Special Committee on Financial Institutions and Insurance

State Implementation of the Patient Protection and Affordable Care Act (PPACA)

Conclusions and Recommendations

Implementation. The Special Committee on Financial Institutions and Insurance notes the timelines for potential PPACA implementation and other activities surrounding a health insurance exchange as follows:

- December 30, 2011, deadline to apply for Level I federal funds (requires enabling legislation and the Governor's signature)*;
- U.S. Supreme Court is expected to hear oral arguments concerning the "individual mandate" in March 2012; a decision is anticipated by June 2012;
- June 29, 2012, deadline to apply for Level II federal funds (requires enacted legislation; funds are unavailable for a state-federal partnership model);
- Health Insurance Exchange required to be operational in October 2013 to allow for open enrollment period;
- Kansas Eligibility and Enforcement System (KEES) currently in Phase 2 development and scheduled for deployment in December 2013 or January 2014;
- Health Insurance Exchange begins paying claims January 1, 2014 ("fully operational"); and
- Health Insurance Exchanges required to be self-sustaining by 2015.

DRAFT

**Staff note:* On November [illegible], 2011, the U.S. Department of Health and Human Services (HHS) announced that this deadline has been extended to June 29, 2012 – the original deadline for the Level II grants – "to accommodate state legislative sessions and to give states more time to apply."

Patient Protection and Affordable Care Act (ACA) Requirements, Legislative Review During the 2012 Session. The Committee recognizes the challenges and uncertainty associated with implementation of the PPACA and requests the 2012 Legislature respond to the requirements contained in the PPACA, including the development and implementation of a health insurance exchange, and recommends information be submitted to the appropriate Senate and House standing committees: Insurance, Financial Institutions and Insurance, Appropriations, Joint Health Policy Oversight, Health and Human Services, Public Health and Welfare, and Ways and Means. The Committee recognizes that conferees generally concluded, if the PPACA exchange requirements remain unchanged, that a state-based exchange would provide the greatest flexibility.

Kansas Eligibility Enforcement System (KEES) Project. The Committee recognizes the importance of the KEES project and retaining Kansas' eligibility criteria, even if a federal

exchange is implemented. The Committee heard testimony concerning interoperability of the KEES, which uses service-oriented architecture and possesses the ability to send and receive information among various state agencies. The Committee notes, while the KEES project does not include funding to interface with a health insurance exchange, it possesses the capability to do so as an "add-on." The Committee recognizes an additional $2 million to $4 million investment would be required to interface KEES to a health exchange.

Exchange Planning – Kansas Insurance Department, Stakeholders. The Committee recognizes the contributions of the Kansas Insurance Department in accepting the challenge to coordinate work groups and stakeholders dedicated to evaluating governance, "best practices," interaction among consumers and insurance industry representatives, navigators, brokers, and outreach/education requirements. That work has produced meaningful and valuable information for legislators' deliberations.

Legal Uncertainty, Funding Challenge. The Committee recognizes the challenges of interpretation and implementation of the Patient Protection and Affordable Care Act, particularly when federal rules and regulations have not been written or released, the U.S. Supreme Court decision regarding the individual mandate will not be issued until at least June 2012, timelines of the KEES implementation and a health insurance exchange (whether the model selected is a state-, federal-, or a state/federal-operated exchange) are not synchronized, and the funding sources are unidentified or could be unavailable – if a federal exchange is implemented, its funding source is not identified in the federal legislation. The Committee notes initial start-up costs could be the State's responsibility and the U.S. Department of Health and Human Services could tax insurers to pay for the exchange's maintenance until it becomes self-sustaining.

Business Forum, Health Insurance Marketplace in Kansas. The Committee recommends the appropriate House and Senate committees hold hearings early in the 2012 Session to evaluate information communicated from the federal government, consider alternative insurance reform options such as Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs), securing insurance through the business marketplace (both inside and outside a health insurance exchange), and address tax relief for employer contributions to an individual's private health insurance plan.

Proposed Legislation: *None*.

Background

The charge to the Special Committee on Financial Institutions and Insurance was to study, review and report on three assigned topics: uninsured motorists, criminal history record checks and fingerprinting requirements for certain financial services representatives, and implementation of the Patient Protection and Affordable Care Act (PPACA) in Kansas.

On the subject of the PPACA, the Committee was directed to:

- Study the federal Patient Protection and Affordable Care Act for any required corresponding state implementation legislation. Review options for a Kansas health insurance exchange that will comply with the federal health care legislation.

The topic was requested by the Kansas Insurance Commissioner and was assigned by the Legislative Coordinating Council for study and review.

Committee Activities

In October, the Committee received an overview of its charge from Committee staff. Agendas with linked testimony and informational documents were made available to assist in the review of this topic, and staff reviewed the documents made available on the Kansas Legislative Research Department website, which address implementation timelines and common key terms and provide links to the two Acts – the Patient Protection and Affordable Care Act (PL 111-148) and the Health Care and Education Reconciliation Act of 2010 (PL 111-152) – commonly referred to as the Affordable Care Act (ACA). *This report refers to the law as the PPACA to be consistent with the assigned topic*.

Testimony and related health insurance exchange planning information was made available on the Kansas Insurance Department's health reform website. Conferees were asked to provide information concerning purchasers and individual populations who intersect with the Kansas insurance market place, the uninsured population, Kansas identifiers and indicators, exchange implementation requirements, and exchange options available under the PPACA.

Health Insurance Coverage in Kansas and the Current Health Insurance Marketplace in Kansas. Suzanne Cleveland, a Senior Analyst for the Kansas Health Institute (KHI) first addressed sources of coverage for Kansans of all ages (2009-2010) and described the demographics of health insurance coverage in Kansas: 53.4 percent receive employment-based insurance; another 5.5 percent seek insurance from private sources; 13.0 percent are uninsured; 10.2 percent receive Medicaid/CHIP (State Children's Health Insurance Program); 1.6 percent receive both Medicare and Medicaid; 13.7 percent receive Medicare benefits; and 2.6 percent of the population is covered through other public insurance (*e.g.,* U.S. Department of Veterans Affairs or military). Ms. Cleveland also provided information concerning the rates of uninsured Kansans by county (percent of non-elderly population, 2009), with the following counties having the highest and lowest rates of uninsurance: Stanton County, 25.5 percent and Johnson County, 9.8 percent. In response to a question concerning whether the uninsured rate could be broken down any further, the analyst responded that, due to the sample size, it is difficult to develop accurate data specific elements when sample sizes are small for specific elements.

Linda Sheppard, Director of the Accident and Health Division and PPACA Project Manager, Kansas Insurance Department (KID), reported on health insurance premium data from 2010, indicating 12 insurance companies were providing individual health insurance coverage in Kansas. Of those 12, 5 companies had 80 percent of the market share and 9 companies had more than 1,000 enrollees. In the small group market, 17 companies offered coverage, and a group of 8 of those had over 75 percent of the market share. The Director discussed the provisions of the PPACA and the medical loss ratio (MLR). In Kansas, two high-risk pools provide coverage: the state high risk pool and the Pre-Existing Condition Insurance Plan (PCIP). Ms. Sheppard provided information related to each pool on operations, eligibility rules, funding, and claim pay-outs. Ms. Sheppard also noted the revision, as required under the PPACA, to nearly all health insurance policies in Kansas that were issued or renewed on or after September 23, 2010: the elimination of lifetime benefits and the phase-out of annual limits; a prohibition against rescission of policies, except in cases of fraud or intentional misrepresentation; coverage for most preventive health services with no out-of-pocket costs; enhancement of the appeals procedures for consumers when dealing with disputes with insurers; elimination of pre-existing condition exclusions for children; and coverage for children up to the age of 26 on their parents' policies. In response to Committee questions, the KID representative noted that under the PPACA, a prohibition against rescission of policies exists, except in cases of fraud or intentional misrepresentation. This issue has been a concern in other states; in Kansas, policy rescission has not been a problem. The conferee also responded that federal law effective September 23, 2010, eliminated pre-existing conditions as a reason to deny coverage for children; Kansas had not taken action on that law. During the 2011 Session, legislative action amended eligibility rules to allow children under age 19, who reside in counties where "child-only" coverage is unavailable to enroll in the high-risk pool. Prior to September 23, 2010, six companies offered "child-only" coverage. One company currently offers

coverage, and only in Wyandotte and Johnson counties.

Dr. Robert Moser, Secretary, Kansas Department of Health and Environment (KDHE), submitted written testimony addressing the potential costs and effects of Medicaid expansion on Kansas. Dr. Moser cautioned that any discussion of estimates must be tempered in the current environment of uncertainty citing both the legal future of the law and regulatory decisions yet to be made. The regulatory decisions to take into consideration when looking at both private and public health insurance include:

- The size and scope of the essential health benefits package that will apply to Medicaid's expansion population (no proposed regulations, as of October 24, 2011).
- Regulations defining PPACA Medicaid and federal tax subsidy eligibility rules (those rules have been issued as proposed regulations, but will not be finalized until next year).
- The basics of a federal exchange have been described broadly, but no version is available to look at or test.

Implementation Requirements, Federal Patient Protection and Affordable Care Act; Exchange Options Under the Law. Insurance Commissioner Sandy Praeger provided an overview of the PPACA, the development and implementation of a health insurance exchange in Kansas, exchange options, and a planning status report. Provisions of the PPACA require creating a health insurance exchange to be operational in each state by January 1, 2014. Commissioner Praeger described the history relative to an Early Innovator Grant awarded to Kansas ($31.5 million), and she reported on the $1.0 million Exchange Planning Grant, which is being used to study the requirements for a state-operated exchange. The Commissioner then commented on the activities of the work groups and a steering committee that were created to address a wide variety of issues such as exchange operations and functions, governance structure, marketplace impact, roles of agents and brokers, consumer education and outreach. The ultimate goal was to develop recommendations for a state-operated exchange for legislative consideration during the 2012 Session.

Commissioner Praeger also addressed the various information technology components required for a state-operated exchange, and a timeline for the activities related to implementation of a state- or federally-operated exchange and explained the differences between a federally-operated and a state-operated exchange. The Commissioner indicated that if no decision is made to move forward with creating a Kansas exchange by the end of the 2012 Legislative Session, preparation will focus on the implementation of a federal exchange. Commissioner Praeger noted that Kansas also is one of 26 states involved in a federal lawsuit seeking to overturn the law’s “individual mandate” — the requirement that, starting in 2014, all Americans purchase health insurance or face financial penalties. Governor Sam Brownback announced in August that the State would return the $31.5 million federal grant that was awarded to help Kansas officials create an insurance purchasing exchange. Following the Governor’s announcement, the Steering Committee met and encouraged the KID to continue the stakeholder planning process and ultimately supported a state-operated exchange.

Committee discussion followed the Commissioner's presentation. Highlighted are excerpts from the Committee discussion (topics notated).

Steering Committee Recommendations, Role of the Kansas Insurance Department. Commissioner Praeger responded to a question about the Steering Committee recommendation regarding the state-based health insurance exchange, by agreeing that many concerns and opinions were voiced regarding the continuation of a process that might not be implemented. However, the Commissioner continued, no strong objections were voiced, and the decision was made to move forward even in light of the concerns expressed. Regarding a question as to whether the Insurance Department is attempting to force a health care exchange, the Commissioner stated that the Department is a regulatory agency, not a policy-making entity; its obligation is furnish

quality information to the Legislature and Governor for their decision-making.

Role of Navigators; Comparative State Experience. Provisions in the PPACA utilize a "navigator." When a consumer requires assistance in navigating an insurance exchange, a navigator is used to ensure fair, accurate and impartial information is available to consumers, conduct public education, and facilitate enrollment in qualified health plans; the navigator cannot recommend a particular plan and cannot be reimbursed by any agent or company. If a state-based exchange were implemented, it is anticipated a strong involvement with the insurance agent community would continue and, therefore, no job losses would occur as a result of the implementation. However, the Commissioner cautioned, the national insurance community is concerned that a federally-operated exchange could operate differently based on its rules and regulations. The Commissioner later indicated that an insurance agent could be a navigator as long as no monetary compensation occurs for providing that service.

In Utah, a web-based marketplace exchange exists and compensates agents and brokers for using its exchange. The market is a voluntary market; it enrolled few residents in the first year resulting in additional legislation in 2010. At the current time, the Utah exchange does not comply with ACA provisions; the state is working to ensure compliance with the federal law.

Federal Grant Awards, Exchange Planning. The $1.0 million Exchange Planning Grant is being used to pay for consulting services and to cover work group and Steering Committee meeting expenses. The $31.5 million Early Innovator Grant was to be used for the design and implementation of IT infrastructure needed to operate an exchange. The grant includes all technology surrounding eligibility and enrollment including Medicaid; $30 million of the grant was for the development of the Medicaid interface to a state-based exchange. It is estimated an additional $5 million would be required to continue the development of a state-based exchange. That funding could come from federal grants; one grant requires the Governor's signature and application must be made before the end of December 2011 (Level I), the other grant is available through the end of June 2012 (Level II).

Insurance Premiums, Business Tax Credits. It was noted that many small businesses are considering eliminating health insurance; a Committee member noted that current Kansas law excludes an employer's contribution to an employee's HSA from income and payroll taxes. The Commissioner commented on the role of a group market (versus individual), noting that the group market rates depend on keeping the group intact; when healthier, less costly individuals are allowed to opt out of the group, the group's premiums increase. The Commissioner indicated that one of the work groups has discussed whether Kansas would require all plans (platinum, gold, silver, and bronze) to be offered by insurers; to date, no decision has been made.

Key Issues for the States – Exchange Options and Activities. Dianne Bricker, Regional Director, America's Health Insurance Plans (AHIP), described AHIP's role in collaborating with member companies to craft comments, analyses, and technical assistance in tracking states' exchange implementations. AHIP supports exchange goals of promoting private market competition, preserving consumer choice, and preventing costly, duplicative regulation. The conferee reviewed the status of federal Exchange Planning Grants, Early Innovator Grants and Level I Establishment Grants awarded to the states. Ms. Bricker also commented on exchange legislation introduced, establishment bills enacted or pending, and Executive Orders initiated in the states. Exchange approaches by states were discussed, including comments on their governance, structure, carrier participation, and funding. Ms. Bricker provided a comparison of federal, California, Massachusetts, and Utah approaches on exchanges. Ms. Bricker recommended Kansas consider moving forward with a state exchange, which she said would encourage private-market competition.

Among the items discussed following the conferee's formal presentations:

- *State approaches.* AHIP's testimony indicated that six states are discussing the potential of allowing the purchase of health plans outside of the exchange – a

Committee member requested clarification of Utah's experience related to carriers' desires to be excluded from the exchange, which resulted in additional legislative requirements. Ms. Bricker elaborated that no exchange has been certified by HHS to date and confirmed that health plans can be sold both inside and outside an exchange.

- *Carrier participation.* The conferee clarified that, with regard to carrier participation, California and Massachusetts have indicated they will "selectively contract" with plans. These two states have determined an exchange board will govern the exchange; the board also is responsible for determining which plans are offered in the exchange. California and Massachusetts will selectively contract with those insurers who meet not only the federal requirements for a qualified plan but also their additional standards. AHIP is concerned about the issue of compressing the numbers of plans offered, which reduces consumer choice and competition within an exchange.

Stakeholder Perspectives on Implementation of a State-Based Health Insurance Exchange; Exchange Planning Work Group Reports and Recommendations. The Director of the Accident and Health Division, KID, noted the Department initiated a stakeholder process for exchange planning in January 2011 and, since then, there have been 48 meetings of members of the various work groups and the Steering Committee involving more than 400 volunteers and an estimated 3,800 volunteer hours. Ms. Sheppard demonstrated information contained on the website http://www.ksinsuance.org/hbexplan/ including HHS-proposed regulations with comment sections, the PPACA law as it currently exists, key federally facilitated exchange milestones, and a glossary to assist consumers in understanding the law. The website includes separate pages for each work group, a calendar of work group and Steering Committee meetings, and each work group's mission. The conferee reviewed three recommendations adopted by the Steering Committee: certification of navigators, training of navigators, and a Kansas exchange governance proposal.

In response to Committee questions, the conferee indicated that:

- A navigator cannot recommend or advise regarding a specific plan; a navigator's role is to facilitate enrollment and provide factual information and education; a navigator cannot be compensated for that work.

- The governance proposal included the following recommendations:

○ The Kansas exchange is a not-for-profit organization;

○ The corporation shall be governed by a Board of Directors comprising residents of the state who represent the ethnic, cultural, health status, age, and geographic diversity of the residents of the state; core competencies for Board members were listed;

○ The Board will consist of 13 voting members and 6 *ex-officio* members; and

○ A process was designed to determine from where nominations come, how nominees are chosen, term limits, filling vacancies, and other requirements for Board operations.

Anna Lambertson, Executive Director, Kansas Health Consumer Coalition (KHCC), discussed the KHCC's participation in the exchange planning process. The conferee indicated that many Kansans, uninsured or underinsured, postpone or forgo recommended health care due to the costs and further commented that she feared Kansas will not meet the upcoming deadlines (health insurance exchange planning). The conferee indicated the KHCC supports the design and implementation of a state-operated exchange and remains committed to moving forward.

Kansas Medicaid Reform and Interface With an Insurance Exchange; Overview of the Kansas Eligibility Enforcement System (KEES). KDHE Secretary Moser commented on the impact of the PPACA on Medicaid reform,

emphasizing the costs of the PPACA, which are dependent on both the legal future of the law and regulatory decisions yet to be made. The Secretary highlighted goals for Medicaid reform in Kansas including integrated and coordinated care for the whole person; preserving or creating paths to independence; alternative access models; and utilizing community-based services. The Secretary also spoke to the pairing of Medicaid expansion under the PPACA with the promised cuts to Medicaid, which could be considered a "starting point" for the Super Committee. One way the federal government proposes to reduce Medicaid spending, the Secretary continued, is to reduce cost-sharing with states.

Secretary Moser then discussed the Kansas Eligibility Enforcement System (KEES), the State's expansion and incorporation of KDHE's K-Med and SRS' Avenues programs on a common platform; KEES will determine Medicaid beneficiary eligibility. The program is anticipated to protect data integrity and assist in fraud reduction, and it can be customized to add other state programs, which will reduce future information technology (IT) infrastructure investments. Secretary Moser identified various data sources that could be cross referenced within the KEES system (*e.g.*, Social Security, Department of Revenue, Kansas Public Employees Retirement System, Homeland Security, and certain tax records). The conferee reported that the Department of Corrections also would be added to users to assist in SRS' fraud and abuse prevention efforts. Secretary Moser indicated the first users will include Medicaid, Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance to Needy Families (TANF). The KEES project is anticipated to be operational by the end of Calendar Year 2013 and is funded through a competitive federal grant awarded in 2009, state funds, and federal matching funds. The contractual cost is $85 million for technology acquisition and $50 million over five years for operation and maintenance fees. Secretary Moser stated KEES implementation does not require Kansas to create an insurance exchange; federal matching funds do, however, require system interoperability with a wide range of applications, including health information exchanges, public health agencies, and any insurance exchange. The federal Centers for Medicare and Medicaid Services (CMS) agreed to language in the KEES contract stating that Kansas is not obligated to develop an exchange.

Committee discussion followed, with Secretary Moser providing additional information and clarification about KEES:

- *Project Costs.* The original cost projection was $35 million to $40 million, which was to be used for replacing the K-Med application. The total cost was increased when other platforms were added to increase interoperability. The original request for proposals included options to add other applications.

- *Project Architecture.* KEES' architecture is designed to allow diverse systems and organizations to work together. Eventually, these interoperable systems could function across all state agencies to accept, receive, send, and use information. Many State legacy systems have been in operation more than 20 years; Secretary Moser indicated the goal is to consolidate state IT systems with a service-oriented, web-based architecture that would provide the mechanism to address the State's business needs.

- *Implementation Schedule.* Secretary Moser reported the system will be completed in late 2013 and will "go live" in January 2014. The timeline has been developed, the system will be developed in appropriate phases, and comprehensive testing will occur for each business application. Timelines and deliverables are in multiple stages to allow for in-depth monitoring and testing.

- *Use of Federal Grant Moneys, Return of Early Innovator Grant.* When asked whether returning the $31.5 million grant with $30 million earmarked for IT impacted the design, development, and rollout of the KEES project, Secretary Moser indicated that once it was clear Kansas not only had 90/10 federal support for KEES but also had SGF funds, the grant funding was unnecessary.

- *Interoperability.* With regard to a question whether the $85 million KEES contract included costs for interfacing with any federal IT system that would be used for a health exchange, Secretary Moser commented it would be difficult to know until the health insurance exchange rules and regulations are defined by the federal government. Concern was expressed that if language is not contained in the contractual agreement, millions of dollars of additional expense could be added to build interfaces that create interoperability. The Department later made available the contractual language for the Committee's review.

Secretary Moser and Commissioner Praeger collaborated to provide clarity related to KEES and its interoperability with a health insurance exchange. The Secretary stated that an enrollment/eligibility system is more complicated than the private insurance environment, and the KEES project is long overdue and will possess the enrollment/eligibility application as well as interoperability to function within a health insurance exchange (state or federal). Commissioner Praeger indicated the federal government had released two contracts to build the data hub envisioned, which the states would use in concert with the KEES for a health insurance exchange. Commissioner Praeger indicated that systems designs should eliminate duplication among systems and agencies. If an exchange is implemented, a three-month enrollment period is required prior to January 1, 2014. A challenge would exist if the KEES system is not ready by (for the 3-month enrollment period) and, therefore, missing the deadline would compromise any implementation of a state exchange by the deadline of January 1, 2014.

Grant Participation and Fiscal Implications for an Exchange; Projection Participation. Commissioner Praeger next discussed the grant opportunities and fiscal implications for an exchange, indicating that if a decision is made to move forward with a state or state-federal partnership exchange, additional funding would be required. The Commissioner noted the Level I and Level II Establishment Grants (federal) and the corresponding deadlines:

- Level I requires the Governor's signature and its submission deadline is December 30, 2011; and

- Level II is available for states whose legislatures have enacted legislation; the deadline for application submission is June 2012. A Level II grant is unavailable for a state-federal partnership model.

Commissioner Praeger indicated that if a state exchange option is to be preserved, enacted legislation in 2012 is required. The other option before the Legislature is to default to a federal exchange, which may or may not use the KEES technology. Committee discussion with the Commissioner and KID staff then followed (*topics* and responses from the KID representatives summarized below).

Exchange Funding; Grant Deadlines; and Exchange Options. Exchanges are required to be self-sustaining by 2015; any exchange (state, federal, or state-federal partnership) is required to be a self-sustaining private marketplace and not reliant on public funding; fees have not been established. A Committee member inquired about the funding options available if upcoming grant deadlines are unmet – if Level I or Level II grant funding is not awarded and the "individual mandate" is upheld. Commissioner Praeger indicated that, absent federal funding, the cost of creating an interface with insurers would be paid from the State General Fund (SGF). Ms. Sheppard responded to another inquiry, stating that if a federal exchange is implemented, the federal government will fund the initial start-up expenses; once implementation occurs, the federal government will determine how it is sustained. Commissioner Praeger later stated that if a federal model is implemented, the State could lose control of numerous decision points.

KEES Timeline and Future Expenditures. If the KEES is not operational by October 1, 2013, it is unclear how the federal government would access Kansas Medicaid eligibility information; the federal government would be required to provide the same verification process that each state currently provides. Commissioner Praeger expressed concern that if the federal government operates exchanges in multiple states, process

standardization would occur and Kansas could lose the flexibility and authority to design and operate its own exchange. (Additional information was requested for the November meeting.)

Legal Implications and Potential Fiscal Obligations. When asked what happens if the U.S. Supreme Court rules the "individual mandate" unconstitutional, Commissioner Praeger commented that opinions have surfaced, indicating other provisions of the PPACA could remain in place; this scenario would present a difficult situation unless the "pre-existing condition" and guaranteed issue provisions are removed, as well. It is unknown whether the exchanges would be eliminated. A Committee member commented that the KEES implementation will require more than five years of maintenance. If Kansas declines any remaining grant opportunities and the Supreme Court upholds the PPACA, Kansas then assumes a different fiscal responsibility. Another concern cited was the costs relating to the integration of KEES and an exchange.

The KHI analyst then discussed the projections for coverage and exchange participation in Kansas. When projections were calculated, the methodology assumed the exchange would be used by individuals or employer groups of 50 or fewer. The KHI analyst explained this would change depending on decisions yet to be made and whether a state- or federally operated exchange is implemented. Using this model, the large employer groups would be excluded from the exchange. The small employer group (estimated 253,000 from small private and public employers) is critical, and a range of options exist:

- Employers may choose to purchase group coverage within the exchange;
- Employers may choose to continue group coverage outside the exchange; or
- Employers may choose to drop group coverage, leaving employees to purchase individually inside the exchange.

The last two categories in the direct purchase market are the 147,000 Kansans who directly purchase their health insurance. Of this population, 98,000 are within the income-eligible range for federal credits/subsidies and may use the exchange; 49,000 are over the income-eligible range and could use the exchange. The uninsured population projections include 142,000 within the income-eligible range for federal credits/subsidies and 36,000 over the income-eligible range that may use the exchange. In response to a question of whether KHI assumed that individuals in the uninsured pool could not afford insurance and whether individuals who chose not to be insured were accounted for, the conferee stated KHI did not attempt to determine reasons for the uninsured; the projections were based on eligibility to determine the potential for exchange participation. The residual rate of uninsured people (people who will not purchase or otherwise have insurance) likely is between 4 percent and 6 percent. In response to an inquiry about whether an employer group may go in and out of an exchange. Commissioner Praeger responded that there is no requirement prohibiting an employer from entering or leaving the exchange at any time.

In November, the Committee continued its review of the assigned topic. Committee staff provided a brief review of the proposed agenda and highlighted related resource materials.

Employer-Sponsored Health Insurance in Kansas; PPACA Requirements, Coverage Options and Cost Implications for Kansas Consumers; Health Savings Accounts. Eric Stafford, the Senior Director of Government Affairs, Kansas Chamber, provided testimony on the implementation of the PPACA in Kansas and its impact on the business community. Mr. Stafford spoke about the employer provisions under the PPACA; discussed the concept of insurance exchanges and exchange requirements under the PPACA; and outlined alternative health reform options, such as Health Savings Accounts (HSAs) The conferee summarized the Chamber's position on health reforms under PPACA and said the law does little to address cost. The PPACA could increase health care costs due to increased demand for services, and studies suggest a large percentage of employers could eliminate health coverage for their employees. Mr. Stafford reviewed penalties contained in the law for employers with varying numbers of employees, and discussed small employer tax credits under the

PPACA, indicating that tax credits are prohibited for self-employed individuals. Mr. Stafford reported he participated in the Steering Committee, praising all individuals engaged in various committees and work groups. With the uncertainty surrounding exchange implementation, rules and regulations, state-versus federally operated exchanges, Mr. Stafford suggested alternative, consumer-oriented options, such as HSAs and tax reform as vehicles to provide portability, consumer choice, affordability, and consumer control.

Dan Murray, Kansas State Director, National Federation of Independent Business (NFIB), spoke about small business and the cost of health insurance, addressing the negative impact of the PPACA. Mr. Murray said, that with its new taxes, mandates, growth in government, and excessive costs, the PPACA delivers little; the law does not address health care costs, the conferee continued, outlining 12 reforms that could provide health insurance coverage solutions to small businesses. These include tax reform, insurance purchasing reform, market and access reforms, lawsuit reform, and other elements, such as entitlements and medical delivery systems. Mr. Murray said his organization has joined the multi-state lawsuit challenging the constitutionality of the PPACA. Mr. Murray stated that NFIB will continue to advocate for reforms that:

- Allow employers to provide employees with more choice;
- Expand tax deductions for health insurance to individuals and the self-employed;
- Create multiple pooling opportunities to reduce risk and to increase competition;
- Enact medical malpractice reform;
- Preserve and expand consumer-driven health care choices (HSAs, flexible spending accounts, and health reimbursement accounts); and
- Empower state innovation.

Beverly Gossage, President and Founder, HSA Benefits Consulting, next discussed the effects the PPACA will have on Kansans' health insurance premiums. The conferee provided information on how premiums currently are calculated and how changes would occur with the implementation of an insurance exchange. Ms. Gossage explained risk rating and regulations, comparing how the PPACA would affect private individual insurance rates and group rates. Comparison elements included portability, guaranteed issue, community rating, rate increases, guaranteed renewal, rescission, arbitration, plan designs, and benefit mandates. The conferee provided information relating to vanishing health benefits in the U.S.: 42 percent of small employers offered medical insurance in 2009 versus 47 percent in 2000; and in 45 states, the share of small businesses offering coverage dropped as premiums rose 82 percent. The conferee suggested further scrutiny of the Massachusetts Health Connector mandatory plan to determine whether efficiencies and cost containment measures met projections.

Keith Barnes, Aetna Market President, next spoke to health care reform and challenges particularly relevant to Kansas residents. Mr. Barnes reported, when the PPACA was passed, it addressed access to care, while neglecting to address the quality and cost of health care. Mr. Barnes indicated the U.S. Census Bureau reported the uninsured rate in Kansas ranges from 9.8 percent to 25.5 percent; the conferee reported a myriad of factors drive this uninsured population, but it is known where high concentrations of uninsured individuals exist, usually where there is little or limited access to health care. By 2014, newly insured percentages will increase under the PPACA. In discussing HSAs, the conferee suggested the concept of "consumerism" relative to the health care delivery model should be addressed; physicians, hospitals, ancillary providers, and pharmacies are not well connected. Therefore, an opportunity exists for a well-engaged and informed consumer to improve decision-making concerning services provided and delivery of care. John Stockton, Vice-President of Sales and Services, Aetna, testified concerning how consumers can play an active role in managing their health through the purchase of HSAs. Mr. Stockton discussed methods to contribute to a HSA, HDHP (High Deductible Health Plan) common plan design features, HSA

withdrawal policies and vehicles, tax implications, portability, and information/tools available to assist a consumer in decision-making.

In response to a question concerning how alternative reforms, such as HSAs could benefit the working poor, retired seniors under age 65 years, and the employed young who do not have discretionary funds to contribute to a HSA, the Chamber representative said his organization advocates for initiatives that are consumer-oriented and consumer-driven. While recognizing the challenge of limited discretionary income, Mr. Stafford indicated that, with prioritization, an HSA offers an option for individuals/families to contribute and control expenditures for medical emergencies and care with tax-free dollars. Mr. Stafford acknowledged the issue is multi-faceted and, while the PPACA does provide access to health care, it is uncertain whether the law will reduce associated costs relative to the gains in coverage.

Regarding employer penalties, Mr. Stafford said, if any employee joins the exchange and receives tax credits and the employer does not offer insurance, the firm must pay $2,000 per employee (minus a 30-employee “exemption”). If the company offers insurance, but an employee “opts out” of the employer coverage and receives tax credits in the exchange, then the firm owes $3,000 per employee receiving tax credits. Mr. Stafford concluded that while the law may give companies incentives to offer insurance, it could be possible an employer would eliminate insurance coverage due to the penalty being less expensive than the cost for providing insurance coverage.

Insurance Information for Consumers and Purchasing: Web-based Insurance Exchanges; Navigators and Work Group Report. Scott Osler, Vice-President of Business Development, Getinsured.com, described his organization as a nationwide private exchange offering more than 6,000 health plans in 48 states and services to more than one million customers annually. Mr. Osler reported Getinsured.com has provided guidance and education to 28 states in preparation for the implementation of the PPACA and then discussed the principles of a state-operated exchange which offers the following benefits:

- Free-market approach, inclusive to all carriers in Kansas;
- Budget neutrality;
- Minimized bureaucracy;
- Elimination of financial dependency on the federal government;
- Avoidance of financial and operational risk; and
- Ease of use for brokers and carriers.

Mr. Osler discussed recent emerging technological advances which allow for utilization of an outsourced or partially outsourced model. The conferee provided “rough” benchmarks for pricing and operations of a web-based, outsourced model and also described examples of exchange technology and features such as a consumer portal, a back-office system, employer/employee portals, a compliance dashboard, an issuer/carrier portal, and a broker/navigator portal.

Cindy Hermes, Director of Public Outreach and Consumer Ombudsman, KID, discussed recommendations from the Agents/Brokers/Navigatrs Work Group; the work group consisted of 46 members, including agents, insurance company representatives, and consumer advocates. The recommendations adopted by the Steering Committee included:

- Agents and brokers should continue to be active participants in the selling, soliciting, and negotiating of qualified health insurance policies offered through a Kansas exchange (adopted June 22, 2011);
- Navigators should be certified and subjected to requirements for training, examination, and continuing education (adopted June 22, 2011);
- A combination accreditation-certification process was developed to ensure the oversight of navigator entities and individual navigators (adopted October

20, 2011); and

- Navigators would be required to undergo extensive training, successfully complete a certification examination, and meet continuing education and training requirements (adopted October 20, 2011).

Governance Options Under the PPACA: States' Options; Work Group Update. The Director of Accident and Health, KID, discussed the governance options under the PPACA and the recommendations submitted by the Governance/Legal/Legislative Work Group. The recommendations, adopted by the Steering Committee on October 20, 2011, included the following:

- The Kansas Exchange would be incorporated as a not-for-profit corporation;

- The Board of Directors for the corporation would consist of 13 voting members and six *ex-officio* non-voting members. The work group recommended this composition of the Board: three representing the health insurance industry, three representing the Kansas health care industry, six members who are consumers/purchasers of health insurance through the Exchange, and one small business owner member selected at large by the other voting members. The proposal for *ex-officio* members of the Board would include the Insurance Commissioner, a representative of the Medicaid program, a representative of the Kansas Health Information Exchange, the Secretary of the KDHE or the Secretary's designee, the Secretary of Social and Rehabilitation Services or the Secretary's designee, and the corporation's chief executive officer;

- Voting Board members would be divided into classes, would serve staggered terms of three years and would be eligible to serve one term or two consecutive three-year terms; the at-large small business owner/director would serve as Board chairperson; *ex-officio* members would serve terms concurrent with the position; and

- The Board would possess authority to establish an executive committee, other standing or special committees, advisory boards, and committees.

Forum: Comments on the Implementation of a State-Based Insurance Exchange. A private citizen provided testimony in opposition to “Obama Care” (referring to the PPACA) in Kansas, stating the original intent of the *Constitution* is violated under the PPACA, and Kansas and other sovereign states have the power to nullify this law as unconstitutional. The forum participant said Medicare also is unconstitutional and provided various examples to support his determination of inequities and inefficiencies within Medicare operations. Another private citizen shared his personal health story and said, while the PPACA is an imperfect solution, it is an improvement over the current system. The participant provided information on various international models of single-payer plans used by other countries to pay for universal health care, reporting that a Kansas Health Policy Authority study determined Kansas could save $800 million yearly if a single-payer plan were implemented.

A representative of the American Cancer Society (ACS) supported the implementation of a state-based exchange as benefiting Kansas health care consumers, stating that if nothing is done in 2012, a federal exchange would be implemented, which may or may not incorporate consumer-focused aspects that would benefit and focus on Kansas residents. The participant supported the Governance Work Group’s recommendation as one of the primary elements in the implementation of a state-based exchange and advocated for the involvement of an “active purchaser” role in an exchange; an “active purchaser” model would encompass a wide range of activities to leverage higher quality, more affordable coverage to individuals and small businesses. A state-based exchange, the representative concluded, would create a marketplace that is transparent and allow Kansans to make their own purchasing decisions. Written testimony from National Alliance on Mental Illness, Kansas (NAMI), urged the Legislature to support the implementation of a

Kansas Insurance Exchange; a Senior Fellow for the National Center for Policy Analysis submitted neutral testimony describing the financial incentives for states to establish state-based health insurance exchanges.

Committee discussion followed on the assigned topic, with the ACS representative clarifying the terms “transparent” and “cost reduction.” The NFIB representative responding to questions about recommendations for health insurance reform, stating that most small businesses want to offer competitive benefits that will reduce costs and expand coverage options. The NFIB organization believes the PPACA does not provide the vehicle for positive health care reform. The Getinsured.com representative was asked to respond to a question concerning how to build and operate a Kansas Exchange that is budget neutral while interfacing with the Kansas Eligibility Enforcement System (KEES); the conferee said there are various methods to accomplish the goal; the ideal system would be a web-based service, which could create the ability to communicate information to and from other systems and agencies. Such systems could operate in real-time or through a batch system. The Insurance Commissioner reported an additional $2 million to $4 million would be required for integration of an Exchange and the KEES system and indicated the PPACA requires a seamless system integrated to the state’s Medicaid eligibility and enrollment system (KEES) and federal grant dollars still are available to fund such integration.

Cost Implications: Federal Health Care Reform. The President of the Kansas Policy Institute (KPI), Dave Trabert, discussed the implications for the State General Fund (SGF) should the PPACA be implemented (projected Medicaid expenditures). Mr. Trabert briefly described the methodology used to calculate the costs to the State with and without the PPACA implementation: projections of Medicaid expenditures were provided for 2014 through 2023, a cumulative expense of $16.04 billion without the PPACA and $20.75 billion with PPACA. The conferee stated the projections identify that by 2023, 21 percent of Kansas’ population will be enrolled in Medicaid (including increases as a result of PPACA implementation). Mr. Trabert referenced a soon-to-be published study that has found major structural deficits in the SGF should the PPACA be implemented: the study found that if SGF revenues increase 3.5 percent annually, if Medicaid expenditures (with the PPACA requirements) meet projections, if HB 2194 is enacted and KPERS funding is at the current 8 percent discount rate, and if all other expenditures increase at rates averaged over the years 1998 through 2012, a SGF cumulative deficit of $1.7 billion will exist in FY 2023. The KPI supports the restructure of the existing Medicaid system so required benefits can be provided at reduced costs and opposes the implementation of a Kansas health care exchange.

In response to a Committee member's questions, Mr. Trabert stated that KPI recommends several things the State could and should do to increase the affordability of health care for the working poor, young, and retired individuals under age 65 years who are ineligible for Medicare: create different rules and regulations on what constitutes a small group; allow employers to contribute to the employee’s private coverage with the same tax treatment as employer-based contributions; allow portability and eliminate any restrictions on portability; and create tax reforms. Written testimony on the implications of the PPACA on Kansas’ health care expenditures was submitted by the study's co-author, Jagadeesh Gokhale, Senior Fellow, Cato Institute, Washington, D.C.

KEES Implementation Update; Health Insurance Exchange Options and Functions, IT Review. Secretary Moser, KDHE, provided a KEES high-level project timeline which indicated phase 2 (full deployment) and phase 3 (integration) will occur in 2013. The KEES contract cost breakdown is $44 million for K-Med (Medicaid), $22 million for SRS Avenues, and $23 million for system hosting costs. The total implementation cost is $89 million, which was revised from the $85 million reported at the October meeting. The $4 million difference is due to reclassification of “operational costs” as “implementation costs,” which qualify for 90 percent federal funding, 10 percent state funding. The total project cost is approximately $135 million to $137 million, which includes maintenance costs of $50 million for a five-year period. Dr. Moser indicated the Accenture contract (KEES project vendor) requires a feasibility analysis (by the end of January 2012)

that uses the KEES as the Medicaid Management Informantion System (MMIS) beneficiary sub-system. If the State moves forward with analysis recommendations, additional funding would be required (at the standard 90/10 funding). Dr. Moser also submitted a graphic of a conceptual service-oriented architecture (SOA) platform. When asked whether the KEES system would be required if a federal-exchange were implemented in January 2014, Dr. Moser responded the federal government eligibility requirements are basic: an individual's income level must meet program qualifications and the individual must be a U.S. citizen; KEES is a robust system that will check other State of Kansas eligibility determinants. Dr. Moser clarified KEES is not an insurance exchange application; it is designed to be Kansas' Medicaid eligibility determination and enforcement system. A Committee member asked if KEES could include Medicaid as well as the health insurance exchange components; the conferee responded KEES is a database to provide a Medicaid eligibility and enrollment system, which is interoperable. If an insurance exchange application were designed, it could be added on to the KEES system.

Neil Woerman, Director of IT, KID, and Dan Oas, Project Manager for STA Consulting, discussed insurance exchange options, with Mr. Woerman offering that the HHS has defined five core functions that must be included in an insurance exchange: consumer assistance, plan management, eligibility, enrollment, and financial management. Mr. Woerman said there are three options for a Kansas exchange: state-operated, federally operated, or a state-federal partnership model. In a state-operated exchange, the State is responsible for all five core functions (contingent on the passage of enabling legislation during the Kansas 2012 Legislative Session). In a state-federal partnership model, the State would assume responsibility for the "plan management" and "consumer assistance" functions (currently, these functions are performed by KID). Mr. Woerman noted Kansas and other states have asked HHS for flexibility with regard to what categories would be under the purview of the State should a state-federal partnership model be implemented. Under a federally-operated exchange, the federal government performs all five core functions. HHS has released statements of work for a federal exchange and federal data hub IT system; the data hub will allow verification from various federal agencies as to an individual's citizenship, immigration status, and tax information. This information will be used to determine eligibility for public programs, tax credits, and subsidies for the purchase of private insurance.

Committee Discussion; Information Updates. Linda Sheppard, KID, provided follow-up to questions from the October meeting, including a request for actuarial information concerning a maternity benefit (defined as a preventive health service, PPACA). The KID representative further stated that the total cost of the PPACA is projected to add about 14 percent to the cost of an individual premium. Ms. Sheppard also stated that HHS has provided no information regarding specific benefits that will be required as part of "essential health benefits" for inclusion in qualified health plans sold beginning in 2014. Those regulations should be known in the spring of 2012. With regard to how a federally operated exchange would be funded, the KID representative said it is believed HHS will use the funds that would have been available for development of a state-operated exchange. HHS also would establish the type and amount of user and transaction fees, which would be required to ensure the exchange is self-sustaining beginning in 2015. In response to the question of waivers and exemptions, Ms. Sheppard indicated the PPACA prohibits annual dollar limits on benefits in health insurance plans. For employers and insurers providing plans with limited benefits ("mini-med" plans), it is estimated that to comply with the PPACA, premiums could increase significantly, forcing employers to drop coverage. To address this concern, CMS has granted temporary waivers from this provision of the law until 2014. Ms. Sheppard provided a list of Kansas entities approved by CMS for waivers of the annual limits requirements during 2010 and 2011.

Small Group Marketplace. Commissioner Praeger provided clarification on the question of guaranteed issue in the small group and individual market:

- In the small-group market, guaranteed issue exists for all employees in the group regardless of the applicant's health status;

- Currently, in the individual marketplace, an insurer can deny coverage to an applicant with a pre-existing condition, cover an individual with a compromised health status at a higher premium, or write out (exclude) coverage for the specific disease/condition of an applicant. Although usually renewed annually, an insurer can terminate coverage at annual renewal; and

- Under PPACA, all new policies nationwide in the individual health insurance market also will be guaranteed issue by 2014.

Commissioner Praeger also discussed the issue of portability in the small-group market which involves a 90-day waiting period before an individual becomes eligible for coverage and enrollment. Once the initial waiting period has been fulfilled, an individual can move to another company and enroll for coverage within that company's prescribed time period (another 90-day waiting period is not required). Ms. Gossage was asked about the exchange of information with HSAs; the conferee reported HSA participants must deal with both an insurance company (HDHP) which tracks and pays claims after deductibles are met, and a bank which collects contributions and pays out expenses before deductibles are met. The conferee said the bank may issue HSA checks or debit cards to pay for these expenses, but the insurance company also needs to track deductible expenses and to take advantage of rates negotiated with providers.

Enrollment Projections, Selling Plans Across State Lines. Reference was made to Kansas individuals currently eligible for Medicaid but not enrolled, and a Committee member requested clarification whether the State should be in a process of identifying those who are eligible and not currently enrolled in Medicaid. Commissioner Praeger said that under the PPACA, the number of Kansas residents eligible for Medicaid coverage is estimated at 130,000; the overall number of "newly insured" Kansans (excluding the Medicaid population) is projected at more than 300,000 (with subsidies for qualified individuals). The Commissioner stated the federal government temporarily will pay the full cost of covering those made eligible for the Medicaid program by the 2014 expansion, but it will continue to pay only 60 percent of the cost for new participants who were eligible but not enrolled prior to the expansion. In 2017, the gradual, phase-in period for state funding begins; the federal share decreases to 90 percent. The "newly insured" must have an income level above the federal poverty level threshold to be included in the "newly insured" expansion category. With regard to the question of allowing insurance companies to sell policies across state lines, Commissioner Praeger expressed concern that if this were allowed, companies would market less comprehensive and less expensive policies that do not meet state regulatory requirements; an unfair marketplace for companies regulated by the Insurance Department would be created.

Further Comments from Stakeholders. A Kansas Health Consumer Coalition representative supported the creation of a state-operated exchange in Kansas that meets needs of consumers, advocating for the participation of consumers, the creation of exchange governance that includes consumers, and the assurance of barrier-free access for Kansans. The representative said that the planning process has produced many recommendations for an exchange governing board, which should be considered as a baseline for any potential action. Written testimony was received from a private citizen who expressed concern that the current debate regarding implementation of a state-operated health exchange includes stakeholders who could profit from such an implementation. The participant encouraged the Legislature to focus on the development of a prevention-based, accessible, and affordable health care system for Kansas families.

Conclusions and Recommendations

Following its review of the assigned topic, the Special Committee on Financial Institutions and Insurance makes the following conclusions and recommendations.

Implementation. The Committee notes the timelines for potential PPACA implementation and other activities surrounding a health insurance exchange as follows:

- December 30, 2011, deadline to apply for Level I federal funds (requires enabling legislation and the Governor's signature)*;

- U.S. Supreme Court is expected to hear oral arguments concerning the "individual mandate" in March 2012; a decision is anticipated by June 2012;

- June 29, 2012, deadline to apply for Level II federal funds (requires enacted legislation; funds are unavailable for a state-federal partnership model);

- Health Insurance Exchange required to be operational in October 2013 to allow for open enrollment period;

- Kansas Eligibility and Enforcement System (KEES) currently in Phase 2 development and scheduled for deployment in December 2013 or January 2014;

- Health Insurance Exchange begins paying claims January 1, 2014 ("fully operational"); and

- Health Insurance Exchanges required to be self-sustaining by 2015.

******staff note:* On November 29, 2011, the U.S. Department of Health and Human Services (HHS) announced that this deadline has been extended to June 29, 2012 – the original deadline for the Level II grants – "to accommodate state legislative sessions and to give states more time to apply."

Patient Protection and Affordable Care Act (PPACA) Requirements, Legislative Review During the 2012 Session. The Committee recognizes the challenges and uncertainty associated with implementation of the PPACA and requests the 2012 Legislature respond to the requirements contained in PPACA, including the development and implementation of a health insurance exchange, and recommends information be submitted to the appropriate Senate and House standing committees: Insurance, Financial Institutions and Insurance, Appropriations, Joint Health Policy Oversight, Health and Human Services, Public Health and Welfare, and Ways and Means. The Committee recognizes that conferees generally concluded, if the PPACA exchange requirements remain unchanged, that a state-based exchange would provide the greatest flexibility.

Kansas Eligibility Enforcement System (KEES) Project. The Committee recognizes the importance of the KEES project and retaining Kansas' eligibility criteria, even if a federal exchange is implemented. The Committee heard testimony concerning interoperability of the KEES, which uses service-oriented architecture and possesses the ability to send and receive information among various state agencies. The Committee notes, while the KEES project does not include funding to interface with a health insurance exchange, it possesses the capability to do so as an "add-on." The Committee recognizes an additional $2 million to $4 million investment would be required to interface KEES to a health exchange.

Exchange Planning – Kansas Insurance Department, Stakeholders. The Committee recognizes the contributions of the Kansas Insurance Department in accepting the challenge to coordinate work groups and stakeholders dedicated to evaluating governance, "best practices," interaction among consumers and insurance industry representatives, navigators, brokers, and outreach/education requirements. That work has produced meaningful and valuable information for legislators' deliberations.

Legal Uncertainty, Funding Challenge. The Committee recognizes the challenges of interpretation and implementation of the Patient Protection and Affordable Care Act, particularly when federal rules and regulations have not been written or released, the U.S. Supreme Court decision regarding the individual mandate will not be issued until at least June 2012, timelines of the KEES implementation and a health insurance exchange (whether the model selected is a state-, federal-, or a state/federal-operated exchange) are not synchronized, and the funding sources are unidentified or could be unavailable – if a federal exchange is implemented, its funding source is not identified in the federal legislation. The Committee notes initial start-up costs could be the State's responsibility and the U.S. Department of

Health and Human Services could tax insurers to pay for the exchange's maintenance until it becomes self-sustaining.

Business Forum, Health Insurance Marketplace in Kansas. The Committee recommends the appropriate House and Senate committees hold hearings early in the 2012 Session to evaluate information communicated from the federal government, consider alternative insurance reform options such as Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs), securing insurance through the business marketplace (both inside and outside a health insurance exchange), and address tax relief for employer contributions to an individual's private health insurance plan.