An explanation of what has been done, including who spoke with the consumer and what they were told (names, dates, times, places, etc.).

Advocate

Consumers shouldn't send original records, and they should keep a copy of the letter sent to KID.

Upon receipt of a complaint, KID will investigate and provide updates as they occur. A consumer filing a complaint will receive a letter from the assigned consumer assistance representative, and the representative will contact the insurance company on the consumer's behalf. KID representatives must have written complaints in order to assist.

Financial ratings

Financial stability helps ensure a company can pay its claims. KID enforces statutory requirements and monitors the financial solvency of companies licensed and operating in the state. Rating agencies consider company earnings, capital adequacy, operating leverage, liquidity, investment performance, reinsurance programs and management ability, integrity and experience.

You can check an insurance company's financial rating by contacting one of the following ratings organizations: A.M. Best Co., Fitch Inc., Moody's Investors Service, Standard & Poor's Insurance Rating services.

Legislative presence

KID introduces bills each legislative session to further strengthen, clarify or bring into compliance existing statutes for legislative consideration. KID participates in the legislative process to explain and clarify how proposed bills would affect Kansas consumers. The agency advocates on behalf of some bills and against others. KID also chairs formal and informal committees. As part of KID's presence at the Statehouse, the agency also works to educate lawmakers about insurance issues.

For more information: Call 785-296-7803

Advocate

Long-term care Partnership

The Kansas Partnership for Long-Term Care is a program that provides insurance consumers dollar-for-dollar asset protection. Each dollar that a long-term care Partnership policy pays out in benefits entitles the consumer to keep a dollar of assets after being eligible to apply for Medicaid services. Partnership-qualified policies must be tax-qualified, contain certain consumer protection provisions and provide inflation protection. About 20 companies have Partnership endorsements approved in Kansas.

Online: www.ksinsurance.org/ltc

Small business tax credits

Eligible employers can receive a tax credit for contributions they make to health savings accounts or insurance plans for employees. Small businesses, associations or trusts with two to 50 employees are eligible if they haven't contributed to a health insurance premium or health savings account on behalf of an employee in the past two years. In the first year, the credit is \$70 per month per eligible covered employee. In the second year, the amount is \$50, and in the third year it's \$35. To participate, a business must contact KID to register.

By phone: (785) 296-7850

Online: www.ksinsurance.org

Advocate



**(Stranger/Investor-
Originated Life Insurance)**

A STOLI is an agreement made by a consumer and a broker or third-party investor to sell the consumer's life insurance policy for a profit. In a life settlement, an existing life insurance policy is sold to a third party for more than its cash value and less than the death benefit amount. A consumer might seek a life settlement for many reasons, including because of hardship or divorce.

A STOLI arrangement uses the same life insurance policy as a viatical or life settlement, but the method used to obtain the death benefits is an attempt to circumvent state insurable interest statutes. "Insurable interest" means a person wanting to buy a life insurance policy on someone else's life must have an interest in that person remaining alive or expect emotional or financial loss if that person died. The investor in a STOLI arrangement, a stranger, has an interest in the early death of the insured individual: Investors are speculating that an insured will die before the investor has paid too much in policy premiums.

Stranger Originated Annuity Transactions (known as STATs or STOAs) are similar to STOLIs because a broker or third-party investor takes out an annuity on a terminally ill individual, then collects the death benefit and interest earned. Many states are currently working to pass laws making these annuity transactions illegal.

See also *Viatical settlement* on Page 26.



We're here to help!

If you have any questions or concerns about an insurance company or product in Kansas, call our Consumer Assistance Hotline:

800-432-2484

Kansas Insurance Department
Sandy Praeger, Commissioner
420 S.W. 9th St.

Topeka, KS 66612-1603

Phone: 785-296-3071

Fax: 785-296-7805

Email: commissioner@ksinsurance.org

Website: www.ksinsurance.org

TTY/TDD: 877-235-3151

Office hours: 8 a.m. to 5 p.m. weekdays

Kansas Insurance Department

Contact us

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Commissioner of Insurance