MINUTES

SPECIAL COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

November 14, 2011
Room 548-S—Statehouse

Members Present

Senator Ruth Teichman, Chairperson
Representative Clark Shultz, Vice-chairperson
Senator Jeff Longbine
Senator Allen Schmidt
Senator Vicki Schmidt
Representative Susan Mosier
Representative Brenda Landwehr
Representative Ann Mah
Representative Melody McCray-Miller (via telephone)
Representative TerriLois Gregory (via telephone)

Member Absent

Senator Ty Masterson

Staff Present

Melissa Calderwood, Kansas Legislative Research Department
Jill Shelley, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Jay Hall, Kansas Legislative Research Department
Ken Wilke, Office of the Revisor of Statutes
David Wiese, Office of the Revisor of Statutes
Jan Lunn, Committee Secretary

Conferees

Eric Stafford, Kansas Chamber
Dan Murray, National Federation of Independent Business-Kansas
Beverly Gossage, HSA Benefits Consulting
Larrie Ann Brown, Aetna
Keith Barnes, Aetna
John Stockton, Aetna
Scott Osler, Getinsured
Cindy Hermes, Kansas Insurance Department
Linda Sheppard, Kansas Insurance Department
W. Paul Degener, private citizen
Ira Stamm, Ph.D., private citizen
Christopher Masoner, American Cancer Society
Dave Trabert, President, Kansas Policy Institute

Dr. Robert Moser, Secretary, Kansas Department of Health and Environment
Neil Woerman, Kansas Insurance Department
Dan Oas, Project Manager, STA Consulting

Morning Session

Chairperson Teichman called the meeting to order at 9:35 a.m. and recognized Melissa Calderwood, Principal Analyst, Kansas Legislative Research Department (KLRD), to provide an overview of the planned agenda. Ms. Calderwood noted the agenda contains informational links for members' review, which will serve as a future resource for the Legislature. Ms. Calderwood reminded Committee members the afternoon session would focus on recommendations for inclusion in its committee report on the topics of:

- Uninsured Motorists;
- Criminal History Record Checks and Fingerprinting of Certain Financial Service Representatives; and
- State Implementation of the Federal Patient Protection and Affordable Care Act (PPACA).

Employer-Sponsored Health Insurance in Kansas; PPACA Requirements, Coverage Options and Cost Implications for Kansas Consumers; Health Savings Accounts

Eric Stafford, Senior Director of Government Affairs for the Kansas Chamber, provided testimony on the implementation of the PPACA (also referred to more generally as the Affordable Care Act, ACA) in Kansas and its impact on the business community. He spoke about the employer provisions under the ACA; discussed the concept of insurance exchanges and exchange requirements under ACA; and outlined alternative health reform options, such as Health Savings Accounts (HSAs) (Attachment 1). Mr. Stafford summarized the Chamber's position on health reforms under PPACA and said the PPACA does little to address cost. The PPACA could increase healthcare costs due to increased demand for services, and studies suggest a large percentage of employers could eliminate health coverage for their employees. He reviewed penalties contained in the PPACA for employers with varying numbers of employees, and he discussed small employer tax credits under the PPACA. He indicated tax credits are prohibited for self-employed individuals. Mr. Stafford reported he participated in the Kansas Insurance Department's (KID) 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 PPACA. He said, that with its new taxes, mandates, growth in government, and excessive costs, PPACA delivers little (Attachment 2). He said the PPACA does not address healthcare costs and outlined 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 PPACA. He summarized 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 healthcare choices (HSAs, flexible spending accounts, and health reimbursement accounts); and
- Empower state innovation.

Chairperson Teichman reported the U.S. Supreme Court announced it will hear oral arguments concerning the PPACA in March 2012; a decision is expected, in late June 2012. (*Note*: the Court will hear the appeal to the 11th Circuit Court of Appeals August 12, 2011 decision.)

Beverly Gossage, President and Founder, HSA Benefits Consulting, next discussed the effects the PPACA will have on Kansans' health insurance premiums. She provided information on how premiums currently are calculated and how changes would occur with the implementation of an insurance exchange (Attachment 3). Ms. Gossage explained risk rating and regulations, and compared 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. Ms. Gossage provided information relating to vanishing health benefits in the United States: 42 percent of U.S. 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. Ms. Gossage suggested further scrutiny of the Massachusetts Health Connector mandatory plan to determine whether efficiencies and cost containment measures met projections.

Senator Teichman requested Ms. Gossage furnish a copy of her PowerPoint presentation to Ms. Calderwood.

Larrie Ann Brown, representing Aetna, introduced Keith Barnes, Aetna Market President, and John Stockton, Vice President of Sales and Service, to provide information on HSAs, healthcare reform and, specifically, challenges particularly relevant to Kansas residents. Mr. Barnes reported, when the PPACA was passed in March 2010, it addressed access to care, while neglecting to address the quality and cost of healthcare. Mr. Barnes indicated the U.S. Census Bureau reported the uninsured rate in Kansas ranges from 9.8 percent to 25.5 percent. He said 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 healthcare. By 2014, newly insured percentages will increase under the PPACA, he said. In discussing HSAs, Mr. Barnes suggested the concept of "consumerism" relative to the healthcare 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 (no written testimony).

Mr. Stockton testified concerning how consumers can play an active role in managing their health through the purchase of HSAs. He discussed the three components of an HSA: high deductible health plan (HDHP), the health saving account (HSA), and member tools/information (Attachment 4). Mr. Stockton discussed methods to contribute to a HSA, HDHP common plan design features, HSA withdrawal policies and vehicles, tax implications, portability, and information/tools available to assist a consumer in decision-making.

Chairperson Teichman recognized Committee members who had questions of the previous conferees as follows:

- In response to a question concerning how alternative reforms, such as HSAs could benefit the working poor, retired seniors under age 65 years (ineligible for Medicare), and the employed young who do not have discretionary funds to contribute to a HSA, Mr. Stafford said his organization advocates for initiatives that are consumer-oriented and consumer-driven. While he recognized the issue of limited discretionary income can be challenging, he 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 healthcare, it is uncertain whether the legislation will reduce associated costs relative to the gains in coverage under the new law.

- 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. He said the conclusion in the scenarios described is, 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.

Based on questions concerning health savings accounts and health reimbursement accounts (HRAs), and the limited amount of time to discuss these issues, Chairperson Teichman recommended each chamber's standing committees schedule time during the Legislative Session to review the concerns outlined today for small businesses, hear testimony on HSAs and HRAs, and discuss how these alternative options could benefit Kansas residents.

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. He reported his firm has provided guidance and education to 28 states in preparation for the implementation of the PPACA (Attachment 5). He 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. He provided "rough" benchmarks for pricing and operations of a web-based, outsourced model. He 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, the Kansas Insurance Department (KID), discussed recommendations from the Agents/Brokers/Navigators Work Group (Attachment 6). She reported the Work Group consists of 46 members, including agents, insurance company representatives, and consumer advocates. The recommendations adopted by the Steering Committee include:

- 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).

Review of Governance Options under the PPACA: States' Options; Work Group Update

Linda Sheppard, Director of the Accident and Health Division and PPACA Project Manager, KID, discussed the governance options under the PPACA and the recommendations submitted by the Governance/Legal/Legislative Work Group (Attachment 7). 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 healthcare 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. She also discussed the proposal for *ex-officio* members of the Board: the Insurance Commissioner, a representative of the Medicaid program, a representative of the Kansas Health Information Exchange, the Secretary of the Kansas Department of Health and Environment 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 and 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

W. Paul Degener, private citizen, provided testimony in opposition to "Obama Care" (referring to the PPACA) in Kansas. He stated the original intent of the *Constitution* is violated under the PPACA, and Kansas and other sovereign states have the power to nullify this legislation as unconstitutional. Mr. Degener said Medicare also is unconstitutional and provided various examples to support his determination of inequities and inefficiencies within Medicare operations (Attachment 8).

Ira Stamm, Ph.D., private citizen, shared his personal story and said while the PPACA is an imperfect solution, it is an improvement over the current system. Dr. Stamm provided information on various international models of single-payer plans used by other countries to pay for universal healthcare. He reported a Kansas Health Policy Authority study, by actuarial consultants Schramm-Raleigh of Phoenix in 2007, determined Kansas could save $800 million yearly if a single-payer plan were implemented. Dr. Stamm requested the Kansas Legislature consider a single-payer plan or a modified single-payer plan during the 2012 Session (Attachment 9).

Christopher Masoner, American Cancer Society, discussed the PPACA and supported the implementation of a state-based exchange as benefiting Kansas healthcare consumers. He stated 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 (Attachment 10). Mr. Masoner said he supported the Governance Work Group's recommendation as one of the primary elements in the implementation of a state-based exchange. He 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. He provided an "active purchaser" example of allowing consumers to pool purchasing power for negotiating rates and coverage, which would provide a balance between "choice" and "value." He concluded a state-based exchange would create a marketplace that is transparent and allows Kansans to purchase insurance and empowers them to make their own purchasing decisions.

Senator Teichman called attention to written testimony submitted by the following:

- Rick Cagan, Executive Director, National Alliance on Mental Illness (NAMI), urged the Legislature to support the implementation of a Kansas Insurance Exchange (Attachment 11); and

- Devon M. Herrick, Ph.D., Senior Fellow, National Center for Policy Analysis, submitted neutral testimony describing the financial incentives for states to establish state-based health insurance exchanges (Attachment 12).

Chairperson Teichman opened the meeting to Committee members' questions for the conferees who commented on the implementation of a state-based insurance exchange:

- A Committee member asked Mr. Masoner what he meant by the terms "transparent" and "cost reduction" in his testimony. Mr. Masoner responded that "transparent" refers to the side-by-side comparisons of insurance plans, ratings, and costs *via* a web-based browser, which the Exchange would offer to consumers; he did not recall using the term "cost reduction";

- Mr. Masoner said he would provide information concerning the percentage of revenue the American Cancer Society expends for salaries and administrative costs. He said the organization funds approximately $100 million to $150 million in cancer research projects each year;

- When asked whether Medicare should be nullified, Mr. Degener clarified that he believes Medicare to be unconstitutional; therefore, the Kansas Legislature should consider nullification of Medicare and the PPACA. A Committee member offered that Medicare is a federally-operated program with no input or funds from the states, but the PPACA places a mandate and requirements on states, which will increase the number of Medicaid recipients and, therefore, would create additional state expenditures;

- Mr. Murray was asked to describe how to bring to fruition several healthcare reform bullet points to which he referred in his testimony, specifically, bullet point eight, *Health insurance reform ought to enable individuals with pre-existing conditions to obtain and maintain health insurance;* and nine, *People should be able to move from one job to another, between a job and no job, and from state to state without losing insurance coverage or encountering excessive cost increases for changing.* Mr. Murray stated the NFIB advocates on behalf of business and the bullet points were intended for additional evaluation; he indicated his willingness to follow-up with the Committee member with more specific information at a later time. His said most small businesses want to offer competitive benefits that will reduce costs and expand coverage options. His

organization believes the PPACA does not provide the vehicle for positive healthcare reform.

- Mr. Osler 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). Mr. Osler 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.

- Insurance Commissioner, Sandy Praeger, reported an additional $2 million to $4 million would be required for integration of an Exchange and the KEES system. She said 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.

Chairperson Teichman encouraged Committee members to contact individual conferees with additional questions. She recessed the meeting until 1:30 p.m.

Afternoon Session

Chairperson Teichman reconvened the meeting at 1:34 p.m.

Minutes Approval

Senator Longbine moved, seconded by Senator Allen Schmidt, to approve the minutes of the October 24, 2011, meeting; the motion carried.

Cost Implications: Federal Health Care Reform

Dave Trabert, President, Kansas Policy Institute (KPI), discussed the implications for the State General Fund (SGF) should the PPACA be implemented (projected Medicaid expenditures). He briefly described the methodology used for a paper prepared for the KPI to calculate the costs to the State with and without 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. He said projections identify that by 2023, 21 percent of Kansas' population will be enrolled in Medicaid (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. Mr. Trabert stated his organization supports the restructure of the existing Medicaid system so required benefits can be provided at reduced costs and opposes the implementation of a Kansas healthcare exchange (Attachment 13).

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.

Mr. Trabert offered to provide additional information to the Committee member at another time.

Written testimony was submitted by Jagadeesh Gokhale, Senior Fellow, Cato Institute, Washington, D.C., on the implications of the PPACA on Kansas' healthcare expenditures (Attachment 14).

Kansas Eligibility Enforcement System (KEES) Implementation Update; Health Insurance Exchange Options and Functions; IT Review

Dr. Robert Moser, Secretary, Kansas Department of Health and Environment (KDHE), answered questions from the October 24 Committee meeting concerning the KEES implementation timeline, the contractual language relating to interoperability, the budget breakdown for the KEES implementation, and the potential inclusion of the Medicaid Management Information System (MMIS). Dr. Moser 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 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 (Attachment 15).

When asked whether the KEES system would be required if a federal-exchange were implemented in January 2014, Dr. Moser respondeded 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. He said 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 the Medicaid as well as the health insurance exchange components. He 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.

When asked if the original KEES contract was awarded at $85 million with $50 million for maintenance over a five-year period, Dr. Moser affirmed that was the original contract award. However, an additional $4 million has been added to the original $85 million award. This was due to the reclassification of some operational expenses to implementation expenses. He said the total Accenture award is $89 million plus $50 million for maintenance over a five-year period.

Neil Woerman, Director of Information Technology (IT), KID, and Dan Oas, Project Manager for STA Consulting, were present to discuss insurance exchange options. Mr. Woerman reported the U.S. Department of Health and Human Services (HHS) has defined five core functions that must be included in an insurance exchange: consumer assistance, plan management, eligibility, enrollment, and financial management. He defined each core component. 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 the federally-operated exchange, the federal government performs all five core functions. He noted 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 (Attachment 16).

A Committee member asked for clarification on how KEES would fit into a state-federal exchange partnership. Mr. Woerman said this is unknown and why Kansas has requested flexibility to handle its own eligibility requirements; the federal government has not indicated when a decision on flexibility might be forthcoming.

Updates, Committee Requests for Information and Topic Recommendations

Linda Sheppard, KID, provided follow-up to questions from the October 24 meeting. With regard to the question concerning a maternity benefit (defined as a preventive health service, Affordable Care Act) and assuming a 3:1 age band community rating, guaranteed issue, the premium is projected to be 35 percent higher than those in 2011. Out of the 35 percent increase, more than 20 percent is attributed to regular cost trends, a 5 percent increase is related to a guaranteed issue requirement, and 9.5 percent for full maternity and newborn coverage. Ms. Sheppard's testimony further stated that the total cost of the ACA is projected to add about 14 percent to the cost of an individual premium.

Ms. Sheppard further 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, Ms. Sheppard 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.

Ms. Sheppard shared she recently attended a Robert J. Dole Institute of Politics event featuring two of the attorneys involved with the federal court cases related to the individual mandate. One of those attorneys said if the Court finds the mandate unconstitutional, states would encourage the Court to also strike the requirements for guaranteed issue, including elimination of pre-existing condition exclusions and the new rating rules that would prevent insurers from charging higher premiums based on health status. The Court could independently decide to address the severability issue.

In response to the question of waivers and exemptions, Ms. Sheppard indicated the PPACA prohibits annual dollar limits on benefits in health insurance plans. She described how companies have begun phasing out annual limits. 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, HHS/Centers for Medicare and Medicaid Services (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 (Attachment 17).

Suzanne Cleveland, Kansas Health Institute, provided written testimony containing answers to questions raised at the October 24 meeting (Attachment 18).

Commissioner Praeger was recognized by the Chairperson and 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.

A Committee member requested Commissioner Praeger clarify the issue of portability (referenced numerous times in the meeting) and how it can be achieved when moving from one employer to another. Commissioner Praeger said portability refers to the individual marketplace and not an employer-based insurance plan. There is portability in the small-group market involving a 90-day waiting period before an individual becomes eligible for coverage and enrollment. Once the initial 90-day 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). These regulations were included in the Health Insurance Portability and Accountability Act (HIPAA).

Ms. Gossage was asked to respond to a Committee member's concern regarding HSAs, specifically, the complexity regarding the exchange of information. Ms. Gossage 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. She 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. Ms. Gossage said she would provide information on the average income level of individuals using HSAs.

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). She said 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, which do not meet state regulatory requirements. Therefore, an unfair marketplace for companies regulated by the Kansas Insurance Department would be created.

Terry Humphrey, speaking on behalf of Anna Lambertson, Executive Director of the Kansas Health Consumer Coalition, supported the creation of a state-operated exchange in Kansas that meets needs of consumers. She advocated for the participation of consumers, the creation of exchange governance that includes consumers, and the assurance of barrier-free access for Kansans. She said that the planning process, as led by the KID, has produced many recommendations for an exchange governing board, which should be considered as a baseline for any potential action. Ms. Humphrey requested consideration of legislation to support the development of a state-operated insurance exchange under PPACA provisions (Attachment 19).

Written testimony was received from Kay Heley, private citizen, Overland Park, who expressed her concern that the current debate regarding implementation of a state-operated health exchange includes stakeholders who could profit from such an implementation. She encouraged the Legislature to focus on the development of a prevention-based, accessible, and affordable healthcare system for Kansas families (Attachment 20).

Written testimony was submitted from the Kansas Insurance Department concerning the recurrent problem of licensing insurance agents who have unknown out-of-state criminal histories. This relates to the topic of criminal history record checks and fingerprinting of certain financial service representatives. KID's experience with KBI record checks was described in the written testimony. The KID requested support of the proposal for fingerprinting and national criminal history background checks of new insurance agent applications (Attachment 21).

Committee Discussion: Conclusions and Recommendations for Committee Reports to the 2012 Legislature

Chairperson Teichman opened discussion on recommendations for inclusion in the Committee's report for the three topics discussed during meetings: Uninsured Motorists, Criminal History Record Checks and Fingerprinting of Certain Financial Service Representatives, and State Implementation of the Federal Patient Protection and Affordable Care Act.

Uninsured Motorists

The Committee discussed its charge to conduct a comprehensive study on the issue of uninsured motorists in Kansas and a method to determine which vehicles are not insured. The Committee was charged with:

- Determining what electronic method is best for Kansas including a review of electronic verification databases maintained by the state or direct queries of insurance company databases;

- Reviewing steps to encourage Kansans to purchase vehicle insurance, including a study of low-cost basic liability policies as provided in selected other states;

- Determining if additional penalties would be effective in prompting non-complying Kansans to acquire vehicle insurance; and

- Studying alternatives to address uninsured vehicles that also are not registered.

Committee members discussed the legislation passed during the 2011 Session (SB 136), as well as HB 2291, which currently resides in the House Committee on Insurance. SB 136 was designed to encourage more drivers to purchase auto insurance, as required by law, and to reduce the number of uninsured motorists on the road. A Committee member stated, since SB 136 went into effect July 1, 2011, there has not been enough time to evaluate whether the legislation has had the intended effect.

Committee members reviewed prior Motor Vehicle Task Force recommendations and stated goals, which included, but are not limited to the following:

- Providing assistance to the Director of Motor Vehicles and county treasurers in the registration of motor vehicles in compliance with the Kansas Automobile Injury Reparations Act;

- Providing law enforcement officers with roadside information during traffic stops to determine whether vehicles are in compliance with the law;

- Providing greater assurance to the motoring public other vehicles are insured, as required by law; and

- Creating and maintaining a convenient insurance policy interface to provide information to the State of Kansas.

Committee members recognized the valuable commentary heard from conferees on topics, which include:

- Insurance verification methods;
- Incentives to lower rates of uninsured motorists;
- Penalties for non-compliance;
- Unregistered vehicles;
- Complexities of how automobile insurance is written for vehicles owned and insured by commercial entities;
- Verification systems in areas where uninsured motorists (UM) are concentrated;
- Current State processes for annual insurance verifications;
- Law enforcement processes for insurance verification and enforcement;
- Technology issues related to the current system and a potential real-time verification system; and
- The Division of Motor Vehicles (DMV) Modernization Project, which is near completion and is designed to replace aging mainframe systems used for driver licensing and motor vehicle titling and registration.

Committee members noted Kansas' UM ranking was 9.8 percent; the highest ranking state was Massachusetts at 4.5 percent. Consideration was given to the possibility that funding costs for a real-time, web-based verification system could outweigh the benefit of reducing the uninsured motorist ratio at the current time.

Recommendation:

The Committee requested its report be directed to the House and Senate Transportation Committees and recommended that interested agencies, parties, and conferees continue their communication on the topic and report when legislative action is appropriate. This would allow time to evaluate the impact of SB 136, the DMV Modernization Project, and the development and implementation of the State's new IT infrastructure.

Criminal History Record Checks and Fingerprinting of Certain Financial Service Representatives

The Committee members reviewed their charge to:

- Study the possible authorization of fingerprinting and criminal history record checks of certain financial services representatives in Kansas; and

- Review the potential impact on financial regulatory agencies and their licensees, as well as on the Kansas Bureau of Investigation.

During the September meeting, the Committee heard testimony on SB 64 as it related to the Kansas Office of the State Banking Commissioner (OSBC) and regulation of money transmitters, banks, and trust departments. The Committee also heard testimony from the KID concerning SB 71 as it related to fingerprinting and record checks for insurance agent applications during the September meeting. Ms. Calderwood called attention to Attachment 21, which was submitted as supplemental testimony, and she suggested the Committee comment separately concerning issues related to the OSBC and the KID.

Chairperson Teichman recognized Judi Stork, OSBC, who reported she had networked with other state banking officials, and there is agreement to support information sharing from the federal level to the state level in an effort to reduce duplication among various agencies. However, without statutory language, restrictions exist that prohibit this process. Ms. Stork indicated her office would work toward this goal; however, limited time would preclude any potential legislation being ready for consideration by the 2012 Session. Ms. Stork suggested, that since SB 64 is still in the Senate Financial Institutions and Insurance Committee, the four OSBC statutes could be amended. Chairperson Teichman reminded Committee members of the additional amendment requested to exclude publicly traded corporations (or subsidiaries) under the regulation of the U.S. Securities and Exchange Commission from fingerprinting/background checks.

Ms. Calderwood briefed Committee members on SB 71 (continuing education requirements for resident insurance agents). She reported that during the bill's review in the Senate Financial Institutions and Insurance Committee during the 2011 Session, the KID submitted a conceptual amendment that would require applicants for a resident insurance agent license and applicants for a public adjuster license be fingerprinted on and after July 1, 2013. There was no action taken on SB 71.

Committee members briefly discussed the continuing education requirements issue contained in the bill. Kris Kellim, KID, said the agency supports the replacement of the state-limited name search with a nationwide background check.

Recommendation:

With regard to fingerprinting and criminal history record checks for certain individuals, the Committee requested its report be directed to the House Financial Institutions and the Senate Financial Institutions and Insurance Committees, and include the following:

- The Committee recognizes that testimony was heard on SB 64 during the 2011 Legislative Session, and amendments were offered at that time; no action was taken. The Committee recommended that the Senate Financial Institutions and Insurance Committee schedule a hearing on SB 64 (including the amendments submitted by the OSBC and the amendment to exclude publicly traded corporations and their subsidiaries from fingerprinting/background checks) at a

date that would allow time for consideration by the House Financial Institutions Committee; and

- The Committee recognizes that testimony was heard on SB 71 during the 2011 Legislative Session, and amendments were offered at that time; no action was taken. In addition, the Committee recommended the Senate Financial Institutions and Insurance Committee schedule time to review SB 71, including its fingerprinting amendment offered by the KID, prior to the 2012 committee bill deadline, to allow time for consideration by the House Insurance Committee.

State Implementation of the Federal Patient Protection and Affordable Care Act

Ms. Calderwood reviewed the Committee's charge:

- To study the federal Patient Protection and Affordable Care Act for any required corresponding state implementation legislation; and

- To review options for a Kansas health insurance exchange that will comply with the federal health care legislation.

Recommendation:

The Committee noted 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);

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

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

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

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

The Committee recognizes 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, 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 ACA exchange requirements remain unchanged, that a state-based exchange would provide the greatest flexibility.

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 noted, 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. The Committee recommends Dr. Robert Moser's testimony about the four options be attached to its report.

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.

The Committee recognizes the challenges of interpretation and implementation of the 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 legislation. The Committee notes initial start-up costs could be the State's responsibility and HHS could tax insurers to pay for the exchange's maintenance until it becomes self-sustaining.

The Committee recommends 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 HSAs and 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.

Senator Teichman thanked all Committee members and conferees for their time and attention and expressed gratitude to the staff. She adjourned the meeting at 4:05 p.m.

Prepared by Jan Lunn
Edited by Melissa Calderwood and Jill Shelley

Approved by Committee on:

January 11, 2012
(Date)