# MINUTES

## SPECIAL COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

October 24, 2011
Room 548-S—Statehouse

### Members Present

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

### Staff Present

Melissa Calderwood, Kansas Legislative Research Department
Jill Shelley, Kansas Legislative Research Department
Jay Hall, Kansas Legislative Research Department
Amy Deckard, 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

Suzanne Cleveland, Senior Analyst, Kansas Health Institute
Linda Sheppard, Director of Accident and Health Division, Kansas Insurance Department
Dr. Robert Moser, Secretary, Kansas Department of Health and Environment
Sandy Praeger, Insurance Commissioner
Dianne Bricker, Regional Director (State Advocacy), America's Health Insurance Plans
Anna Lambertson, Executive Director, Kansas Health Consumer Coalition

### Morning Session

Melissa Calderwood, Principal Analyst, Kansas Legislative Research Department (KLRD), provided an overview of the third topic for consideration by the Committee: "State Implementation of the Federal Patient Protection and Affordable Care Act." The topic was requested by the Insurance Commissioner and provides several directives:

The Committee studies the federal Patient Protection and Affordable Care Act (PPACA) for any required corresponding state implementation legislation; and

The Committee reviews options for a Kansas health insurance exchange that will comply with the federal health care legislation.

Ms. Calderwood reviewed the agenda, which serves as a future resource for the Legislature, as the Committee contemplates the regulation of the health insurance marketplace in Kansas. Conferees were asked to provide links of informational documents to assist in the review of the topic. Most of the linked documents available on the KLRD website, Ms. Calderwood continued, were created last January as each chamber's Insurance Committee considered this issue. The linked documents provide definitions for common key terms and outline implementation timelines. 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 Affordable Care Act.

**Health Insurance Coverage in Kansas and the Current Health Insurance Marketplace in Kansas**

Suzanne Cleveland, Kansas Health Institute (KHI), discussed sources of coverage for all Kansans of all ages, 2009-2010 (Attachment 1). Ms. Cleveland described the demographics of health insurance coverage in Kansas, noting 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, 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.*, Department of Veterans Affairs or military). Ms. Cleveland also provided information concerning the rates of uninsured Kansans by county.

Questions from Committee members and Ms. Cleveland's responses are listed below:

- A Committee member inquired where insurance programs such as Medi-Share and Samaritan would appear. Ms. Cleveland responded she will clarify and provide a response at a later time.

- In response to a question concerning whether the uninsured rate had been broken down any further to reveal elements such as employment, Ms. Cleveland responded that, due to the sample size, it is difficult to break down a population into specific elements when sample sizes are small and maintain integrity of the statistics.

- When asked about the data source and the sample size, Ms. Cleveland indicated KHI uses the Current Population Surveys—Annual Social and Economic Supplement. It is a survey of about 78,000 households nationwide and asks specific health insurance questions.

Linda Sheppard, Kansas Insurance Department (KID), discussed the current health insurance marketplace in Kansas (Attachment 2). She reported that data from 2010 indicated there were 12 insurance companies 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, there were 17 companies offering coverage and a group of 8 of those had over 75 percent of the market share. Ms. Sheppard discussed the provisions of ACA and the medical loss ratio (MLR). In Kansas, there are two high-risk pools providing coverage: the state high risk pool, administered by the Board of Directors of the Kansas Health Insurance Association (KHIA), 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.

Responding to questions, Ms. Sheppard said:

- Since 1981, the MLR requirement in Kansas has been 55 percent. In order to provide Kansas companies with additional time to adjust business practices, KID has requested an adjustment to the 80 percent requirement, which was enacted under provisions of the ACA.

- Both adults and children are among the 271 members in the Kansas PCIP.

- Under ACA provisions, young adults can be insured under parents' health insurance plans until the age of 26 years; the KID does not have information concerning how many of that population are now covered in Kansas.

- Under the ACA, 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.

- 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. Now one company offers coverage, and only in Wyandotte and Johnson counties.

- Concerning the PCIP pool, Kansas received an allocation of $36 million to operate the pool and pay claims for a three-year period. During the first year of operation, Kansas drew down $5.3 million in claims, which exceeded the projected amount.

- When asked what process is in place if the claims exceed the $36 million PCIP pool, Ms. Sheppard reported the federal Secretary of Health and Human Services has the authority to reallocate dollars among states.

- With regard to a question as to whether KID had information on insurance plans that were granted exemptions from the ACA. She said the federal Department of Health and Human Services (HHS) has information on its website concerning companies that were granted exemptions; however, the KID has not routinely monitored that element. It was requested that the Insurance Department gather information relative to exemptions as well as the number of federal employees in

Kansas who could be exempt from the requirements. In addition, it was requested that information concerning the basis or eligibility requirements of exemptions be provided.

Sandy Praeger, Kansas Insurance Commissioner, provided an overview of the ACA, the development and implementation of a health insurance exchange in Kansas, exchange options, and a planning status report (Attachment 3). Provisions of ACA require creating a health insurance exchange to be operational 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. She 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 referred to additional information contained in her testimony concerning 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. She explained the differences between a federally operated and a state-operated exchange. She 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 Brownback announced in August that the State would return the $31.5 million grant to the federal government that was awarded to help Kansas officials create an insurance purchasing exchange required by federal health reform. Following the Governor's announcement, the Steering Committee met and encouraged the KID to continue the stakeholder planning process for a state-operated exchange. Commissioner Praeger reported that the Steering Committee supports a Kansas-operated exchange.

Commissioner Praeger responded to Committee members' questions; Committee members' comments also appear below.

- During the August Steering Committee meeting, many concerns and opinions were voiced regarding the continuation of a process that may not be implemented. However, no strong objections were voiced, and the decision was made to move forward even in light of the concerns expressed.

- In Kansas, there are 22,000 to 23,000 Kansas resident insurance agents and over 90,000 from Kansas and other states. Whether an agent resides in Kansas or not, the agent still is required to be licensed in Kansas. The majority of agents deal with automobile and home insurance sales.

- Provisions in the ACA utilize a role called 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 insurance agent or company. If a state-based exchange were implemented in Kansas, 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 national insurance community is concerned that a federally operated exchange could operate differently based on its rules and regulations. In Utah, a web-based marketplace exchange exists and compensates agents and brokers for using its exchange.

- The Utah 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; Utah is working to ensure compliance with the federal law.

- An insurance agent could be a navigator as long as no monetary compensation occurs for providing that service.

- The $1 million Exchange Planning Grant is being used to pay for consulting services and to cover expenses of work group and steering committee meetings. Approximately $750,000 remains of the Exchange Planning Grant.

- The $31.5 million Early Innovator Grant was to be used for the design and implementation of information technology (IT) infrastructure needed to operate a health insurance 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, the other grant is available through the end of June 2012.

- In response to federal health insurance reform (ACA), some states' attorneys general have filed suits challenging some portions of the Act. It is possible the U.S. Supreme Court could add the lawsuit to its docket in November 2011, hear the case in March 2012, and render a decision by June 2012.

- There appears to be some controversy about whether to return the $20 million Establishment Grant that Missouri received from the federal government.

- Regarding a question as to whether the KID is attempting to force a health care exchange, Commissioner Praeger said the KID is a regulatory agency, not a policy-making entity; its obligation is furnish quality information to the Legislature and Governor for their decision-making.

- The federal government has assured states that federal funding does exist to create federally-operated exchanges. A federal RFP has been issued for building technology components. HHS is aware a process must be in place to operate federal insurance exchanges since some states' legislatures do not meet in 2012.

- A Committee member noted that under provisions of the ACA, the Internal Revenue Service (IRS) is writing regulations for the funding and eligibility determinations [health insurance premium tax credits], which could exceed

Congressional intent. The IRS will develop eligibility determinations following the creation of tax credits. At the current time, there are many unknown factors.

- Under the ACA, January 2014 is the date a health exchange begins paying claims; October 1, 2013, is the deadline to have the technology operational for a state- or federally-operated exchange; the October 2013 date allows for a three-month enrollment period.

- Within the ACA is the Community Living Assistance Services and Supports (CLASS) program. The CLASS program is designed to expand options for people who become functionally disabled and require long-term services and supports. The Congressional Budget Office has indicated that individuals should plan for healthcare needs in retirement; the CLASS Act may be unsustainable and, therefore, the administration has put the implementation of this provision on hold. It was noted that affordability and sustainability are always of concern, and funding resources are uncertain in these economic times. A Committee member commented that if the CLASS Act were implemented, the premiums would fund a large part of the ACA due to the provision that individuals pay premiums for five years before the benefit can be used. The CLASS provision cannot be repealed because it is part of the ACA, but implementation can be eliminated.

- The highest uninsured rates are in western Kansas; this trend has remained unchanged in the past 11 years.

- With regard to a question concerning allowing insurance companies to sell policies across state borders as a method to increase competition and decrease costs, Commissioner Praeger indicated wider implications exist. In this scenario, market rules from another state would govern the Kansas marketplace. Kansas companies would push competitors to respond to Kansas laws and regulations in order to create fair competition, cross-state sales could offer less comprehensive coverage at a lesser price thus driving up costs, and high-risk individuals may not have an option of affordable insurance. If a comprehensive set of benefits that all states would offer across state borders were implemented, benefits could be realized.

- A Committee member noted that some actuaries have projected Kansas insurance rates to increase up to 400 percent, and the option of choice is restricted. Commissioner Praeger said the concept of insurance is to spread the risk over the broadest number. If a consumer is allowed to select the most desirable benefits, a dysfunctional marketplace could result [healthy beneficiaries leaving the group market]. The most stable marketplace results when benefits are leveled across a large population so everyone shares in the cost.

- It was noted that in Massachusetts, younger, healthier consumers often have a choice of $250 premium (possibly reduced with a subsidy) for the cost of insurance or a $95 penalty. This has caused the members of that population to buy insurance when they need it and dropping it when they do not. The Commissioner indicated medical underwriting cannot be used; underwriting can be used for family status, tobacco use, geography, and age. A rating band exists

that compresses the rate and drives up the cost for younger, healthier consumers; the penalty is less expensive.

- A question arose whether it was possible to offer a federal exchange with a state exchange in place. Commissioner Praeger reported there may be an opportunity for the federal government to offer a multi-state plan. If a multi-state plan were offered, it should comply with all of the states' mandates and rules, thereby eliminating any advantage for this type of plan. If a state-operated exchange is in place, there would be no federal exchange in the state.

- Commissioner Praeger indicated that the KID has not generated any actuarial numbers to determine rates; she clarified that some of the grant funding would be used for actuarial studies as soon as the essential benefits are known.

- In response to a question concerning what companies in the state are changing their plans, Commissioner Praeger reported many employers are self-insured, and the KID would not have information regarding those companies; Employee Retirement Income Security Act of 1974 (ERISA) rules, through the Department of Labor, regulate self-funded insurance plans.

- Insurance plans offered through the Federal Employees Health Benefit Plan would meet ACA exemption requirements.

- Under the ACA, the number of newly insured 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 over 300,000 (with subsidies for qualified individuals). For Kansas, this is a significant expansion. The federal government, which shares the cost of Medicaid with the states, will temporarily pay the full cost of covering those made eligible for the program by the 2014 expansion. However, it will continue to pay only about 60 percent of the cost for new participants who were eligible but not enrolled prior to expansion. The gradual phase-in period for state funding begins in 2017 after which the federal share decreases to 90 percent in 2020.

- Concern was expressed with the requirement for the federal government to pay 100 percent of the expanded Medicaid population until 2017. The Debt Commission has announced that could be changed. Commissioner Praeger indicated this could be revised only after additional legislation is passed.

- The number of overall "new insured" does not include small businesses (fewer than 50 employees) that could drop employer-sponsored healthcare insurance. Some studies have indicated it is possible "new insured" could increase up to 30 percent, but there still are tax benefits for employers to provide a portion of employees' wages in health benefits.

- A Committee member noted that many small businesses are considering eliminating healthcare insurance as a benefit to their employees and said the result of such action would reduce business, growth, and revenue for the State.

- A Committee member commented that with the creation of health savings accounts (HSAs), affordability and flexibility is enhanced for individuals. In Kansas, an employer's contribution to an employee's HSA is excluded from income and payroll taxes; the Committee member encouraged that business write-offs be allowed to occur. Commissioner Praeger indicated that as the ACA law evolves and the market begins to transform, opportunities may arise that would allow modification of the current standard. She clarified that 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 premium increases. When asked whether some of the high-cost individuals would be eligible for the Kansas high-risk pool, Commissioner Praeger confirmed that the high-risk pool would be available but not until the individual had been uninsured for six months. Insurance coverage alternatives must be developed to cover an individual's six-month gap.

- When asked whether insurance premiums have been calculated, Commissioner Praeger indicated calculations can occur when benefits are known. She commented that one of the work groups discussed whether Kansas would require all plans (platinum, gold, silver and bronze); no decision has been made at this time.

- In response to a question concerning whether an individual could purchase non-qualified plans under ACA provisions, Commissioner Praeger responded that marketplace rules inside and outside the exchange are required to be the same.

- With regard to discussions concerning the federal government allowing states to delay implementation of an exchange, Commissioner Praeger offered that, if the court upholds ACA provisions, there will be an exchange in Kansas in 2014, a federal exchange, a state exchange, or a type of federal-state partnership. Grant money and other federal financial assistance to the state for developing an exchange would be unavailable in 2014. Commissioner Praeger elaborated that in a federal-state exchange partnership, the federal entity would govern eligibility, enrollment, and financing; the state would retain authority to regulate navigators, to perform planned certification, and, perhaps, to set marketplace rules.

- A Committee member complimented the KID on its website showing information about the ACA, the exchange work groups, and steering committee recommendations.

- When asked whether 90 percent of uninsured Kansans could meet ACA guidelines that would qualify them for Medicaid, CHIP or other federal assistance, Commissioner Praeger reported the new eligibility rules will include many low-income adults in Kansans who today do not qualify for Medicaid. All Kansans under age 65 with annual incomes between 133 percent and 400 percent of the Federal Poverty Level (FPL) will be eligible.

- A Committee member cited multiple examples within ACA provisions and Section 1311 related to how a state could structure its exchange to provide flexibility. Many of the examples required approval by HHS. The Commissioner responded that the KID continues to advocate for flexibility within ACA provisions. She

commented that the federal law is unfolding in a landscape of growing uncertainty; therefore, the Insurance Department is committed to support Kansas and its residents by ensuring information is gathered and presented in a way to promote good decisions.

Dianne Bricker, Regional Director, America's Health Insurance Plans (AHIP), discussed key issues for the states' exchange options and activities (Attachment 4). Ms. Bricker described her association's role in collaborating with member companies to craft comments, analyses, and technical assistance in tracking exchange implementations throughout the United States. Her organization supports exchange goals of promoting private market competition, preserving consumer choice, and preventing duplicative regulation. She reviewed the status of federal Exchange Planning Grants, Early Innovator Grants, and Level I Establishment Grants. In addition, Ms. Bricker commented on exchange legislation introduced, establishment bills enacted or pending, and Executive Orders initiated. Various exchange approaches by states were discussed, including on their governance, structure, carrier participation, and funding. Included in her testimony was a comprehensive comparison of federal, California, Massachusetts, and Utah approaches on exchanges. Ms. Bricker recommended Kansas consider moving forward with a state exchange, which would encourage private-market competition.

In response to Committee members' questions, Ms. Bricker provided the following answers:

- Ms. Bricker had indicated in her testimony 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; she confirmed that health plans can be sold both inside and outside an exchange.

- Ms. Bricker 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.

- Health exchanges must be self-sustaining in 2015, under provisions contained in the ACA. When asked what happens if a federally operated exchange is implemented in Kansas, Ms. Bricker could not answer whether the federal government would be responsible for funding and maintaining the Kansas exchange; however, Ms. Bricker will investigate and report back to Committee members.

- A Committee member noted that while the information reveals potential legislation has been introduced for various states, legislative bills for actual implementation have not been passed. Ms. Bricker confirmed that shades of gray

do exist at the current time. Colorado has passed establishment legislation which includes a legislative oversight group with the power to direct the future of its exchange.

- Massachusetts and Utah already have implemented their state exchanges (pre-ACA legislation); in January 2013, HHS will determine whether a state is ready for implementation.

**Minutes Approval**

Upon a motion by Representative Mah and a second by Senator Longbine to approve the minutes of the September 27, 2011, meeting, the minutes were approved as submitted.

## AFTERNOON SESSION

**Stakeholder Perspectives on Implementation of a State-Based Health Insurance Exchange; Exchange Planning Work Group Reports and Recommendations; Question and Answer; Response to Work Group Report**

Linda Sheppard, KID, was recognized to present information concerning steering committee and work group meetings. She reported that since January there have been a total of 48 meetings involving more than 400 volunteers and an estimated 3,800 volunteer hours (Attachment 5). Ms. Sheppard demonstrated the information contained on the website http://www.ksinsuance.org/hbexplan/ including HHS-proposed regulations with comment sections, the ACA law as it currently exists, key federally facilitated exchange milestones, and a glossary to assist consumers in understanding the law. There are separate pages set up for each work group, a calendar of work group and steering committee meetings, and each work group's mission. Ms. Sheppard reviewed three recommendations adopted by the Steering Committee: certification of navigators, training of navigators, and a Kansas exchange governance proposal. Additionally, resource material for the Special Committee has been made available at the Exchange Planning work group website.

In response to questions, Ms. Sheppard provided the following information:

- 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 six *ex officio* members; and
- A process was designed to determine from where nominations come, how nominees are chosen, term limits, occurring vacancies, and other requirements for Board operations.

A Committee member commented that all nominees may not possess all of the core competencies contained in the governance proposal. Ms. Sheppard indicated this proposal would be a recommendation for presentation to the Legislature as a foundation on which to build.

Anna Lambertson, Executive Director of the Kansas Health Consumer Coalition, next discussed her organization's participation in the comprehensive exchange planning process (Attachment 6). She indicated that many Kansans, uninsured or underinsured, postpone or forgo recommended healthcare due to the costs. Ms. Lambertson commented that she feared Kansas will not meet the upcoming deadlines. She indicated her organization supports the design and implementation of a state-operated exchange and remains committed to moving forward.

Robert Moser, M.D., Secretary of the Kansas Department of Health and Environment (KDHE), presented information related to cost estimates and effects on the Kansas Medicaid expansion envisioned in the ACA (Attachment 7). Secretary Moser commented the goals for Medicaid reform include integrated and coordinated care, preserving paths to independence, developing alternative access methods and models of care, and utilizing community-based services. Secretary Moser discussed the Kansas Eligibility Enforcement System (KEES), which is the State's expansion and incorporation of KDHE's K-MED and SRS' Avenues programs on a common platform; the KEES system 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 IT infrastructure investments. Secretary Moser named various state 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). He reported that the Department of Corrections also would be added to users to assist in SRS' fraud and abuse 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 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 reported the KEES implementation does not require Kansas to create an insurance exchange; federal matching funds 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.

Responding to questions, Secretary Moser said:

- He would report back to Committee members whether an upgrade to the Medicaid Management Information System (MMIS) would be included in the $85 million acquisition cost.

- When asked about the KEES acquisition cost, Secretary Moser noted the original cost projection was $35 million-$40 million, which was to be used for replacing the KMED 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.

- With respect to the funding provided by SRS, Secretary Moser indicated he would provide the funding breakdown.

- Secretary Moser clarified the KEES system's architecture is designed to create the ability of diverse systems and organizations to work together. Eventually, these interoperable systems could function across all state agencies to accept, receive, send, and use information. In the State of Kansas, many legacy systems exist that 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.

- A Committee member expressed appreciation for the technology upgrades and agreed the goal of interoperability was in the best interest of the state; however, concern was expressed concerning the final cost for the system.

- The KEES implementation is an enrollment and eligibility system for Kansas Medicaid and SRS; it does provide the interoperability for a health insurance exchange. However, CMS approved the program and agreed to language that this approval does not obligate the state to implement an insurance exchange. The approval of the KEES project provides Kansas with the flexibility to implement an exchange if the individual mandate is upheld.

- When asked about the KEES implementation, 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. Secretary Moser will forward the timeline and deliverables (within the contract) to Ms. Calderwood for dissemination to Committee members.

- When asked whether returning the $31.5 million 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.

- 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 additional expense could be added to build interfaces that create interoperability. Secretary Moser will provide to Committee members the language in the contract.

- Secretary Moser and Commissioner Praeger collaborated to provide clarity related to KEES and its interoperability with a health insurance exchange. 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 her understanding was 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 October 1, 2013 (for the 3-month enrollment period) and, therefore, missing the deadline would compromise any implementation of a state exchange for January 1, 2014.

Commissioner Praeger was next recognized to discuss the grant opportunities and fiscal implication for an exchange. She indicated that if a decision is made to move forward with a state or state/federal exchange partnership, additional funding would be required (Attachment 8). Commissioner Praeger discussed Level I and Level II Establishment grants and deadlines for each:

- Level 1 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 for this grant 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, legislation in 2012 is required. The other option is to default to a federal exchange, which may or may not use KEES technology.

Responding to questions, Commissioner Praeger or a member of her staff reported:

- Exchanges are required to be self-sustaining by 2015; this means exchange users will pay a fee to use the exchange and, therefore, pay for its operation. Kansas consumers using a federal exchange will pay to use it; any exchange is required to be a self-sustaining private marketplace and not reliant on public funding. Fees have not been established.

- If the KEES system is not operational by October 1, 2012, 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 provides. Commissioner Praeger expressed concern that if the federal government operates exchanges in multiple states, process standardization would occur. Kansas could lose the flexibility and authority to design and operate its own exchange.

- A Committee member suggested KID IT representatives communicate/network with federal government IT representatives to assess ramifications should the State's eligibility system (KEES) be non-operational by October 1, 2013. Commissioner Praeger and her staff offered to submit additional information to the November meeting.

- Concern was expressed that upcoming grant deadlines may be unmet. If Level I or Level II grant funding is not awarded, and the "individual mandate" is upheld, no additional funding would exist that would enable Kansas to implement a state-operated exchange. Commissioner Praeger indicated that, absent federal funding, the cost of creating an interface with insurers would be paid from the State General Fund (SGF).

- A Committee member commented that with regard to the KEES maintenance and operation fee, Kansas is responsible for $15 million with $13 million already appropriated from the SGF and noted the inclusion of other platforms; Kansas is not expending $85 million to go forward. Commissioner Praeger clarified when the $31.5 million grant was returned to the federal government, funding was reallocated as a 90/10 matching grant. It was used to fund the KEES project (formerly the K-MED project).

- Ms. Sheppard commented 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.

- When asked what happens if the Supreme Court rules the "individual mandate" unconstitutional, Commissioner Praeger commented that opinions have surfaced indicated other provisions of ACA could remain in place. This would present a difficult situation unless the ACA "pre-existing condition" and guaranteed issue are removed from the ACA. It is unknown at this time 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 U.S. Supreme Court upholds the ACA, Kansas then assumes a different fiscal responsibility for many years. In addition, interoperability of the federal system and its integration to the KEES is undefined at this time. The concern is the potential growth of expenditures from the SGF.

- Another Committee member suggested there is potential expenditure growth if a state-operated exchange model is selected; if a federal model is implemented, the federal government will fund the initial start-up expenses. Commissioner Praeger commented that if a federal model is implemented, the State could lose control of numerous decision points.

Suzanne Cleveland, Kansas Health Institute, discussed the projections for coverage and exchange participation in Kansas (Attachment 9). Ms. Cleveland discussed the methodology that was used to determine the potential exchange participation. When projections were calculated, it was assumed the exchange would be used by individuals or employer groups of 50 or fewer. She 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 (253,000 in Kansas) is critical, and a range of options exists:

- 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 primary 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 KHI accounted for those individuals who chose not to be insured, Ms. Cleveland said KHI did not attempt to determine reasons for the uninsured; the projections were based on eligibility to determine the potential for exchange participation. Ms. Cleveland indicated the Committee member's point was a valid one; the residual rate of uninsured people (people who will not purchase or otherwise have insurance) is likely between 4 percent and 6 percent.

A Committee member inquired whether an employer group can go in and out of an exchange. Ms. Cleveland deferred to Commissioner Praeger. The Commissioner indicated there is no requirement prohibiting an employer from entering or leaving the exchange at any time.

**Committee Discussion**

Chairperson Teichman indicated there are uncertainties that require consideration: whether the "individual mandate" is upheld, whether the "individual mandate" is overturned, whether the law is changed resulting from elections, and severability.

At the request of Chairperson Teichman, Ms. Calderwood presented identified topics for the agenda on November 14, listed below:

- Employer-sponsored insurance in the small business category and how eligibility is determined;
- HSAs and consumer health plans as a business solution;
- Web-based exchanges working in a voluntary environment or in a state or federal exchange;

- Opportunities for comments from the public, stakeholders, interested groups or citizens prior to Committee recommendation on the state implementation of the ACA. These comments would be included in the record;

- Addressing exchange governance issues, a not-for-profit board concept, legislative requirements, statutory changes necessary, and minimum requirements for implementation;

- Obtaining additional information on a federal exchange model should the Legislature choose not to act;

- The role of navigators and how they interact with the exchange;

- The KEES implementation and essential interface with the federal exchange; and

- Recommendations from the Committee on the three topics:

    - Topic 1 – Uninsured Motorists Recommendations;
    - Topic 2 – Criminal History Record Checks and Fingerprinting of Certain Financial Service Representatives; and
    - Topic 3 – State Implementation of the Federal ACA.

She said the Legislative Research Department will work with KDHE and KID to obtain responses concerning KEES (project timeline; a breakdown of the $85 million of funding; contractual language; SRS budget information); granted health plan exemptions and what those plans are; federal employee health benefit enrollment in Kansas; federal exchange and requirements for self-sustaining financing; identification of reasons for being uninsured; and the funding requirements and differences between a state versus a federal exchange.

A Committee member requested information at the next meeting from the KID concerning maternity coverage [preventive health service] and asked that an actuary provide the rate using a 3:1 community rating band as well as a guaranteed issue. A copy of the KDHE contract for the KEES project containing language relating to CMS approval also was requested.

The meeting was adjourned at 4:05 p.m.

Prepared by Jan Lunn
Edited by Melissa Calderwood and Jill Shelley

Approved by Committee on:

November 14, 2011
(Date)