Approved:
Date: 1-29-02

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Sandy Praeger at 9:30 a.m. on January 24, 2002 in Room 234 N of the Capitol.

All members were present except:

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Ken Wilke, Office of the Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Steve Rarrick, Deputy Attorney General
Matthew D. All, Assistant Insurance Commission, KID
Mary Ann Deagle, SRS

Others attending: See attached list.

**Introduction of bills**

Steve Rarrick, Deputy Attorney General, requested introduction of a bill that would amend the Discount Card Deceptive Practice Act to provide investigative and enforcement remedies to the Attorney General by making the Discount Card Act part of the Kansas Consumer Protection Act. (Attachment 1) Senator Teichman made a motion that the Committee introduce the proposed legislation, seconded by Senator Salmans. The motion carried.

**Special Orders**

The Chair noted that Subsection (d) of K.S.A. 9-1715, as amended requires the State Bank Commissioner to provide the Committee with a summary of Special Orders issued by their office in 2001. In a letter dated January 17, 2002, from Franklin W. Nelson, Bank Commissioner, he noted that their office did not issue any Special Orders in 2001. (Attachment 2)

**Report on Health Insurance Survey**

Matthew D. All, Assistant Insurance Commissioner, briefed the Committee by way of a power-point presentation on the results of a health insurance survey funded by a federal grant to the state of Kansas and overseen by the Kansas Insurance Department. Mr. All noted that a steering committee was assembled and their goal is to develop a plan to make health insurance accessible and affordable to all Kansans within five years. Results of the survey are outlined in the attached material. (Attachment 3) During Committee discussion Mr. All noted there are approximately 212,000 uninsured Kansans.

Mary Ann Deagle, SRS, gave a brief presentation on the Business Health Partnership which was established to make access to health care coverage affordable to uninsured working families. A grant from the Robert Wood Johnson Foundation had been received to help in the planning process. She noted that an RFP was issued, and the award granted to Benefit Management, Inc. of Great Bend, Kansas.

**Adjournment**

The meeting was adjourned at 10:30 a.m. The next meeting is scheduled for January 29, 2002.

SENATE FINANCIAL INSTITUTIONS & INSURANCE
COMMITTEE GUEST LIST

DATE: 1-24-02

| NAME | REPRESENTING |
|---|---|
| Kevin Davis | Am. Family Ins. |
| Rick Guttman | Health Midwest |
| Steve Karrick | A.G. |
| Harry Bossi | Dept of Admin |
| Matt All | KID |
| Bill Sneed | HEAN |
| Bonnie Ann Power | KAHP |
| John Frederick | Humana |
| Linda McCannon | KS Ins. Dept |
| Mary Ellen Conlee | Via Christi |
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State of Kansas
Office of the Attorney General
CONSUMER PROTECTION / ANTITRUST DIVISION
120 S.W. 10TH AVENUE, 2ND FLOOR, TOPEKA, KANSAS 66612-1597
PHONE: (785) 296-3751 FAX: (785) 291-3699

CARLA J. STOVALL
ATTORNEY GENERAL

CONSUMER HOTLINE
1-800-432-2310

Testimony of
Steve Rarrick, Deputy Attorney General
Consumer Protection/Antitrust Division
Office of Attorney General Carla J. Stovall
Before the Senate Financial Institutions & Insurance Committee
RE: Kansas Discount Card Deceptive Practice Act
January 24, 2002

Chairperson Praeger and Members of the Committee:

Thank you for the opportunity to appear on behalf of Attorney General Carla J. Stovall today to introduce a bill for your consideration. My name is Steve Rarrick and I am the Deputy Attorney General for Consumer Protection.

The bill proposed by the Attorney General would amend the Discount Card Deceptive Practice Act, an act passed during the 2000 Session which addresses health-related discount cards. Our proposal would amend the Discount Card Act to provide investigative and enforcement remedies to the Attorney General by making the Discount Card Act part of the Kansas Consumer Protection Act (KCPA). Some agencies and private associations have assumed the Discount Card Act directs the Attorney General to enforce its provisions. Unfortunately, while the Discount Card Act has been placed in Chapter 50 by the Revisor, the Act is not part of the KCPA and does not even mention the Attorney General. In addition to making the Discount Card Act part of the KCPA, we have made minor amendments to the requirements of the Act to provide greater protection to consumers.

I have a draft of the proposals for your review, and would be happy to answer questions of the Chair or any member of the Committee.

Senate Financial Inst. & Insurance
Date: 1-24-02
Attachment No. 1

KANSAS

BILL GRAVES
GOVERNOR

Franklin W. Nelson
*Bank Commissioner*

Sonya L. Allen
*General Counsel*

Judi M. Stork
*Deputy Bank Commissioner*

Kevin C. Glendening
*Deputy Commissioner*
*Consumer and Mortgage*

OFFICE OF THE
STATE BANK COMMISSIONER

January 17, 2002

The Honorable Sandy Praeger
Senate Financial Institutions
and Insurance Committee, Chairperson
Kansas Statehouse
300 S.W. Jackson, Room 255 E
Topeka, Kansas 66612

Dear Senator Praeger:

Subsection (d) of K.S.A. 9-1715, as amended, requires me to provide you with a summary of Special Orders issued by our office for the year 2001. This letter is to notify you that our office did not issue any Special Orders in the year 2001.

Sincerely,

Franklin W. Nelson
Bank Commissioner

FWN:SLA:lb

File: L

Senate Financial Inst. & Insurance
Date: 1-24-02
Attachment No. 2

700 Jackson, Suite 300 • Topeka, Kansas • 66603-3714 • 785-296-2266 •
www.ink.org/public/osbc

# Finding and Filling the Gaps: Making Health Insurance Affordable for All Kansans

Matthew D. All
Assistant Insurance Commissioner

Presentation to the Senate Committee on Financial Institutions and Insurance
January 24, 2002

## What are we doing?

- We are trying to find a way to make health insurance affordable and accessible to all Kansans.
- The State of Kansas received a federal grant to study this issue.
  - HRSA State Planning Grant
  - One of eleven states
  - $1.3 M
  - If you could make health insurance affordable to all citizens, how would you do it?

## What have we done so far?

- Assembled a Steering Committee
  - Nonpartisan
  - Public / Private
  - Geographically diverse
- Task: Oversee the project, develop a plan to make health insurance affordable to all Kansans within five years

## What have we done so far?

- Assembled a group of experts on health insurance.
- Task: Perform a large, comprehensive study of health insurance coverage in Kansas
  - Telephone household survey (8000 households)
  - Dozens of in-depth, individual interviews with uninsured Kansans across the state
  - Eight focus groups with small business owners

## What have we done so far?

- Assembled a Stakeholders Group
  - Consumers, including business owners
  - Insurers
  - Agents / Brokers
- Task: Brainstorm on how to make health insurance affordable to all Kansans

## What have we done so far?

- Held a series of town hall meetings.
  - Pittsburg
  - Overland Park
  - Manhattan
  - Hays
  - Garden City
  - Kansas City
  - Topeka
  - Wichita
- Received valuable input from hundreds of Kansans.

## What have we accomplished?

- Completed the research
- Brainstormed on how to make health insurance affordable to all Kansans
- Developed some preliminary proposals

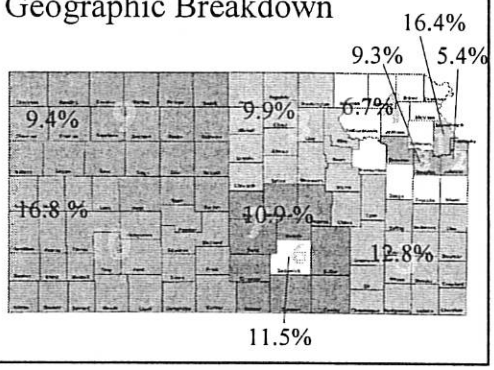
## What do we have left to do?

- Continue thinking through proposals
- Develop cost, effectiveness estimates
- Finalize plan

## What have we learned?

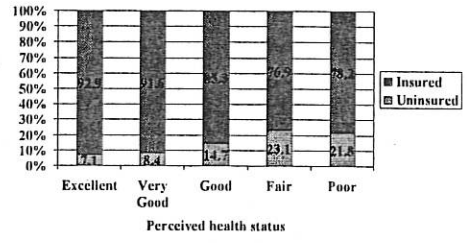
- 10.5% of non-elderly Kansans have no health insurance
- 244,000 Kansans
- Lower than national average (approximately 18%)
  - Kansas appears to have been below the national average since at least 1987.
- Still too many—we can do better!

## Geographic Breakdown




## But . . . why do we care?

## Quality of Life: People who are healthy tend to have health insurance. . .



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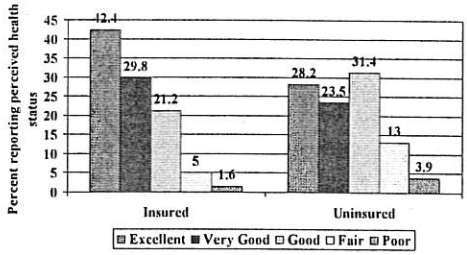
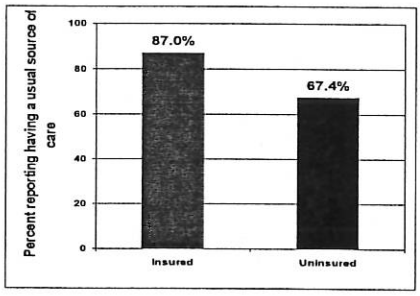
3-28

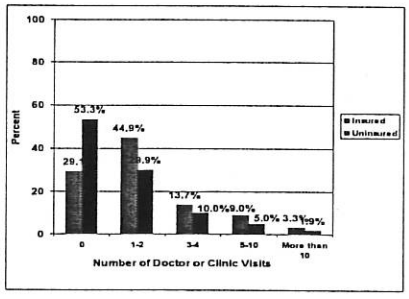
. . . and people who have health insurance tend to be healthier.



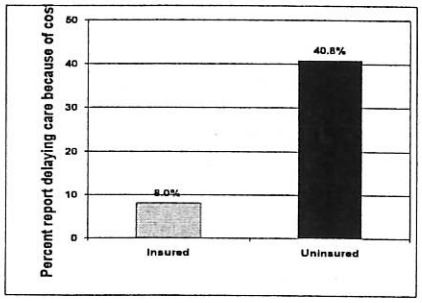

The insured more often have a usual source of health care . . .



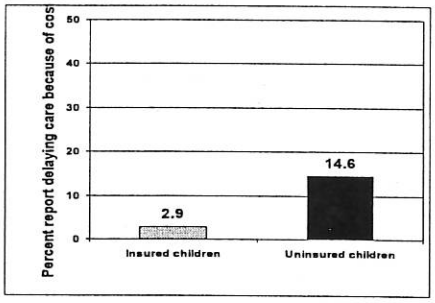

. . . and they get primary care more often.



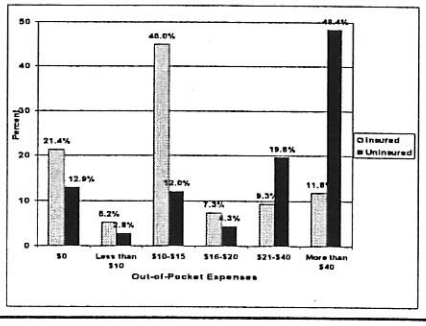
The uninsured delay care more often because they can't afford it . . .



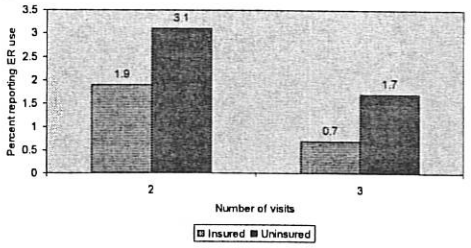

. . . and that's true for children, too.




The uninsured pay more for their care.

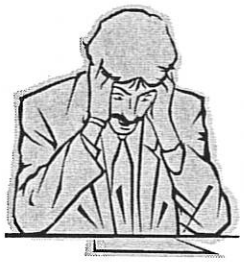


## The uninsured use the ER more often.




## Real Life Example: Bill

- 50 years old
- Married, four children
- Urban area, central Kansas
- After financial downturn in his construction business, lost health insurance



## Real Life Example: Bill

- Three years ago, started getting sick
- Avoided getting care because of expense
- Diagnosed with diabetes

## Real Life Example: Bill

- Even after symptoms worsened, avoided treatment because of cost
- Developed foot ulcers: "That's when I got a bill for $275 and they needed to see me every week and I'm going, oh my God, I can't do that!"

## Real Life Example: Bill

- Finally, Bill went to a government-supported clinic and received treatment.
- But his treatment was costlier and less effective than it would have been if he had received treatment all along.

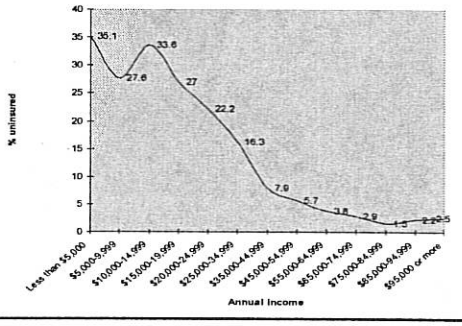
## And so . . .

- Not only do the uninsured have a lower quality of life . . .
- . . . but their use of the health care system is inefficient and costly, which raises the price of health care and health insurance for everyone.
- Recent testimony by a representative of BCBS of KS estimated the increased health care costs to be 20-25%.

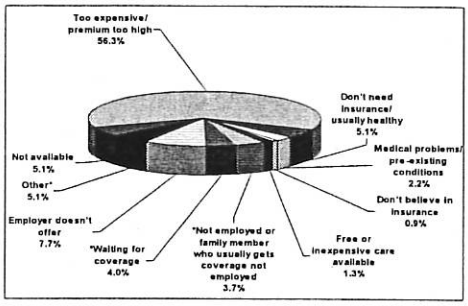
## And so . . .

- If we can do it, making health insurance affordable is the right thing to do.
- It helps the uninsured and the insured—all of us—alike.

## Those who make less money tend to have health insurance less.



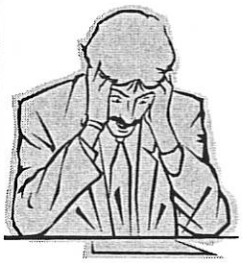

## Typically, the uninsured just can't afford it.





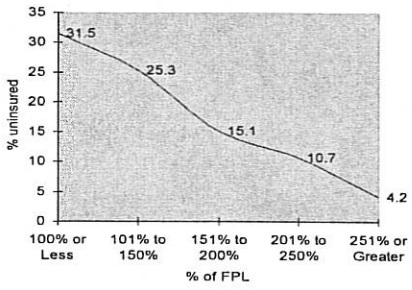

3-8

## But remember Bill . . .

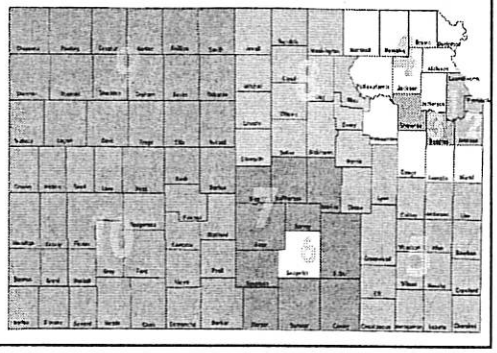


- His lack of insurance was unexpected.
- At one time, both he and his wife had job-based coverage.
- A short-term financial downturn sent them reeling: "we went from anticipating prosperity to financial disaster."
- The point: most Kansans are an unlucky break away from losing health coverage.

## Those who make less money can less often afford health insurance.




## But the devil is in the details: Comparing Regions 3, 4, 2, and 10





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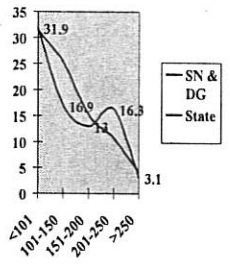
3-8

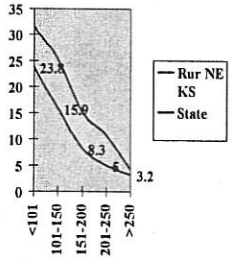
## Region 3: Shawnee and Douglas Counties

- Poor pattern
  - Poor more likely to be uninsured than near-poor
- Bump in 201-250 % FPL
- Overall, slightly lower than state average



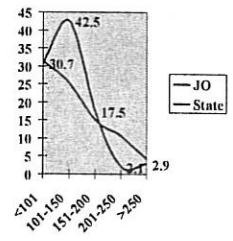

## Region 4: Rural Northeastern KS

- Poor pattern
  - Poor more likely to be uninsured than near-poor
- Low uninsurance across the board.



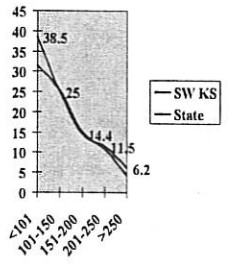

## Region 2: Johnson County

- Severe near-poor pattern
  - Near-poor more likely to be uninsured than poor
- Extremely low rate of uninsurance among relatively affluent
- Lowest overall rate

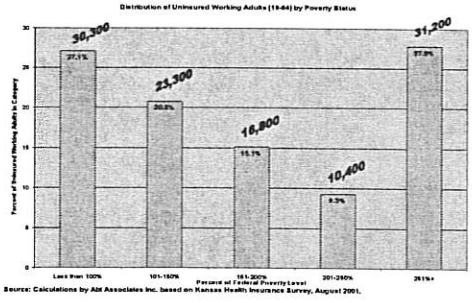


## Region 10: Southwestern Kansas

- Poor pattern
  - Poor more likely to be uninsured than near-poor
- Very high rate of uninsurance among poor
- Close to state average between 101% FPL and 200% FPL
- Highest rate of uninsurance among most affluent
- Highest rate overall

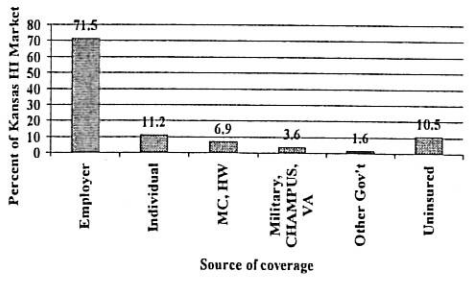



## Most uninsured working adults have low incomes.




Source: Calculations by Abt Associates Inc. based on Kansas Health Insurance Survey, August 2001.

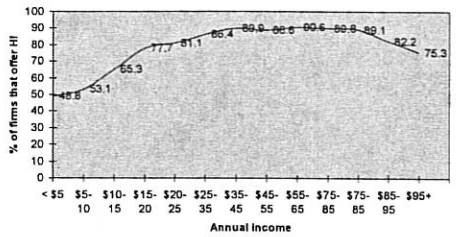
## Most Kansans get their insurance from their employer.






3-12

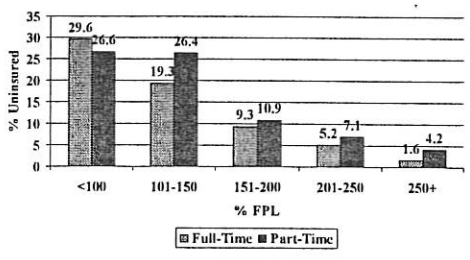
## Low-wage firms offer less, high-wage firms offer more.




## Business owners say . . .

- The most important factor in NOT offering health insurance is COST RELATIVE TO PROFIT.
- Offering HI to low-wage employees increases labor costs by a greater percentage than offering it to high-wage employees.

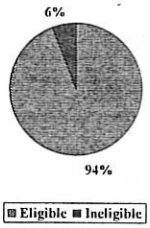
## When employers offer coverage, most low-wage employees take it, but many don't.



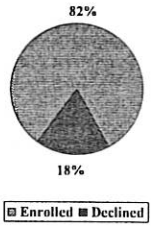



3-13

## Most Kansas employers offer HI to all their employees, if any



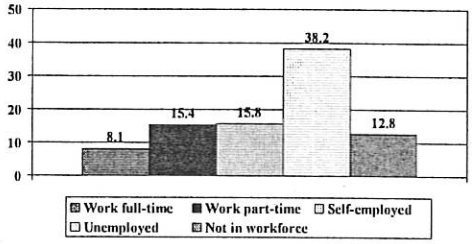

## But almost 1 in 5 Kansans who are offered employer coverage decline it



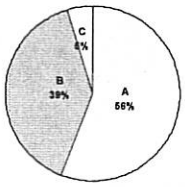

## Business owners say . . .

- Many low-wage employees would rather have higher wages to pay for more critical items.
- So even if they theoretically could afford it, they simply need more take-home money.

## The effect of employment status




## But most of the uninsured work




A: Uninsured Working Families with No Access to Employer-Sponsored Health Insurance

B: Uninsured in Working Families with a Worker who is Offered Health Coverage, But Declines

C: Uninsured Families With no Link to Employer Coverage

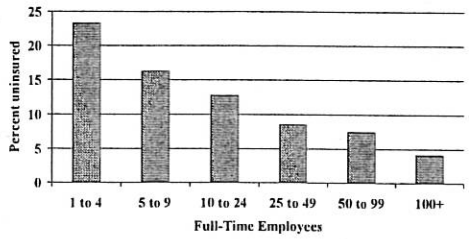
## Real life example: Jeanne and Larry

- 40 and 43 years old
- Rural community, central Kansas
- Larry works for concrete company.
- Jeanne cleans houses.
- Because neither job offers insurance, and they can't afford private insurance, their family is uninsured.

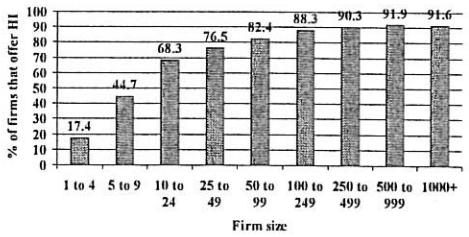


3-15

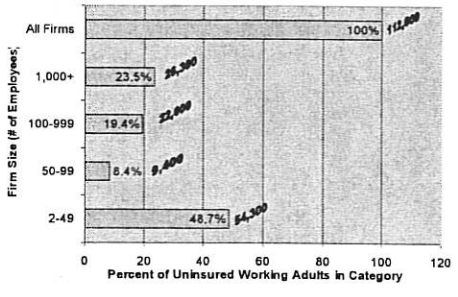
## Those who work for big firms have insurance more often.




## That's largely because big firms offer insurance more often.




## Almost half of uninsured working adults work for small firms.



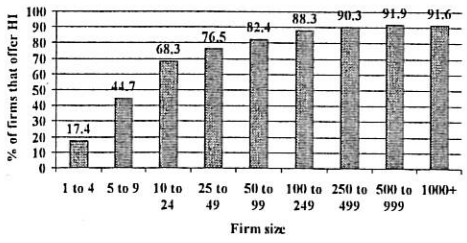
## Small business owners say . . .

- The lack of clear and understandable information is one of the largest barriers to offering coverage.
- Small businesses typically don't have an HR department to sort these issues out.

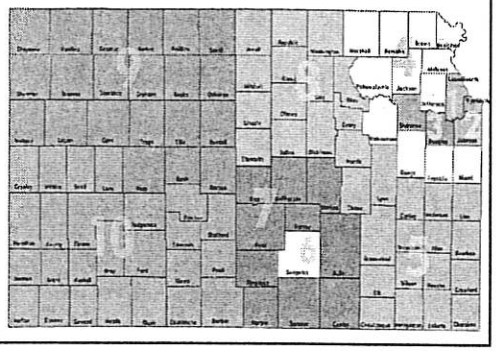
## Small business owners say . . .

- Unpredictable, volatile rate increases discourage them from offering coverage.
- Small businesses are less able to absorb these unpredictable costs than large businesses.

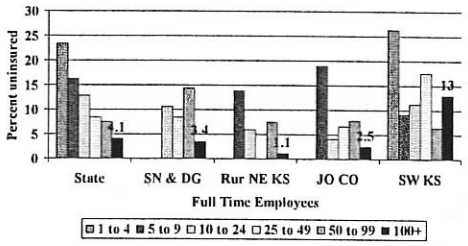
## Big firms offer insurance more often.



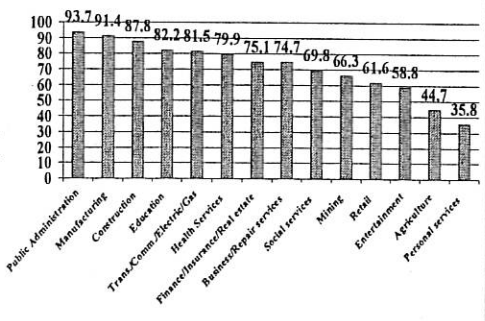
The devil is in the details: Comparing Regions 3, 4, 2, and 10



The effect of firm size in Regions 3, 4, 2, and 10



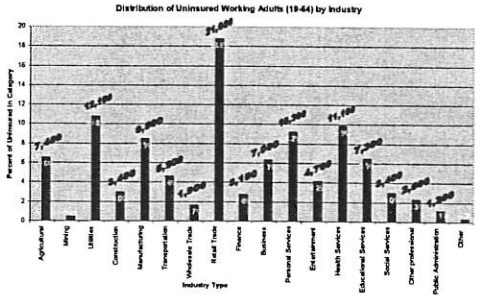

Where you work matters!



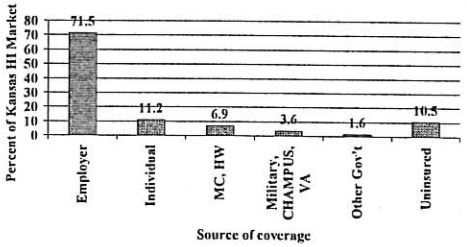



3-18

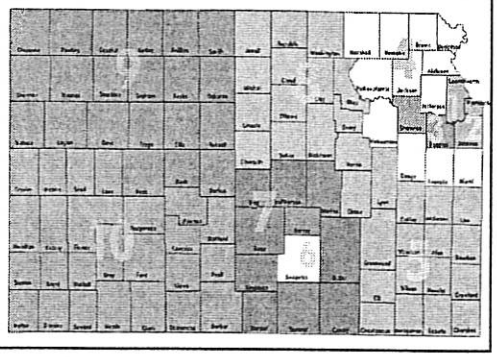
## Retail trade leads (or trails) the pack.



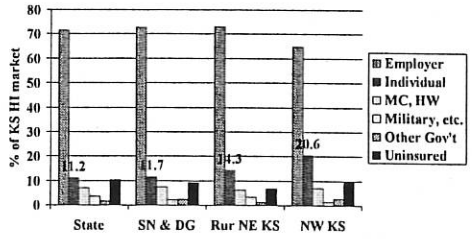

## Most Kansans get their insurance from their employer.



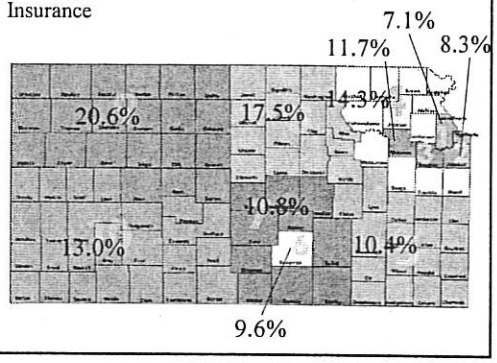

## The devil is in the details: Comparing Regions 3, 4, and 9



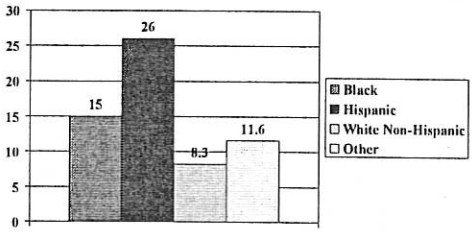
## Comparing source of insurance in Regions 3, 4, and 9



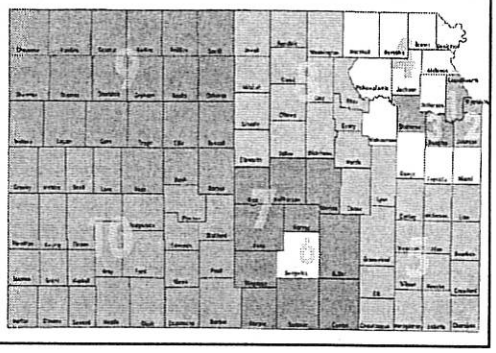

## Geographic Breakdown of Individual Health Insurance



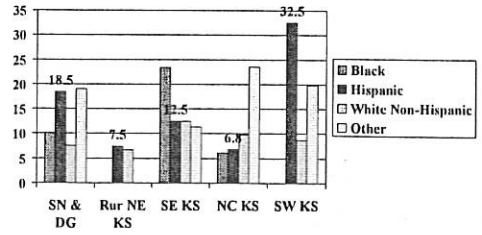

## Hispanic Kansans have the highest rate of uninsurance.



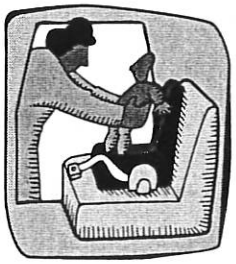
But, again, the devil is in the details: Comparing Regions 3, 4, 5, 8, and 10



## Race and ethnicity in Regions 3, 4, 5, 8, and 10

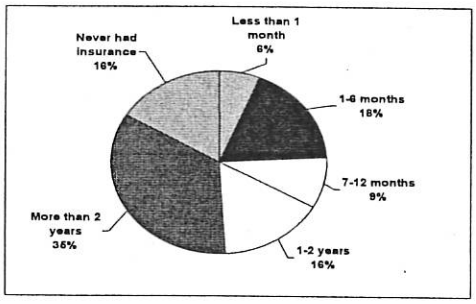



## Real life example: Juanita



- 30 years old
- Moderate-sized town, western Kansas
- Recent Mexican immigrant.
- Because she is new to our employment-based health insurance system, and because of language barriers, she is suspicious of health insurance and is reluctant to sign up.

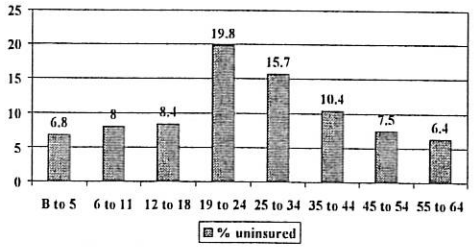
## More than half of uninsured Kansans are "chronically uninsured."




## Real life example: Jeanne and Larry

- 40 and 43 years old
- Rural community, central Kansas
- Because their jobs have never offered insurance, neither has had health insurance for 17 years.

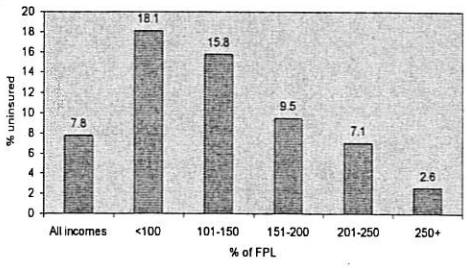
## Young adults have insurance less than all others.



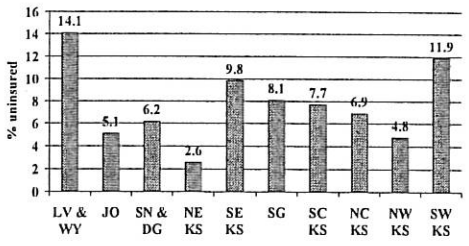
## Real Life Example: Bill

- "The younger you are, the more you tend to believe you are bulletproof. When I developed diabetes my first reaction was I was absolutely ticked off. I was angry. How could this possibly happen to me?"

## We must do better for our children.




## Uninsured children by region



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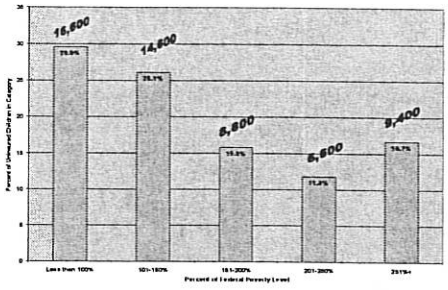
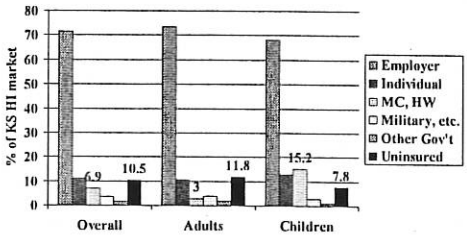
## Most uninsured children are in low-income families.




## Public programs help account for more insured children.




## Real life example: Beth

- 33 years old
- Rural community, western Kansas
- Married, two daughters, 10 and 3
- Works as a child caregiver
- Husband works for a small feedlot.
- No employment-based coverage, and they can't afford private coverage.
- But HealthWave covers their daughters

Let's talk solutions . . .

Remember . . .

- These are only proposals for discussion.
- No one on the Steering Committee has endorsed these proposals as the right way to make insurance affordable for all Kansans, but we think they have promise.
- Any solution will cost money, and would have to be balanced with other budgetary priorities.

We could help employers afford coverage.

- Expanded, enhanced small employer tax credit
  - Phase One: Education
  - Phase Two: Expansion of credit
    - Larger dollar amount
    - Streamlined application
- Enhanced Business Health Partnership



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## We could use our public programs more effectively.

- Using Medicaid/Healthwave funds to buy private, employment-based insurance
  - Promotes work, prevents stigma
  - Complicated
  - Takes dollars
- Expansion of Medicaid/HealthWave
  - Parents of Medicaid/HealthWave eligible children
  - Expensive, but leverages federal dollars

## We could address volatility in the small group market.

- Reinsurance tool
  - Spread risk of sickest groups across entire market or entire tax base
  - Will allow small groups to have more stable prices
  - Will require public dollars to bring down premiums

## We could find a way to reach alternative populations.

- Facility-based Health Benefits
  - Use clinic as center of benefit package
  - Partner with providers
  - Connect with public programs
  - Allow employers to buy in
  - Ensure continuity of care, more cost-effective use of health care system

## But whatever we do . . .

- We are going to have to deal with health care costs.
- If costs continue to increase at a double-digit pace, any solution will be unstable.

## In closing . . .

- We welcome your thoughts and suggestions.
- Please comment on the data, proposed solutions.
- Feel free to attend our meetings!

## Questions?



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