Approved: _____
Date Apr. 5, 2000

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Senator Don Steffes at 9:00 a.m. on March 28 , 2000 in Room 234-N of the Capitol.

All members were present except: Senators Feleciano, Biggs, Becker, and Corbin

Committee staff present: Dr. William Wolff, Legislative Research
Ken Wilke, Office of Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Kathleen Sebelius, Insurance Commissioner
Kim Moore, United Methodist Health Ministry Fund
Terry Leatherman, KCCI
Robert Day, SRS
Bob Corkins, Kansas Public Policy Institute
Jim Schwartz, Alliance Employee Health Access
Thomas M. Rork, Security Transport Services, Inc.
Mike Larkin, Kansas Employer Coalition on Health
Mary Becker, Kansans Respond
Joyce Volmut, Kansas Association for the Medically Underserved
Jerry Slaughter, Kansas Medical Society

Others attending: (See Attached)

Hearing on SB 668-Establishment of the Kansas business health partnership

Senator Praeger explained that this bill would provide for worker-based insurance coverage. The plan fits nicely within the welfare to work system by providing subsidies through the Children's Health Insurance Plan for low income families. It is beneficial to families to have their insurance coverage through one plan rather than having fragmented coverage. By offering health insurance, small businesses can build loyalty from employees and thus have continuity of service.

Kathleen Sebelius, Commissioner of Insurance, offered testimony in support of the proposal which would explore strategies to make comprehensive health insurance available to working Kansans who currently have no coverage (Attachment 1). Also included in her testimony was a copy of a White House press release outlining the President's initiative for health insurance for families. Eighty percent of parents of CHIP eligible children are uninsured and have no access to employer-based coverage or cannot afford the coverage that is offered.

Kim Moore, President of United Methodist Health Ministry Fund, explained the history and success of "health insurance purchasing cooperatives" (HIPC) in other states and their participation in the first one in Kansas–Alliance Employee Health Access (Attachment 2). Their reasons for granting the seed money were:

- Special problems of small employers
- HIPC addresses the small employer market and has enjoyed success in other states
- Providing health insurance through employers is the best way to produce health care access

Terry Leatherman, KCCI, explained the bill's strength is due to building on the backbone of today's health insurance delivery system, employer-based coverage (Attachment 3). Eighty-five percent of the uninsured in America have a connection to the workforce. Half of America's uninsured work for employers with less than 100 employees. Reasons why affordable health insurance is problematic for the small employer are:

- Law of large numbers (large companies much more likely to offer health insurance program)
- State insurance mandates (mandates drive the cost up, **SB 668** allows structuring a very basic product)

- Subsidies (could serve as a premium reduction that would draw more people to coverage within the program)

Thomas M. Rork, Vice President of Security Transport Services, Inc., expressed their interest in the passage of this bill as his company recently lost its health insurance group plan because enrollment dropped below the minimum level set by their former carrier (Attachment 4). He requested the section removing mandates for certain preventive measures be restored.

Robert Day, Director of Medical Policy/Medicaid for SRS, stated their support of the effort to assist small business through a pooling of resources to increase the purchasing power of the business (Attachment 5). He cited the intent of the Department was to work with the Kansas business health partnership, should it be created, to bring its Title XIX (Medicaid) and Title XXI (CHIP) programs into the partnership. Concerns with the bill center around the interweaving of the Department's programs and contractors with the new entity:

- Requiring both the submission of a good faith bid by and participation of all health plans that contract with SRS (hesitant to place additional burdens on participating health plans which might pose a threat to current efforts).

- Technical amendments changing "waiver" to "variance." Need language which directs SRS to explore how it might bring HealthWave and Title XIX eligible families employed by small businesses into this partnership.

- Bill should establish the construction for the new entity to implement the concept behind the bill without the addition of regulatory/administrative requirements.

Mr. Day said the passage of the bill and ultimate development of a plan would move SRS from a bill payer to a purchaser of insurance.

Bob Corkins, Kansas Public Policy Institute, stated that the key to a successful solution to the insurance problem is to move toward greater exercise of personal responsibility that compels the free market to satisfy its needs (Attachment 6). He described the idea as "defined contribution health insurance" as employers would pay a set dollar amount to each employee that the employee then uses to purchase health insurance. The employee has the option of selecting a policy that costs less than the employer's contribution and then investing the difference in something like a Medical Savings Account, or the employee can upgrade the policy but adding additional funds. Two primary reforms are needed to make this possible: tax policy and availability of product. He suggested the inclusion of the following in **SB 668**:

- The health partnership should be allowed to expand the scope of its participants.

- Employees must have personal ownership of their partnership policy.

- State should not be allowed to coerce insurance carriers into submitting bids to sell health insurance within the partnership.

- Government should not subsidize the cost of health insurance.

Jim Schwartz, Executive Director of Alliance Employee Health Access, testified that the solution for low-wage earners to have health insurance coverage is to have a sliding-scale subsidy toward their coverage (Attachment 7). He praised the proposal as it would combine the purchasing power of many small groups, use the power of the bid process to get maximum value from subsidy dollars, and give employees a choice of competing health plans. Mr. Schwartz explained that their organization sent out more than 70 invitations to insurance companies to become potential health insurance providers of the Alliance network. Only one company responded.

Michael Larkin, Kansas Employees Coalition on Health, explained that his company is a consortium of more than 60 employers throughout Kansas who provide cost-effective healthcare (Attachment 8). He expressed support of the bill but was less than enthusiastic about the requirement of bidding by carriers who currently contract with the Departments of Administration and/or SRS. Their concern regarding eligibility of all employees was clarified by Senator Praeger in that all employees of a company involved in the partnership would be eligible for insurance but only those with children enrolled in CHIP would receive the subsidy.

Mary Becker, Executive Director of Kansans Respond, stated their support of the proposed legislation due to (Attachment 9):

- High disparity in income in Kansas
- High level of need experienced by low-income Kansans
- High risk of low income working parents being uninsured
- Many low-income ineligible for publicly-funded coverage such as Medicaid due to Kansas' earning cutoffs

Joyce Volmut, Executive Director of the Kansas Association for the Medically Underserved, presented examples of states and the District of Columbia development of health coverage programs which are funded partially by federal funds (Attachment 10). Advantages of the parent coverage options are:

- States have full discretion to scale back the program in response to fiscal issues
- Nominal "cost sharing" can be imposed
- States have flexibility in determining the scope of coverage

Ms. Volmut urged the Committee to consider broader guidelines in developing eligibility, setting premiums, and assuring comprehensive and preventive services.

Jerry Slaughter, Executive Director of the Kansas Medical Society, spoke in support of the proposed legislation which he termed "preferable to a federal solution" (Attachment 11). This would mean a loss of control at the state level which would not be positive for patients, the providers, nor the industry. He explained the state's role as being a catalyst to bring the small employers, providers and the insurance industry together and facilitate action.

(Attachment 12) Written testimony from the Manhattan Area Chamber of Commerce.
(Attachment 13) Written testimony from Roland Smith Insurance Services
(Attachment 14) Newspaper article from ***Lawrence Journal World***

The hearing was continued.

Senator Praeger moved that the minutes of March 22 and March 24 be approved as presented. Motion was seconded by Senator Clark. The minutes were conditionally approved by request of Committee.

The meeting was adjourned at 12:00 noon.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: 3-28

NAME	REPRESENTING
Sarah Kessinger	HNS
Jim Schwartz	Alliance
Vern Burdist	Alliance
MIKE LARKIN	KS EMPLOYER COALITION on HEALTH
Tawny Stottlemire	KS Asso Community Action Progs.
Mary Becker	Kansans Respond
Jerri Green	Federico Consulting
John Armbrust	Manhattan Area Chamber of Commerce
Jay Benati	DofA
[illegible]	United Methodist Health Ministry Fund
[illegible]	United Methodist Health Ministry Fund
Sam Sellers	KAIA
Thomas Rork	Security Transport Secure Inc.
Tom Bell	Ks. Hosp. Assn.
Cheryl Ballard	HealthNet
[illegible]	Kansas Assoc for the Medically Underserved
Joyce Volmert	Kansas Assoc. for the Medically Underserved
Trish Hein	SBG
Bruce Witt	Preferred Health Systems
Larrie Ann Lower	KAHP
Kristen Van Vorst	Humana
Robert Day	SRS
Lyn Goering	SRS
Andy Allison	Kansas Health Institute
[illegible]	KANSAS HEALTH INSTITUTE
Brad Smoot	BCBS
Rick Friedstra	KAIFA
Amy Campbell	KAHHC
Kevin Brown	Hein/Weir Chtd.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Financial Institutions and Insurance Committee

FROM: Kathleen Sebelius, Insurance Commissioner

RE: Senate Bill No. 668

DATE: March 28, 2000

Today I am appearing to support the initiative offered by Senator Praeger to explore strategies to make comprehensive health insurance available to working Kansans who currently have no coverage. Kansas is not alone in trying to find solutions to the problem of uninsured citizens, and various proposals are being considered at the state and federal level.

We know that approximately 1500 owners of small businesses in Kansas who offer no health insurance coverage to their employees. We also know that an estimated 250,000 Kansans have no health insurance coverage, and most of them are in the workforce. While the children of these workers may benefit from the new children's health initiative, the parents usually have no options for affordable health insurance.

As a reminder to the Committee, we have made some efforts in the past few years to make affordable coverage more accessible to Kansans. The Legislature did create enhanced tax credits for small employers, and we have evidence that a number of firms who didn't previously offer health

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

insurance are taking advantage of the new law. The Health Commission also opened the state purchasing pool to school districts, and is exploring further expansion of the pool strategy for other employees covered by the KPERS system. The children's insurance initiative has enrolled thousands of Kansas children who previously had no health coverage.

But we haven't made a serious dent in the problem of family coverage, and know that children are more likely to have coverage and access preventive health care if their parents also have coverage. Attached to my testimony is a copy of a White House press release from January, 2000, outlining the President's initiative for health insurance for families. The statement highlights the problem: 80% of parents of CHIP-eligible children are uninsured. They either have no access to employer-based coverage or can't afford the coverage that is offered. Proposed are higher subsidies to states which cover parents as well as children, and also a plan to assist families in affording private employer-based coverage. SB668 would further these goals.

I am currently serving on a national task force, sponsored by the Commonwealth Trust, studying the future of health insurance for working Americans. What is clear from our preliminary meetings, is that every state is coping with this same issue, and we have numerous strategies, already in operation in various parts of the country, which can serve as examples for Kansas.

We look forward to continuing to work with the Kansas Legislature and the Governor in finding a solution to the serious problem of 250,000 Kansans without health insurance coverage. Consideration of proposals like SB668 are an important step in this process.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release January 19, 2000

CLINTON-GORE ADMINISTRATION UNVEILS
MAJOR NEW HEALTH INSURANCE INITIATIVE
January 19, 2000

Today, President Clinton will unveil a 10-year, $110 billion initiative that would dramatically improve the affordability of and access to health insurance. The proposal would expand coverage to at least 5 million uninsured Americans and expand access to millions more. It addresses the nation's multi-faceted coverage challenges by building on and complementing current private and public programs. Specifically, the initiative will: (1) provide a new, affordable health insurance option for families; (2) accelerate enrollment of uninsured children eligible for Medicaid and S-CHIP; (3) expand health insurance options for Americans facing unique barriers to coverage; and (4) strengthen programs that provide health care directly to the uninsured.

The Challenge of the Uninsured and Its Implications. Over 44 million Americans lack health insurance. Although there are many causes of this problem, it generally results from lack of affordability and/or access to coverage. Family health insurance premiums cost on average $5,700 -- which represents a large share of income for a family trying to make ends meet. Purchasing affordable, accessible insurance is a particular challenge for many older people, workers in transitions between jobs, and small businesses and their employees. Lacking health insurance has serious consequences. The uninsured are three times as likely not to receive needed medical care, 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions like pneumonia or uncontrolled diabetes, and four times more likely to rely on an emergency room or have no regular source of care than the privately insured.

The President's four-pronged initiative significantly expands coverage and improves access by:

I. providing A NEW, affordable health insurance OPTION FOR families ($76 billion over 10 years, about 4 million uninsured covered). Over 80 percent of parents of uninsured children with incomes below 200 percent of poverty (about $33,000 for a family of four) are themselves uninsured. Yet, while states have aggressively expanded insurance options for children through Medicaid and the State Children's Health Insurance Program (S-CHIP), parents are often left behind. There are about 6.5 million uninsured parents with income in the Medicaid and S-CHIP eligibility range for children. These parents frequently do not have access to employer-based insurance, and when they do, cannot afford it. Recognizing that family coverage not only helps a large proportion of the nation's uninsured adults but increases the enrollment of children, the Vice President, the National Governors' Association, and a wide range of groups including Families USA and the Health Insurance Association of America have called for building on S-CHIP to cover parents. The Administration's budget adopts this approach by:

- Creating a New "FamilyCare" Program. This proposal, which has been advocated by Vice President Gore, would provide higher Federal matching payments for state coverage of parents of children eligible for Medicaid or S-CHIP. Under FamilyCare, parents would be covered in the same plan as their children. States would use the same systems and follow most of the same rules as they do in Medicaid and S-CHIP today, and the program would

be overseen by the same state agency. State spending for FamilyCare would be matched at the same higher matching rate as S-CHIP (up to 15 percentage points higher than the Medicaid rate). To ensure adequate funding, $50 billion over 10 years would be added to the current state S-CHIP allotments. To access these higher allotments, states would have to first cover children to 200 percent of poverty as 30 states now have done. Given states' enthusiastic response to S-CHIP and the NGA support for this option, we expect strong state response and significant expansion to parents under FamilyCare. If, after 5 years, some states have not expanded coverage of parents to at least 100 percent of poverty ($16,700 for a family of 4), a fail-safe mechanism would be triggered to require states to expand coverage to that level.

- Assisting Families in Affording Private Employer-Based Coverage. FamilyCare would also facilitate the option to pool state funding with employer contributions toward private insurance, which can be a cost-effective way to expand coverage. Under this option, families otherwise eligible for FamilyCare coverage could get assistance in purchasing their employers' health plan if it meets FamilyCare standards and their employer pays for at least half of the premium. This minimum employer contribution, along with the S-CHIP crowd-out policies, should discourage employers from reducing or dropping coverage. This option is supported by the National Governors' Association as well.

Testimony--Kim Moore, President, United Methodist Health Ministry Fund
Senate Financial Institutions and Insurance Committee
Senate Bill 668--an Act concerning the establishment of the Kansas business health partnership
March 28, 2000

The United Methodist Health Ministry Fund has seen improved access to primary health care as one of its basic callings. Since our establishment in 1987, we have supported the start-up and program expansion of several of the clinics that form a safety net of providers in Kansas. As part of our strategic planning process in late 1998 and early 1999, we questioned what new strategies could be developed, in addition to strong safety net providers, to improve access to primary care for Kansans. The large number of Kansans who are self-employed and employed in small businesses who lack health insurance caused us to ask what could be done to improve medical access through health insurance for this population.

The term "health insurance purchasing cooperative (HIPC)" was quickly evident in our discussions and in our reading. Many states had them--Kansas didn't. With the help of the Kansas Employer Coalition on Health, we commissioned a feasibility study to determine the need for and the likely acceptability of a health insurance purchasing cooperative for small employers in Kansas. As part of that study, a survey of small Kansas businesses was conducted. Between 45-50% of Kansas small businesses questioned were interested in a HIPC. With a number of caveats, the study determined that a HIPC was feasible.

We then solicited comments from persons involved in HIPC operation in other states. Sandra Shewrey, Executive Director of the California Managed Risk Medical Insurance Board, discussed that state's HIPC which had 7800 employers and 148,000 enrollees. She noted that between 19-23% of groups in that HIPC had previously been uninsured. She also attributed some suppression of premium prices for small employer groups to the operation of that HIPC. Terry McCorvie, Executive Director, Community Health Purchasing Alliance, Orlando, Florida, described his HIPC with 23,000 small businesses covering nearly 93,000 lives. In Florida, 55% of the HIPC enrollees were previously uninsured. Rick Curtis of the Institute for Health Policy Solutions, Washington, D.C., provided information about retention rates of employers in HIPCs nationwide which was much higher than traditional small group insurance. He also felt HIPCs were programs which could be used for coordination with HealthWave and other federal and state subsidies to gain even greater coverage expansion. We visited with representatives of Blue Cross and Blue Shield of Kansas who we have been privileged to work with in the Caring Program for Children. They shared strong concerns, which I imagine they will share today.

After several months of consideration, our Board decided in March, 1999 to fund the start-up of Kansas' first HIPC--now known as the Alliance Employee Health Access--with a grant of $325,000 and a $100,000 line of credit.

On balance, why was that decision made...

First, something needs to be done to address this segment of the market that presents special problems. Those special problems of small employers include:

the need to have group rate structures to keep premium costs as low as possible;

the need for assurance that someone is really working for the interests of the small employers to secure the best premiums and coverages for them and their employees;

the need for as much stability as possible in premiums through longer term arrangements and access to good contracting experience;

the need to have access to choice of products and health networks for small size groups of employees; and

the need to have benefit expertise available to handle paperwork, quality of product assessments and more.

These are all factors which discourage owners of small businesses from seeking group health insurance for their employees. It is logical that minimizing or eliminating these factors impeding group health insurance for small employers can increase coverage rates in that sector.

Second, we were unaware of any other good strategy besides the HIPC to address the small employer market and there is evidence that HIPCs are working in other states. We did not believe that Kansas small employers and their employees are that different from those in other states.

Third, providing health insurance through employers is the best way to produce health care access in a system which says that insurance is the American way of paying for care. Expanding the ability of Kansans to produce a health insurance card, not only buys access and health, but also creates a sense of personal worth and dignity and contributes very directly to a more just society.

These reasons combined in the minds of our 24 trustees to help them decide that support for a health insurance purchasing cooperative for small employers and their employees is an important strategy worthy of our investment. I hope that our experience is helpful as you consider this legislation.

Kim Moore
President
United Methodist Health Ministry Fund
1803 Landon, Hutchinson KS 67502
316-662-8586 (voice) 316-662-8597 (fax)
kmoore@healthfund.org

LEGISLATIVE TESTIMONY

the Kansas Chamber of Commerce and Industry
The Unified Voice of Business

835 SW Topeka Blvd. • Topeka, KS 66612-1671 • 785-357-6321 • Fax: 785-357-4732 • E-mail: kcci@kansaschamber.org • www.kansaschamber.org

SB 668

March 28, 2000

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Financial Institutions and Insurance

by

Terry Leatherman
Vice President, Legislative Affairs

Mr. Chairman and members of the Committee:

My name is Terry Leatherman. I am Vice President of Legislative Affairs for the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to explain why the Kansas Chamber supports the expanded opportunity for small Kansas employers to secure health insurance coverage for their employees, as promised by SB 668.

An initial observation of SB 668. The bill's strength is it builds on the backbone of today's health insurance delivery system. Employer-based health care programs provide coverage for more

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 2,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 48% of KCCI's members having less than 25 employees, and 78% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

Senate Financial Institutions & Insurance
Date 3/28/00
Attachment 3

- SB 668 , at least one segment of the small employer market to ture a variety of insurance products, much like a self-insured employer.
- The private market will drive the construction of an insurance product, rather than the elements of the policy being structured to comply with state mandates.
- The opportunity will be present to build a very basic insurance product, a starter set for health care insurance coverage.

3) SUBSIDIES

If the law of large numbers is to apply to the members of the Partnership, an important component might be the subsidy provisions in SB 668. In essence, the subsidies could serve as a premium reduction that could draw more people to coverage within the program.

The small business and human resources committees of the Kansas Chamber have been extremely interested in recent years in promoting a new and innovative approach to the systemic problems small employers face securing an affordable insurance benefit for their employees. There are certainly aspects of this legislation, which will receive critical review. Because of the complexity of this issue, there will no doubt be changes to this structure in the years to come. However, KCCI appreciates introduction and consideration of SB 668 in trying to address today's impediments to small employer health insurance, and would encourage the Committee's support of the bill. I would be happy to attempt to answer any questions.

Security Transport Services Inc
304 SE 21st ST
Topeka, KS 66607

3\21\00

Senator Steffes and members of the committee:

Our company recently lost its health insurance group plan because enrollment dropped below the minimum level set by our former carrier. The stated reason for our employees who dropped out was the cost of the employee contribution. Although we wish it were possible, our company cannot afford to pay the entire premium cost.

Low to modest wage earners would benefit greatly from some form of assistance to secure and maintain health insurance for themselves and their families. Such assistance would mean so much not only to the employees, but also to small businesses as well. Small businesses would then be able to attract and retain employees in a stable work force, unaffected by the necessity to switch employment to obtain health insurance coverage.

The bill now before this committee goes a long way towards addressing these concerns. However, it appears one section of this bill removes mandates for certain preventive measures. We urge this committee to re-visit these mandates in its deliberations.

Thank you for this opportunity to address this committee.

Thomas M. Rork
Vice- President

Senate Financial Institutions & Insurance
Date 3/28/00
Attachment 4

State of Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

for additional information, contact:

OFFICE OF THE SECRETARY

Laura Howard, Chief of Staff
915 SW Harrison Street, Sixth Floor
Topeka, Kansas 66612-1570
phone: (785) 296-3271
fax: (785) 296-4685

for fiscal information, contact:

OFFICE OF FINANCE

Diane Duffy, Deputy Secretary of Finance,
Information Technology, and Administration
915 SW Harrison Street, Sixth Floor
Topeka, Kansas 66612-1570
phone: (785) 296-3271
fax: (785) 296-4685

Senate Financial Institutions and Insurance Committee
March 28, 2000

Establishment of the Kansas Business Health Partnership

Health Care Policy
Lyn Goering, Assistant Secretary
(785) 296-3773

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Financial Institutions and Insurance Committee
March 28, 2000

Mr. Chairman and members of the committee, thank you for the opportunity to appear before you today. I am Robert Day, Director of Medical Policy/Medicaid. Affordable health insurance for low wage workers is a major concern in creating healthcare policy. This problem is further aggravated when one considers that many of these workers are employed in small businesses which, because of their size, lack the purchasing power necessary to obtain affordable health coverage. SRS is supportive of efforts to assist small businesses through a pooling of resources to increase the purchasing power of the business. Senate Bill 668 goes a long way toward assisting the small business community to provide affordable health insurance for its workers. SRS in general supports the basic concepts of this bill and pledges to work with the Kansas business health partnership, should it be created, to bring its Title XIX and XXI programs into the partnership.

This having been said, SRS has several concerns about Senate Bill No. 668 as introduced by the Committee on Ways and Means. This bill establishes the Kansas Business Health Partnership and outlines its operations, powers and duties. The Department is generally supportive of any efforts to increase the number of Kansas covered by health insurance. To the extent that this bill attempts to accomplish this through a purchasing cooperative for small business, we are supportive of the bill. The Department's specific concerns with the bill are outlined briefly below. In general the concerns center around the interweaving of the Department's programs and contractors with the new entity. There are also several references and provisions in S.B. 668 which need additional clarification.

Section 2(h) on page 3 of the printed bill gives the Health Partnership the authority to require both the submission of a good faith bid by, and the participation of, all health plans that contract with SRS. The Department believes this provision could seriously impair its ability to attract and maintain adequate health plans to insure persons eligible for coverage in Title XIX and Title XXI. We are at a point in our managed care programs (both Title XXI and Title XIX) where we are trying to make Kansas a viable market in which health plans are willing to participate. We have made significant progress in streamlining administrative functions and requirements to make Kansas more attractive to potential health plans. The Department is concerned that placing additional potential burdens on participating health plans would pose a threat to our current efforts.

Section 5 of the printed bill requires SRS to develop and seek federal approval for a "family waiver" for the Title XXI and Title XIX programs. There are a couple of technical

items and one policy concern the Department has with this section. The first technical item is the reference to a "waiver" which should be referred to as a "variance" for purposes of Title XXI. Second, no new waiver is needed for the HIPPS program in Title XIX as we already purchase policies that include coverage of an adult. This variance would be required in order for any adults to be covered under a policy purchased with Title XXI funds. A policy concern the agency has is that the receipt of a family variance from HCFA is only one of a myriad of regulatory issues to be dealt with in implementing this bill, but it is the only one singled out in the bill. For instance, a much more critical issue with the participation of Title XXI in the purchase of coverage through this process is the approval of a state plan amendment to purchase employer-sponsored coverage by HCFA. We would be more comfortable with language which directs SRS to explore how it might bring Healthwave and Title XIX eligible families employed by a small business into this partnership.

The Department believes it would be more appropriate for this bill to establish the construct for the new entity to implement the concept behind the bill without the addition of regulatory/administrative requirements which need to be accomplished. The Department is willing to work on overcoming potential challenges to the participation of our public health insurance programs in the Health Partnership without specific statutory requirements. In conclusion, the Department is very supportive of the concept of increasing the ability of small business to purchase health insurance for their employees' families and will work to investigate how Title XXI and Title XIX can be a part of the solution for eligible families.

That concludes my testimony, but I will be happy to respond to questions.

KPPI

KANSAS PUBLIC POLICY INSTITUTE

P.O. Box 1946 • Topeka, KS 66601-1946
Ph: 785/357-7709 • Fax: 785/357-7524

March 28, 2000

Testimony before the Kansas Legislature
Senate Committee on Financial Institutions & Insurance
Re: Health partnership act (SB 668)

by
Bob L. Corkins
KPPI Executive Director

Honorable Chair and Members of the Committee:

My name is Bob Corkins, president and executive director of the Kansas Public Policy Institute. KPPI is a nonpartisan, nonprofit research firm that educates people about free-market economic principles in the context of today's important public policy debates. KPPI was founded in Wichita in 1996, is now based in Topeka, and continues to decline any government funding of our work.

KPPI's direct involvement with the Legislature is minor, but our research on the general topic of employee benefits warrants my appearance today to explain our work and aid your deliberations on this subject.

KPPI's mission is to advance the constitutional principles of limited government, individual rights, personal responsibility and free markets. For nearly two years, our mission has led us to concentrate on the issue of defined-contribution pension programs. Five months ago, our pension research revealed a very promising application of this concept to the health insurance field.

The same idea that has hugely benefitted over 55 million Americans holding a 401(k) pension account may provide the best path to greater availability and affordability of health insurance. The key to a successful solution — in addressing pension programs, health insurance or an endless array of other issues — is to move toward greater exercise of personal responsibility that compels the free market to satisfy its needs.

Dr. Daniel Johnson, past president of the American Medical Association, advocates and explicitly describes the idea as "defined contribution health insurance". Under the approach, employers would pay a set dollar amount to each employee that the employee then uses to purchase his or her own health insurance. The employee would select a policy that costs less than the amount of the employer's contribution and invest the difference in something like an MSA, or the employee would add her own money to the employer's in order to purchase "Cadillac" health plan coverage.

Again, the key is to create employee ownership of (in this case) their own insurance policy. Each employee would decide what sort of coverage he is willing to pay for. Each employee would decide, with his personal physician, what medical procedures to undergo. In today's health care market where 75%

(more

Senate Financial Institutions & Insurance
Date 3/28/00
Attachment 6

of citizens have their insurance provided by either their employer or government, we are witnessing rapidly escalating costs that stem directly from the schism between the consumers of health care and the payers of health care. Employees must move beyond the health benefits question of "What do I get?" and replace it with the question "What do I get for my money?". Only then can competitive market forces determine the correct prices for medical coverage.

Here is the linkage to SB 668. Two primary reforms are needed to enable defined contribution health insurance. The first is one of tax policy. Federal law may need changes (but not necessarily) to assure that defined contribution health plans create no tax disadvantages to neither employers nor employees. For tax purposes, they should be treated like 401(k) pension plans. The second reform area regards the Kansas insurance market. Once an employee effectively has a "health voucher" in hand, will there be anything affordable to buy with it? KPPI's preliminary research points to the kind of voluntary "partnership" proposal contained in SB 668 as an answer to that question.

KPPI's thoughts about the plan in SB 668 include:

1. **The health partnership should be allowed to expand the scope of its participants**. If the partnership so chooses, every Kansan could participate; employers of more than 50 workers should be allowed in, just as individuals not affiliated with any business should be allowed in. All employees of participating employers, not just their subsidized workers, should be allowed to select from the partnership's array of coverage plans.

2. **Employees must have personal ownership of their partnership policy**. That is, employees should be allowed to maintain their partnership-acquired policy even after leaving employment.

3. **The state should not be allowed to coerce insurance carriers** into submitting bids to sell health insurance within the partnership.

4. **Government should not subsidize the cost of health insurance**. The advantages of reducing the number of uninsured and making insurance premiums more competitive would be achieved without the subsidy components of this bill or other tax credits that may apply. The partnership could obtain market negotiating leverage that accompanies increased pool size while policies sold within the partnership would be free of much regulation that adds to insurance expense.

Dr. Johnson is just one voice together with several influential national sources that recognize the merit of this fundamental shift toward personal responsibility in health care. The latest position of the U.S. Chamber of Commerce calls for defined-contribution insurance and expanded MSAs. The top executive of Aetna, the nation's largest health insurer, publicly stated that within a decade a majority of its health insurance products will be drafted on the defined contribution model. The Xerox Corporation has already announced its plans to shift to defined-contribution health plans within five years.

The existence of a Kansas Health Partnership would prepare this state for the time when the federal tax treatment of defined contribution health insurance is clarified. Kansas could begin realizing the benefits of improved access now, while nurturing the framework for broader reform to follow.

# # #

Alliance
Employee Health Access

1609 S.W. 37th Street
Topeka, Kansas 66611
Voice- 785-266-1970
Fax- 785-266-5064

Testimony to Senate Committee on Financial Institutions and Insurance
March 28, 2000

by
James P. Schwartz, Jr.
Executive Director
Alliance Employee Health Access

Thank you, Mr. Chairman and members of the Committee. I am Jim Schwartz, executive director of Alliance Employee Health Access. You may recall from my appearance here last month that Alliance is the first health insurance purchasing group for small businesses in Kansas. We're a not-for-profit organization that was launched last year with startup funding by the United Methodist Health Ministry Fund.

Alliance is able to help small businesses obtain affordable choices for health insurance. But we can only go so far. Many, perhaps most, of the state's uninsured population simply can't afford to contribute substantially to their coverage, blocking them from even the most advantageous arrangements. The solution for low-wage earners is to have a subsidy toward their coverage. With this approach, we can harvest the contribution that employers are willing to make, combine that with a modest contribution by employees, and complete the package with a sliding-scale subsidy. That's an approach that builds on the existing system of employer-sponsored insurance and takes advantage of its virtues.

A remarkable feature of SB 668 is that it doesn't just throw money at the problem of the uninsured. You could have simply given tax credits or given the money to insurance companies to buy policies. Instead you would funnel the subsidies through a "health partnership" to accomplish much more. For one thing, the health partnership would combine the purchasing power of many small groups. It would also use the power of the bid process to get maximum value from subsidy dollars. In addition, the health partnership would overcome the greatest handicap of managed care by giving individual employees a choice of competing health plans. That's the way large employers like the state and federal government, Boeing and Western Resources operate. The result is a more competitive market and happier patients.

Passage of SB 668 will put Kansas on the map as a leader in health reform, with a public-private partnership that reflects both our hearts and our heads. I commend you for advancing this remarkable legislation.

Testimony to the Senate Committee on Financial Institutions and Insurance
Senate Bill 668
Kansas Business Health Partnership

Michael F. Larkin
Kansas Employer Coalition on Health
March 28, 2000

Good Afternoon. My name is Mike Larkin, and I am the Director for the Kansas Employer Coalition on Health. The Kansas Employer Coalition on Health, known also as KECH, is a consortium of over 60 employers throughout Kansas devoted to providing high quality, cost-effective healthcare to their employees and their families. Its members include large corporations in Kansas such as Sprint and Western Resources as well as smaller employers such as the Wichita Area Chamber of Commerce and Midwest Grain Products in Atchison. In order for member employers to continue to provide quality healthcare benefits to all their employees, we believe healthcare costs must remain affordable.

The Kansas Employer Coalition on Health is in favor of the provisions of SB 668. We support the concept that affordable healthcare insurance should be available to everyone. And I think that this bill is certainly a step in that direction. I am sure you have heard on a regular basis the many statistics concerning the rising numbers of Americans unable to afford health insurance, and I believe this bill begins to address those concerns. Low and modest wage employees in many cases work for smaller employers who are themselves struggling to succeed. These job creators would like to offer benefits to their employees but are simply not in a position to take on the financial burden required to do so in today's competitive business environment. Likewise, many employees of these small employers cannot contribute significant portions of their income toward health insurance.

Like any bill that tries to address an important social and economic issue as this one does, there may be a number of interests that favor some provisions more than other provisions. KECH is no exception. For example, we feel that the provisions of SB 668 as written is good in that it has the ability to leverage state and federal subsidy dollars with dollars from the employer giving the purchaser greater negotiating power. This environment of competition should foster lower prices and higher quality, something we all strive for in a free market.

We are less enthusiastic about the provision allowing for the health policy committee to require bidding by carriers contracting with either the Department of Administration or the Department of Social and Rehabilitation Services. If the health policy committee structures its policy in a way that is conducive to growth and competition, there should be no problem obtaining sufficient bids from potential health partnerships.

One last provision of this bill we hope you look closely at concerns eligibility. It appears that the bill as currently written would create a situation where some employees of a group would be eligible for coverage and others not eligible. Those that are eligible, the lower wage earners, are typically the younger, healthier employees. By carving out the younger employees, the balance of the group would be faced with higher health insurance rates. Consequently, it would be more difficult for the owner/employer to afford insurance. This approach would seem to be contradictory to the goal.

On behalf of KECH, I hope this information assists you in refining and crafting a bill beneficial to all Kansans. Mr. Chairman, this concludes my prepared statement. I would be happy to answer questions you or other members of the committee may have.

Kansans Respond

P.O. Box 2234
Topeka, KS 66601

(785) 232-8663
ksrespond@aol.com

TO: Members of the Financial Institutions and Insurance Committee

FROM: Mary Becker, Executive Director

Date: March 28, 2000

RE: Senate Bill 668

I. Income Disparity High in Kansas

A major national report was released in January by the Center on Budget and Policy Priorities and the Economic Policy Institute, called "Pulling Apart: A State-by-State Analysis of Income Trends". Below is a brief summary of the report's findings:

- Kansas is one of only 15 states whose poor have actually become poorer in the decade of the prosperous '90's, while high-income families grew richer. The poorest fifth of Kansas families saw a reduction of $1,140 in average annual income from the late 1980's to the late 1990's, from $15,610 to $14,470.
- Kansas ranks 6th worst in the **growth** of inequality between the richest and poorest families from the late 1980's to the late 1990's.

III. Level of Need Being Experienced by Low-Income Kansans

Emergency service providers throughout the state report a high volume of clients, some report record increases. Increasingly, agencies report that a large percentage of their clients, if not the majority, are working people. They are turning to community agencies for helpwith rent, utilities, food, transportation, medical care, and prescription drugs.

- The Kansas Foodbank Warehouse, food distributor to 450 food programs in the state such as food pantries and soup kitchens, increased their distributions by 37 percent in 1999.

- Catholic Charities in Wichita served 7,000 clients for emergency services in 1999. They turned away 10,000 people during the same time period, due to lack of resources.

IV. Low Income Working parents at high risk of being uninsured

A report released last year the Center on Budget and Policy Priorities found that one out of four of Kansas' low-income working parents are uninsured.

- In the mid-1990's, according to the Census Bureau data analyzed in the Center's report, there were 167,000 working parents in Kansas with income below 200 percent of the federal poverty level ($27,300 a year for a family of three in 1998). Approximately one quarter of these low-income working parents — 42,000 — were uninsured.

- The problem was even more extreme among the 40,000 working parents in Kansas with income below 100 percent of the federal poverty level ($13,650 for a family of three in 1998). An estimated forty-one percent of these working poor parents — 16,000 parents — lacked health insurance coverage.

This data tells us that we already had a major problem in the mid-1990s. Since then, the number of Kansas families on welfare has plummeted and so it is likely that there now are an even greater number parents struggling to get by in the low-wage job market without health insurance coverage.

As the report "Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance" points out, low-income working parents are at high risk of being uninsured because they typically work in low-wage jobs that often do not provide health care coverage. At the same time, they are largely ineligible for publicly-funded coverage, such as Medicaid.

- Kansas' earnings cutoff in Medicaid is so low that a parent in three-person family who applies for Medicaid can work no more than 16 hours a week at a job that pays $7 an hour before they become ineligible for coverage.

- Parents in Kansas who are employed at jobs that pay the federal minimum wage of $5.15 an hour can work no more than 22 hours a week and still be found eligible for coverage.

Health care is a basic need of every person. Yet thousands of working people throughout our state simply do not have access to quality health care. We are excited that our state is looking seriously at a way to provide critical support to many of the low-income families trying to get by in the low-wage job market. We urge your support of this initiative.

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

112 SW 6th Ave., Suite 201 Topeka, KS 66603 785-233-8483 Fax 785-233-8403 www.ink.org/public/kamu

March 28, 2000

Senate Financial Institutions and Insurance Committee
Senator Don Steffes, Chairman

My name is Joyce Volmut. I am Executive Director of the Kansas Association for the Medically Underserved. I am here in support of SB 668.

Although Kansas currently provides health care coverage to uninsured and other low income children through Medicaid and Health Wave, their parents continue to be at risk for being uninsured.

Until recently states have had little opportunity to cover parents under such programs as Medicaid unless they were on welfare or had recently left welfare. Options changed however in 1996 when the Personal Responsibility and Work Opportunity Act broke the eligibility link between welfare and medicaid.

What this did was open for states a great deal of flexibility in expanding coverage to families by giving states the option of making parents eligible for Medicaid at various levels of income in the same way that states now set varying income levels for children and pregnant women - with the federal government matching the expansion with anywhere from 50 to 79% of the cost.

Although it is not clear in reading SB 668, how parents will be covered, it is encouraging to see this legislation. This places Kansas with a growing number of states who are taking advantage of this new opportunity.

In October, 1998, the District of Columbia created DC Healthy Families, a program that provides Medicaid for families with earnings up to 200% of federal poverty level. There is no assets test in this program and the application is a simple 2 page document that can be mailed in.

In July 1999, Wisconsin began implementing it's program, called Badger Care under a federal waiver- although much of the program could have been implemented without a waiver. This program provides health coverage to families with incomes up to 185% of the Federal poverty level. Wisconsin uses Medicaid funds to cover parents and child health funds to cover eligible children.

Maine also has used the option to expand coverage for single parent families only. Their income eligibility is 100% of the federal poverty level.

Senate Financial Institutions & Insurance
Date 3/28/00
Attachment
10

Oregon, like Wisconsin has combined Medicaid and the child health block grant to provide coverage for their program, which is simply called the Oregon Health Plan regardless of how the eligibility plays out - whether Medicaid or funded through the child health block grant, the family simply enrolls in the Oregon Health Plan.

Other states also following suit include, Missouri, New York, Oklahoma and Ohio. All appear to be developing programs that utilize Medicaid, Health Wave and in some instances other state funds to initiate innovative programs that cover families.

The advantage of this new opportunity, which the federal government refers to as the parent coverage option, appears to be within it's flexible guidelines. For example,

1. States have full discretion to scale back the program in response to fiscal issues.
2. Nominal "Cost sharing" can be imposed- up to $3.00 per service or up to 5% of the state payment for that service.
3. States have considerable flexibility in determining the scope of coverage. Once again we are pleased to see options laid out in SB668- dental coverage and other kinds of health insurance, including life.

We are especially supportive of this bill because we believe it could have a positive impact on our member organizations, patient population. Although we know that the majority of clients served by the clinics work, we can't answer, at this point, where they work. We know many hold temporary jobs, work in fast food and in other positions where they are considered temporary and health benefits are not offered. Some are also seasonal, work in construction and other type of labor jobs where again health benefits are not offered. In other words there will undoubtedly continue to be families who fall through the cracks. We urge you to consider broad guidelines in developing the program, especially where eligibility is concerned, where premiums are set and to assure the program is comprehensive - especially that prevention services are given a primary focus. Other services we have found especially important for our clientele include transportation and other kinds of support services, such as care coordination.

Included with this testimony, I have included two documents that include data about the population served by the primary care clinics and health centers.

The first, ***Kansas Primary Care Clinics and Community Health Centers - Who are the people we serve,*** is taken from our annual directory - which was provided to each of you earlier this session - Overall the uninsured make up 66% of the clinic population. This represents an increase of 34% in the uninsured visits since 1996.

The second, ***1998 Survey Report, Access to Care-*** This includes data from a survey of 1605 families who were currently utilizing services in the primary care clinics and FQHC's. A listing of participating clinics is included in the back of the document. The survey was completed in late 1997. A summary of findings is listed on the first page. At that time 46% of adults stated they lost health insurance within the last year. Fifty- six percent did not have insurance because they could not afford the premium. We plan to repeat this survey this summer with assistance from the Kansas Health Institute. One thing we are hoping to learn is more about where people work.

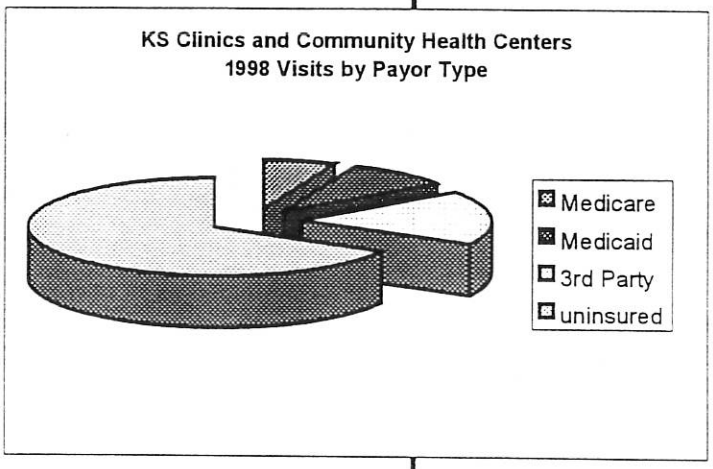
Kansas Primary Care Clinics and Community Health Centers

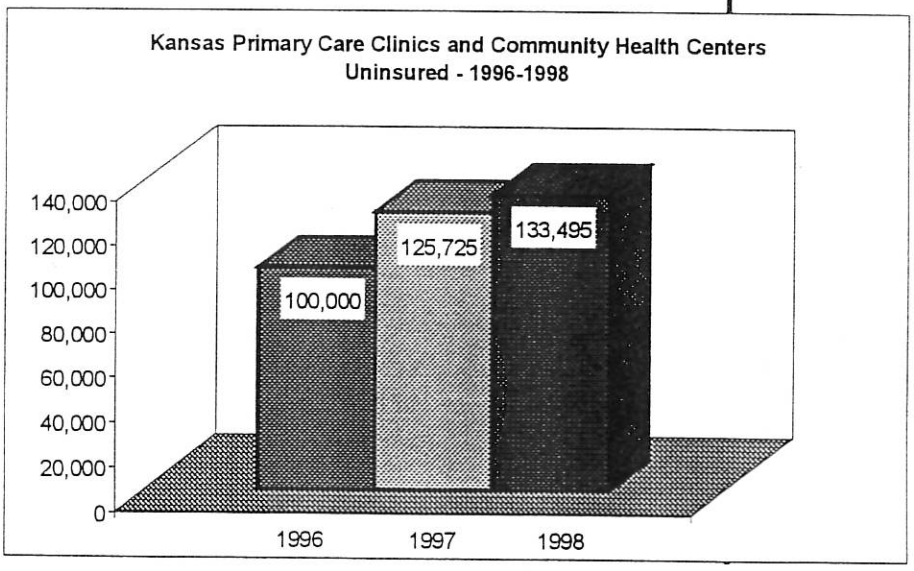
The Uninsured

Kansas Primary Care Clinics and Community Health Centers vary in how they establish eligibility requirements. Federally Qualified Health Centers, for example are required to provide services to anyone in need who resides within their catchment area. In all Clinics, charges are based on a nominal fee or sliding fee sched-

In 1999, over 66% of clients were without health insurance.

Since 1996, there has been a 34% increase in the number of uninsured.





10-3

Kansas Association for the Medically Underserved

1998 Survey Report
Access to Care --
-The Families We Serve

10-4

Kansas Primary Care Clinics and Health Centers
Analysis of User Survey
1998

Introduction

In late 1997, concerned by the number of new clients presenting themselves for care in Health Centers across the state, the Kansas Association for Medically Underserved completed a study of member organizations to gain a insight into family need.

The study consisted of an eleven question survey of families who visited primary care clinics and health centers between September 29 and October 10, 1997. Centers involved in the study included Federally funded Community Health Centers (CHC's) and other Federally Qualified Health Centers (FQHC's), State Funded Community Based Primary Care Clinics and other not for profit Primary Care and Dental Clinics across the state. The study focused on family information only, such as insurance status, income, family size and length of time the family had been utilizing this facility for care. Lastly the study looked at the need for dental care.

Methodology

Twenty six not for profit health centers and primary care clinics participated in the study. In order to assure a 95% reliability for each clinic, a minimum number of surveys were collected from each site. Care was also taken to assure that a statistically sample was collected from across the state. The survey was conducted over a two week period, using a self-administered methodology within each participating clinic sites. A total of 1605 families participated in the study. Both a Spanish and English version of the questionnaire were available.

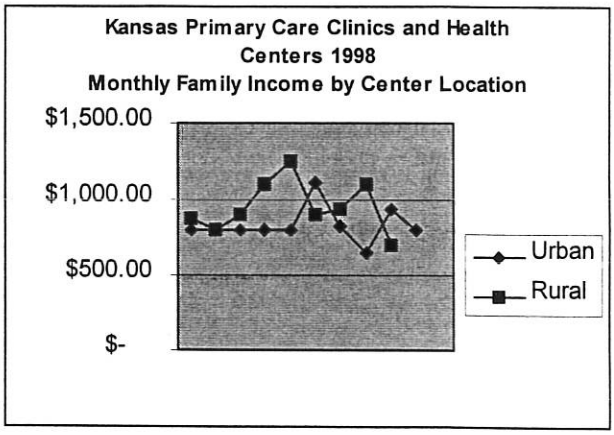
Statistical frequencies were used to calculate the count and percentages of each response to the questions. Where possible the mean, mode and median scores were calculated. The "top box" or most frequently answered question was used where possible to calculate majority response.

Summary of Findings

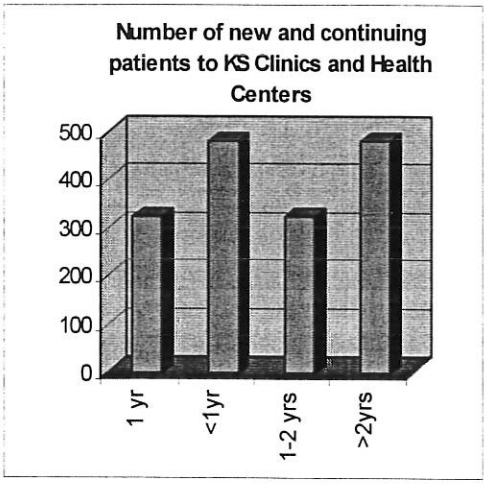
- Mean family income is low, $900.00 per month
- At least one person works full time
- Rural families tend to have slightly higher income than do their urban counterparts.
- At least 50% of the families have used the same primary care site for more than two years, another 50% are new.
- 46% adults and 17% children in these agencies have lost health insurance within the last year.
- 56% of the families state they do not have health insurance because they cannot afford the premium.
- 61.5% of all family members over age 18 and over as well as 62% of all family members who are under age 18 are in need of dental care.

Summary Analysis
Income and Employment

Overall the mean family income reported for 57% of the families utilizing health center or clinic services was $900.00 a month with a range of $640.00 a month to $1200.00. Approximately 78% of the families reported at least one person in the household was employed. Sixty-six percent of the families reported that the employed person worked full time. In general families who utilized clinics in rural areas tended to have a slightly higher earning than families who utilized clinics or health centers in Urban areas.



Clinic/Health Center Usage



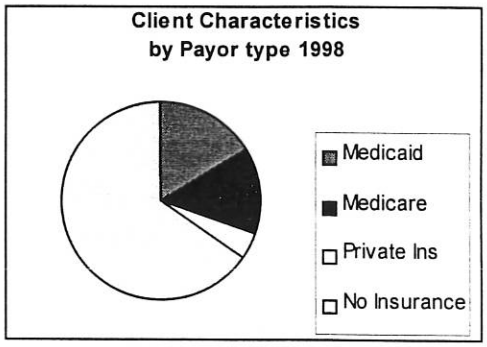
The data demonstrates that Kansas Health Centers play an important role in the delivery of primary care services throughout the state. *In 1998, 50% of all clients were new, reporting that they had been using the primary care site for less than one year. Another fifty percent, however, reported being registered as a patient at the site for more than 2 years.*

This finding illustrates the important role primary care clinics and health centers play in the dispels the notion that the uninsured do not actively seek primary care but rely instead on the emergency room for all of their primary care needs. Continued enrollment (two years plus) was found on average in older state health centers who provide comprehensive primary care services. These clinics include the United Methodist Mexican American Ministries in Garden City, a federally funded Community Health Center and Migrant Health Center who report approximately 59%of their clients have been regular clinic users for 2 years or more, the United Methodist Urban Health Center, a Federally qualified Health Center, where 61% of their clients report utilization of more than 2 years, the Shawnee County Health Agency, where 56% of their clients utilize comprehensive primary care services, Duchesne Clinic in Kansas City Kansas and St. Vincent Clinic in Leavenworth, where primary care services were initiated with state funding in 1991, and 70% of their clients have been using the service for more than two years and the Northwest Health Services , a Federally funded Community Health Center in Mound City Mo., that

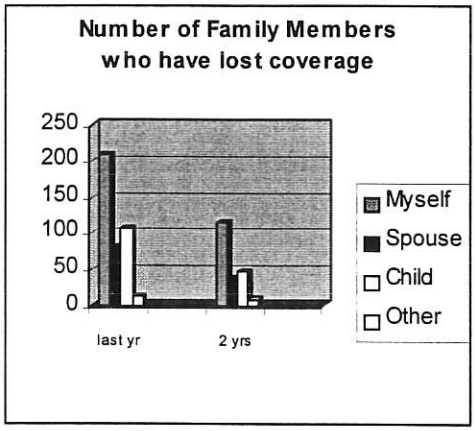
operates 2 sites in Doniphan County where almost 90% of the clients report having used the service for two years plus.

Health Insurance Coverage

When asked about health insurance or third party pay, the family respondents answered in the following way.
Twenty three percent reported they had medicaid coverage for at least one family member, 16% Medicare and 5% private insurance. It must be remembered in interpreting this data that these questions were answered for the entire family.



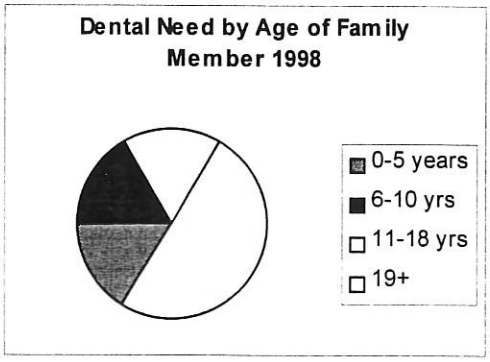
Overall data illustrates that the majority of clients who receive primary care services in Kansas Primary Care Clinics and Health Centers do not have health insurance.



When asked why they did not have health insurance, respondents answered in the following way. Thirty- four percent reported either they or their spouse had lost health insurance within the last year. Another 16% reported that a child in the family had lost health insurance within the last year. This may account for the number of new clinic registrants. Another 31% reported they had lost health insurance sometime during the last two years.

Of those who reported they had lost health insurance or did not have health insurance coverage, 55.5% stated they could not afford the payments, 20% stated they worked for employers who did not provide coverage and 10% reported they changed jobs and lost coverage.

Need for Primary Dental Care



Finally the survey examined the need for dental care. In this category the following was reported by age group.
61.5% (843 respondents) ages - 18+
20.8% (285 respondents) ages 11-18
21.2% (291 respondents) ages 6-10
20.4% (279 respondents) ages 0-5

Problems with the Survey

Several problems were identified in the Survey design that did not allow as clean an analysis as possible.

1. The survey was dependent upon an individual client to complete a series of questions aimed at collecting family information.

2. In order to gain a more representative sampling of families, smaller clinics needed more time than the two weeks allotted to complete the process.

3. Although the number of new families (50% of all families surveyed) was high, the survey did not provide insight into why, although some correlation may be made between the number of clients who lost health insurance and the number of clients who stated they were new to the clinic.

Kansas Primary Care Clinics and Health Centers who participated in this study :

Brookside UMC Clinic, Inc., Wichita
Cherryvale Rural Health Clinic, Cherryvale (a division of Mercy Hospital System of KS)
Community Health Center of Finney County, Inc. Garden City
Community Health Center, Hutchinson
Duchesne Clinic, Kansas City, KS (a division of Caritas Clinic, Inc.)
Elk County Rural Health Clinic, Howard (A division of Mercy Hospital System of KS)
Good Samaritan Clinic, Wichita
Health Care Access, Inc., Lawrence
Health Ministries of Harvey Co., Newton
Health Partnership Clinic, Overland Park
Konza Prairie Community Health Center, Junction City
Flint Hills Community Health Center , Emporia
Marian Clinic, Topeka
Martin de Porres Health Clinic, Topeka
Northwest Health Services, Inc. Mound City Mo, satellite clinics in Wathena and Troy
Pleasanton Family Practice, Pleasanton, KS (a division of Mercy Hospital System of KS)
Riley County-Manhattan Health Department, Primary Care Clinic, Manhattan
St. Vincent Clinic (a division of Caritas Clinic, Inc.
Salina Cares Health Clinic, Salina
Shawnee County Health Agency, Topeka
United Methodist Health Clinic of Wichita, Inc, Wichita
United Methodist Mexican American Ministries and Clinic, Garden City, Ulysses, Liberal and Dodge City.
We Care, Inc., Great Bend
Wichita-Sedgwick County Department of Community Health, Primary Care Childrens Clinic, Wichita

Kansas Association for the Medically Underserved
Report Access Survey - 1998

Total Number of Questionnaires completed - 1605

Survey Question		Response
1.	What is your family's total monthly income?	$900.00 month
2.	How many persons living in the same household does this income support?	57% - 1-2 persons 32% - 3-4 persons
3.	How many persons living in the same household work to earn this income?	78% - 1 person 20% - 2 persons
4.	How many of the workers in the family work full time?	66% 1 person 12% 2 persons
5.	How many of the workers in the family work part time?	26% 1 person
6.	How many of the working age family members are unemployed?	37% - 1 person
7.	How long has the family been using this clinic?	20% - 1 year 30% - < 1 year 20% 1-2 years 30% - > 2 years
8.	Check whether any family members have any of the following health care coverage?	Medicaid - 23% Medicare - 16% Dental Ins - 10% Private Ins - 5%
9.a	Check whether any family members have lost health insurance during the last year?	Myself - 56% Spouse - 13% Child - 17% Other - 3%
9.b	Check whether any family members have lost health insurance within the last 2 years?	Myself -15% Spouse - 7% Child - 9% Other - 2%
10.	Check the reason individual members of the family do not have health insurance?	Cannot afford - 56% Employer does not provide - 20% Changed jobs and lost health insurance - 10%

11.	Check below the age of any family member who needs dental care?	ages - 0-5- 20% ages 6-10- 21% ages 11-18 - 21% > age 18 - 62%

1. **What is your family's ...l monthly income?**
Write in the monthly income

$_____per month

2. **How many persons living in the same household does this income support?**
Check only one box

☐ 1 ☐ 4 ☐ 7
☐ 2 ☐ 5 ☐ 8
☐ 3 ☐ 6 ☐ 8+

3. **How many persons living in the same household work to earn this income?**
Check only one box

☐ 1 ☐ 2 ☐ 2+

4. **How many of the workers in the family work full-time?**
Check only one box

☐ 0 ☐ 2
☐ 1 ☐ 2+

5. **How many of the workers in the family work Part-time?**
Check only one box

☐ 0 ☐ 2
☐ 1 ☐ 2+

6. **How many working-age family members are unemployed?**
Check only one box

☐ 0 ☐ 2
☐ 1 ☐ 2+

7. **How long has the family been using this clinic?**
Check only one box

☐ First visit ever ☐ 1- 2 years
☐ Less than 1 year ☐ 2+ years

HC___ CT___
Kansas Association for the Medically Underserved 9/97

8. **Check whether any fa... ...embers have any of the following Health care coverage.**

	Yes	No
Health Insurance through work		
Medicaid		
Medicare		
Dental Insurance		
Private Insurance		

9. **Check whether any family members have lost health insurance during the last year or during the last 2 years.**

Family Member who lost health insurance	Lost During Last year		Lost During Last 2 years	
	Yes	No	Yes	No
Myself				
Spouse				
Child				
Other				

10. **Check the reason individual members of the family do not have health insurance.**
Check only one box

☐ Cannot afford payment
☐ Employer does not provide
☐ Changed jobs and lost coverage

11. **Check below the age of any family member who needs Dental Care.**

Age Range	Needs Dental Care?	
	Yes	No
0 - 5		
6 - 10		
11 - 18		
18+		

Thank you for helping us collect this information.

10-12

Kansas Association for the Medically Underserved
112 SW 6th St, Suite 201
Topeka KS 66603

Voice:- 785-233--8483
Fax 785- 233- 8403

jvolmut@idir.net or jeyerly@idir.net

http://www.ink.org/public/kamu

10-13

KMS
KANSAS MEDICAL SOCIETY

To: Senate Financial Institutions and Insurance Committee

From: Jerry Slaughter
Executive Director

Date: March 28, 2000

Subject: **SB 668; concerning the small employers health insurance partnership**

The Kansas Medical Society appreciates the opportunity to appear today as you consider SB 668, which would establish a program to make health insurance more available to small employers. We commend Senators Praeger and Salisbury, and the subcommittee, for their leadership in developing this proposal.

Unquestionably one of the most difficult and complex health insurance problems for policymakers and the industry alike, is how to make comprehensive health insurance affordable and available for small employers. Many different solutions have been discussed and tried, all with limited success and acceptance. This sector of employer groups typically are too small to demand the discounts and choices that are readily available to larger employers. Additionally, many of these businesses are in the service sector, where salaries are low, operating margins thin, and resources available to provide health insurance limited. In spite of numerous legislative efforts to stabilize this market through rating and underwriting regulation, it remains difficult for insurers to underwrite, price and deliver insurance products which are acceptable to the small employer market. Consequently, the numbers of employed uninsured continue to grow, and as the pool of insureds dwindles, costs will inevitably increase for those who are insured. This only exacerbates the problem of cost-shifting, which again just drives up costs for the insured population.

There probably isn't a perfect solution to this problem, and almost every state struggles with it. However, efforts such as the one you are considering are much preferable to a federal solution. It is clear that if something is not done to stem the growth of the uninsured, currently estimated at around 45 million countrywide, the federal government is not likely to remain passive or uninvolved. That will mean a loss of control at the state level, which will probably not be positive for patients, providers or the industry.

Conceptually SB 668 seems like a promising approach. Using funds from the children's health insurance program as a partial subsidy to stimulate wider participation by small employers just may have the desired effect. Plus, it provides the promise of continued insurance coverage for entry-level wage earners who leave public assistance and join the workforce often in service based, small employer settings. To the extent that this whole structure can empower the private

623 SW 10th Ave. • Topeka KS 66612-1627 • 785.235.2383 • 800.332.0156 •
Western Kansas office • 108 E 12th St. • Hays KS 67601 • 785.625.8215 • 800.293.

sector and minimize regulation and oversight, it will be beneficial. Neither the insurance market, nor small employers, will be interested in any structure that is overly bureaucratic or regulatory.

Our belief is that we all stand a much better chance of making positive changes if we approach problem solving in a cooperative manner. While this bill roughly outlines a promising concept, it will take the willing involvement of the state's insurers and small employers to make it work. It is impossible to legislate a successful market-based approach if the underlying assumptions and structure are not valid and market based. We would encourage the state to approach this as a partnership with employers, providers and the insurance industry, built on good, solid dialogue and sharing of concerns and ideas. If this effort is to be successful, it will need to be built from the ground up, with the state's principal role being that of a catalyst to bring the parties together and facilitate action.

We think SB 668 represents a good start to addressing the problem of making affordable insurance more readily available to small employers and their employees.

From: John <john@manhattan.org>
To: "'steffes@senate.state.ks.us'" <steffes@senate.state.ks.us>
Date: Fri, Mar 24, 2000 3:48 PM
Subject: SB 668

Senator Steffes,
The Manhattan Area Chamber of Commerce has been exploring small group health insurance initiatives for several years. The structure of SB 668 is an appropriate response to the health insurance concerns of small businesses and I urge your full support.

John Armbrust
Vice President, Membership Development
Manhattan Area Chamber of Commerce
501 Poyntz Avenue
Manhattan, KS 66502
Phone: (785) 776-8829
Fax: (785) 776-0679
E-Mail: john@manhattan.org

Senate Financial Institutions & Insurance
Date 3/28/00
Attachment 12

ROLAND SMITH INSURANCE SERVICES

Suite 201 West River Plaza 2604 West Ninth Street North Wichita, Kansas 67203-4792
316-942-8805 1-888-663-6717 FAX 316-942-8988
e-mail rolande@swbell.net

Roland E. Smith - Agent

March 28, 2000

TO: SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
FROM: Roland Smith
SUBJECT: SB 668

Due to previous commitments I am unable to attend the hearing today on such short notice. I do thank the Chairman's staff for calling me yesterday and alerting me of the hearing.

I would like to comment on what the passage of this bill in its current form would mean to the WIBA sponsored health plans in Kansas. As you know I am the agent of record for the plans. If many of the families with children would opt out of the WIBA plans in favor of the plans with subsidized premiums it would increase the adverse selection and cause increases in premiums for the older employees without children remaining in the WIBA plans. This would mean many older employees would be forced to drop their coverage because of the cost. 200% of the poverty level would include most employees of small businesses in Kansas. You need to be aware of these facts. This is well-intentioned legislation, but to rush into at in the closing days of the session, I believe, is ill advised. Approving a joint interim committee to explore this issue I believe would be more advisable.

Another concern I have is the use of federal funds designated for children and used to help insure adult employees. There is a possibility of a challenge, even thought some states are doing it, and would require changes in federal legislation to legally implement portions of this bill.

Thank You!

Roland E. Smith

Senate Financial Institutions & Insurance
Date 3/28/00
Attachment 13

Bill would extend health coverage

● **The bill would use money** in the state's insurance program for low-income children to encourage small businesses to insure low-income workers.

By Dave Ranney
Journal-World Writer

Topeka — Sen. Sandy Praeger thinks she's figured out a way to extend health insurance benefits to many of Kansas' low-income workers.

"The idea is to encourage more employers to provide coverage and to make that coverage more affordable for those who feel they can't afford it," Praeger, R-Lawrence, said.


Praeger

Praeger, who chairs the Senate Public Health and Welfare Committee, wants Kansas to use some of its Children's Health Insurance Program (CHIP) money to help small businesses offset the costs of covering fewer than 50 workers.

The money would not go directly to businesses. Instead, state officials would work with businesses and insurance companies to develop coverage plans financed by the business, its employees and the state.

The state would only contribute what it's already spending on the children of low-income workers employed by the small business.

"This would be revenue neutral," Praeger said. "The state would act as a 'pass through' for the CHIP funds, which are federal. It's a way we could maintain coverage for the children in way that would pick up the adults — their parents — as well."

CHIP coverage is available to children in families with incomes at or below 200 percent of the federal poverty guideline. A family of three — a mother and two children, for example — earning less than $28,300 a year would qualify.

'A terrific idea'

Praeger wants to encourage several small businesses to consolidate their plans in ways that would further reduce workers' costs.

Praeger's plan — Senate Bill 668 — had its first hearing Monday before the Senate Financial Institutions and Insurance Committee.

Insurance Commissioner Kathleen Sebelius called the bill "a terrific idea," noting that in Kansas 1,500 small businesses do not offer health insurance, and that 250,000 adults and their dependents are without coverage.

Most of those adults are in the work force, she said, and many have access to health insurance "but they can't afford the payments."

If the bill becomes law, Sebelius said Kansas would be in position to take advantage of a move to reward states willing to expand their CHIP-like programs to include adults.

"The issue here is not so much 'access' as it is 'money,'" Sebelius said afterward. "And what I like about this bill is that comes up with the money, which is going to bring people to the table."

Also endorsing the bill were the United Methodist Health Ministry Fund, Kansas Chamber of Commerce and Industry and Kansas Association for the Medically Underserved.

Industry concerns

Brad Smoot, a lobbyist representing Blue Cross and Blue Shield of Kansas, the state's largest insurer, said insurance companies were close to backing Praeger's bill.

"We think it's a great idea," Smoot said, "and it's certainly better than handing down a mandate that, in the end, only leads to fewer people being covered."

But the industry, Smoot said, has concerns about encouraging too many businesses consolidating too many of their plans.

"There are other options out there that we would like to see discussed — vouchers, for example — but all we're really saying is we don't want do something that's going to disrupt the marketplace."

Praeger said she's confident Smoot's concerns will be resolved during the hearing process.

The bigger problem, she said, is getting the bill through the Legislature before first adjournment April 8.

"I want it to pass this year," Praeger said.