

Approved: 2-3-11

Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 a.m. on January 11, 2011, in Room 152-S of the Capitol.

All members were present.

Committee staff present:

Ken Wilke, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Heather O'Hara, Kansas Legislative Research Department
Beverly Beam, Committee Assistant

Conferees appearing before the Committee:

Bob St. Peter, Kansas Health Institute
Suzanne Cleveland, JD, Senior Policy Analyst

Chairman Teichman welcomed the Committee and Staff, as well as others in attendance, to the first meeting of the 2011 Legislative Session. The Chair asked the Staff to introduce themselves.

The Chair presented F I & I Committee rules for the 2011 Legislative Session. She asked that Committee members arrive on time and that cell phone usage be limited.

Melissa Calderwood, Kansas Legislative Research Department, briefed the Committee on Federal Health Insurance Reform and provided resource material.

Bob St. Peter, Kansas Health Institute, also gave a brief overview of the Federal Health Insurance Reform Law. (Attachment 1)

Suzanne Cleveland, JD, Senior Policy Analyst, presented graphics and information on the Federal Health Insurance Reform Law. Q & A followed her presentation.

The next meeting is scheduled for January 12, 2011.

The meeting was adjourned at 10:30 a.m.

HEALTH REFORM RESOURCE DOCUMENT

The Impact of Health Reform on Health Insurance Coverage in Kansas



KANSAS
HEALTH
INSTITUTE

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More Information

This resource document provides more in-depth information about concepts discussed in the brief, *The Impact of Health Reform on Health Insurance Coverage in Kansas*. The brief, along with others in the series about health reform, can be found online at www.khi.org.

If you are reading this document online, clicking on a term in the table of contents will direct you to the information.

Funding for this project was provided by the United Methodist Health Ministry Fund, a philanthropy based in Hutchinson, and the Kansas Health Foundation in Wichita, a philanthropic organization whose mission is to improve the health of all Kansans.

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ADEQUATE AND AFFORDABLE COVERAGE

These concepts will be more fully defined as implementation of the ACA unfolds but generally speaking, “adequate” will describe a health plan that covers the “minimum essential health benefits” package and adheres to other established market rules. “Affordable” will describe a health plan with out-of-pocket costs and premiums that do not exceed a certain percentage of annual income.

ADVERSE SELECTION

This phenomenon is defined as the tendency for higher-risk individuals to purchase insurance in greater frequency than lower-risk individuals. An insurance pool depends on having a large enough number of healthy members to keep the average costs of the plan low. If a larger than expected (or desired) number of sick members enters the pool and the costs escalate, healthy people may choose to exit and either forego insurance altogether or find a cheaper policy. As more healthy people exit the pool, average costs escalate even further for those that remain, creating a cycle that is untenable.

AFFORDABLE CARE ACT (ACA)

Federal health reform, commonly referred to as the Affordable Care Act (ACA), came about in two separate pieces of legislation. First, the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. Then, a few days later, the Health Care and Education Reconciliation Act (HCERA), which modified several provisions of the PPACA, was signed into law. The two are collectively known as the ACA.

CONSORTIUM ON HEALTH CARE REFORM LEGISLATION IMPLEMENTATION

<http://www.nga.org/portal/site/nga/menuitem.751b186f65e10b568a278110501010a0/?vgnextoid=7f8844ce25208210VgnVCM1000005e00100aRCRD&vgnnextchannel=92ebc7df618a2010VgnVCM1000001a01010aRCRD>

CONSUMER PROTECTIONS

In Kansas, small employers with between two and 50 employees are already protected by guaranteed issue rules (see definition on page 4). Insurance for larger employers is governed by either state or federal law depending on the type of insurance, and consumers are fairly well protected in the large-group market.

COST-SHARING SUBSIDIES

The cost-sharing subsidies will reduce out-of-pocket expenses and are tied to family income level.

COVERAGE TIERS

The tiers of private coverage in the health insurance exchanges vary in how generous the covered benefits are. This is measured by a term known as the actuarial value. The Center on Budget and Policy Priorities explains it this way: “Actuarial value in its most basic form measures how much a particular health insurance plan is expected to cover of a typical population’s costs for covered medical services. It usually is expressed as a percentage of those costs, although it also can be converted into a dollar value. For example, a plan with an actuarial value of 75 percent would be expected to pay 75 percent of the medical expenses for covered health services for a typical population.”

Actuarial Value of Plans Offered in the Exchanges

“Bronze”	This plan represents the required minimum creditable coverage standard; the actuarial value is 60%
“Silver”	Actuarial value of 70%
“Gold”	Actuarial value of 80%
“Platinum”	Actuarial value of 90%
“Catastrophic”	Provides catastrophic coverage along with some preventative and primary care benefits (only available in the individual market) to young adults (under age 30) and those to whom the individual mandate does not apply due to income reasons

DEPENDENT COVERAGE

Prior to the ACA, some insurers in Kansas defined age 19 as the cut off for dependent coverage, while many others used age 23. It is important to note that the ACA does not require dependent coverage; rather, it creates a new age limit for those plans that do provide dependent coverage.

ESSENTIAL HEALTH BENEFITS

The ACA imposes a requirement that certain insurance plans provide at least a minimum threshold of covered health services known as the essential health benefits. The requirements for the essential benefits package have not yet been fully defined, but will include services such as hospitalizations, outpatient care and prescription drugs.

EXEMPTIONS TO THE MANDATE

People exempt from the individual mandate's requirement to purchase coverage include those with qualifying religious exemptions, those in a health care sharing ministry, individuals not lawfully present in the United States, incarcerated individuals, those who are without coverage for less than three months (with only one period of three months allowed in a year) or members of Indian tribes. Qualifying individuals who would otherwise be subject to the mandate, but who reside outside of the United States, as well as bona fide residents of any possession of the United States will be considered to have minimum essential coverage and therefore will not be subject to the financial penalty.

FEDERAL CONTRIBUTION

The federal government will pay 100 percent of the costs of the newly eligible Medicaid enrollees when the program expands in 2014. Those payments will decrease over time as follows, and the remaining amount will be paid by the states:

2014–2016:	100%
2017:	95%
2018:	94%
2019:	93%
2020 and on:	90%

FEDERAL HIGH-RISK POOL

Officially known as the Pre-existing Condition Insurance Plan or PCIP, the federal high-risk pool was actually set to be in place 90 days after enactment of the ACA, but was slightly delayed. The federal high-risk pool imposes cost-sharing limits for out-of-pocket expenses — \$5,950 for an individual and \$11,900 for a family. This out-of-pocket limit does not include the cost of premiums. The federal high-risk pool requires that a person have been without insurance for at least six months to qualify.

FEDERAL POVERTY LEVEL (FPL)

The federal government's working definition of poverty that is used as the reference point for the income standard for eligibility for public programs. Published by the Department of Health and Human Services in the form of Poverty Guidelines, the FPL varies by family size and is adjusted annually for inflation. The 2010 Poverty Guidelines are provided at the top of the next column.

2009–2010 Federal Poverty Guidelines for 48 Contiguous United States, District of Columbia, Guam and Territories, Effective July 1, 2009 (Annual Income)

Percent FPL	1 Person*	2 People	3 People	4 People
100%	\$10,830.00	\$14,570.00	\$18,310.00	\$22,050.00
133%	\$14,403.90	\$19,378.10	\$24,352.00	\$29,326.50
200%	\$21,660.00	\$29,140.00	\$36,620.00	\$44,100.00
300%	\$32,490.00	\$43,710.00	\$54,930.00	\$66,150.00
400%	\$43,320.00	\$58,280.00	\$73,240.00	\$88,200.00

*Number of people in household.

Source: *Federal Register*. (2010, January 22). Volume 75, Number 14, pp. 3734–3735.

FINANCIAL PENALTIES

The financial penalty for individuals who do not secure acceptable health insurance coverage phases in as follows:

2014: \$95 financial penalty per household member, up to three members, or 1 percent of annual household income capped at the amount described below.

2015: \$325 financial penalty per household member, up to three members, or 2 percent of annual household income capped at the amount described below.

2016: \$695 financial penalty per household member, up to three members, or 2.5 percent of annual household income capped at the amount described below.

The penalty in a given year will be capped at the national average premium for a “Bronze” level health plan offered through the health insurance exchanges.

FINES

If an employer of 50 or more employees does not provide any insurance coverage, and one or more employees seeks coverage through the health insurance exchanges and receives federal assistance (i.e., premium tax credits or cost-sharing subsidies), that employer will be fined \$2,000 for each employee of the company. The first 30 employees will be deducted from the total number of employees when determining the amount of the fine.

For example, an employer with 75 employees would pay $\$2,000 \times (75-30) = \$90,000$.

If an employer provides some coverage, but the coverage does not meet adequacy or affordability guidelines and an employee seeks coverage in the exchanges and receives federal assistance, the fine is the lesser of \$3,000 per person receiving federal assistance

(rather than per the total number of employees) or \$2,000 per each person in the company, minus the first 30 employees. For example, an employer of 75 with 5 employees receiving federal assistance would pay $\$3,000 \times 5 = \$15,000$.

GUARANTEED ISSUE

A requirement that an insurer offer a health insurance policy to any individual or group.

HEALTH INSURANCE EXCHANGES

A purchasing arrangement through which small employers and individuals purchase private health insurance. States and the federal government will establish standards for what benefits must be covered, how much insurers can charge and other rules insurers must follow in order to participate in the insurance exchange market. Individuals and small employers will select their coverage from among the private insurers offering coverage within this organized arrangement.

MAY 2010 REPORT

KHPA Analysis of the Impact of Federal Health Reform in Kansas: http://www.khpa.ks.gov/ppaca/KHPA_Analysis.html

PRE-EXISTING MEDICAL CONDITION

An illness or health problem in existence before the purchase of a health insurance policy. Historically, some insurance policies could be written so as to exclude coverage for pre-existing conditions, or an insurance policy could be denied on the basis of a pre-existing condition. Certain individual market plans are grandfathered from the pre-existing condition rule imposed by the ACA.

PREMIUM TAX CREDITS

The premium tax credits are based on family income, such that the total amount paid for annual insurance premiums will not exceed a defined percentage of annual family income. The maximum percentage of annual income paid in premiums is related to income level as follows:

Up to 133% FPL: 2% of income
133% up to 150% FPL: 3–4% of income

150% up to 200% FPL: 4–6.3% of income
200% up to 250% FPL: 6.3–8.05% of income
250% up to 300% FPL: 8.05–9.5% of income
300% up to 400% FPL: 9.5% of income

RATING FACTORS

Health insurers use these factors to set prices for premiums and other health plan expenses. Depending on the type of insurance, rates can be based on the health status of plan participants, as well as age, gender and other factors.

RESCISSION

The practice of cancelling an insurance policy, even if premiums and other amounts have been paid, because a medical condition develops. In some cases, the cancellation is based on a beneficiary's failure to disclose medical issues at the time of enrollment in the insurance plan. Under the ACA, rescissions will only be allowed for fraudulent or intentional misrepresentation of facts.

STATE HIGH-RISK POOL

Run by the Kansas Health Insurance Association, the state high-risk pool offers coverage to people with pre-existing conditions who have been denied coverage or for some reason are unable to purchase coverage in the private market. The state high-risk pool was created by the Kansas Legislature in 1992.

TAX CREDITS

To qualify for a tax credit, a small business must employ fewer than 25 employees, have an average annual salary of less than \$50,000, and contribute roughly 50 percent of the cost of its employees' health insurance coverage. The tax credit, against the general business tax (for tax exempt organizations the credit will be in the form of a reduced withholding), is initially up to 35 percent of the employer's premium costs (up to 25 percent of the premium costs for nonprofit organizations). Beginning in 2014, tax credits will only be given for coverage purchased through the health insurance exchanges, and the credit will expand to up to 50 percent of the employer's premium costs (up to 35 percent for nonprofit organizations).

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

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