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 am. on January 12, 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
Beverly Beam, Committee Assistant

Conferees appearing before the Committee:
Sandy Praeger, Insurance Commissioner
Dr. Andrew Allison, Kansas Health Policy Authority

The Chair welcomed everyone to the meeting.

Sandy Praeger, Kansas Insurance Commissioner, gave an overview of Federal Health Insurance Reform and implementation in Kansas along with regulatory perspectives.

Dr. Andrew Allison, Kansas Health Policy Authority, reported on state responsibilities with regard to implementation of the Affordable Care Act, and KHPA priorities and potential impact on Kansas. (Attachment 1)

The Insurance Commissioner introduced the following bills.

1. Surplus Lines Agreement – the bill would provide for participation in a multi-state agreement in order to recover premium tax on this product line. After July 24, 2011, individual states cannot collect this tax due to the Dodd-Frank Act of 2010.

2. Risk-Based Capital – the bill would revise the date of the NAIC instructions to December 31, 2010. This year's RBC reserves varied by more than the 2.5% trigger compared to last year's standard.

3. High Risk Pool – the bill would provide for the ability of the Board to increase the life time limit with the approval of the Commissioner. The bill will allow the Kansas Health Insurance Association to accept children under 19 who are otherwise eligible for the pool to be eligible if no such coverage is available in the county in which they live.

4. Internal and External Review – the bill would revise the utilization review statute to modify the definition of "emergency medical condition," to increase the time allowed for a consumer to challenge an adverse decision from 90 to 120 days, and decrease the turnaround time for a decision from 7 days to 72 hours.

Senator Masterson moved to introduce all bills as proposed. Senator Merrick seconded. Motion passed.

The next meeting is scheduled for January 13, 2011.

The meeting was adjourned at 10:30 am.

SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE
GUEST LIST

DATE: 1-12-11

NAME	REPRESENTING
Bill Sneed	AHIP
[illegible]	United Health Group
[illegible]	KID
[illegible]	KAHHD
[illegible]	FHP
[illegible]	ACS
Michelle Butler	Cap. Strategies
Chad Austin	KHA
Mandy Miller	SCoSKS
Sandy Braden	GBA
Dan Murray	NFIB
David Hanson	KS INSUR ASSNS

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Implementing the Affordable Care Act: Agency Priorities and State Policy Choices

Senate Financial Institutions and Insurance Committee

January 12, 2011

Dr. Andrew Allison, KHPA Executive Director

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Kansas Medicaid and CHIP at-a-glance

- Medicaid: Free coverage for very-low income families, elderly and disabled
  - Pregnant women and infants up to 150% FPL
  - Children: 100% or 133% of FPL, depending on age
  - Elderly and Disabled: income limits vary, 100 – 200% FPL
  - Adult Parents and Caregivers: appr. 30% FPL
  - "Medically Needy" – Adults with incomes above threshold with large medical bills
  - Childless adults are not covered
- CHIP
  - Income limit: 250% of 2008 FPL (appr. 241% current FPL)
  - Premiums: $20 - $75 per-family, per-month, depending on income (CMS will reject a state plan amendment to raise these by $40-100 per month)
  - "HealthWave:" State contracts with MCO; pays flat, capitated rate for each beneficiary – also serves 141,000 Medicaid children and parents

2

FI&I Committee
1-12-11
Attachment 1-1

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Brief Summary of the ACA

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Federal Health Reform: Two New Laws

- **Patient Protection and Affordable Care Act of 2010 (ACA)**
  - Based on Senate health reform legislation
  - Passed March 23, 2010
- **Health Care and Education Affordability Reconciliation Act of 2010**
  - Added some elements of House reform proposals to the Senate version
  - Passed April 2, 2010

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Affordable Care Act: Private Insurance

- **Changes taking effect within six months**
  - New, temporary re-insurance pool for early retirees
  - Create new high-risk pools for those with pre-existing conditions
  - Provide dependent coverage for children up to age 26 for all policies
  - Eliminate lifetime limits on dollar value of coverage
  - Prohibit insurers from retroactively dropping coverage except for fraud
  - Prohibit pre-existing condition exclusions for children
  - Up to a 35% subsidy for small employers (under 25) to provide insurance
- **Changes taking effect in 2014**
  - Guaranteed offers of insurance to all eligible consumers
  - Eliminate any premium differences based on health risks or gender and limit age-rating to a premium ratio of 3-1
  - Income –related subsidies for both premiums and cost-sharing
  - Create new insurance marketplace through "exchanges"

5

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Affordable Care Act: Health Insurance Subsidies

- **Sliding scale premium subsidies based on income**
  - Under 150% FPL: Max. of 2-4% of income
  - 150-200% FPL: Max . of 4-6.3%
  - 200- 400% FPL: Max . of 6.3-9.5%
- **Cost-sharing protections based on income**
  - Under 150% FPL: Max. of 6% of covered costs
  - 150-200% FPL: Max. of 15%
  - 200-400% FPL: Max. of 27-30%
  - Separate income-related out-of-pocket caps
- **Insurance reforms, subsidies, and cost-sharing protections interact**
  - Some out-of-pocket costs shift into premiums
  - Raw premiums for young adults will go up
  - Young adults are most likely to qualify for subsidies and protections
- **Federal government bears limited risk for premium increases**
  - After 2014, increases in subsidies will be limited to growth in income
  - After 2018, subsidy growth will also be tied to inflation

6

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Affordable Care Act: Insurance Exchanges

- Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP)
- States may default to federal government to establish the exchange
- Administered by governmental agency or non-profit
- Subsidies available only through the new exchanges
- Available to individuals and small businesses (up to 100 employees)
- States can allow larger businesses to buy coverage in SHOP in 2017
- States may form regional exchanges with other states or within the state
- Federal funding available to establish exchanges through 1/1/2015

7

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Affordable Care Act: Medicaid Expansion

- Maintenance of effort for Medicaid eligibility: current Medicaid eligibility rules are set in stone (only until 2014 for adult eligibility above 138% of poverty)
- Medicaid is expanded in 2014
- All non-disabled under 65, up to 138% FPL (includes childless adults)
- Feds cover 100% of cost for expansion group in 2014 through 2016
  - 2017: 95%
  - 2018: 94%
  - 2019: 93%
  - 2020 and thereafter: 90%
- Some state flexibility in covered benefits for newly-eligible
  - Must meet minimum standards set by Federal government
  - Minimum standards may entail new benefits like "habilitation" and "rehabilitation"
  - ACA language indicates that states can opt to provide additional benefits to the expansion population

8

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Affordable Care Act: Children's Health Insurance Program

- Require states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019
- Extend funding for CHIP through 2019
- Benefit package and cost-sharing rules continue as under current law
- In October 2015, federal CHIP match rate increased by 23 percentage points
- Federal allotments for CHIP funding remain in place, limiting potential enrollment
- Eligible children who can't enroll due to limited funding will be eligible for tax credits in the state exchanges

9

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Affordable Care Act: Presumed Objectives

- **Define health insurance coverage**
  - Minimum coverage includes standard benefits and implies affordable cost-sharing
  - Includes prescription drugs and mental health parity
- **Secure access to an offer of group-like insurance coverage for everyone**
  - Eliminates differences in insurance premiums due to the health risks of individuals or co-workers
  - Private, portable insurance for those buying as individuals and employees
- **Get insurers to compete with each other rather than consumers**
  - New exchanges should facilitate price shopping and ease enrollment
  - Stabilize private insurance markets through required participation
- **Buy or subsidize minimum coverage to ensure affordability**
  - Greatly expand Medicaid to cover the lowest-income Americans
  - Cost-sharing protections and Federal tax subsidies for premiums aid others

10

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Implementation

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Affordable Care Act Implementation: State Responsibilities

- **Implement insurance reforms**
  - decide whether to accept the responsibility and opportunities that come with the establishment of an exchange
  - define what kind of competition they want inside the exchange
  - decide how to govern these new and potentially dominant health insurance markets
  - decide whether, and how, to use the buying power and regulatory influence they have been given in Federal legislation
- **Coordinate Medicaid and the new exchange(s)**
  - ensure access to coverage
  - seamless transitions between different sources of coverage
  - link Medicaid's insurance market with the new private insurance market?
- **Determine Medicaid's new role in the health care system**
  - simplify eligibility and select benefit package for Medicaid expansion group
  - set Medicaid payment rates and secure access to providers
- **Respond to numerous grant and demonstration project opportunities**

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Affordable Care Act Implementation: KHPA Priorities

- Closely monitor and work with federal agencies
  - Federal health reform panels
  - National Association of Medicaid Directors
- Understand and describe reform
  - Estimate Potential Impact on Kansas (May 2010)
- Coordinate information system changes
  - Build a new platform for Medicaid and the Exchange (RFP released October 2010)
- Detailed analysis of state policy choices under the ACA
  - $250,000 in grants from five Kansas grant makers (matched 1-for-1)
  - Create options for Medicaid benefit packages and to simplify Medicaid eligibility (RFP for contract analysis pending; analysis due mid-2011)
- Coordinate planning for the exchange with Kansas Insurance Department
  - Develop Innovator Grant application with KID (submitted December 21, 2010)
- Solicit input from stakeholders and inform policymakers

13

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Analysis of Potential Impact on Kansas

14

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ACA State-Level Estimates: Key Motives

- **State spending is best understood in a more comprehensive estimate**
  - Employer-sponsored coverage offsets Medicaid (for those also eligible for both)
  - Impact of coverage mandate affects Medicaid participation
  - Overall reduction in the number of uninsured could have an impact on ongoing spending for state programs designed for the uninsured
- **State fiscal impact is dependent on future state decisions**
  - Programs designed to secure access for the uninsured may need to be reviewed
  - Estimates examine state spending under a range of future policy choices, including potential increases in Medicaid provider payment rates
- **State estimates create a baseline to assess key policy choices**
  - Actuarial modeling requires up-front fixed costs
  - State agencies will need to be contribute given ACA's impact on existing programs

15

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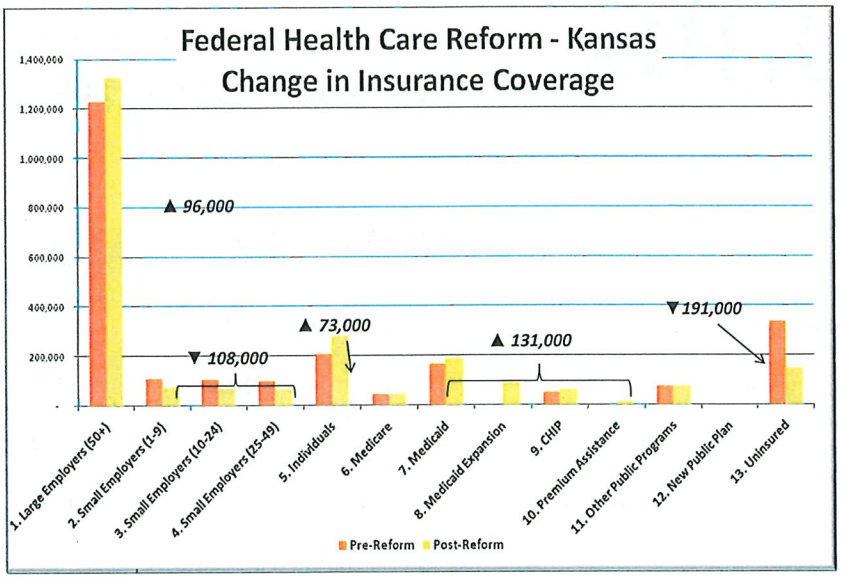
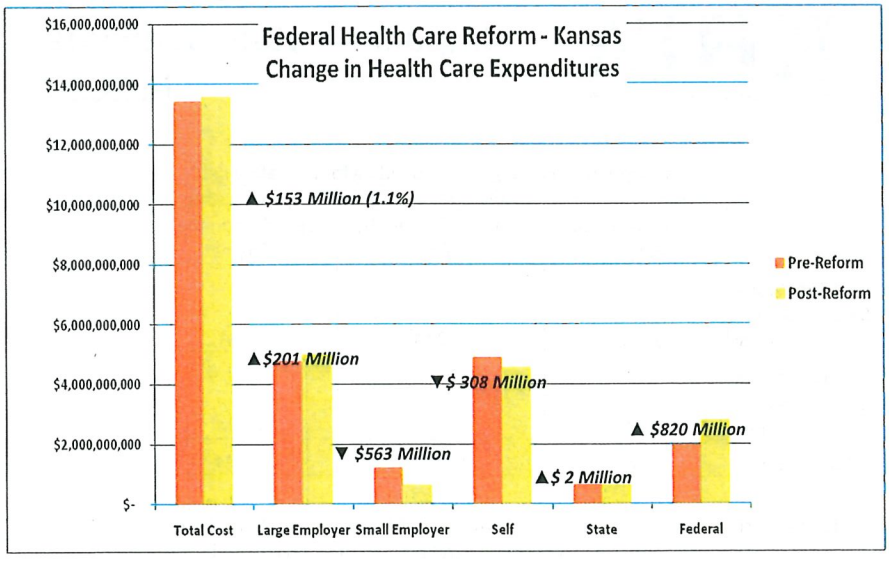
ACA State-Level Estimates: Sources and Process

- **Coverage and basic cost estimates produced by *schramm-raleigh Health Strategy (now Optumas)* with funding from the United Methodist Health Ministry Fund**
  - Additional analysis of impact on state spending by KHPA
- **Results are consistent with national estimates by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS)**
  - 6% residual rate of un-insurance (rate for Medicaid eligibles was raised to 4%)
  - Small net impact on employer-sponsored coverage
  - Small positive impact on total health spending
- **Estimates include increased cost of program administration**
  - 5% of gross increase in spending; matched by the Federal government at 50%
- **Estimates expressed in constant dollars using 2011 as a base**
- **Limitations**
  - Estimates reflect impact on under-65 population only
  - Estimates do not reflect reductions in Medicare payments included as funding sources in health reform legislation
  - Do not replicate other analyses of the impact on Federal taxpayers

16


Federal Health Care Reform - Kansas
Change in Insurance Coverage
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
-
▲ 96,000
▼ 108,000
▲ 73,000
▲ 131,000
▼ 191,000
1. Large Employers (50+)
2. Small Employers (1-9)
3. Small Employers (10-24)
4. Small Employers (25-49)
5. Individuals
6. Medicare
7. Medicaid
8. Medicaid Expansion
9. CHIP
10. Premium Assistance
11. Other Public Programs
12. New Public Plan
13. Uninsured
Pre-Reform
Post-Reform


Federal Health Care Reform - Kansas
Change in Health Care Expenditures
$16,000,000,000
$14,000,000,000
$12,000,000,000
$10,000,000,000
$8,000,000,000
$6,000,000,000
$4,000,000,000
$2,000,000,000
$-
▲ $153 Million (1.1%)
▲ $201 Million
▼ $563 Million
▼ $ 308 Million
▲ $ 2 Million
▲ $820 Million
Total Cost
Large Employer
Small Employer
Self
State
Federal
Pre-Reform
Post-Reform

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Affordable Care Act: Impact of Enhanced Match Rates on Medicaid in 2020

	All Funds Spending ($ millions)	Average State Share	State Spending ($ millions)
Baseline spending	1,541	40.2%	619
Spending with reform	1,972	31.5%	621
Change	+432	-8.7%	+2
Percent change	28.0%		0.3%

Notes: Reflects point estimate. Includes spending on medical care only. Excludes administrative costs and changes in DSH spending.

19

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Affordable Care Act: Impact on State Spending in 2020

State options regarding direct spending for the safety net*

	Maintain all state spending on the safety net	Reduce state spending on the safety net by half	Eliminate state spending on the safety net
Point estimate plus 5% provider rate increase	$35 M	$12 M	-$8 M
Upper bound estimate of coverage	$7 M	-$16 M	-$35 M
Point estimate	$4 M**	-$19 M	-$39 M

Additional risk: +/- $15 million variance in true cost of Medicaid benefit package. Impact subject to state choice and federal regulation over covered benefits.

*Options are illustrative and do not reflect the opinions of KHPA staff, nor the KHPA Board. State spending totals for the uninsured through the safety net are preliminary ($40-$45 million annually) .

**To the estimate from the actuaries model, this adds new administrative costs and reductions in DSH spending.

20

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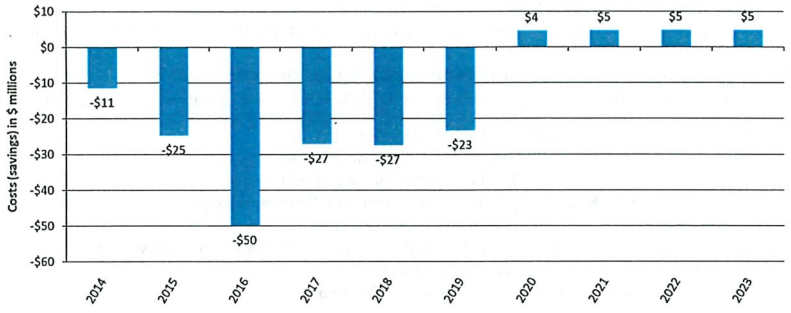
Affordable Care Act: Net Impact on State Spending 2014-2023

Net Impact of Federal Health Reform on State Spending:
Point estimates: no additional reduction in State spending on the uninsured



Note: Reflects point estimates. Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.

21

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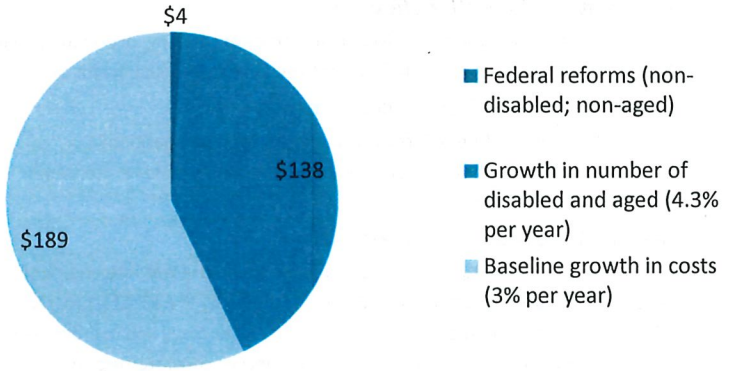
Sources of Growth in Medicaid Spending 2011 vs. 2020



(estimates in $ millions)

Note: Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.

22

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Affordable Care Act: Implications for Medicaid

- **Expanded role for Medicaid in funding the safety net**
  - Medicaid will become the major payer for some providers
  - Approach to payment and cost control will be more important
- **Reduced turnover among Medicaid beneficiaries**
  - Higher, uniform income threshold will increase continuity
  - Larger, more stable Medicaid population increases financial returns to the state for investments in prevention and care management
- **States will need to re-evaluate programs designed for the uninsured**
  - The state helps mitigate uncompensated care through Medicaid disproportionate share hospital (DSH) payments, direct state subsidies to health care and mental health clinics, special Medicaid reimbursements to clinics and critical access hospitals, etc.
  - Health reform will bring at least $150 million in new health spending in the state
  - Many of the remaining uninsured will be eligible for subsidized coverage
  - Cultural expectations for coverage and individual responsibility may change
  - Key questions:
    - How much of current state spending on the safety net is devoted to the uninsured?
    - How much uncompensated care will remain?
    - What is the state's ongoing responsibility for those costs?

23

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ACA State-Level Estimates: What It Does Not Do

- **Change individual *health behaviors***
  - Directly confront the true cost drivers in health care: smoking, over-eating, inactivity
  - Make sure individuals face the right incentives as consumers of health care
- **Reduce *health care prices* for consumers**
  - Expand the number of providers to create more price competition?
  - Fill in "missing" provider markets with changes in training and/or licensing?
  - Enact malpractice reforms?
- **Reduce *public spending* on health care**
  - Public spending on health care is unsustainable at the present rate of growth
  - In Kansas, increases in public spending will be driven by the existing program
  - Will require changes in the delivery of care, e.g., technology and coordination
  - Federal reform created new opportunities, but leaves concrete steps to states

24

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Implementing the ACA: Transforming the Eligibility Process

25

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Implementing the Affordable Care Act: The Eligibility Challenge

- **Twice the scale**. The state needs an on-line real-time system to support eligibility determinations for 33% larger Medicaid population and another Medicaid-sized exchange population receiving at least $600 million in income-based premium subsidies annually.
- **One-third the time**. Business process must support enrollment of the expanded population in an annual "open enrollment period."
- **Perfectly integrated**. The ACA requires a single, integrated application and enrollment process for health insurance provided through Medicaid and the exchange, that communicates in real time with a federal information portal (IRS, Homeland Security, SSA, other federal programs).
- **Ready in three years**. First open enrollment starts October 2013.

26

Assessing Kansas' Readiness for the Eligibility Challenge

- Combined "system" for Medicaid, cash assistance, food stamps, and child care often doesn't speak with itself
- Aging mainframe system has "hardening of the arteries"
  - Programs written in a dead language
  - Paper applications are required: mail-in or hand carry
  - Labor-intensive reviews and work-flow management
  - Off-system calculations and "work-arounds"
- Very difficult to support additional eligibility categories
- Lack of a simple consumer interface limits outreach
- Can support on-line electronic adjudication of eligibility for neither Medicaid nor for subsidies in the exchange
- "Scalable" neither in the complexity nor the size of programs it can support
- Tens of thousands of un-enrolled eligible individuals

27

Changing Needs in Medicaid Eligibility and Outreach

Current Model

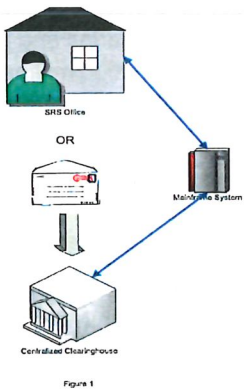

Figure 1

New Model

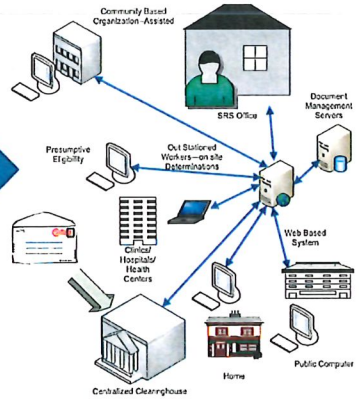

Figure 2

28

Kansas' Solution: HRSA Grant to Pave the Way

State Health Access Program (SHAP) Grant from Health Resources and Services Administration (HRSA)

- Final grant in a series of HRSA/SHAP grants
- Kansas previously had 2 SHAP grants, documenting the over-riding problem of eligible, but un-enrolled children
- Grant is to provide support for starting up programs that extend coverage to the uninsured population
- SHAP grants will demonstrate, proof-test, and de-bug key elements of federal reform

KHPA's project to cover the uninsured

- Awarded multi-year grant
- Includes funds to build IS base for modern approach to outreach
- Out-stationed eligibility workers to recruit and train community outreach partners
- Pilot expansion of coverage to young adults

29

Planned Eligibility System for Health Insurance Coverage

HRSA grant objectives

- Create full "vertically integrated" eligibility system for Medicaid and the exchange
- Create online application for Medicaid/CHIP and presumptive eligibility screening tool for community partners
- Use full electronic adjudication to reduce error and increase the number and speed of determinations

Additional benefits related to the ACA

- Provide a base for seamless eligibility determinations between health insurance products including subsidies for participants in insurance exchanges under the ACA
- Provide platform that can be used as a building block for the future Medicaid Management Information System (MMIS) – appr. 2015
- Work together with human service agency (SRS) to create a common, flexible platform that could be used (later) to build an integrated process for administering and coordinating means-tested programs, e.g., cash assistance & food stamps

30

KHPA's Role as the Medicaid Agency – Eligibility

- KHPA determines eligibility policy and rules
- Eligibility determination performed by:
  - SRS
    - 15% of family cases
    - All disabled and elderly cases (those with asset limitations)
  - KHPA Enrollment Clearinghouse (includes some KHPA staff)
    - All SCHIP eligibility cases
    - 85% of low-income families that apply
- Competing priorities create challenges in health reform
  - SRS owns and maintains 20+ year old, labor-intensive eligibility system
  - KHPA is responsible for implementing Medicaid expansion and coordinating with the new exchange

31

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32