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 13, 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:
Bill Sneed, America's Health Insurance Plans
Matt All, General Counsel, Blue Cross/Blue Shield of Kansas
Chad Moore, Children's Mercy Health Partners
Marlee Carpenter, Kansas Association of Health Plans
Sandy Braden, National Association of Insurance and Financial Advisors-Kansas
Scott Day, National Association of Health Underwriters, Kansas

The Chair welcomed all in attendance to the meeting.

Bill Sneed, America's Health Insurance Plans (AHIP). Mr. Sneed gave a general overview of the Patient Protection and Affordable Care Act. (Attachment 1)

Matt All, General Counsel, Blue Cross/Blue Shield of Kansas, said BCBS of Kansas supports many of the reforms in the Patient Protection and Affordable Care Act. He said BCBS believes guaranteeing all Americans the ability to obtain insurance regardless of their health is a big step forward, so long as it is accompanied by other reforms that insure all Americans actually purchase insurance. He said, however, there are concerns with other provisions. He said BCBS believes the taxes within PPACA are too high, the personal coverage requirements are too weak, and cost controls uncertain. He continued that BCBS believes it is imperative that Kansas run its own exchange and retain control over its insurance marketplace. In conclusion, he said because of the unusual burden PPACA has placed on health insurers and business owners, it is critical for state legislators to refrain from adding additional requirements and mandates for now. He said it would be better to wait until many of these issues are settled before making any other changes in health insurance. (Attachment 2)

Chad Moore, Children's Mercy Health Partners (CMFHP), stated that CMFHP has been working with the Kansas Health Policy Authority and the Kansas Department of Insurance to provide its perspective on the challenges presented by components of the federal health insurance reform bills. He said overall, CMFHP believes there must be strong coordination between government agencies charged with program policy development and oversight for Medicaid and the new state-based health insurance exchange. He noted this will be critical as there will be significant overlap between populations such as kids covered through CHIP with parents eligible for coverage through the exchange. (Attachment 3)

Marlee Carpenter, Kansas Association of Health Plans, provided input on the enactment of new health insurance mandates in Kansas. She said the mandates should be deferred until the federal definition of "essential benefits" has been finalized. Also, she said legislators should look at the enactment of a state-based exchange by the January 1, 2013 deadline so Kansas does not default into the federal exchange. (Attachment 4)

Sandy Braden, National Association of Insurance and Financial Advisors-Kansas, reported that NAIFA has been working with the National Association of Insurance Commissioners on various aspects of the Patient Protection Affordable Care Action. She said NAIFA has asked the state associations to participate in discussions regarding the implementation of state exchanges and suggested ten guidelines on state exchanges. (Attachment 5)

Scott Day, National Association of Health Underwriters, presented an outline of Health Insurance Reforms that will impact private health insurance coverage under the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010. (Attachment 6)

The next meeting is scheduled for January 18, 2011. The meeting was adjourned at 10:30 am.

SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE
GUEST LIST

DATE: 1-13-11

NAME	REPRESENTING
Bill Sneed	AHIP
Haley Dakes	KCUL
Chad M. Moore	Children's Mercy Family Health Partners
Brad Smoot	BCBS / FHP
Scott Day	KAHU
[illegible]	Cap. Strategies
Sandra Braden	NAIFA KS
[illegible]	KCUA
[illegible]	United Health Group
Kari Presley	Kearney & Assoc.
Larry R Baer	LKM
Mandy Miller	SCOFKS
Derek Klein	Klein Law Firm

Polsinelli Shughart PC

Memorandum

TO: Senator Ruth Teichman, Chair
Senate Financial Institutions and Insurance Committee

FROM: William W. Sneed, Legislative Counsel
America's Health Insurance Plans

SUBJECT: Patient Protection and Affordable Care Act and its impact on the health insurance industry

DATE: January 13, 2011

Madame Chair, Members of the Committee: My name is Bill Sneed and I represent America's Health Insurance Plans. AHIP is a trade association representing nearly 1,300 member companies providing health insurance coverage to more than two million Americans. Our member companies offer medical expense insurance, long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers. I have been asked to give a general overview on the Patient Protection and Affordable Care Act.

The Patient Protection and Affordable Care Act (the "Act") signed by President Obama on March 23, 2010 was intended to improve the performance, transparency and accountability of health insurers and health insurance products.

In lieu of testimony, I have attached a compendium of material created by my client that you and your Committee may find useful in reviewing the new Federal Act.

I am available for questions at your convenience.

Respectfully submitted,

William W. Sneed

WWS:kjb
Attachments: 1

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Attachment 1-1

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Testimony of Matthew D. All
Vice President/General Counsel
Blue Cross and Blue Shield of Kansas, Inc.
Senate Financial Institutions & Insurance Committee
Regarding The Patient Protection and Affordability Act (PPACA)
Thursday, January 13, 2011

Madame Chair and Members:

My name is Matthew D. All, and I am General Counsel and Vice President for Public Policy and Human Development for Blue Cross and Blue Shield of Kansas. As a mutual, not-for-profit health insurer, headquartered here in Topeka and serving nearly 900,000 fellow Kansans in our service area, our sole mission is to provide high quality, affordable health insurance to Kansans. We do that by offering world class customer service, the broadest provider networks, and by keeping our administrative costs to an absolute minimum – just under 9 cents of a premium dollar.

The year 2010 was one of the most significant and momentous in our nearly 70- year history. The passage of the Patient Protection and Affordable Care Act (PPACA) created enormous challenges for our employees. PPACA has required us to do essentially two things at once: implement a wide array of short-term reforms within our current business model while planning for the fundamentally changed insurance market that will exist in 2014. Our 1,450 employees have spent tens of thousands of hours during the past 10 months implementing these reforms while planning for the future. We are proud of the work we have accomplished and confident about our future, but well aware of the extraordinary amount of work ahead of us, as well as continued uncertainty, as we prepare for the new marketplace.

Blue Cross and Blue Shield of Kansas, along with the Blue Cross and Blue Shield Association and many other health insurance companies across the country, support many of the reforms in PPACA. We believe guaranteeing all Americans the ability to obtain insurance regardless of their health, for example, is a big step forward, so long as it is accompanied by other reforms that insure all Americans actually purchase insurance. We are concerned, however, with other provisions. We believe that the taxes within PPACA are too high, the personal coverage requirements are too weak, and the cost controls are uncertain. Until these issues and others are addressed, successfully reforming the health care system for all Americans will remain unaccomplished.

State policymakers like you have important decisions to make during the next couple of years regarding whether and how to set up an exchange. As you have heard from previous speakers, PPACA envisions individual and small group health insurance sold through an exchange, beginning in 2014. PPACA gives each state an opportunity to set up its own exchange; if a state fails to do so, the Department of Health and Human Services is required to run an exchange in that state. We believe it is imperative that Kansas runs its own exchange and retains control over

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its insurance marketplace. We believe this is important for Kansas business owners and consumers, along with the Kansas insurance industry. Health insurance, after all, is fundamentally a local product, and is dependent upon the specific conditions and circumstances of the local health care provider marketplace. Answering to a regulator in Washington, D.C., instead of Topeka, would be bad for businesses and consumers alike.

Because of the unusual burden PPACA has placed on health insurers and business owners, we believe it is critical for state legislators to refrain from adding additional requirements and mandates for now. Although there may be a wide array of worthy public policy initiatives that legislators could pursue, this just isn't the right moment. It would be far better to wait until many of these issues are settled before making any other changes in health insurance.

Thank you for the opportunity to speak to you today.

Children's Mercy
FAMILY HEALTH PARTNERS
www.fhp.org

Statement of Chad Moore
Director of Government Relations & Public Affairs
Children's Mercy Family Health Partners
Senate Committee on Financial Institutions & Insurance
Regarding Federal Health Insurance Reform Implementation in Kansas
January 13, 2011

Dear Madam Chair and Members of the Committee:

On behalf of Children's Mercy Family Health Partners (CMFHP), thank you for this opportunity to comment on certain aspects of the federal health insurance reform bills passed in March 2010. CMFHP is a not-for-profit safety net health plan owned by Children's Mercy Hospitals & Clinics, a not-for-profit free-standing pediatric health system based in Kansas City. CMFHP operates an integrated care system that contracts with the state of Kansas to provide health insurance benefits to children and adults who are eligible for HealthWave, which includes Medicaid managed care and the Children's Health Insurance Program (CHIP).

While Kansas has contracted with managed care organizations since 1995 to provide Medicaid and CHIP services, CMFHP began serving these populations on January 1, 2007. We currently serve approximately 70% (more than 125,000) of the eligible HealthWave participants. We strongly believe that we have demonstrated great value to the state of Kansas by providing affordability through budget predictability and cost savings, better health care access and outcomes, outstanding provider and customer satisfaction results, and accountability to taxpayers and policymakers.

Federal Health Insurance Reform

In light of the approaching Medicaid eligibility expansion, as well as the development of a state-based health insurance exchange, CMFHP has been working with the Kansas Health Policy Authority and the Kansas Department of Insurance to provide its perspective on the challenges presented by these components of federal health insurance reform bills. Overall, CMFHP believes that there must be strong coordination between government agencies charged with program policy development and oversight for Medicaid and the new state-based health insurance exchange (the "Exchange"). This will be critical as there will be significant overlap between these populations, i.e. kids covered through CHIP with parents eligible for coverage via the Exchange.

Exchange Development

CMFHP has identified several issues critical to ensuring access to affordable quality health care coverage that will effectively meet the needs of individuals and families accessing health coverage through the new Exchange. Our comments can be summarized in the following five main themes:

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- The Exchange must be designed to provide options that offer the best value for low income consumers, including individuals and families who will newly access coverage through the Exchange and those who may transition out of Medicaid in the future.

- The Exchange structure must be flexible enough to ensure that safety net health plans, like CMFHP, are allowed to participate if they choose. That is, state regulations should not erect barriers to participation that would disproportionately impact the ability of safety net health plans to participate in the Exchange, particularly plans that already meet the rigorous certification process and stringent quality and access standards required to contract with the State to offer benefits to HealthWave and CHIP participants.

- The Exchange should encourage and support continuity of coverage for individuals and families that may shift between the Exchange and other sources of coverage, such as Medicaid and CHIP. It is widely expected that small changes in income will result in frequent changes in eligibility for Medicaid, CHIP, and subsidized coverage in the Exchange. And even a temporary loss of health coverage can have significant, adverse consequences. One approach would be for the Exchange to prospectively assign individuals to a plan based on what Medicaid health plan they were under. Further, there will also be situations where kids are covered under CHIP or Medicaid, while their parents or caretakers become eligible for coverage under the Exchange. It makes sense to keep the entire family covered under the same health plan. State policies and regulations should support such occasions.

- The Exchange should look to build on existing Medicaid and CHIP systems, processes, and policies, which are familiar to consumers who will be interacting with the Exchange. For example, the Exchange and Medicaid should maintain the same complaint and appeal process, the same customer service performance standards, and the same provider access standards which would simplify issues for consumers and insurers.

- As the Exchange is designed and developed for Kansas, there must be a robust process for stakeholder input which will allow for the design of a highly efficient Exchange that connects individuals with the most appropriate coverage. We are pleased that this stakeholder input has already begun with the Kansas Insurance Department and the Kansas Health Policy Authority.

Thank you again for allowing me the time to introduce our organization to the Committee and to discuss these issues.

Kansas Association of Health Plans

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January 13, 2011

Testimony Before the Senate Financial Institutions and Insurance Committee
Marlee Carpenter, Executive Director

Chairman Teichman and members of the Committee;

I am Marlee Carpenter, Executive Director of the Kansas Association of Health Plans (KAHP). The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comments to the committee.

KAHP is here today to provide some input on federal reform and its enactment in Kansas. There are two specific points that I want to discuss. First, the enactment of new health insurance mandates in Kansas should be deferred until the federal definition of "essential benefits" has been finalized. Second, the legislator should look at the enactment of a state-based exchange by the January 1, 2013 deadline so that Kansas does not default into the federal exchange.

Even though federal health care reform has been signed into law, we continue to wait on rules and regulations from HHS for definitions and directions for implementation. One issue that will affect the state legislative process is the federal definition of "essential benefit." HHS is working on federal definition of "essential benefit" and it is not expected to be finalized until August 2011 or later. This definition is important because these federally defined "essential benefits" will be subject to the federal/state funding split for Medicaid/HealthWave dollars. States are able to offer benefits in excess of the "essential benefits" but will be required to pay 100% for these benefits for their state Medicaid/Health Wave plans. It is important that before any new mandates are enacted that legislators know what the definition of federal "essential benefits". In addition, after the definition is finalized, Kansas should look at its current mandates and how they match up with the federal essential benefits definition.

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Second, the federal reform bill has put into place a deadline for the enactment of a state-based exchange. Under federal reform, flexibility has been given to the state to enact a state-based exchange. If the state fails to implement a state-based exchange that is certified by HHS no later than January 2013, the federal government will enact a federal exchange in the state. KAHP encourages the legislature to enact a state based exchange so Kansas can maintain control of its health insurance market. This is important to both insurance companies and citizens in the state to have a Kansas based entity looking out for their needs, well-being and health insurance coverage.

Again, KAHP encourages the legislature to wait for the federal definition of "essential benefits" before enacting any new state mandates and that the state begin the process of working towards the enactment of a state-based exchange.

Thank you for your time and I will be happy to stand for questions.

NAIFA KANSAS

NATIONAL ASSOCIATION OF INSURANCE AND FINANCIAL ADVISORS OF KANSAS

Comments by Sandy Braden
National Association of Insurance and Financial Advisors of Kansas (NAIFA Kansas)
On the 2010 Patient Protection and Affordable Care Act
Before the Senate Financial Institutions and Insurance Committee
January 13, 2011

NAIFA Kansas is an organization made up of over 800 insurance and financial services agents in Kansas. NAIFA Kansas is a federation of national, state and local associations. In 2009, a sister association made up of agents involved in providing health care products to clients, AHIA, merged into NAIFA. NAIFA then became involved in the 2010 Patient Protection and Affordable Care Act. NAIFA has also been working with the NAIC (National Association of Insurance Commissioners) on various aspects of the Patient Protection Affordable Care Act.

NAIFA has asked the state associations to participate in discussions regarding the implementation of state exchanges and suggests the following guidelines on state exchanges:

1. States should create a state exchange as opposed to letting the Federal government come in as a fallback.
2. A single public state exchange should be created allowing individual and small business owners access to coverage options
3. A single public state exchange should be created. Regional exchanges should be considered with caution as differing states laws may complicate the exchanges and prove to be more costly to administer. The Kansas City area market may be an exception.
4. The state exchange should be an online enhancement, not a replacement of the existing insurance market.
5. States should limit participation to individuals and small groups.
6. A market outside of the state exchange must be allowed to continue.
7. States should create a risk-adjustment mechanism rather than rely on the Federal government.
8. A simple administrative structure, using the existing insurance departments is preferred.
9. Funding should be broad based in nature and not fall on any one group or segment of society.
10. Licensed insurance agents should be a part of the state exchange in order to continue to provide service to their clients.

More information on the above issues can be provided upon request.

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Outline of Health Insurance Reforms that Will Impact Private Health Insurance Coverage under H.R. 3590, the Patient Protection and Affordable Care Act and H.R. 4872, the Health Care and Education Affordability Reconciliation Act of 2010

Presented by Scott Day
State Treasurer of the Kansas Association of Health Underwriters

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Reform Provisions and their effective dates

Reform	Provisions of the Reform	Effective Date of Change	Possible Outcomes
Insurance Market Reforms			
Modified Community Ratings	Allows for a (3:1) rating difference for age; (1.5:1) for smoking; and eliminates (0:0) differences for sex.	2014	Raises Insurance premiums
Guaranteed Issue policies for Children	Cannot deny coverage for pre-existing conditions for children	2010 (6 month)	Raises insurance premiums
Guaranteed Issue policies for Adults	Cannot deny coverage for pre-existing conditions for adults	2014	Raises insurance premiums
Preventative covered 100%	Must cover preventative services in all insurance plans	2010 (6 month)	Raises insurance premiums
Minimum Loss Ration	Plans must pay 80% of premiums (individual & small group) & 85% of premiums (large group)	2014	Encourages utilization spending...cuts services
Dependent Age	Allows "children" to remain on parents policies until age 26	2010 (6 month)	Raise group premiums
Emergency Services	Emergency services will be covered as In Network regardless of provider	2010 (6 month)	Raises utilization
Prohibits limits	Prohibits annual and lifetime limits on coverage	2010 (6 month)	Expected to be neutral
Highly Compensated Employees	Group plans cannot discriminate to this group	2010 (6 month)	Eliminate those plans?
Policy Recissions	Prohibits policy rescissions except for cases of fraud.	2010 (6 month)	Neutral
te Based Exchanges	States must create a market place for individuals and small groups to shop for health insurance	2014	Restriction of the market
Administration	New requirements on reporting policy changes & enrollment reqs.	2010	Increases premiums

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Reform	Provisions of the Reform	Effective Date of Change	Possible Outcomes
Employer Requirements			
W-2 Reporting	Must report on W-2 aggregate cost of employer sponsored health insurance	2014	Employer admin increase, tax increase for Cadillac plans
Free Choice Vouchers	All employers that provide health insurance must provide vouchers for EE's who pay 8 to 9.8% of their salary to health insurance. The voucher must equal what the employer contributes. EE keeps excess amounts.	2014	Employer admin increase, hurts group market.
Employer Mandate for insurance	Employers with 50+ FTE (includes PT) are required to provide group insurance or pay a fine. Fine is $2000 per EE...exempting the first 30 EE's.	2014	Employers dropping insurance?
Exchange Notification	Employers must notify employees of the state insurance exchange.	2014	Employer admin increase, hurts group market.
LTC Enrollment	All employers must enroll employees in the new public LTC program unless the EE opts out	2014	Employer admin increase
Auto Enrollment	Employers with 200 + employees must enroll new EE's into health insurance.	2014	Employer admin increase
Waiting period	Cannot exceed 90 days	2014	Employer admin increase
Premium Assistance	If EE pays more than 9.5% of salary and earns less than 400% of FPL, State will provide assistance to purchase employer insurance.	2014	Employer admin increase & fine.

Reform	Provisions of the Reform	Effective Date of Change	Possible Outcomes
Individual Requirements			
Individual Mandate to purchase	All citizens & legal residents must purchase health insurance. Provides exceptions for religious objectors, illegal aliens, incarcerated, those under FPL, and Indian tribe members. Fines are 1% of salary in 2014;2% in 2015; and 2.5% capped at bronze level plans in 2016	2014	Federal intrusion, additional costs to uninsured, Fines to the uninsured, lower health premiums?
Tax Requirements			
Pharmaceutical tax	$2.3 Billion in 2010 will increase by $4.8 Billion over next 10 years	2010	Insurance premium increase
Indoor Tanning	10% tax on indoor tanning	2010	Tax on tanners
Medicare Part D deduction	Eliminates the deduction for employers providing retiree Medicare Part D coverage...costs AT&T $1 Billion...and others.	2010	Services will cost more to the consumer
Small group Tax Credit	Provides a 2 year 50% tax credit for small employers that provide insurance and pay at least 50% of the premium. Credit is for employers with >25 employees	2010	Will encourage small employers to keep plans for next 2 years.
Medical Device Tax	Installs a $2 Billion tax on medical devices...increases to $3 Billion in 2017.	2011	Inflates price on medical devices and raises insurance premiums.
HSA/FSA Tax Changes	Increases HSA penalty for non-medical distributions from 10% to 20%; limits medical FSA to $2500 from unlimited; Excludes OTC drugs from tax exemption unless prescribed by physician.	2011	Loss of tax shelter for individuals...increase of tax burden.
Insurance premium Tax	Premium tax of $2/person for Comparative Effectiveness Research	2012	Increases premium cost
Itemized Health Deduction	Increases the health deduction threshold from 7.5% to 10% of AGI	2013	Loss of tax shelter for individuals...increase of tax burden.
Medicare Tax	Increases Medicare tax for self-employed or individuals earning more than $200,000 or $250,000 for joint filers from 1.45% to 2.35%. Does not change the employer contribution amount. Also has 3.8% tax on certain unearned income.	2013	Tax increase on employers

Form	Provisions of the Reform	Effective Date of Change	Possible Outcomes
Health Insurance CEO cap	$500,000 deduction limit for CEO's of health insurance companies.	2013	Neutral
Tax on uninsured individuals	1% of salary in 2014; 2% of salary in 2015; and 2.5% of salary capped at the annual cost of a bronze level health insurance plan	2014	Force some people to buy insurance or cause some people to drop insurance & pay the fine.
Employer Tax	For Employers with 50+ FTE Employees and DON'T provide insurance...$2000/employee and the first 30 EE's are waived.	2014	If $2000 is less than the cost of insurance, employers may drop health insurance.
Premium Assistance fine	For Employers that provide health insurance, but if any of their EE's don't take their coverage and instead use the premium assistance tax credit will be fined $3000 per employee receiving the credit	2014	Going to discourage employer sponsored plans.
Health Insurance Tax	Tax on insurance companies begins with $8 Billion in 2014; $11.3 Billion in 2015 & 2016; $13.9 Billion in 2017; $14.3 Billion in 2018 and will make adjustment each year thereafter.	2014	Insurance premiums increase.
"Cadillac" Tax	A 40% excise tax on "rich" plans valued at $10,200 for an individual & $27,500 for families. Includes in the calculations reimbursements from FSA's, HRA's and employer contributions to HSA's.	2018	Shift to plans with lesser benefits
Medicare/Medicaid Changes			
Medicaid Expansion	Expands eligibility to 133% of FPL	2014	Produces "crowd out".
Premium Assistance	Adds premium assistance to pay subsidies for EE's to buy employer sponsored insurance	2014	See fine above.
Non-Medicaid Plan	States can create a non-medicaid plan for individuals earning 133 to 200% FPL	2014	Produces "crowd out".
Medicare Cuts	Medicare Advantage takes most of the $500 Billion in cuts.	2014	Reduces available benefits & MA will struggle.