Approved: January 31, 2011
Date

MINUTES OF THE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Vicki Schmidt at 1:30 p.m. on January 18, 2011, in Room 526-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Senator Dick Kelsey
Kelly Hedlund, Kansas Practicing Perfusionsts Society
Suzanne Cleveland, Kansas Health Institute

Others attending:
See attached list.

Bill Introductions

John Federico, representing the Kansas Naturopathic Physicians Association, requested introduction of legislation regarding the Association's scope of practice. Moved by Senator Brungardt and seconded by Senator Kelsey. Motion carried.

Mr. Federico also requested introduction of a bill on behalf of the Kansas Association for Oriental Medicine for licensure of acupuncturists. Moved by Senator Steineger, seconded by Senator Brungardt. Motion carried.

Ron Hein, on behalf of the Kansas Physical Therapists Association to amend the licensure act. Moved by Senator Kelsey, seconded by Senator Huntington. Motion passed.

The Chairman opened the hearing on **SB 5-Board of Healing Arts; licensure and education of perfusionists.**

Senator Kelsey testified in support of the bill. The bill is essentially the perfusionists bill that was passed by the Senate 37-3 last year but did not receive a hearing in the house committee.

Staff presented a brief outline of the bill with particular attention being drawn to the changes made to the proposed legislation from the bill previously submitted last year.

The Chair recognized Kelly Hedlund, Secretary/Treasurer, Kansas Practicing Perfusionists Society, who spoke in favor of **SB 5.** Mr. Hedlund told the committee that the benefit from licensure is evidence to the public as to the standards that are in place. It is felt that the time is right for this type of legislation even though transplants and open heart surgeries have been taking place for more than 40 years (Attachment #1).

Written testimony was submitted by Marla Rhoden, Director, Health Occupations Credentialing, Department of Health and Environment (Attachment #2).

After clarification of questions from the committee, the hearing on **SB 5** was closed.

Suzanne Cleveland, Senior Analyst, Kansas Health Institute, presented an overview of the Affordable Care Act and provided the committee with copies of the following documents: Health Reform Resource Document (Attachment #3), Health Reform Brief (Attachment #4), Eligibility for Insurance Coverage Under Health Reform (Attachment #5), and The Affordable Care Act: How would it impact public health and health insurance in Kansas? (Attachment #6). Ms. Cleveland focused her presentation on the three primary components of the ACA which were Public Health, Cost Containment, Payment and Delivery

Refort, and Access to Coverage and Care. Several committee members requested additional information and Ms. Cleveland said that she would gather the requested data and distribute it to the committee at a later date. There being no further discussion the Chair thanked Ms. Cleveland for her time.

The next meeting is scheduled for Thursday, January 19, 2011.

The meeting adjourned at 2:30 p.m.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: January 18, 2011

NAME	REPRESENTING
Bill Sneed	AHIP
Berend Koops	Hein Law Firm
Leigh Keck	Capitol Strategies
Mike Casey	BSA
John Kiefhaber	Ks. Chiropractic Assn.
Sonja Olmos	KHCC
Chad Austin	KHA
Kathleen Selzer Hippert	KSBHA
Kris Mehl	Kennedy & Assoc.
Larrie Ann Brown	Aetna
Dan Murray	Federico Consulting
Marlee Carpenter	KAHP
Dan Morin	KMS

KANSAS PRACTICING PERFUSIONIST SOCIETY

TO: Senate Public Health & Welfare Committee -
Senator Vicki Schmidt, Chairperson; Senator Terry Bruce, Vice Chairperson; Senator Roger Reitz; Senator Chris Steineger; Senator Terrie Huntington; Senator Dick Kelsey; Senator Mary Pilcher-Cook; Senator Laura Kelly; Senator David Haley, Ranking Minority Member

FROM: Kelly Hedlund, Secretary/Treasurer, Kansas Practicing Perfusionist Society

DATE: Tuesday, January 18th, 2011

RE: Testimony regarding Senate Bill No. 5 -
An act concerning the Kansas Board of Healing Arts; relating to licensure and education of perfusionists; establishing perfusion council

To all distinguished members of this committee,

I stand before you this afternoon in full support of Senate Bill No. 5. With your kind indulgence, I would like to outline a few of the reasons why the state of Kansas should regulate and license practicing perfusionists. To begin, I am a practicing perfusionist myself, with over 25 years of experience. Compared to other allied healthcare workers, our profession is fairly young. In 1977, the American Medical Association recognized perfusionists as bonifide allied healthcare professionals. As a young and rapidly growing specialty, the practitioners of our craft spent their energies during the 1980's and 1990's constructing and consolidating agencies necessary for a medical profession to exist; namely, educational societies, scientific journals, and a voluntary certification board. Today, however, perfusion has evolved to a point where governmental regulation is the next obvious step in protecting the public from the high liability of unqualified practitioners.

Open-heart surgery is one of the most commonly-performed operations in the United States. Perfusionists are responsible for operating the heart-lung machine and other life support devices during these surgical procedures. The heart-lung machine takes over the function of the patient's heart and lungs. Perfusionists, therefore, must use split-second skills and mechanical equipment to replace the patient's cardiac and pulmonary functions. The improper management of perfusion devices or techniques generally leads to severe impairment or death of the patient. In fact, according to one recognized source*, the number of severe injuries or death from a perfusion-related accident is 1 per 1,000 cases performed. Since there are approximately 3,500 open-heart surgeries performed in the state of Kansas each year, it's likely that 3 or 4 patients die or are injured annually in the Sunflower State as a direct result of the perfusionist's actions.

The marketplace has failed to adequately regulate the perfusion profession. First, as an entity, perfusion is very low in profile. Most open-heart surgery patients are unaware of the existence or importance of the perfusionist. In general, a poor patient outcome due to a perfusion-related accident is more likely to reflect on the surgeon's abilities, rather than on the perfusionist's incompetency. While the surgeon may exert some control over the perfusionist's future employment, there are no state regulatory processes in place to keep an incompetent perfusionist fired by Hospital A from moving down the street to practice at Hospital B. Clearly, the public safety and welfare is better served by preventative measures than retrospective punishment, when the risk to the patient is so high. Secondly, the only mechanism currently in place to protect the public from unqualified perfusionists is the Joint Commission on Accredited Healthcare Organization's (JCAHO) requirement that hospitals "credential" all healthcare workers and physicians. For perfusionists, this credentialing process generally consists of completing an application form; nothing more. Perfusionists are not only few in number

*Textbook on Cardiopulmonary Bypass 2nd Edition by Reed & Stafford, 1989

(approximately 3,000 in the United States; 45 in Kansas), but their scope of practice is not legally defined. In general, hospitals do not have access to criteria on which to judge a perfusionist's education, training, or performance. As a result, it's the perfusionists themselves who often determine their own criteria for employment and performance. Surely, public safety cannot be assured when the range of control is so broad. Furthermore, it must be stressed that the national certification process for perfusionists is voluntary. As such, hospitals are not mandated to require this credential of their practitioners. At least 3 professional societies have published ethical standards for perfusionists. While these standards are useful as guideposts, membership in these societies is, once again, voluntary. In addition, these standards deal primarily with fraudulent record keeping, the inappropriate use of credentials, and adequate staffing of personnel, not the safe performance of perfusion (or lack thereof). While these standards serve to educate and unify the perfusion community to a degree, there is no assurance to the public that the local perfusionist applies these recommended safeguards in his or her daily practice.

California was the first state to enact perfusion legislation in 1992 (Titling Act). Since then, 16 additional states have begun licensing perfusionists. In essence, over half the perfusionists working in the United States today require a license to practice in their respective states. Kansas is virtually surrounded by states that have previously enacted laws for licensing perfusionists; Nebraska, Missouri, Arkansas, and Oklahoma. At present, there are 10 additional states (Kansas included) with licensure initiatives at work.

Perfusion is a demanding profession, requiring a unique combination of highly specialized medical and mechanical training. Senate Bill No. 5 will serve to protect the citizens of Kansas from untrained and unqualified practitioners. Currently, all cardiac surgery team

members are recognized by the state of Kansas EXCEPT perfusionists. Essentially, the person who can do the most harm to the patient is at present unregulated. Enactment of Senate Bill No. 5 ensures that all citizens of Kansas enjoy the benefits of knowing that all members of the cardiac surgical team are qualified.

- Licensing perfusionists **WOULD** establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion in the state of Kansas.
- Licensing perfusionists **WOULD** assure that the health and safety of the citizens of Kansas are protected from unqualified practitioners, or from the unprofessional practice of perfusion.
- Licensing perfusionists **WOULD** assure that in the future anyone entering Kansas to work as a perfusionist would meet Kansas' legislated high standards of patient care.

- Licensing perfusionists **WOULD NOT** permit perfusionists to privately bill for their services.
- Licensing perfusionists **WOULD NOT** prohibit the employment of anyone currently working in the state of Kansas.
- Licensing perfusionists **WOULD NOT** increase the cost of healthcare in the state of Kansas by requiring hospitals to hire more expensive professional employees.

Perfusion practitioners make judgments of consequence, independently, on a daily basis, and continually during operation of the heart-lung machine. Although the surgeon-in-charge supervises the perfusionist and may provide protocols as a guide, the actual decision-making is taking place at the heart-lung machine by the perfusionist on a minute-to-minute basis. When problems occur, split-second analysis and response is required without time for consultation with the surgeon. While a nurse anesthetist can call the anesthesiologist, and a physician's assistant can call their supervising physician, the perfusionist does not enjoy this luxury. In many centers, perfusionists work totally alone. The growth in complexity of perfusion as a discipline, and the proliferation of mechanical device options and equipment, combine to warrant strict regulation and oversight of this healthcare specialty. The citizens of Kansas who undergo open-heart surgery rarely ask about the expertise of the surgical team members. The assumption is that each is suitably qualified to perform his or her respective job. Senate Bill No. 5 will mandate minimum educational and training standards for all perfusionists working in the state of Kansas. If enacted, this legislation will help guarantee that all Kansans receive the highest quality perfusion care.

The Kansas Practicing Perfusionist Society respectfully asks for your support in passing Senate Bill No. 5. Thank you.

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Sam Brownback, Governor
Robert Moser, MD, Acting Secretary

www.kdheks.gov

January 14, 2011

The Honorable Vicki Schmidt, Chair
Senate Committee on Public Health and Welfare
State Capitol, Room 546-S
Topeka, Kansas 66612
BUILDING MAIL

Dear Chairperson Schmidt:

I am writing on behalf of the Kansas Department of Health and Environment in regard to SB 5, concerning perfusionists. HB 5 enacts the Perfusion Practice Act and establishes licensure as the level of credentialing for perfusionists.

The Kansas Department of Health and Environment administers the Health Occupations Credentialing Act, KSA 65-5001 *et seq.* In accordance with the Act, in 2008 the Kansas Practicing Perfusionist Society applied for a credentialing review seeking licensure of perfusionists. The review was completed in 2009, and the technical committee recommended licensure. The secretary of KDHE concurred with the committee's recommendation in his report to the Legislature.

The language in SB 5 establishing licensure as the level of credentialing for perfusionists is consistent with the findings of the 2009 credentialing review.

If you have questions or need further information, please feel free to contact me. I can be reached at 296-1281 or by e-mail at mrhoden@kdheks.gov.

Sincerely,

Marla Rhoden

Marla Rhoden, Director
Health Occupations Credentialing

c: Joseph F. Kroll

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 540, TOP
Voice 785-296-0461 Fax 785-368-6368

HEALTH REFORM RESOURCE DOCUMENT

The Impact of Health Reform on Health Insurance Coverage in Kansas

KANSAS HEALTH INSTITUTE

January 2011
KHI/11-HR1-S

TABLE OF CONTENTS

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.

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&vgnextchannel=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 x (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 x 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.

212 SW Eighth Avenue, Suite 300 • Topeka, Kansas 66603-3936 • Telephone (785) 233-5443 • Fax (785) 233-1168 • www.khi.org

HEALTH REFORM BRIEF

The Impact of Health Reform on Health Insurance Coverage in Kansas

KANSAS HEALTH INSTITUTE

January 2011
KHI/11-HR1

More information

This is the first in a series of briefs about the impact of health reform in Kansas. Contributors to this publication include Suzanne Cleveland, J.D., Jim McLean, Anne Berry, Sharon Barfield, M.S.W., LSCSW, and Cathy McNorton.

Online readers can select the words underlined in blue to be taken to a document with definitions and more in-depth information. This document and the other briefs in the series are available online at www.khi.org.

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.

INTRODUCTION

The Affordable Care Act (ACA), the name of the new federal health reform law, stands to produce big changes in the health insurance industry and in the way that consumers obtain coverage. Provisions ranging from coverage requirements for individuals and businesses to new regulations aimed at protecting consumers and expanding their choices — while still controversial — are designed to make health insurance accessible to more Americans and Kansans. Under the new law, nearly two-thirds of all Kansans could meet income eligibility guidelines to qualify for either Medicaid or for federal subsidies to be used to purchase private health insurance coverage in newly created health insurance exchanges. Of the almost 350,000 Kansans who are currently uninsured, nearly 90 percent could meet income guidelines to qualify for subsidies or Medicaid. Not all of the anticipated changes brought about by the ACA are expected to be positive, however. Many industry experts have concerns about the legislation's burden on insurers and about its potential to raise overall medical spending. This brief explores how the ACA may affect the accessibility and affordability of health insurance coverage in Kansas.

WHAT IS IN THE LEGISLATION?

The ACA uses a multipronged approach that will require individuals, employers, private insurers and states to participate in restructuring the health insurance system. The key access and affordability pieces are:

- New insurance regulations such as the guaranteed coverage of pre-existing conditions;
- The creation of health insurance exchanges;
- Individual insurance mandate and employer coverage requirements; and
- Expansion of Medicaid.

Kansas policymakers will play an important role in the design and implementation of these provisions.

KANSAS IMPACT

The ACA dictates new rules for insurers. Some have already taken effect. Others will begin in 2014, the year when many of the most important reforms are scheduled to be implemented.

The changes that took effect this fall require insurance companies to:

- Allow young adults to remain on their parents' policies until they're 26 — three years later than the previous dependent coverage limit of most insurance companies. Around 72,000 Kansans between ages 19 and 25 don't have health insurance coverage for a variety of reasons, including because they choose not to purchase it. This provision for extended dependent coverage may help to insure a significant number of these young adults.

- Cover all children regardless of whether they have a pre-existing medical condition. Many insurance companies — including the state's two largest insurers, Blue Cross Blue Shield of Kansas and Coventry Health Care of Kansas — stopped issuing "child only" policies rather than comply with the new rule. This same rule will apply to coverage for adults with pre-existing medical conditions in 2014.
- Stop cancelling policies when people make mistakes on their applications. The practice, known as rescission, received a lot of attention during the congressional debate on reform, though it was not widely used by Kansas companies. The new rules say that companies can only rescind policies if policyholders intentionally misrepresented important facts on their health insurance applications.

Other ACA changes that have already occurred include the creation of a federal high-risk pool that provides insurance coverage to Kansans with pre-existing medical conditions who have been without insurance for more than six months. The federal high-risk pool limits the annual out-of-pocket cost-sharing a consumer could potentially incur. These limits are set at $5,950 for individuals and $11,900 for families, though the federal pool in Kansas offers only individual plans. A state high-risk pool has existed in Kansas since 1992 and continues to operate, now side-by-side, with the new federal pool. The state pool does not impose the same out-of-pocket cost-sharing limits. Initial uptake of the federal high-risk pool has been very low nationwide as well as in Kansas; as of early December, only 121 Kansans were enrolled in the federal pool. Less than 2,000 beneficiaries are currently enrolled in the state high-risk pool. The Department of Health and Human Services (HHS) is exploring ways to encourage greater utilization of these plans, such as by lowering premiums.

Future health insurance changes

In Kansas, many consumer protections already exist for consumers with small- and large-group insurance policies. However, consumers who purchase coverage directly from an insurer — including 137,000 Kansans between ages 19 and 64 — will likely benefit from two important rules set to take effect in 2014. One — known as guaranteed issue — will require insurance companies to offer coverage to anyone who applies regardless of health status or other factors that may predict usage of health services. Another rule will limit the rating factors that can be used when pricing policies to include only age, place of residence, family composition and tobacco use.

Insurers and employers who offer health benefits are concerned about the potential consequences of removing gatekeeping tools like rating factors and pre-existing condition exclusions. Not allowing insurers to deny or limit coverage to people with existing and potentially expensive health needs could threaten the financial viability of insurance companies if people wait until they become ill to purchase coverage. As more sick people enter the insurance pool, costs could go up, causing relatively healthy people to exit the market — which would cause costs to those remaining in the pool to go up even more. This phenomenon, known as adverse selection, is the reason that the ACA also calls for the implementation of an individual mandate to purchase coverage, which is discussed on page 3.

Expanded private insurance options

Beginning in 2014, consumers will have access to an entirely new way to purchase private health insurance. New marketplaces — called health insurance exchanges — will be established by the states to help individuals and businesses with 100 or fewer employees purchase coverage. Until 2016, states may choose to narrow the exchanges to include only businesses employing 50 and fewer employees; Kansas has indicated it will do this. Private insurance plans grouped into four coverage tiers will be sold through the exchanges. All of the exchange plans will be required to cover essential health benefits, to be determined by HHS. The mechanism through which individuals and businesses purchase the coverage will be designed with simplicity and standardization in mind, allowing for comparison shopping between plans. While a few states had implemented some type of health insurance exchange before the adoption of the ACA, this model will be a new method of purchasing insurance in Kansas. The Kansas Insurance Department (KID) is actively engaged in preparing for the exchanges and has applied for, and received, ACA grants related to planning and outreach. Critical decisions have yet to be made about the design of the new exchange model; for instance, whether Kansas will operate one exchange, multiple exchanges or a regional exchange in collaboration with other states.

4-2

In order to increase the affordability of the coverage offered through the exchanges, the ACA offsets the cost of premiums and out-of-pocket expenses for some individuals. These premium tax credits and cost-sharing subsidies will be tied to the second tier of coverage in the exchange known as the "Silver" plan, and will be available to consumers with incomes between 100 and 400 percent of Federal Poverty Level (FPL), currently $22,050 to $88,200 for a family of four. Over 50 percent of Kansans are in families with incomes between 100 and 400 percent of FPL. Even if income eligibility guidelines are met, credits and subsidies will only be available to those without access to affordable and adequate employer-sponsored coverage (as defined by the ACA). Participation in the exchanges, however, is open to any U.S. citizen or legal resident.

Medicaid expansion

Starting in 2014, Medicaid eligibility will rise to 133 percent of FPL (Figure 1). This will be a major change in Kansas, where Medicaid eligibility for adults is roughly 30 percent of FPL and is among the lowest in the country. A May 2010 report, prepared for the Kansas Health Policy Authority (KHPA), estimated that more than 87,000 additional Kansas residents may become eligible for Medicaid under the new rules and as many as 33,000 more, who are currently eligible but not enrolled, may choose to enroll in 2014. The federal government will initially pay 100 percent of the cost of covering these additional enrollees. The federal contribution will reduce over time, and in 2020 and beyond will cover 90 percent of the costs for the new enrollees. The states will pay the remaining 10 percent.

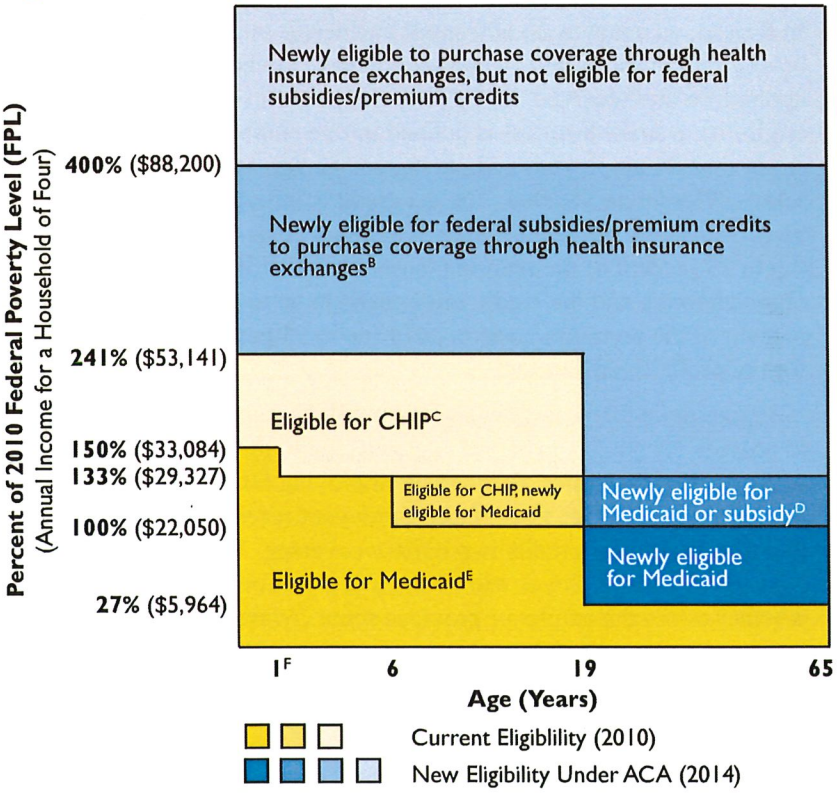
The ACA retains the Children's Health Insurance Program (CHIP), an insurance option for children who are not Medicaid-eligible, but are in families earning less than 241 percent of FPL. The ACA increases the portion of CHIP expenditures that the federal government pays by 23 percentage points. In Kansas, there are 39,000 children currently enrolled in CHIP.

Individual mandate

One of the most debated provisions of the ACA also becomes effective in 2014, the so-called individual mandate. The mandate will require virtually everyone to purchase health insurance or face financial penalties. Exemptions to the mandate can be granted for a handful of reasons, including religious objections and financial

ELIGIBILITY FOR INSURANCE COVERAGE UNDER HEALTH REFORM IN KANSAS

Figure 1. **Current Eligibility (2010) and New Eligibility Under ACA (2014)[A]**



A. This chart represents eligibility guidelines based on income, but does not represent eligibility for individuals that may qualify based on disability or other conditions/criteria.
B. Eligibility for subsidies is tied to the lack of affordable employer-sponsored coverage.
C. A monthly premium between $20 and $75 applies to families with income between 150 percent to 241 percent of FPL.
D. In the legislation, there appears to be overlap between the populations eligible for Medicaid and those eligible for federal subsidies/premium credits between 100 to 133 percent of FPL.
E. Some parents are eligible to receive Medicaid up to about 27 percent of FPL, income guidelines vary slightly by county. Childless adults are not eligible.
F. Pregnant women are also eligible for Medicaid up to 150 percent of FPL.

4-3

hardships. For example, Kansans for whom purchasing the lowest cost plan would expend more than 8 percent of their income would qualify for the financial hardship exemption. In 2014, those Kansans who fail to purchase insurance — and who do not qualify for an exemption — will initially pay the greater of $95 or 1 percent of their annual income, up to a maximum amount set by the law. The fines will increase by 2016 to the greater of $695 or 2.5 percent of annual income — up to a maximum amount set by the law. The penalties then will increase yearly by an amount equal to the annual cost of living adjustment.

Employer responsibilities

Beginning in 2010, small businesses that cover roughly half of the costs of their employees' health insurance coverage are eligible to receive tax credits intended to offset the expense of providing coverage. In Kansas, as many as 50,600 small businesses may be eligible for this credit — and several have already applied for and received this benefit. For purposes of eligibility, a small business is defined as one employing fewer than 25 employees and paying an average annual salary of less than $50,000. The tax credit is initially up to 35 percent of the employer's premium costs (up to 25 percent of the premium costs for nonprofit organizations), and the credit will expand to up to 50 percent of the premium costs in 2014 (up to 35 percent for nonprofit organizations).

Beginning in 2014, larger employers will be required to provide adequate and affordable coverage to their employees or face fines. Businesses employing 50 or more people may face fines if any employees receive federal subsidies or credits to purchase coverage. The amount that the employer will be fined depends on whether or not the employer provides some coverage or no coverage at all. Given the expense of providing health insurance coverage, it is possible that some large employers will opt to pay the fine rather than provide coverage to their employees. It is important to note that almost 75 percent of private Kansas businesses have fewer than 50 employees, so will not be subject to these penalties.

NEXT STEPS FOR KANSAS

Although the ACA provides a national framework for reform, much of the responsibility for translating the legislation into daily operations falls to the states and to the private sector. KID has applied for, and received, federal health reform planning and administration grants, and personnel from both KID and KHPA serve on a national steering committee for the Consortium on Health Care Reform Legislation Implementation, which provides technical assistance to states. With several implementation milestones reached in September 2010, the state is looking ahead to the infrastructure needs underlying the 2014 reform provisions including the creation of the exchanges, enforcement of individual and employer requirements and oversight of private and public insurance changes.

CONCLUSION

Public opinion about the potential success or failure of the ACA varies widely, and there's no doubt that the ACA will be a major topic in the new Congress in 2011. However, even as the legislation continues to be debated, changes that have already occurred in states are having a variable impact. For example, in Kansas, one Kansas City area private insurer has already reported large growth in the sale of small business group insurance policies, attributable to the availability of the ACA's small business tax credits. At the same time, uptake for the new federal high-risk pool has been very low. Further implementation of the ACA over the next several years is likely to yield similarly mixed results. To help Kansans prepare for the changes ahead, it is critical that Kansas policymakers and stakeholders stay informed about the ACA as it continues to be shaped through congressional action, the development of numerous federal regulations, legal rulings and state initiatives.

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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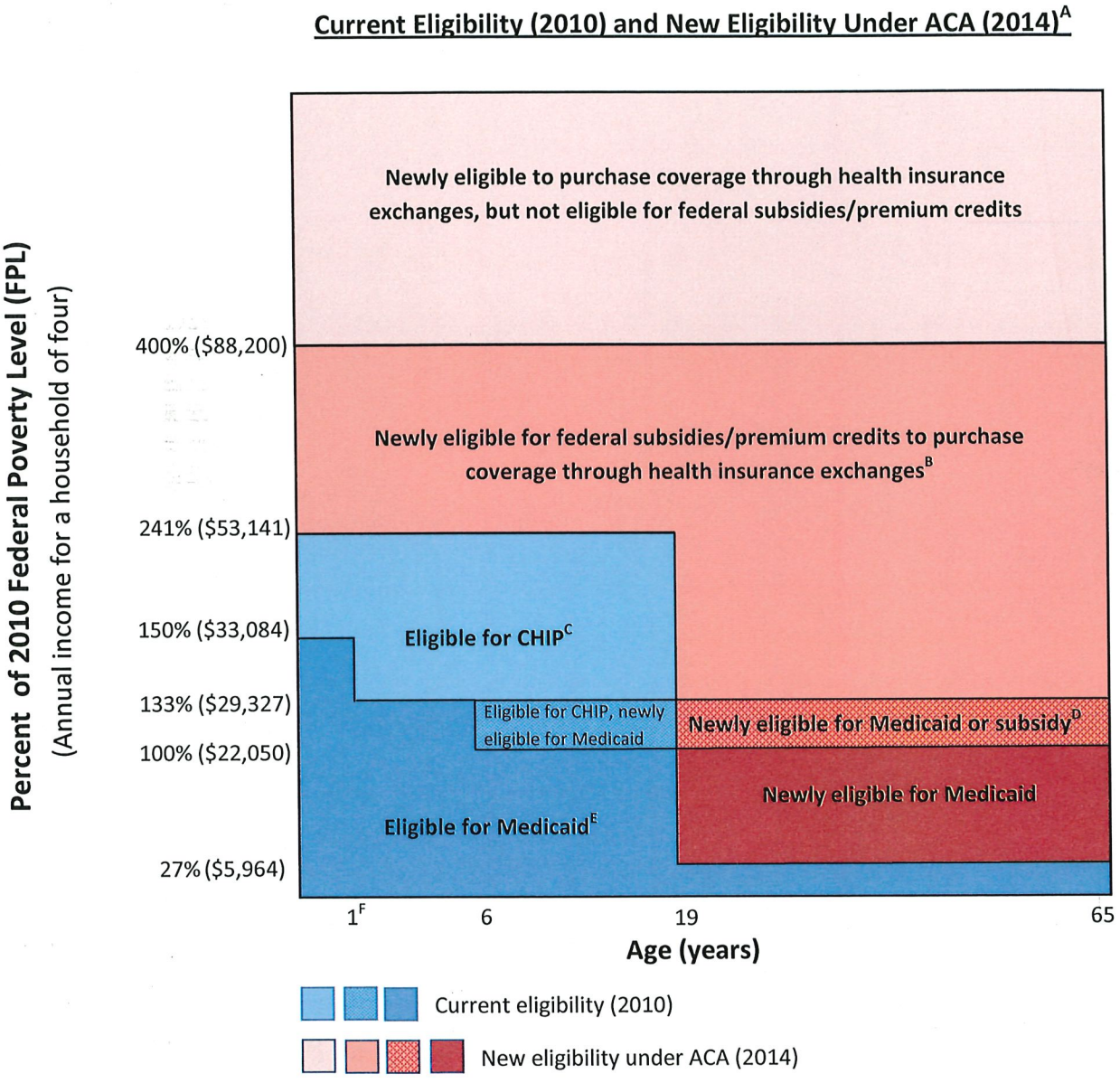
ELIGIBILITY FOR INSURANCE COVERAGE UNDER HEALTH REFORM



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The Affordable Care Ac
How would it impact public heal
and health insurance in Kansas?

Testimony Prepared for the Senate
Public Health and Welfare Committee
January 18, 2011

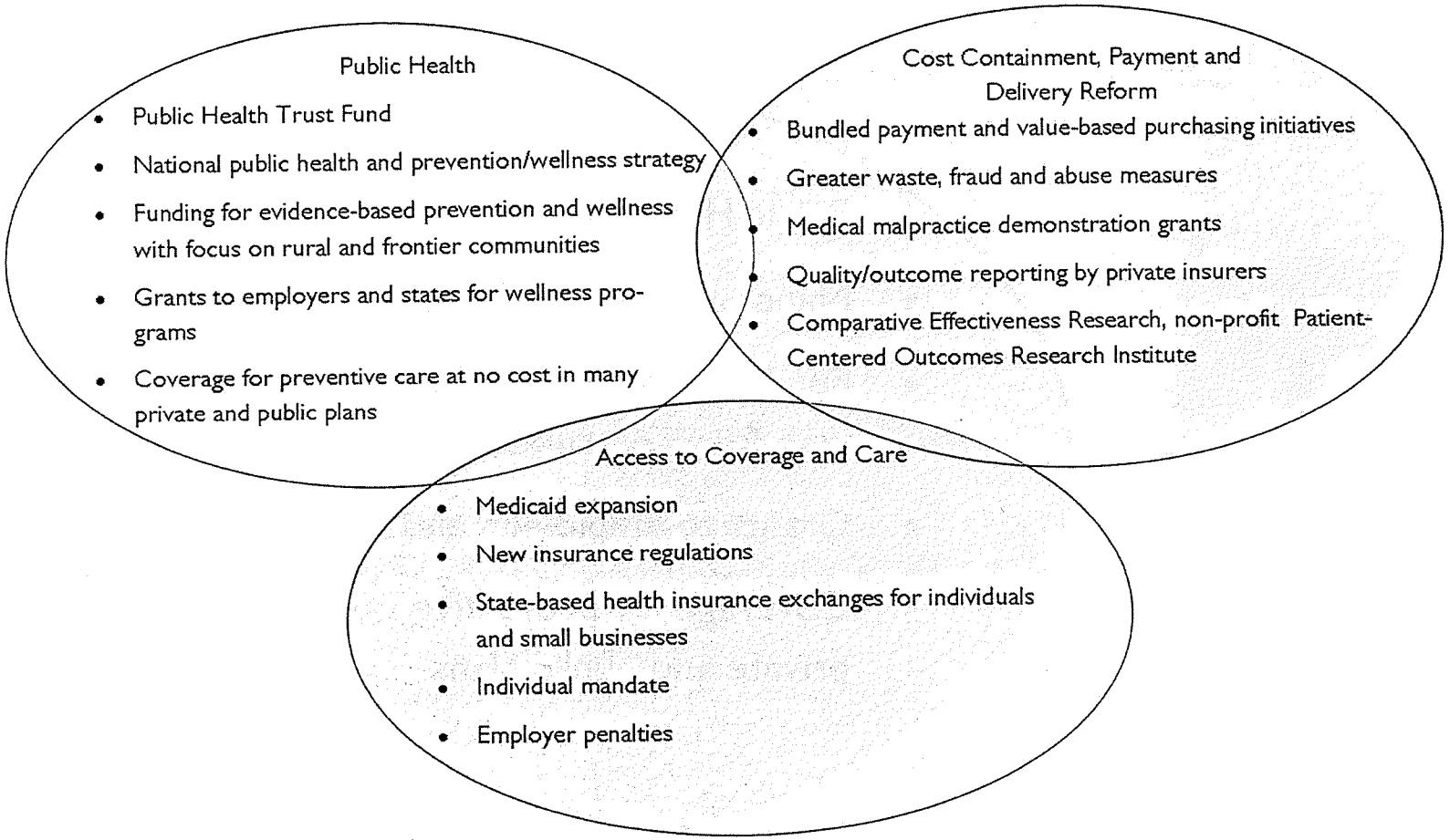
Suzanne Cleveland, J.D.
Kansas Health Institute

Kansas Health Institute

The Kansas Health Institute is an independent, nonprofit health policy and research organization that informs policymakers about important issues affecting the health of Kansans.

Our mission is to inform policymakers by identifying, producing, analyzing and communicating information that is timely, relevant and objective.

Three Primary Components of the ACA



6-3

Public Health

Public Health

- Public Health Trust Fund
- National public health and prevention/wellness strategy
- Funding for evidence-based prevention and wellness with focus on rural and frontier communities
- Grants to employers and states for wellness programs
- Coverage for preventive care at no cost in many private and public plans

Public Health

Areas of focus for public health programs include;

- Obesity and nutrition
- Tobacco cessation
- Teen and adolescent risk behavior
- Chronic disease
- Early childhood development
- Health inequities

Public Health

Since ACA enactment, $10.9 million from HHS

Grants include;

- $2.8M Demonstration Projects to Address Health Professions Workforce Needs
- $900,000 Home Visitation Programs
- $200,000 Public Health Infrastructure
- $300,000 Laboratory and Health Information Systems Capacity
- $200,000 State Health Care Workforce Development Grants

Access to Coverage and Care

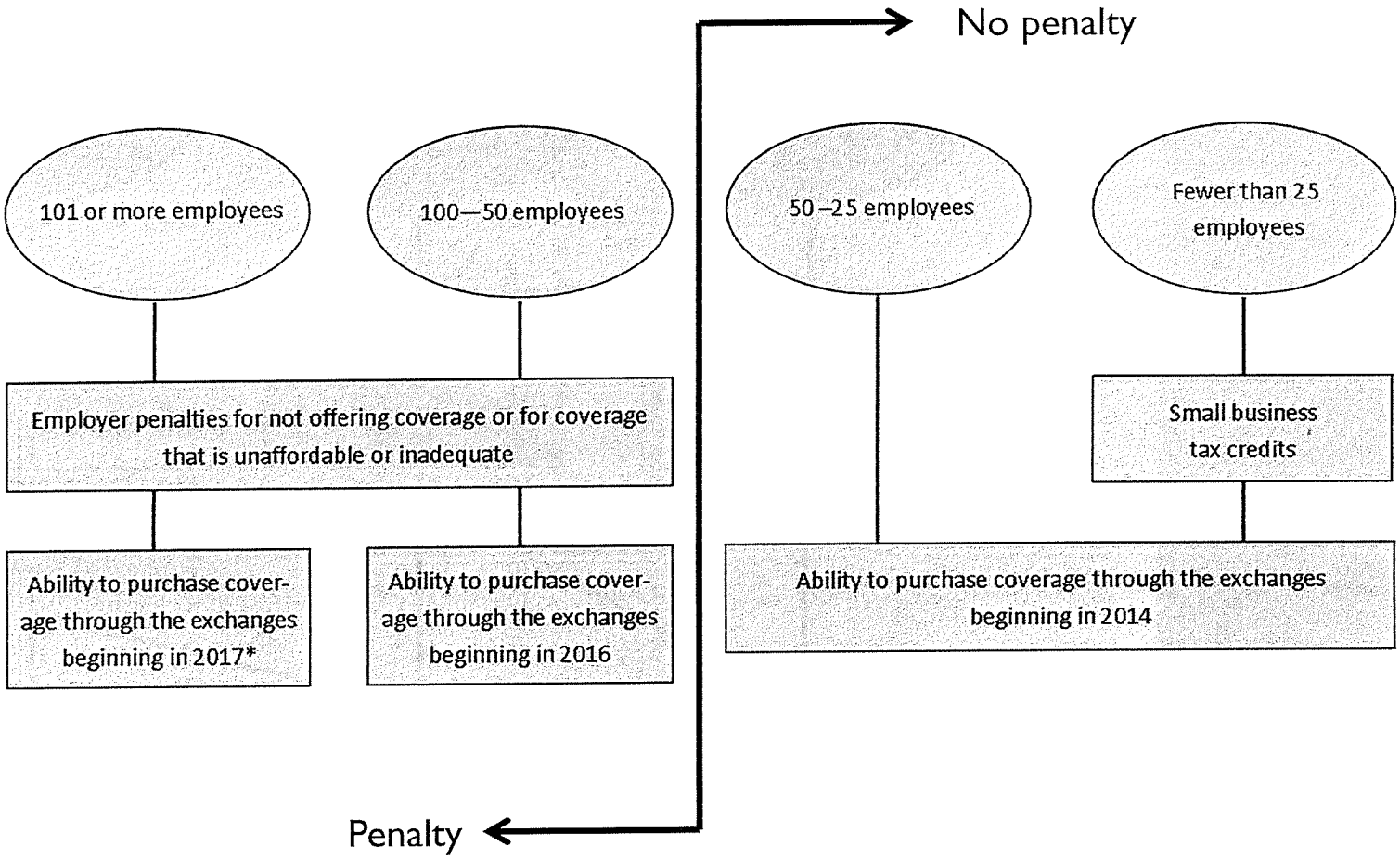
Access to Coverage and Care

- Medicaid expansion
- New insurance regulations
- State-based health insurance exchanges for individuals and small businesses
- Individual mandate
- Employer penalties

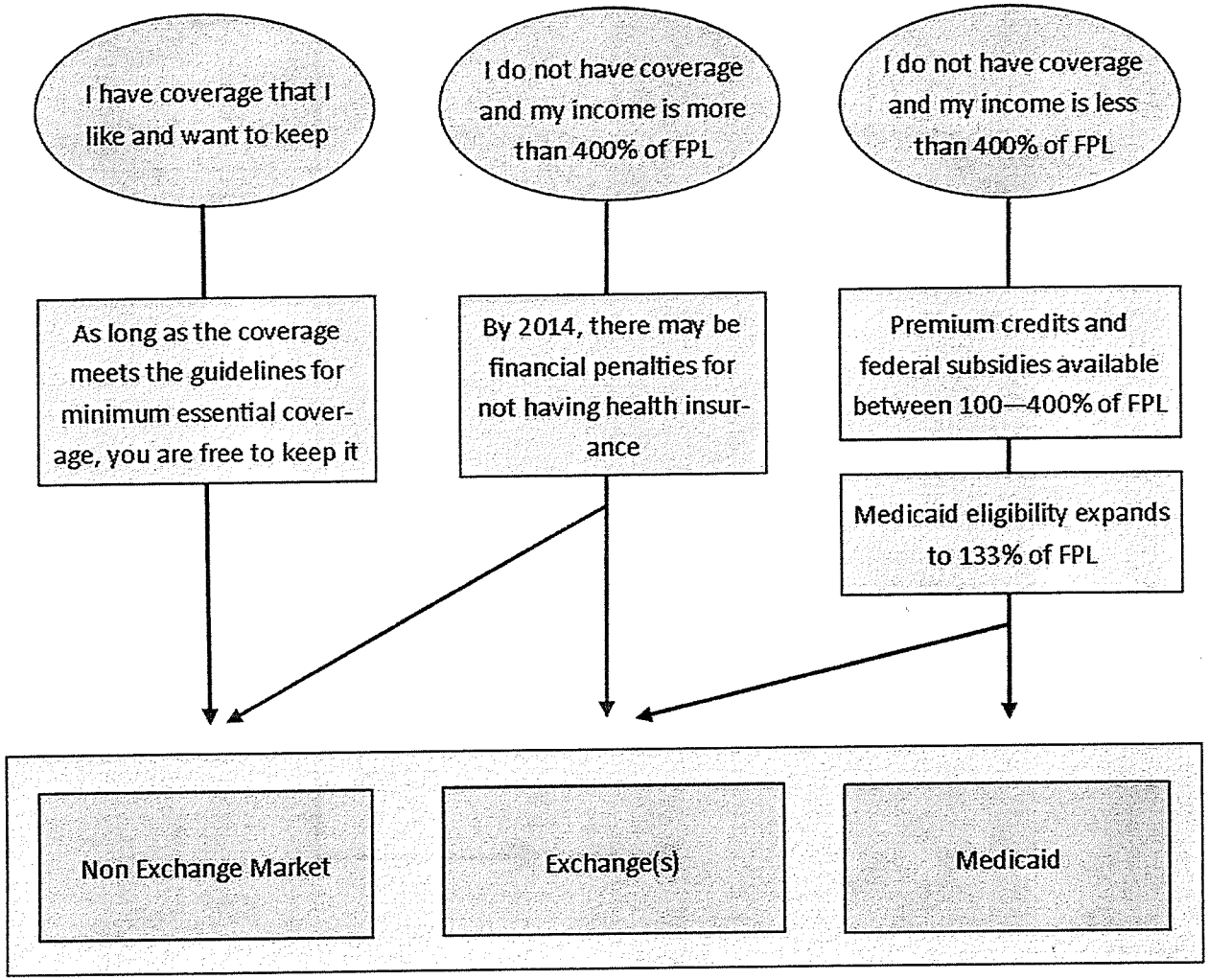
Changes in the Insurance Market

- Medicaid expansion to 133% of Federal Poverty Level (FPL)
- With exceptions, guaranteed access to health insurance coverage regardless of health status
- New limits on rating practices and cost-sharing
- State-based health insurance exchanges for individuals and small businesses

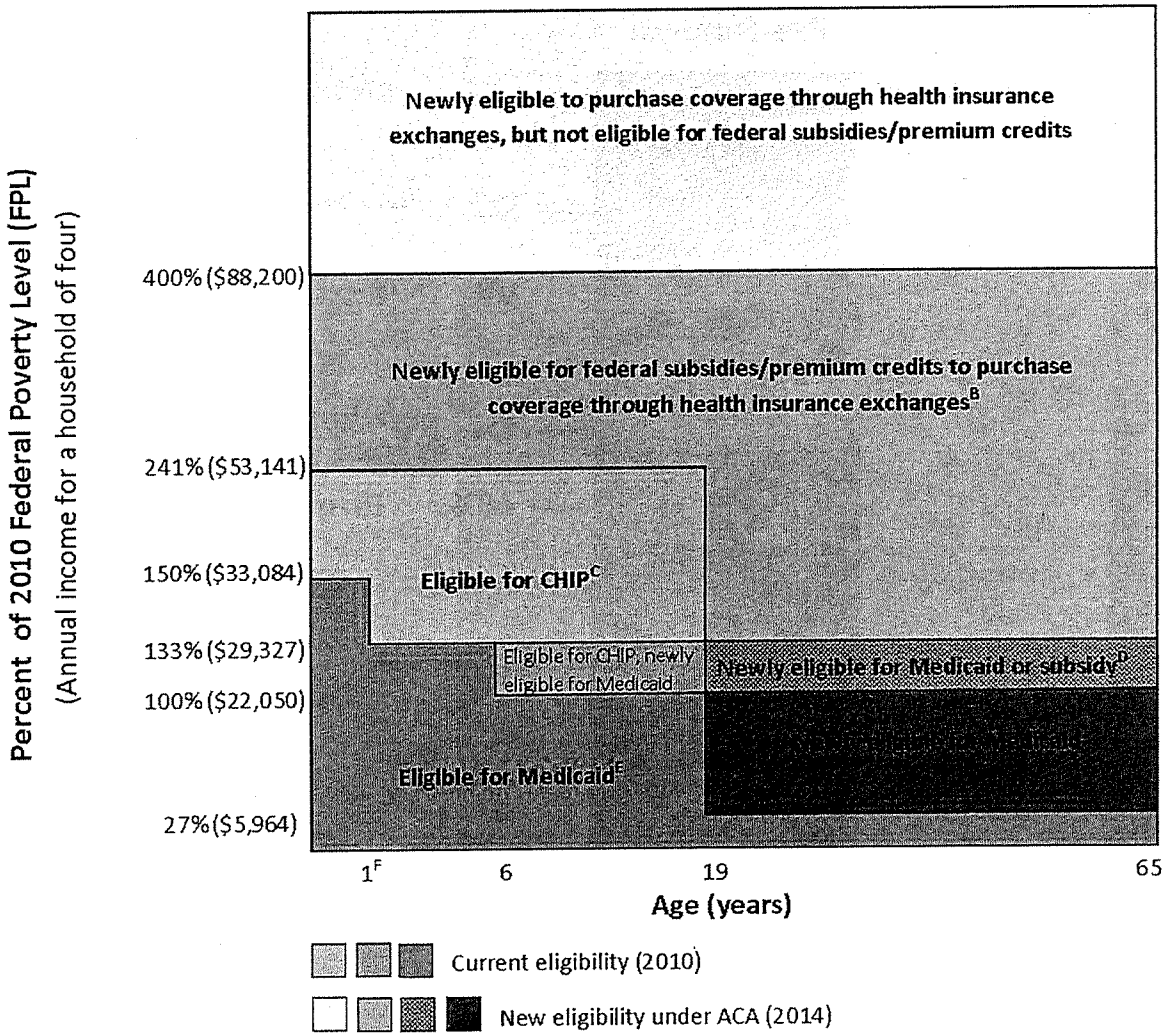
The Employer Experience



The Consumer Experience

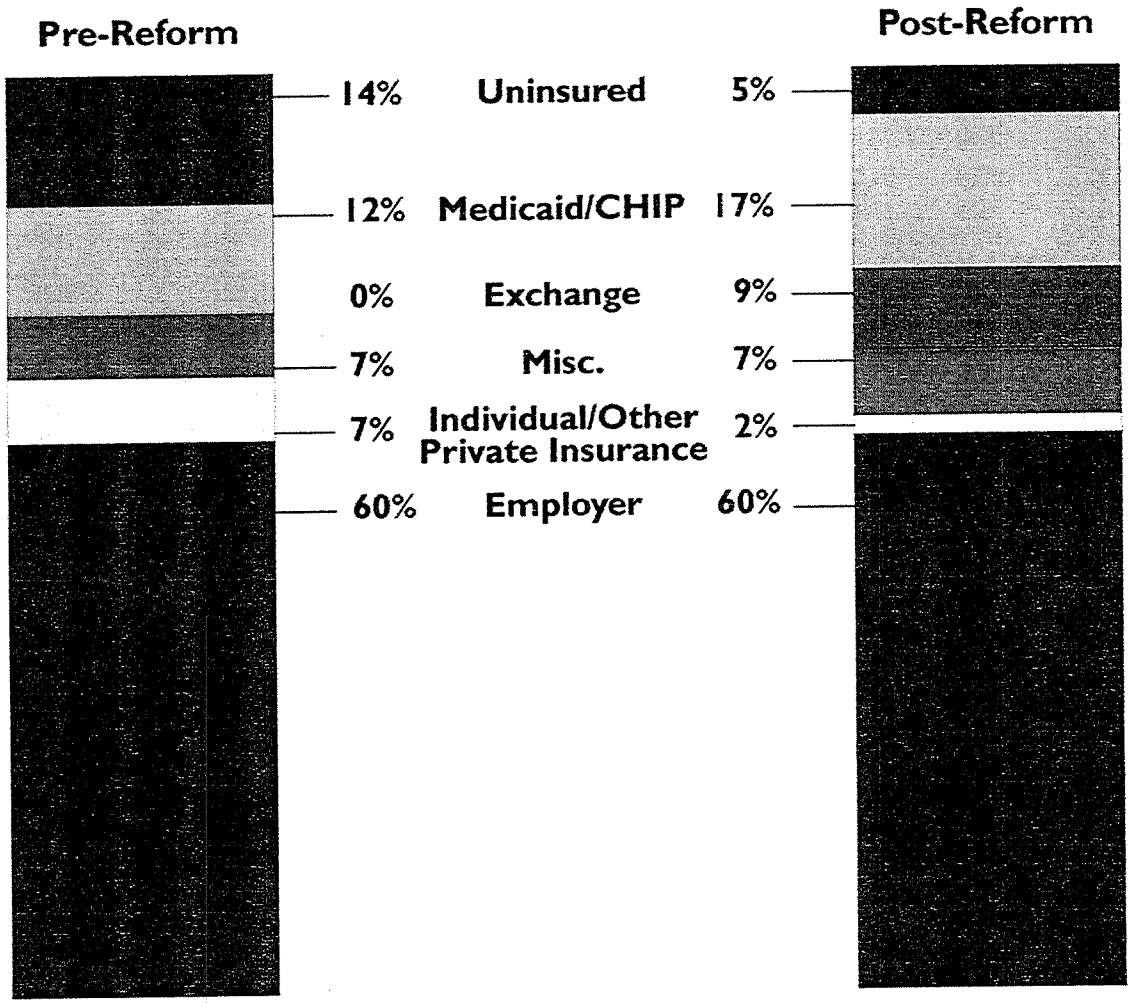


Current Eligibility (2010) and New Eligibility Under ACA (2014)



Changes in Projected Sources of Insurance Coverage in Kansas

6-12



Data courtesy of Georgia Health Policy Center, 2011

Looking Ahead: Public Health

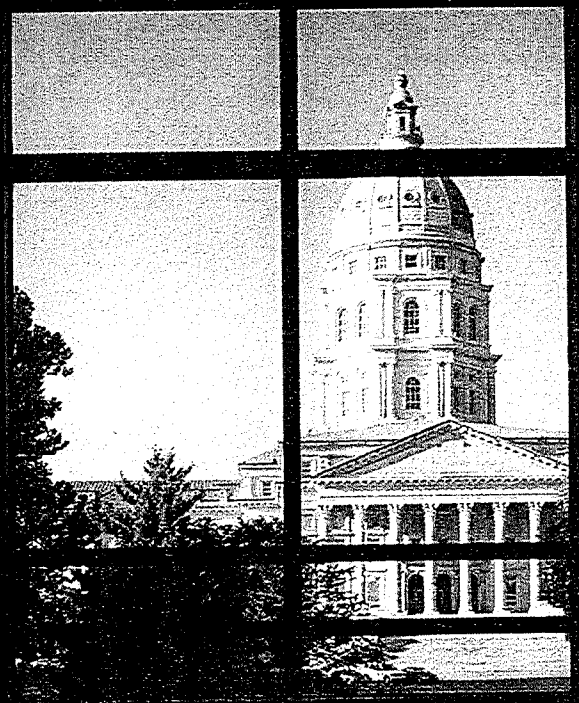
- Infrastructure and capacity needs for state public health system
- Interagency coordination of grant applications and implementation
- Support for community-based funding ventures
- Potential cost-savings through enhanced prevention and wellness efforts

Looking Ahead: Access to Coverage and Care

- Infrastructure needs for health insurance exchanges and Medicaid expansion
- Health profession workforce capacity
- Information and outreach to consumers, specifically in rural and underserved areas
- The role of the safety net

Questions?

Kansas Health Institute



Information for policy makers. Health for Kansans.