Approved: April 3, 2007
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairman Susan Wagle at 1:30 P.M. on February 12, 2007 in Room 231-N of the Capitol.

Committee members absent:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee:
Mr. Ken Wilkie, Assistant Director, Kansas Legislative Research Dept.
Senator Barnett

Others in attendance: Please see attached Guest List

Approval of Minutes

Upon calling the meeting to order, the Minutes of January 22 and 30th were distributed to the Committee. Chairperson Wagle asked that the Committee contact Ms. Cianciarulo with any changes and if none are received by Friday, February 16, 2007, these Minutes would stand approved.

Handouts

The Chair then called the Committee's attention to the two sets of handouts in front of them:

1) The first set is requested information by the Committees in the joint meeting held on January 30, 2007 including:

A.) The full report from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on their 2006 survey of Larned state Hospital;

B.) Corrective actions taken by Larned State Hospital in response to the 2006 (JCAHO) survey;

C.) Deaths that have occurred since 2000 at Larned State Hospital.

2) The second set is information from Mr. Ed Haislmaier, Research Fellow, The Heritage Foundation including:

A.) A "Report on: Massachusetts Commonwealth Health Insurance connector Program" from the Kansas Health Policy Authority;

B.) An article from "Backgrounder" paper, published by The Heritage Foundation entitled, "The Massachusetts Health Plan: Lessons for the States;

C.) Two charts, one entitled "Coverage Instability Problem" and the other, "Subsidy Implications".

A copy of the handouts are (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

Review of SB309 - An act enacting the Kansas Health Care Connector Act

The Chair then called upon Mrs. Terry Weber, Kansas Legislative Research Department, to give an overview of her handout. Referring to the "Bill Worksheet", Mrs. Weber stated that this was for the

committee's use and that Research had gone through and identified each section of the bill, provided a title, and tried to summarize each of the 16 sections. A copy of the "Bill Worksheet" is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

As there were no questions of Mrs. Weber, the Chair called upon Mr. Ken Wilkie, Assistant Revisor, Kansas Legislative Research Department. She mentioned that he actually wrote the bill and asked him to give a detailed overview on the bill. Mr. Wilkie stated that he was requested by Senator Barnett to put the bill together based a state health insurance exchange model act, which was the basis for Mr. Ed Haislmaier's remarks during his visit last week, keeping in mind that this act is just a first pass or starting point.

He went on to explain:

1) Throughout the act, the word "exchange" and the phrase "health care connector"can be found. The word "exchange", defined in Sec.2 as being the "Kansas Health Care Connector", is used throughout the bill as a term of art so as not to keep repeating the phrase"health care connector";

2) Section 1 basically provides a name for the act;

3) Section 2 gets into definitions:

A) Re: "carrier", did not use the definition in the model as it is very similar to the term "health insurer" as defined KSA40-4602 (just cross referenced to an existing definition, something we already had as with "credible coverage");

B) COBRA - if you loose your health insurance and need to go somewhere else, you may ending up buying your insurance through them;

C) Eligible individual - set up in such a way as you can be:

1.) A Kansas resident, or if not,

2.) You are employed at least 20 hours/week at a Kansas location by a bonafide employer in Kansas and the employer does not offer a group health plan or is not eligible to participate in a group health plan;

D) Accepted benefits - generally not covered under major medical type plans, (Ex. Workers Compensation)

E) Subsection K - defined "exchange" as the Kansas Health Care Insurance Connector established by this act, also established in Sections 4 and 5;

F) Down at the bottom of page 2, (m) "Health benefit plan" is cross tied to KSA 40-2118, should have referenced to have the meaning of health insurance in that statute (which is any hospital or medical expense policy, hospital or medical service corporation contract, or contract provided by municipal group funded or health maintenance organization contract offered by an employer or any certificate issued under those policies. This is how health insurance is defined and also the definition of a health benefit plan under KSA40-2209d;

G) Line 30, page 3, which is part of the definition of "Producer", there is a printing error. The statute should read "K.S.A.2006 Supp. 40-4902. Also "Producer" is another name for insurance agent and is in a Uniform Act which was passed by this body about 5 years when "licensing insurance agent" was updated.

4) Section 3 creates the Insurance Connector within the Health Policy Authority (the model as drafted indicated two choices, as a free standing organization or within a state agency and the directions were to put this in the Health Policy Authority as they already had a lot of things in place);

5) Section 4 sets forth several duties for the Health Care Insurance Connector including establish procedures for enrolling individuals (see criteria) and establish & administer procedures for the election of coverage by the participating individuals (the criteria for that are set forth in Section 6). These "duties" or detailed policies decisions the Committee will have to deal with because this is the type of detail that will have to be developed in order to more fully flush out the concept that this bill contains;

6) Section 5 - there are several types of contracting (ex. Outsourcing), also regarding "set and collect fees" Subsection (e) allows them to seek grants from the US Government or other agencies of the state or philanthropic organizations;

7) Section 6 - deals with more how an eligible individual can apply to the connector and Subsection (a) basically sets it up; limitations are shown in Subsection (b) ex. enrollment period; Subsection (d) similar to many healthcare plans regarding "a waiting period" if a "triggering event" occurs;

8) Section 7 - puts some limitations on the types of plans (requirements are checked by the Commissioner of Insurance;) also:

A.) In Subsection (d) the certification is set up so that the validity of the plan is automatically renewable unless there a withdrawal by the commissioner or a discontinuation;

B.) In Subsection (f) a detailed description of benefits offered including limits (Ex. Exclusions for certain types of cancer treatments, this would have to be disclosed);

C.) Subsection (g) deals with the types of major medical coverage that has to be included (listed at the top of page 6. Mental health benefits was not really defined in the model but would include anything that you find now in your health plans);

D.) Subsection (j) line 21, the exchange cannot decline or restrict an offering to any participating individual or sponsor a plan that hasn't first been

9) Section 8 states the rules that fall upon the carriers for the companies that are offering the plans dealing with pre-existing conditions and imposes requirements on dealing with these issues (Ex. If a person who has BCBS in one year and changes to Travelers the next year, this provision says you cannot subject them to a pre-existing provision just because of changing carriers within the exchange.)

10) In Section 9, if you are a participating individual, you can continue with the connector as long as you are eligible, but it does allow a company to cancel for nonpayment of premiums or fraud. It does prohibit the carrier from cancelling or non renewing the coverage to another year, because of a change in employer, marital or employment status and some other factors. (Basically, once you get a policy through the connector, you have coverage even if you change employment, get divorced, remarried, etc. as long as you continue to see that the premium is paid; if you voluntarily quit your job you are still covered, if you are fired for gross misconduct you are not.)

11.) Section 10 deals with procedures imposed on the Insurance commission and resolves disputes arising from the operation of the exchange (ex. Eligibility, coverage on surcharges, etc.) This section may have a slight overlap with the policies of the KHPA. (This could be a concurrent jurisdictional issue as it is a procedural rule that the KHPA set or an insurance issue with respect to the policy being offered.) As the top of page 11, he stated, this section also covers the process of appeals.

12.) Section 11 explains what happens if an employer wants to apply to the exchange to be a sponsor of a

participating plan:

A.) In subsection (b), they must enter into a binding agreement with the exchange and sections one through eight lists the various things that have to be included in this agreement (Ex. In paragraph one, "The exchange becomes the plan administrator.")

B.) In Section 2, the employer is basically saying they are only offering one plan and are getting it through the exchange and no place else;

C.) Paragraph three states that employees have a right to elect any product that is in the exchange, so the employee has, in effect, a cafeteria type plan to choose from, but the employer is providing the employee access "to the menu" and agrees not to restrict the employee's right to choose.

D.) In paragraph four it states that if the employer wants to offer additional benefits, other than what is offered through the connector, then the employer is the one responsible. The exchange does not become the plan's administer for these supplemental benefits. (Ex. A disability insurance policy that is not one of the coverages, listed on page 8, line 1-6. He said the policies coming through the connector are designed to deal primarily with major medical.)

E.) In paragraph five there is a "non competing clause" stating that the employer agrees to not offer any competing plan with another company or elsewhere that has the same benefits.

F.) In subsection (d) it basically states that the exchange has to be an equal opportunity provider of access, all the plans have to stay substantially the same.

G.) In subsection (e) it states what happens with the first year when the exchange gets into operation. NOTE: This does require that the Health Care Commission enter into agreement with the exchange that the state employee group goes into the exchange.

13.) Section 12 refers again to the insurance producers/agents in that, if they are going to enroll in the exchange, and there is a provision where there is a commission to be paid to the insurance agent and could be fixed on so much a policy or could be based on the amount of the premium.

14.) Section 13 deals with some filing requirements by each employee that is covered under the connector. (Mr. Wilkie noted that this has an interesting aspect to it, in that, if the employees are not covered through the exchange, then the employer has to file the employee's election to post a bond or other form of financial responsibility to show that they are able to cover their medical expenses as shown more in the next section.) Also, in subsection (d), there are some filing requirements by the KHPA.

15.) Section 14 deals with a situation that the carrier cannot issue or remove health benefit plans other than through the exchange (making the exchange an exclusive marketplace if you will, Mr. Wilkie stated.) Subsection (b) deviates slightly from the existing Kansas definition of "group" which would allow a single person business to fall in this situation. (Ex. A group of one, right now the groups are limited to two to 50.);

16.) Section 15 deals with the financial responsibility mechanism with the start date of January 1, 2009, basically stating that people between the ages of 18 and 65 must show proof of their ability to pay for medical care for themselves and/or their dependents and that they are not going through the connector. This type of responsibility if found in some of the licensing acts in the State.)

17.) Section 16 states the acts will be in effect after publication in the statute book.

The Chair thanked Mr. Wilkie and asked for questions from the Committee which came from Senators Palmer and Wagle ranging from the ERISA base plan; mandated coverages on the State's plan to:

- What is the cost involved of the connector and who will pay?

- Is there any legislative oversight besides the KHPA?

- Who is not eligible?

- How will employees be covered who work for large chains, like Boeing, and only allowed to work part time?

As there were no further questions of Mr. Wilkie, the Chair announced that she had originally planned for Senator Barnett to give an overview of the concept of the Connector and the Committee is not going to get to this, but will cover next Monday. She did request a memo from the Legislative Research Department regarding ERISA since they are a company that is exempted from this bill and we need to know who they are.

Adjournment

As it was going on 2:30 p.m., Chairperson Wagle announced that the meeting was adjourned. The time was 2:29 p.m.

The next meeting is scheduled for February 19, 2007.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

PLEASE PASS ON

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Monday, February 12, 2007

NAME	REPRESENTING
Jerry Slaughter	KMS
Paul Johnson	Ks Catholic Conf.
Luke Thompson	KHPA
Scott Brunner	KHPA
Mike Huttles	KAMU
Susan Zalenski	Johnson + Johnson
Suzanne Wikle	Kansas Action for Children
Cara M. Grove	KAMU
Cindy Gregersen	ESU Student
Larry Green	CMFHP
Peggy Galvin	Blue Cross of Kansas City
Linda Lubensky	KS Home Care Assoc
Carolyn Middendorf	Ks St Ns Assn
Mark P Martz	VIA Christi Health System
Derek Hein	Hein Law Firm
Josie Torrez	SILCK
Karl Wenger	Kearney + Associates
Will Deir	Federico Consulting
Sheena Smith	KS Chamber

See next sheet when full

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SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

PLEASE PASS ON

GUEST LIST

DATE: February 12, 07 cont'd

NAME	REPRESENTING
Marylynne Hillchurst	TFKC
Shelly Sweeney	Assoc. of Community Mental Health Ctrs.
Janel Forbes	United Healthcare
Cheryl Dillard	Coventry Health Care of Ks.
Mike Reecht	Sackes Brader
Brad Smoot	BCBS / FHP / CMH
Ira Stamm	SCH
KEN DANIEL	TOPEKA IND. BUS. ASSN.
Mike Shields	KHI NEWS
Bill Sneed	AHIP
Anna Staatz	Topeka Capital-Journal
Lanne [illegible]	KAHP
Amy Campbell	KS Mental Health Coalition

[illegible] in att

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Kathleen Sebelius, Governor
Don Jordan, Acting Secretary

www.srskansas.org

February 2, 2007

The Honorable Susan Wagle, Chair
Senate Health Care Strategies
Kansas Capitol, Room 221-E
Topeka, Kansas 66612

The Honorable Brenda Landwehr, Chair
House Health and Human Services
Kansas Capitol, Room 115-S
Topeka, Kansas 66612

Dear Committee Chairs:

Attached is information requested by your Committees in the joint meeting held on January 30, 2007. The attached includes:

- The full report from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on their 2006 survey of Larned State Hospital;
- Corrective actions taken by Larned State Hospital in response to the 2006 (JCAHO) survey; and
- Deaths that have occurred since 2000 at Larned State Hospital

Please let me know if you additional information is needed.

Sincerely,

Don Jordan
Secretary

attachments

Senate Health Care Strategies Committee
Date: February 12, 2007
Attachment 10

OFFICE OF THE SECRETARY
Docking State Office Building, 915 SW Harrison Street, 6th Floor, Topeka, KS 66612-1570
Voice: (785) 296-3271 • Fax: (785) 296-4685 • TTY (Hearing Impaired): (785) 296-3487

Joint Commission

on Accreditation of Healthcare Organizations

Setting the Standard for Quality in Health Care

Larned State Hospital

Route 3, Box 89

Larned, KS 67550-9329

Organization Identification Number: 3186

Date(s) of Survey: 8/28/2006 - 8/31/2006

PROGRAM(S)

Hospital Accreditation Program

SURVEYOR(S)

David K. Samples
H D. Brown, FACHE
Jay S. Flocks, MD
Marsha A. Barnden, MSN

Executive Summary

Based on the results of the accreditation survey, your organization has met criteria for Conditional Accreditation. The time frame for submission of clarifying Evidence of Standards Compliance (ESC), for one or more standards in question at the time of survey, is 10 business days. Should the central office review of the clarifying ESC result in your organization no longer meeting criteria for Conditional Accreditation, an on-site Clarification Validation Survey (CVS) will occur. This survey will be performed by a member of our Standards Interpretation staff within 5 days of the completion of our review of the clarifying ESC. Your Account Representative will contact you regarding this process.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Assessment and Care/Services

Standard: PC.8.10

Program: HAP

Standard Text: Pain is assessed in all patients.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C

1. A comprehensive pain assessment is conducted as appropriate to the patient's condition and the scope of care, treatment, and services provided.

Surveyor Findings

EP 1

Observed in in the south unit at the ATC building site.
During an individual tracer of a 32 year old female psychiatric patient who was admitted on April 19, 2006, it was noted that there was no documentation of an initial comprehensive pain assessment as required by hospital policy.

Observed in East Unit at Meyer site.
During individual patient tracer activities it was noted that several comprehensive pain assessments had been documented, however, none of the assessments included a pain score mutually agreed upon by the patient and care providers as part of an individualized pain management plan.

Observed in ATC West at Main site.
During a patient tracer, it was noted that hospital policy dictates a yes/no pain assessment on admission followed by a comprehensive pain assessment if the answer by the patient is yes. On this chart the yes/no assessment was not checked either way, and no comprehensive pain assessment was done.

Observed in Ray North 3 at Main site.
During a patient tracer, it was noted that hospital policy dictates a yes/no pain assessment on admission followed by a comprehensive pain assessment if the answer by the patient is yes. On this chart the yes/no assessment was not checked either way, and no comprehensive pain assessment was done.

Observed in Ray South 3 at Main site.
During a patient tracer it was noted that there was no pain assessment or history transmitted during the hand off of this patient from a different level of care.

Observed in Ray 3 South at Main site.
It was noted during a patient tracer that there was no numerical pain assessment, as required on Form MS-23, Comprehensive pain assessment through the rest of the form was completed. This represents a different provider than above.

Standard: PC.9.30

Program: HAP

Requirement(s) for Improvement

Standard Text: Resuscitation services are available throughout the hospital.

Secondary Priority Focus Area(s): Equipment Use

Element(s) of Performance

Scoring Category : A

3. Appropriate equipment is placed strategically throughout the hospital.

Surveyor Findings

EP 3

Observed in West 1 at Dillion site.

During individual patient tracer activities, it was noted that the unit did not have prompt access to an AED. Staff indicated that the AED is shared between several units. Additionally, in an emergency the AED would have to be brought to the unit via several locked security doors that would greatly impact the timeliness of getting the AED to the patient.

Observed in Ray Building, All units at Main site.

It was noted that all of the patient units in a large maximum security building which houses seven patient units share one Electronic Defibrillator. This defibrillator is stored in the main security area and anyone bringing the defibrillator to a code would have to traverse long corridors blocked by electric security doors. At best this would take several minutes. This is a dangerous situation which must be remedied by placing defibrillators on each unit or similar solution.

Standard: PC.12.70

Program: HAP

Standard Text: A licensed independent practitioner orders the use of restraint or seclusion.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A

2. As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, qualified staff does the following:

Notifies and obtains an order (verbal or written) from the licensed independent practitioner

Consults with the licensed independent practitioner about the patient's physical and psychological condition

Surveyor Findings

Requirement(s) for Improvement

EP 2

Observed in Child and Adolscent Unit at the ATC Building site.
During an individual tracer of a 16 year old adolescent patient it was noted that the the patient was placed in restraint (manual hold) at 8:15 pm on August 26, 2006. The physician did not sign the order for the restraint or see the patient until 9:35 pm one hour and twenty minutes later. Hospital policy requires that a restraint order by obtained and signed by the physician and the patient seen within one hour after the initiation of restraint.

Observed in South Unit at the ATC building site.
During an individual tracer of a 32 year old female patient it was noted that the the patient was placed in a chair restraint at 0030 hours on August 29, 2006. The physician did not sign the order for the restraint or see the patient until 0139 hours the same day, one hour and nine minutes later. Hospital policy requires that a restraint order by obtained and signed by the physician and the patient seen with in one hour after the initiation of restraint.

Observed in East 1 at the Ray building site.
During an individual tracer of a 38 year old male patient it was noted that the the patient was placed in a chair restraint at 1535 hours on July 16, 2006. The physician did not sign the order for the restraint or see the patient until 1802 hours the same day, 2 hours hour and twenty minutes later. Hospital policy requires that a restraint order by obtained and signed by the physician and the patient seen with in one hour after the initiation of restraint.

Observed in East 2 at the Ray Building site.
During an individual tracer of a 37 year old male patient it was noted that the the patient was placed in a chair restraint at 2037 hours on June 27, 2006. The physician did not sign the order for the restraint or see the patient until 2205 hours the same day, one hour and twenty seven minutes later. Hospital policy requires that a restraint order by obtained and signed by the physician and the patient seen with in one hour after the initiation of restraint.

Observed in East 2 at the Ray Building site.
During an individual tracer of a 37 year old male patient who was admitted on December 10, 2004 it was noted that the the patient was placed in a chair restraint at 0020 hours on April 20, 2006. The physician did not sign the order for the restraint or see the patient until 0141 hours the same day, one hour and twenty one minutes later. Hospital policy requires that a restraint order by obtained and signed by the physician and the patient seen with in one hour after the initiation of restraint.

Standard: PC.16.10

Program: HAP

Standard Text: The hospital establishes policies and procedures that define the context in which waived test results are used in patient care, treatment, and services.

Secondary Priority Focus Area(s): Information Management

Element(s) of Performance

Scoring Category : B

1. Quantitative test result reports in the clinical record are accompanied by reference ranges specific to the test method used and are appropriate to the population served.

Surveyor Findings

Requirement(s) for Improvement

EP 1

Observed in East Unit at Meyer site.

During individual patient tracer activities it was noted that the Precision G Log used for documenting fingerstick blood sugars did not contain reference ranges for glucose. The results of the fingerstick were used as definitive results rather than screening and actions may be taken based on these results. Further, physician notification was required for blood glucose results of <50 or >400. Although the staff member performing the fingerstick sent the results to the lab and received a computerized print out of the results (which did include reference ranges), this computerized record did not get sent back to the patient care unit sometimes for several days.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Infection Control

Standard: PC.7.10

Program: HAP

Standard Text: The hospital has a process for preparing and/or distributing food and nutrition products as appropriate to the care, treatment, and services provided.

Secondary Priority Focus Area(s): Patient Safety

Element(s) of Performance

Scoring Category : C

2. Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.

Surveyor Findings

EP 2

Observed in West Unit at Meyer site.

During individual patient tracer activities and unit tour it was noted that the patient snack refrigerator was out of normal range for several days with no corrective action documented.

Observed in East Unit at Meyer site.

During individual patient tracer activities and unit tour it was noted that the Snack Room refrigerator was out of normal temperature range for several days. The temperature log indicated that the refrigerator was "broken" for 2 days however, there was no evidence that corrective action was taken.

Observed in Main Kitchen at Cafeteria site.

During the unit tour it was noted that a refrigerator storing salad dressings did not contain a thermometer nor was there a temperature log for the refrigerator which contained three expired salad dressings. Staff were confused about what the date on the container indicated; some staff stated the date referred to date received from supplier and others stated the date indicated the expiration date. The walk-in refrigerator contained expired salad dressing and the produce refrigerator contained a bag of sliced fresh fruit that was not dated. Staff again expressed confusion related to the interpretation of the date found on containers and trays; when asked what the date indicates responses included date received, opened, made/prepared, or expired.

Observed in Kitchen at Dillion site.

During a unit tour it was noted that a tray of grapes stored in the walk-in refrigerator were not dated and there was evidence of mold growth on the grapes. Additionally, a bag of lettuce and bag of carrots in the same refrigerator were not dated.

Standard: IC.2.10

Program: HAP

Standard Text: The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.

Secondary Priority Focus Area(s): Quality Improvement Expertise/Activities

Element(s) of Performance

Scoring Category : B

Requirement(s) for Improvement

Standard: IC.2.10

Program: HAP

Standard Text: The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.

Secondary Priority Focus Area(s): Quality Improvement Expertise/Activities

Element(s) of Performance

1. The hospital identifies risks for the transmission and acquisition of infectious agents throughout the hospital based on the following factors:

The geographic location and community environment of the hospital, program/services provided, and the characteristics of the population served
The results of the analysis of the hospital's infection prevention and control data
The care, treatment, and services provided

Scoring Category : A
2. The risk analysis is formally reviewed at least annually and whenever significant changes occur in any of the above factors.

Surveyor Findings

EP 1
Observed in Infection Control Tracer at Main site.
During infection control tracer activities it was noted that the organization had not identified risks for the transmission and acquisition of infectious agents throughout the organization based on the community environment of the organization, the services provided and the population served. Additionally, risks were not identified based on the results of infection control data and the care, treatment, and services provided.

EP 2
Observed in Infection Control Tracer at Main site.
During the infection control tracer activities it was noted that the organization had not performed a risk analysis and formal review as annually required by the standards.

Standard: IC.5.10

Program: HAP

Standard Text: The infection control program evaluates the effectiveness of the infection control interventions and, as necessary, redesigns the infection control interventions.

Secondary Priority Focus Area(s): Quality Improvement Expertise/Activities

Element(s) of Performance

Scoring Category : A
1. The hospital formally evaluates and revises the goals and program (or portions of the program) at least annually and whenever risks significantly change.

Surveyor Findings

EP 1
Observed in Infection Control Tracer Activity at Main site.
During infection control tracer activities it was noted that the organization had not formally evaluated and revised the infection control goals and program.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Medication Management

Standard: MM.2.20

Program: HAP

Standard Text: Medications are properly and safely stored.

Secondary Priority Focus Area(s): Patient Safety

Element(s) of Performance

Scoring Category : A
2. Medications are stored under conditions suitable for product stability.

Scoring Category : A
7. All expired, damaged, and/or contaminated medications are segregated until they are removed from the hospital.

Scoring Category : C
15. All medication storage areas are periodically inspected according to the hospital's policy to make sure medications are stored properly.

Surveyor Findings

Requirement(s) for Improvement

EP 2

Observed in West Unit at Meyer site.
During individual tracer activities and unit tour it was noted that the medication refrigerator temperature log indicated a temperature of 34 degrees for 18 days of the month of August (expected range 36-46) and there was no evidence that corrective action was taken.

Observed in Night Locker/Satellite Pharmacy at Hospital Building site.
During unit tour of the Night Locker/Satellite Pharmacy it was noted that the thermometer on the medication refrigerator indicated a low range limit of 31. The required low range had been established at 36 by the organization.

EP 7

Observed in Ray North 3 at Main site.
On a patient tracer, inspection of a medication storage refrigerator revealed a vial of Lantus insulin which had been expired for three days. In part this happened because the expiration date had been calculated incorrectly by the clinician who opened the vial. A solution to this safety hazard was proposed by the pharmacist during the survey.

Observed in Ray 2 South at Main site.
An expired vial of Tuberculin Test Solution was noted in the refrigerator of this unit.

Observed in Ray North SBU at Main site.
An expired vial ol DDAVP was discovered in the refrigerator of this unit and was still being administered after the expiration date.

EP 15

Observed in Ray 2 South at Main site.
During a patient tracer, it was noted that a medication refrigerator in the med room had no record of having been cleaned weekly as required by policy, and here was excessive ice buildup.

Observed in Ray South 3 at Main site.
During a patient tracer, it was noted that a refrigerator temperature had not been recorded for two days out of 28 days. Policy requires daily noting of refrigerator temperatures.

Observed in Ray North SBU at Main site.
During a patient tracer, it was noted that the medication refrigerator temperature on this unit was not recorded for one day in the month.

Standard: MM.3.10

Program: HAP

Standard Text: Only medications needed to treat the patient's condition are ordered, provided, or administered.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C

1. There is a documented diagnosis, condition, or indication-for-use for each medication ordered.

Surveyor Findings

Requirement(s) for Improvement

Observed in West Unit at Meyer site.
During individual patient tracer activities in was noted in the medical record that a prn medication order did not include indications for use as required by the organization's policy.

Observed in Ray North 3 at Main site.
During a patient tracer, an order was seen for Selsyn (selenium sulfide shampoo) as a prn with no indication for use. This is an agent that has a number of dermatologic uses besides dandruff. Nonetheless, hospital definition of a complete order demands an indication for every prn order as well as a frequency of administration.

Standard: NPSG 3

Program: HAP

Standard Text: Improve the safety of using medications.

Secondary Priority Focus Area(s): Patient Safety

Element(s) of Performance

Scoring Category : A
Requirement 3C - Identify and, at a minimum, annually reviews a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

Surveyor Findings

Requirement 3C
Observed in West Unit at Meyer site.
During individual patient tracer activities and unit tour it was noted that several different types of insulin were stored together in one bin. Although the insulin was intended for use by one patient, there were no actions taken to alert the user to be aware of the look-alike/sound alike implications, i.e., labelling the insulins with a look-alike/sound-alike sticker, separating the vials, etc. The insulins were included on the organization's Look-Alike/Sound-Alike List of Medications.

Observed in Night Locker/Satellite Pharmacy at Hospital site.
During a tour of the Night Locker/Satellite Pharmacy, it was noted that several drugs including Risperdal, Depakote, and Nifetamide were flagged as high-risk/high-alert medications as indicated by red lettering on the bins where they were stored. These medications were not listed on the organization's High-Risk/High-Alert Medications. Additionally, the Risperdal in the medication refrigerator was not labeled as a high alert medication as was the Risperdal stored in the medication cabinet. Different types of insulin were stored together in the medication refrigerator and no actions were taken to alert the user as to the look-alike/sound-alike implications related to the insulins.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: NPSG 1

Program: HAP

Standard Text: Improve the accuracy of patient identification.

Secondary Priority Focus Area(s): Information Management

Element(s) of Performance

Scoring Category : A
Requirement 1A - Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

Surveyor Findings

Requirement 1A
Observed in Laboratory at Main site.
During a departmental tour of the lab staff stated that they routinely label blood specimens drawn at the bedside with a handwritten label that only includes the patient's name and the date and time the specimen was drawn. These specimen labels do not include the patient's identification number. Staff further stated that the specimen was labeled a second time with a computerized label (containing the patients identification number) after it was returned to the lab. The rationale for this practice (as provided by the staff) is that patients frequently remove their bracelets or photo identification and the lab staff do not have access to the identification number. The staff further indicated that when patients are newly admitted, there is often a delay in getting a patient identification number. Additionally, there were two urine samples on a counter in the lab, one with a handwritten label (completed by nursing staff) and the other with a computer-generated label. Lab staff stated not all units have the same process for labeling blood and urine specimens.

The organization's Lab Procedure Manual 2004 stated that "LSH patients do not wear any type of identification. It is necessary for lab personnel to be sure that blood sample is taken from the correct patient. Nursing personnel must be on hand to identify each patient for lab staff". Other policy statements include, "Urine Specimens: No label attached to the specimen"; it was unclear to staff members what this statement was referring to. The organization's policy had not been updated to reflect the NPSG requirement of using at least two identifiers when taking blood samples or other specimens. The organization had established that the two identifiers to be used throughout the organization were the patient identification number and photo identification.

Further, the organization did not have a policy for managing a name alert situation where two patients shared the identical or similar name. Staff indicated that there had been more than one occasion when patients shared the exact same first, middle and last name as well as many occasions when patients shared similar names.

Standard: NPSG 2

Program: HAP

Standard Text: Improve the effectiveness of communication among caregivers.

Secondary Priority Focus Area(s): N/A

Requirement(s) for Improvement

Standard: NPSG 2

Program: HAP

Standard Text: Improve the effectiveness of communication among caregivers.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
Requirement 2A - For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.

Surveyor Findings

Requirement 2A
Observed in South Unit at the ATC building site.
During an individual tracer of a 31 year old female psychiatric patient who was admitted on April 19, 2006, it was noted that on July 21, 2006 an RN received a telephone order for porch privileges for this patient from a physician. The telephone order was not documented having been read back by the staff member as required by hospital policy.

Observed in East 1 at the Ray building site.
During an individual tracer of a 38 year old male psychiatric patient who was admitted on April 5, 2006, it was noted that on May 5, 2006 an RN received a telephone order for thorazine and benadryl for this patient from a physician. The telephone order was not documented as having been read back by the staff member as required by hospital policy.

Observed in East 2 at the Ray building site.
During an individual tracer of a 37 year old male psychiatric patient who was admitted on Dec 12, 2004 it was noted that on June 21, 2006 an RN received a telephone to change the watch status for this patient from a physician. The telephone order was not documented as having been read back by the staff member as required by hospital policy.

Standard: NPSG 8

Program: HAP

Standard Text: Accurately and completely reconcile medications across the continuum of care.

Secondary Priority Focus Area(s): Communication

Element(s) of Performance

Scoring Category : A
Requirement 8A - Implement a process for obtaining and documenting a complete list of the patient current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

Scoring Category : A
Requirement 8B - A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.

Requirement(s) for Improvement

Surveyor Findings

Requirement 8A
Observed in South Unit at ATC Building site.
During an individual tracer of a 32 year old female patient who was admitted on April 19, 2006 it was noted that there was no documentation that the physician had participated in the medication reconciliation process. The medication reconciliation form was completed by nursing and listed the patient's medications however there was no documentation in the medical record or on the medication reconciliation form that the physician had reviewed the patient's medications as required by hospital policy.

Observed in West 1 at Dillion site.
During individual patient tracer activities it was noted in two patient records that the Medication Reconciliation form was not dated making it unclear as to when it was initiated. Additionally, the Medication Reconciliation form was not updated on an ongoing basis as new medications were ordered or medications were discontinued.

Observed in West Unit at Meyer site.
During individual patient tracer activities it was noted that the patient record did not contain a Medication Reconciliation form.

Observed in East Unit at Meyer site.
During individual patient tracer activities, it was noted that the medical record did not contain a Medication Reconciliation form.

Observed in ATC West at Main site.
On a patient tracer, it was noted that this patient had been on many attempts to start the patient on medication but that he was poorly compliant. The initial meds were listed as "no meds". There was no note of an effort to elicit from the patient past medications which may or may not have been useful. There was no note or acknowledgement by the MD that he had seen the reconciliation in choosing his new orders for medication

Observed in Ray North 3 at Main site.
It was noted on a patient tracer that the medication reconciliation form contained only a list of medications transferred with the patient from DOC. There was no acknowledgement by the MD that he had seen or used this list in writing new orders, or, was there evidence that the patient participated in the reconciliation. Additionally, as medications were changed because of changes in the symptom profile, these changes were not noted on the reconciliation sheet, providing no treatment rationale for the next level of service.

Requirement 8B
Observed in Pharmacy at Main site.
During an interview with the pharmacist it was noted that the organization did not have a process for providing the next provider, when known, a list of the patient's current medications at discharge (Community Mental Health Clinic, for example). Additionally, the organization's External Transfer Form does not include any reference related to the patient's current medications.

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Physical Environment

Standard: EC.5.20

Program: HAP

Standard Text: Newly constructed and existing environments are designed and maintained to comply with the Life Safety Code®.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B

1. Each building in which patients are housed or receive care, treatment, and services complies with the LSC, NFPA 101® 2000; OREach building in which patients are housed or receive care, treatment, and services does not comply with the LSC, but the resolution of all deficiencies is evidenced through the following:

An equivalency approved by the Joint Commission Or

Continued progress in completing an acceptable Plan For Improvement (Statement of Conditions™, Part 4)

Surveyor Findings

See life safety code

Life Safety Code

Inpatient Occupancy Existing Healthcare Occupancies; Section I - Buildings

Requirement: EC.A.1A.4.b

Phrase: Existing Health Care Occupancies The following assemblies are constructed of materials with the minimum fire resistance rating based upon the type of construction: structural frame. (EC.A.1A)(EC.A.1A.4)(EC.A.1A.4.b)

Surveyor Findings:

At the Isaac Ray building boiler room there were 18" structural beams and pan ceiling corner support beams that have not been fireproofed but the columns they rest on have been boxed in by FRR construction.

Requirement: EC.A.1C.5

Phrase: Existing Health Care Occupancies Doors in two-hour fire resistance rated separations are: provided with <= 3/4 in. undercuts. (EC.A.1C)(EC.A.1C.5)

Surveyor Findings:

Sliding prison type doors in the Isaac Ray building in smoke and fire separations have 3-4" gaps underneath them. The HCO has requested equivalencies on their buildings and some have been granted, but others are are still pending

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Inpatient Occupancy Existing Healthcare Occupancies; Section III - Compartments

Requirement: EC.A.3C.1

Phrase: Existing Health Care Occupancies Smoke barriers are: continuous from outside wall to outside wall. (EC.A.3C)(EC.A.3C.1)

Surveyor Findings:

There were several large penetrations from the boiler room and mechanical room. There was a 2' x 2' hole by the boilers leading to the exit corridor and a 6" x 12" hole into a mechanical shaft. There were also many voids surrounding mechanical pipes that were 1" and greater that also need to be filled.

Inpatient Occupancy Existing Healthcare Occupancies; Section V - Exits

Requirement: EC.A.5E.3

Phrase: Existing Health Care Occupancies Exit stair doors: are self-closing or automatic closing. (EC.A.5E)(EC.A.5E.3)

Surveyor Findings:

The exit stairwell door number 106 on the first floor of the Dillion Building was proped open with a piece of wood. This was corrected immediately.

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

Accreditation Survey Findings

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Assessment and Care/Services

Standard: PC.2.130

Program: HAP

Standard Text: Initial assessments are performed as defined by the hospital.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : C
1. Each patient is assessed per hospital policy.

Surveyor Findings

EP 1
Observed in Child and Adolscent Unit at the ATC East site.
During an individual tracer of a 16 year old child and adolescent patient it was noted that the initial treatment plan as not signed and dated as required by hospital policy. The initial treatment plan is created by nursing staff as part of the initial assessment process and must be completed in 24 hours. There is no documentation in the medical record to indicate when the initial treatment plan was developed.

Observed in West 1 at Dillion site.
During individual patient tracer activities, it was noted in the medical records of three patients that the Treatment Plan was not completed within 24 hours as required by organizational policy.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Credentialed Practitioners

Standard: MS.4.20

Program: HAP

Standard Text: There is a process for granting, renewing, or revising setting-specific clinical privileges.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
3. Criteria are developed that determine an applicant's ability to provide patient care, treatment, and services within the scope of privileges requested.

The criteria include evidence of current competence.
The criteria include peer recommendations when required.

Surveyor Findings

EP 3
Observed in Medical Staff Credentialing Tracer at Main site.
In reviewing a credentialing file of a family practitioner, it was noted that she was recredentialed to do incision and drainage of skin lesions. There was no data available as to whether or not this practitioner had done this procedure in the last credentialing period, and no outcome data. Also, no one with similar privileges had reviewed her work even though she is a full time staff member.

Observed in Medical Staff Credentialling Tracer at Main site.
A psychiatrist was given privileges to read EKG's when no evidence that he was ever trained to read them and no plan to monitor the MD by someone who also was competent to do this in this hospital.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Equipment Use

Standard: EC.6.20

Program: HAP

Standard Text: Medical equipment is maintained, tested, and inspected.

Secondary Priority Focus Area(s) Patient Safety

Element(s) of Performance

Scoring Category : C
4. The hospital documents inspection and maintenance of non-life support equipment on the inventory that is consistent with maintenance strategies to minimize clinical and physical risks identified in the equipment management plan (see standard EC.6.10).

Surveyor Findings

EP 4
Observed in Examination Room at Podiatry, Optometry, OB Clinic site.
During a departmental tour it was noted that a suction machine was labeled with a sticker stating "Inspection on 0/4/2". Staff were unaware of what this number indicated. There was no other inspection sticker on this piece of equipment.

Observed in Laboratory at Main site.
During a departmental tour of the lab, the Accustasis 2000 used for pro-times was found to have been last inspected 2/05. Staff indicated that this piece of equipment should have been inspected at least quarterly.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Infection Control

Standard: IC.1.10

Program: HAP

Standard Text: The risk of development of a health care-associated infection is minimized through an organizationwide infection control program.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
9. The hospital has a written IC plan* that includes the following:

A description of prioritized risks
A statement of the goals of the IC program
A description of the hospital's strategies to minimize, reduce, or eliminate the prioritized risks
A description of how the strategies will be evaluated

*Written plan A succinct, useful document, formulated beforehand, that identifies needs, lists strategies to meet those needs, and sets goals and objectives. The format of the "plan" may include narratives, policies and procedures, protocols, practice guidelines, clinical paths, care maps, or a combination of these.

Surveyor Findings

EP 9
Observed in Infection Control Tracer Activitiy at Main site.
During the infection control tracer activity it was noted that the organization's Infection Control Plan did not contain a description of prioritized risks, the hospital's strategies to minimize, reduce, or eliminate the prioritized risks, or how the strategies will be evaluated.

Standard: IC.4.10

Program: HAP

Standard Text: Once the hospital has prioritized its goals, strategies must be implemented to achieve those goals.

Secondary Priority Focus Area(s) Patient Safety

Element(s) of Performance

Scoring Category : B
4. Implementation of applicable precautions as appropriate based on the following:

The potential for transmission
The mechanism of transmission
The care, treatment, and service setting
The emergence and reemergence of pathogens in the community that could affect the hospital

Surveyor Findings

Supplemental Findings

EP 4

Observed in West 2 at Dillion site.
During individual patient tracer activities and unit tour, it was noted that paper plates and cups for patient use were stored with dirty linen and housekeeping equipment.

Observed in East 1 at Dillion site.
During individual patient tracer activities and unit tour, it was noted that clean linen was stored with dirty laundry.

Observed in East 2 at Dillion site.
During individual patient tracer activities and unit tour it was noted that clean linen was stored in a patient room that was being used for storage. The toilet in this storage area contained stagnant water. In the Clothing Room, clean towels and blankets were stored with dirty laundry. Paper cups used for patient use were stored in the dirty storage supply room.

Observed in West Unit at Meyer site.
During individual patient tracer activities and unit tour it was noted that clean linen was removed from plastic bags and stored on open shelves with no protection from dust. Additionally, housekeeping supplies and equipment was stored with patient belongings/lockers.

Observed in East Unit at Meyer site.
During individual patient tracer activities and unit tour it was noted that dirty housekeeping equipment was stored with patient belongings/lockers. Additionally, clean linen was removed from plastic bags and stored on open shelves with no protection from dust. Clean patient supplies and toiletries were stored with dirty housekeeping equipment and supplies in the Supply Room. Clean mop heads were stored within large covered plastic trash barrels in the patient shower area.

Observed in Main Kitchen at Cafeteria site.
During unit tour a mop bucket and mop with water was stored next to clean pots and pans.

Observed in West 1 at Dillion site.
During individual patient tracer activities and unit tour it was noted that the medication refrigerator in the upstairs medication room had an excess of ice build up. Organizational policy requires weekly defrosting.

Observed in Night Locker/Satellite Pharmacy at Hospital site.
During a unit tour it was noted that there was excessive ice build up in the medication freezer.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Medication Management

Standard: MM.4.30

Program: HAP

Standard Text: Medications are labeled.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
1. Medications are labeled in a standardized manner according to law or regulation and standards of practice.

Surveyor Findings

EP 1
Observed in Ray 2 South at Main site.
During a patient tracer, it was noted that two inhalers were labelled by the pharmacy but there was no expiration date on the label and the expiration date on the vial was obscured by the inhaler dispenser.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Physical Environment

Standard: EC.1.10

Program: HAP

Standard Text: The hospital manages safety risks.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B

4. The hospital conducts comprehensive proactive risk assessments that evaluate the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff, and other people coming to the hospital's facilities.

Surveyor Findings

EP 4

Although the organization has a strong proactive risk assessment process in practice the process is not well designed in that both the safety management plan and the hospital safety manual lack any description of how the proactive risk assessment process actually functions. The risk management plan also lacks information on this process.

Standard: EC.4.10

Program: HAP

Standard Text: The hospital addresses emergency management.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : A

4. At a minimum, an emergency management plan is developed with the involvement of the hospital's leaders including those of the medical staff.

Surveyor Findings

Supplemental Findings

Observed in Dillion 1 east unit at Dillion Building site.
During the tour of the first floor of the Dillion Building it was noted that there was a build up of lint behind the washer and dryer in room E 118. This situation could lead to a fire if a spark set the lint on fire.

Observed in the first floor at Meyer Building site.
During the tour of the first floor of the Meyer Building it was noted that there was a build up of lint behind the washer and dryer in room 195. This situation could lead to a fire if a spark set the lint on fire.

Observed in the first floor at the Dillion and Meyer buildings site.
It was noted that the washers and dryers in the Dillion and Meyer building were not equiped with ground fault interrupters. While not required by the electrical code the psychiatric patients who use this equipment unsupervised are at greater risk for physical injury or suicide from the shock huzzard of water coming in contract with high voltage (240 volt) electricity.

Observed in the first floor at the Meyer Building site.
During the life safety building of the Meyers building it was noted that patient bathrooms were equipped with commercial type non break-away shower heads. One steel shower curtain rod was noted. The organization needs to accomplish a risk assessment to determine if this type of shower hardware is appropriate for the type of patient cared for on this unit.

Observed in West Units 1 and 2 at Dillion site.
During unit tour and individual patient tracer activities it was noted that all the patient rooms had electrical plugs that were not protected to prevent patient injury.

Observed in Ray 2 South at Main site.
In the patent laundry room in this unit there were no GFI plugs on the washer or dryer which were 220v lines. This represents an unsafe condition if the water should ever overflow or there was a buildup of lint or dirt behind either machine. Additionally, given the high risk population for suicide, or for confusion, some form of patient protection over and and above the building code requirements is necessary.

Observed in Ray 2 South at Main site.
In one room there were 2 handicap assist bars above the toilet. One, appropriately was fitted with a metal plate to prevent a patient from threading something through the bar and hanging himself. Inexplicably, the other bar contained no such precaution and could have been used to commit suicide.

Observed in Ray 2 South at Main site.
On a tour of this unit, it was noted that in at least 2 rooms there were non tamper-proof 110v electrical outlets in the patient rooms. These pose a patient safety hazard.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Staffing

Standard: LD.3.50

Program: HAP

Standard Text: Services provided by consultation, contractual arrangements, or other agreements are provided safely and effectively.

Secondary Priority Focus Area(s) Organizational Structure

Element(s) of Performance

Scoring Category : B
5. Services provided by consultation, contractual arrangements, or other agreements meet applicable Joint Commission standards.

Surveyor Findings

EP 5
Observed in Contract Review at Main Site site.
During review of contracts for outsourced services three of seven contracts were noted not to include a written requirement that the services provided meed applicable Joint Commission standards.

Standard: LD.3.70

Program: HAP

Standard Text: The leaders define the required qualifications and competence of those staff who provide care, treatment, and services, and recommend a sufficient number of qualified and competent staff to provide care, treatment, and services.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
1. The leaders provide for the allocation of competent qualified staff.

Surveyor Findings

EP 1
During individual patient tracer activities and staff interviews it appeared that the organization may not have had sufficient number of qualified professional dieticians to support the needs of a high number of complicated psychiatric patients.The nutritional assessment process did not appear to be adequately designed to facilitate timely nutritional referrals.

Standard: HR.1.30

Program: HAP

Standard Text: The hospital uses data from clinical/service screening indicators and human resource screening indicators to assess and continuously improve staffing effectiveness.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Supplemental Findings

Scoring Category : B
10. The hospital does the following:

Collects data for all indicators selected
Analyzes data for all indicators selected
Reviews all indicator data together when analyzing variation from desired performance for additional information that may assist in identifying any potential causes of variation
Investigates to identify any staffing effectiveness issues when indicator data varies from expected
Takes appropriate action in response to analyzed data

Surveyor Findings

EP 10
Observed in the data systems tracer at main hospital conference room site.
During the data systems tracer it was noted that the organization had stopped collecting and analyzing data from thier staffing effectiveness indicators in December 2005. New indicators were established in July 2006 and data is now being collected.

The following are JCAHO's Requirements for Improvement (RFIs) for Larned State Hospital following the August 2006 survey. Each RFI notes the Standard and the specific Element of Performance within the Standard found to not be in substantial compliance.

Also noted for each RFI are details provided by the surveyors in support of the citation, what corrective actions LSH has taken to achieve compliance with the Standard, and what corrective actions are pending.

Requirement for Improvement (RFI)
Standard PC.8.10: Pain is assessed in all patients.
Element of Performance #1: A comprehensive pain assessment is conducted as appropriate to the patient's condition and the scope of care, treatment and services provided.
Surveyor Findings: Per available documentation, four (4) patient records found that the hospital's policy was not followed regarding performance of an initial pain assessment and/or comprehensive pain assessment. In several records, though pain assessments were documented, the assessments did not reflect a pain rating mutually agreed-upon by the patient and care providers as part of an individualized pain management plan.
Completed Corrective Actions: Previously a paper-document, LSH has implemented its electronic Admission Intake Assessment (AIA). The AIA is completed on every patient at admission. A pain assessment is a required field in the AIA; the system will not allow completion of the AIA if this information is not entered. LSH's Pain Management policy has been updated to indicate how an agreed-upon numerical pain indicator, along with an individually-determined pain threshold, will be determined with each patient. Education has occurred, accordingly.
Pending Corrective Actions: The Pain Management policy will be updated to identify conditions warranting a comprehensive pain assessment. Anticipated completion date: February 2007.

Requirement for Improvement (RFI)
Standard PC.9.30: Resuscitation services are available throughout the hospital.
Element of Performance #3: Appropriate equipment is strategically placed throughout the hospital.
Surveyor Findings: Units in the Dillon Building were determined to lack prompt access to an Automatic External Defibrillator (AED) machine, as a single AED machine was shared between several units. Similarly, units in the Isaac Ray Building were found to share one AED machine. With only one AED machine per building, the distance between units and the need to unlock multiple security doors would impact the timeliness of the AED reaching the patient.
Completed Corrective Actions: LSH ordered an additional twelve (12) AED machines. All machines have been distributed to strategically-identified locations. The Automatic External Defibrillator (AED) policy has been updated to reflect locations of all machines, and signs have been posted on every building noting the closest AED machine. Training has occurred, accordingly.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard PC.12.70: A licensed independent practitioner orders the use of restraints or seclusion.
Element of Performance #2: No longer than one hour after the initiation of restraint or seclusion, qualified staff notifies and obtains an order (verbal or written) from the licensed independent practitioner and consults with the practitioner about the patient's physical and psychological condition.
Surveyor Findings: In five (5) patient records, licensed independent practitioner(s) did not consistently follow the hospital's policy requiring every restraint or seclusion order to be signed by the practitioner, and the patient seen by the practitioner, within one hour of placement in seclusion or restraints.
Completed Corrective Actions: LSH Medical Staff have established additional back-up arrangements to the Physician On-Call system to help ensure such assessments are not delayed. Additionally, all restraint and seclusion episodes are reviewed and monitored by the Seclusion/Restraint Review Team, including timeliness of the Medical Staff assessments.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard PC.16.10: The hospital establishes policies and procedures that define the context in which waived test results are used in patient care, treatment and services.
Element of Performance #1: Quantitative test result reports in the clinical record are accompanied by reference ranges specific to the test method used and are appropriate to the population served.
Surveyor Findings: Through a review of medical record documentation, it was noted that the Precision G Log used for documenting fingerstick blood sugars did not contain reference ranges for glucose.
Completed Corrective Actions: LSH revised its Whole Blood Glucose and Insulin Administration forms to specify normal ranges, critical values and linearity limits. Corresponding policies were updated. Training has occurred, accordingly.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard PC.7.10: The hospital has a process for preparing and/or distributing food and nutrition products as appropriate to the care, treatment and services provided.
Element of Performance #2: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation and security.
Surveyor Findings: On two (2) units, Temperature Logs for two (2) small snack refrigerators noted temperatures being outside approved range on several occasions, with no corrective action documented. In the central Kitchen, one (1) refrigerator was found without a Temperature Log, and one (1) refrigerator was found without a thermometer. Also found were four (4) expired salad dressings, three (3) bags of fresh produce without date-labeling, and one (1) tray of grapes without date-labeling. Some confusion was also found among staff regarding interpretation of dates labeled on food products (date received, opened, prepared or expired).
Completed Corrective Actions: LSH has implemented monitoring processes to help ensure temperatures of food-refrigerators are checked daily, with follow-up actions as appropriate, and that outdated foods are promptly disposed. The hospital has created standardized labels for use on food containers/products in all areas. For use in on-unit refrigerators, labels clearly note "Receipt Date" and "Discard Date." For use in Kitchen refrigerators, labels clearly note "Product Name", "Date Opened/Prepared" and "Discard Date." Policies have been adjusted accordingly, with education provided to relevant personnel.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard MM2.20: Medications are properly and safely stored.
Element of Performance #2, 7 & 15: Medications are stored under conditions suitable for product stability. All expired, damaged and/or contaminated medications are segregated until they are removed from the hospital. All medication storage areas are periodically inspected according to the hospital's policy to make sure medications are stored properly.
Surveyor Findings: On one (1) unit and in the Satellite Pharmacy, Temperature Logs on the medication refrigerators noted temperatures being outside the approved range on several occasions, with no corrective action documented. In three (3) units, one (1) refrigerator had no record of weekly cleaning, and two (2) refrigerators missed one or two daily temperature recordings in the preceding month. In three (3) units, outdated medication was found: one (1) vial of insulin, one (1) vial of Tuberculin Test Solution and one (1) vial of DDAVP.
Completed Corrective Actions: LSH has implemented monitoring processes to help ensure temperatures of medication-refrigerators are checked daily, with follow-up actions as appropriate; has implemented monitoring processes to help ensure cleaning occurs weekly; and as implemented monitoring processes to help ensure identification and appropriate disposal of outdated medications. Additionally, in the Pharmacy a computerized temperature-reading device was installed which emits an alarm if the temperature is out of range. Personnel have been educated regarding expectations. Policies have been adjusted accordingly.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard IC.2.10: The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.
Element of Performance #1 & 2: The hospital identifies risks for the transmission and acquisition of infectious agents throughout the hospital based on various factors. This risk analysis is formally reviewed at least annually, and whenever significant changes occur in any of the risk factors.
Surveyor Findings: The hospital had not identified risks for the transmission and acquisition of infectious agents throughout the hospital, and had not performed a risk assessment and formal, annual review as required by the Standard.
Completed Corrective Actions: An Infection Control Risk Assessments (ICRA) notebook was established which contains risk assessments of different classifications of infections in the hospital and community, including trends and rates, as well as the hospital's pro-active actions for prevention, treatment and control of infections. Surveillance activities include monitoring the Daily Infection Report Forms from the units, and information from the pharmacy and laboratory regarding types of antibiotics used, cultures and sensitivities. LSH has updated its Infection Control policy to reflect these processes and expectations.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard IC.5.10: The infection control program evaluates the effectiveness of the infection control interventions and, as necessary, redesigns the infection control interventions.
Element of Performance #1: The hospital formally evaluates and revises the goals and program at least annually, and whenever risks significantly change.
Surveyor Findings: The hospital had not formally evaluated and revised the infection control goals and program.
Completed Corrective Actions: LSH has updated its Infection Control policy to reflect these processes and expectations.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard MM.3.10: Only medications needed to treat the patient's condition are ordered, provided or administered.
Element of Performance #1: There is a documented diagnosis, condition or indication-for-use for each medication ordered.
Surveyor Findings: Per hospital policy, all prescribed medications must have a stated rationale. In two (2) patient records, a PRN ("as needed") medication order did not include a rationale for use.
Completed Corrective Actions: LSH Medical Staff were re-educated regarding this expectation. Initially, a temporary safe-guard step was implemented within the Pharmacy, giving Pharmacy the authority to delay processing any order pending receipt of a rationale. LSH has since implemented its agency-wide electronic medication-order system. Compliance with this Standard has been built-in to this electronic system, as the system will not allow omission of a rationale. The order will not be accepted if a rationale is not provided.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard NPSG 1: Improve the accuracy of patient identification.
Element of Performance #1A: Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.
Surveyor Findings: The hospital did not consistently label laboratory specimens with two forms of patient identification. According to Laboratory personnel, the routine process for labeling blood specimens drawn at the patient's bedside involved affixing a handwritten label noting only the patient's name and date/time of the draw. Laboratory policies had not been updated to reflect the NPSG requirement of using at least two identifiers.
Completed Corrective Actions: Standardized, electronically-accessible lab labels were developed and for use with all collected specimens. Information on the lab labels includes: patient name, hospital ID number, admission date, date of birth, gender, age, date/time the specimen was drawn, and staff initials. If a patient refuses to present his/her identification wristband/card when Laboratory personnel are collecting specimens on the unit, a unit nursing staff familiar with the patient verifies the identification of the patient. Laboratory policies were updated accordingly. Training was provided to appropriate personnel.
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard NPSG 2: Improve the effectiveness of communication among caregivers.
Element of Performance #2A: For verbal or telephone orders or for reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read back" the complete order or test result.
Surveyor Findings: The hospital did not consistently follow its policy for documenting the "read-back" of phone orders given the prescribing physician. In three (3) patient records, a telephone order from a physician did not have documentation of having been read-back to the physician.
Completed Corrective Actions: LSH has implemented its agency-wide electronic medication-order system. This system will not allow omission of documentation that a phone order was read-back to the physician. Read-back expectations are clearly outlined in LSH's Verbal Orders/Telephone Orders for Medication/Treatment policy.
Pending Corrective Actions: none

Requirement for Improvement (RFI)

Standard NPSG 8: Accurately and completely reconcile medications across the continuum of care.

Element of Performance #8A & 8B: Implement a process for obtaining and documenting a complete list of current medications upon a patient's admission, with the patient's involvement, to include a comparison of the medications the organization provides to those on the list. Communicate a complete list of the patient's medication to the next service provider when the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization.

Surveyor Findings: As evidenced in several patient records, one or more of the following were noted regarding the hospital's medication reconciliation processes: lack of documentation that the physician reviewed pre-hospitalization medications prior to prescribing, failure to update the Medication Reconciliation Form on an on-going basis, and lack of a Medication Reconciliation From in the patient's record. It was also noted that the hospital did not have a consistent process for providing a list of the patient's current medication to the next service provider at discharge.

Completed Corrective Actions: LSH's Medication Reconciliation policy clearly details actions by the admitting nurse, medical staff, and pharmacy regarding the process of medication reconciliation. Patient Safety Teams conduct audits of the Medication Reconciliation Forms, to assess compliance. Any incomplete Forms are directed to the appropriate personnel, that day, to be completed.

Pending Corrective Actions: none

Requirement for Improvement (RFI)

Standard NPSG 3: Improve the safety of using medications.

Element of Performance #3C: Identify and, at a minimum, annually reviews a list of look-alike/sound-alike drugs used in the organization, and takes action to prevent errors involving the interchange of these drugs.

Surveyor Findings: On one (1) unit, several different types of insulin for one patient were found stored together in one bin. Though listed on the hospital's Look-Alike/Sound-Alike List of Medications, no clear actions were taken to alert personnel to the look-alike/sound-alike implications. In the Satellite Pharmacy, different types of insulin were stored together in the medication refrigerator with no clear actions taken to alert personnel to the look-alike/sound-alike implications.

Completed Corrective Actions: Various processes and tools have been implemented on units as well as in the Central and Satellite Pharmacies. Checking insulin bins was added to LSH's monthly National Patient Safety Goal audits, performed by Patient Safety Teams. Unit medication rooms are also checked to ensure all medications are labeled appropriately, and that insulin types are separated. "High-Alert" stickers are affixed to insulin bins on the units, and the pharmacy marks insulin boxes with "High Alert" stickers before dispensing.

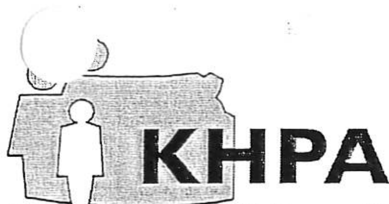
Pending Corrective Actions: none

Requirement for Improvement (RFI)
Standard EC.5.20: Newly constructed and existing improvements are designed and maintained to comply with Life Safety Codes.
Elements of Performance EC.A.1A.4.b; EC.A.1C.5; EC.A.3C.1; EC.A.5E.3
Surveyor Findings: The hospital did not evidence full compliance with three (3) Life Safety Codes: gaps were found at the base of sliding fire doors in one (1) building; in one (1) boiler room and mechanical room, several large wall penetrations and gaps around pipes were found; in one exit stairwell the door was found propped open.
Completed Corrective Actions: The door wedge propping open the exit door was removed at the survey; staff have been re-educated that propping open fire doors is unacceptable.
Pending Corrective Actions: Equivalency requests have been submitted to JCAHO regarding the sliding fire doors, as this is an intentional structural design. Anticipated completion date for making corrections to wall penetrations and gaps in the boiler and mechanical room is May 2007.

Submitted 2/2/07 by:
Tabi Murray
Director of Quality Management
Larned State Hospital

Larned State Hospital Patient Deaths 2000-2007

Year	Number of Deaths	Cause of Death	Location of Death	Average Daily Census
2000	3	• Arteriosclerotic heart disease • Necrotizing renal abscesses • Asphyxia due to hanging	• LSH • Medical Facility • Medical Facility	PSP – 112 SSP – 170 **Total - 182**
2001	4	• No death certificate • Pulmonary embolism • Pulmonary embolism • Suicide	• Medical Facility • Medical Facility • Medical Facility • Medical Facility – discharged from LSH on 6/5/2001, date of death 6/25/2001	PSP – 116 SSP – 136 **Total - 252**
2002	1	• Suicide	• LSH	PSP – 102 SSP – 110 **Total – 212**
2003	2	• Acute renal failure • 89 years old with multiple medical problems	• LSH • LSH	PSP – 91 SSP – 111 SPTP – 75 **Total - 277**
2004	3	• Aspiration – elderly patient on NG Tube and oxygen, multiple medical issues. Standards of Care were met. • Cardiac Dysrhythmia • Heart attack	• LSH • Medical Facility • Medical Facility	PSP – 92 SSP – 112 SPTP – 100 **Total - 304**
2005	2	• Metastatic Neoplasm (Cancer) • Colon Cancer	• LSH • Medical Facility	PSP – 72 SSP – 122 SPTP – 107 **Total – 301**
2006	4	• Cause unknown – autopsy pending • Cancer • Choking on food • Upper GI bleed	• LSH • Medical Facility • Medical Facility • Medical Facility	PSP – 82 SSP – 136 SPTP – 108 **Total - 376**
2007	0	• N/A	• N/A	PSP – 82 SSP – 168 SPTP – 159 **Total - 409** *Estimated



Kansas Health Policy Authority

Coordinating health & health care for a thriving Kansas

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Report on:

Massachusetts Commonwealth Health Insurance Connector Program

Presented to:

2007 Kansas Legislature

February 1, 2007

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Report on the Massachusetts Commonwealth Health Insurance Connector Program

The 2006 Kansas Legislature, as outlined in proviso, directed the Kansas Health Policy Authority (KHPA) to prepare a report about the Massachusetts Commonwealth Health Insurance Connector Program. The proviso specified that the KHPA "...study the Massachusetts commonwealth health insurance connector program and provide a report....on the feasibility of implementing a similar plan in Kansas."

Executive Summary

In 2006, Massachusetts enacted a law that would provide nearly universal health coverage to all state residents. Key elements of that law include:

- An individual mandate requiring all state residents to purchase health insurance;
- A requirement that employers offer health insurance or pay an assessment;
- Creation of the Commonwealth Health Insurance Connector that links funding sources and health plans in a simplified market; and
- Provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance.

Massachusetts began the first phase of implementation in October 2006, enrolling non-Medicaid eligible adults with household incomes at or below the federal poverty level (FPL) ($10,210 for an individual) in the Commonwealth Care Health Insurance Program. This program is administered by the newly created Commonwealth Health Insurance Connector Authority. The Connector is an independent public authority established to facilitate the purchase of health insurance for individuals and small businesses (50 employees or less). The Connector is governed by a ten-member board. Funding for the Connector comes from the state, Federal Medicaid matching funds, employer contributions, and individual premiums.

The Connector is a private insurance purchasing pool designed to connect individuals and small employers with affordable, quality insurance products. Two sets of health insurance plans are to be offered through the Connector: Commonwealth Care plans and Commonwealth Choice plans. Commonwealth Care is a heavily-subsidized set of health insurance plans designed primarily for individuals below 300 percent FPL ($30,630 for an individual). Commonwealth Choice is an array of health plans sold through the Connector for individuals with incomes greater than 300 percent of FPL. Commonwealth Choice health plans are not subsidized.

In assessing the feasibility of replicating the Massachusetts Connector in Kansas, it is important to examine the climate and extenuating circumstances which existed when this policy initiative was adopted in Massachusetts. The state has a high level of employer-sponsored health insurance and over the last decade has undertaken Medicaid expansions, resulting in Massachusetts having a relatively low rate of uninsured individuals. In addition, the state had great incentive to undertake health care reform, because $385 million in federal funds were at risk when their Medicaid waiver expired in July 2006.

Kansas too has a relatively low rate of uninsured, moderately high level of employer-sponsored health insurance, and similar level of Medicaid coverage for children. The majority of the uninsured in our state are low-wage full-time workers employed in small businesses. Small employers struggle to find affordable health

insurance for their employees, and there are very limited options for those in the non-group market. An entity such as the Connector, which serves as a clearinghouse to facilitate the pooling and purchasing of health insurance, would enhance access to health insurance products by small employers and individuals. Certain elements of the Massachusetts Connector model, however, appear to be fundamental to that goal: subsidies for low-income workers, a mechanism to pool payments from multiple payers, variation in plans, use of pre-tax dollars for health insurance purchase, plan quality verification, and establishment of an adequately financed infrastructure.

Background

On April 12, 2006, the Governor of Massachusetts signed into law legislation (H. 4650) that would provide nearly universal health care coverage to residents of the state. As mentioned above, key elements of that law include:

- An individual mandate requiring all state residents to purchase health insurance
- A requirement that employers offer health insurance or pay an assessment
- Creation of the Commonwealth Health Insurance Connector that links funding sources and health plans in a simplified market
- Provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance

On October 2, 2006, Massachusetts began the first phase of implementation, enrolling non-Medicaid eligible adults with household incomes at or below the federal poverty level (FPL) ($10,210 for an individual) in the Commonwealth Care Health Insurance Program. This program is administered by the newly created Commonwealth Health Insurance Connector Authority. By the end of 2006, over 28,000 adults had enrolled in one of the Commonwealth Care health plans.

Commonwealth Health Insurance Connector

Definition. The Connector is an independent public authority established to facilitate the purchase of health insurance for individuals and small businesses (50 employees or less). The Connector is governed by a ten-member board. Six directors come from the private sector: three appointed by the Governor (an actuary, a health economist, and a small business representative); three appointed by the Attorney General (an employee health benefits plan specialist, a health consumer representative, and a representative of organized labor); and four directors representing state agencies (Secretary of Administration and Finance, Secretary of Health and Human Services, Commissioner of Insurance, and the Medicaid Director). The stated mission of the Connector is "promoting health care coverage across the Commonwealth".

Agency Functions. The Connector is a private insurance purchasing pool designed to connect individuals and small employers with affordable, quality insurance products. Larger businesses with more than 50 employees are not eligible to participate in the Connector, but may use the Connector to arrange for coverage for their employees who are not eligible for benefits. Plans that are purchased through the Connector are selected by individuals, rather than groups, and are portable, which means that individuals can maintain their insurance coverage regardless of where they work. There are numerous functions assigned to the agency, including: developing benefit guidelines for Commonwealth Care Health Insurance products; certifying the insurance products are "high value and good quality"; contracting with private insurers to provide health plans; collecting premium payments from multiple sources; determining the sliding scale subsidy guidelines for individuals with

incomes less than 300 percent of FPL ($30,630 for an individual); transmitting premium payments to insur and enrolling the individual in the health plan of their choice or auto-enrolling those who don't select a plan.

The Connector allows multiple employers to contribute to an employee's premium purchase. For the 19-26 year old age population who as a group have high rates of uninsurance, the Connector is responsible for offering health insurance plans that are specifically designed to be affordable. The Connector is also charged with defining premium affordability standards and establishing an appeals process that allows individuals to be exempted from the law if they demonstrate they can't afford insurance.

Funding. Funding for the Connector comes from the state, federal Medicaid matching funds, employer contributions, and individual premiums. Small businesses enrolling through the Connector are not required to make premium contributions, but they must adopt at a minimum a Section 125 "cafeteria plan" which permits workers to purchase health care with pre-tax dollars. Companies with 11 or more employees that do not contribute to their employees health insurance premiums will be assessed a "fair share" surcharge and may be assessed a free rider surcharge if their employees access free care. The free rider surcharge assessment is triggered if the employees access free care paid from the uncompensated care pool a total of five times per year, or if one employee accesses free care more than three times. The surcharge will exempt the first $50,000 of free care used by employees, but beyond that, the employer will be charged between 10-100 percent of the cost to the state. The exact assessment rate will be determined by the Massachusetts Division of Health Care Finance and Policy.

Health Plans. Two sets of health insurance plans are to be offered through the Connector: Commonwealth Care plans and Commonwealth Choice plans. Commonwealth Care is a heavily-subsidized set of health insurance plans designed primarily for individuals below 300 percent FPL. Premiums and cost-sharing increase with income. Commonwealth Care has been implemented in two phases: the first phase was implemented in October 2006 and covers about 28,000 poverty-level adults; the second phase is being implemented this month and will cover individuals up to three times the federal poverty level (FPL). Commonwealth Choice is to be implemented in July of this year and is designed for participating groups as well as individuals with incomes above 300 percent FPL. A wider selection of health plans is planned for this arm of the Connector, including high-deductible plans for young adults. Each set of health plans is described in more detail below.

Commonwealth Care Health Insurance Plan

Definition. Commonwealth Care is a subsidized insurance program for individuals and employees of small firms who have incomes at or below 300 percent FPL. An individual is eligible to participate if they have been a resident of the state for six months, are Medicaid eligible, and the individual's employer has not provided health insurance in the last six months. Children of parents eligible for Commonwealth Care are covered through the Medicaid program.

Phase I. Commonwealth Care is being phased in over time for low-income individuals. For uninsured individuals with incomes at or below the FPL, Commonwealth Care is currently available and no monthly premiums are charged. Benefits include: inpatient hospital services; outpatient and preventive services; inpatient and outpatient mental health and substance abuse services; dental and vision care; and prescription drugs. The Connector has contracted with four nonprofit health insurance providers to offer Commonwealth Care. The four managed care organizations providing this insurance are: Boston Medical Center Health Net, Fallon Community Health Plan, Network Health, and Neighborhood Health Plan. The premiums paid by the state on behalf of low-income individuals for this insurance coverage range from $280 to $387 per member per month. The four providers cover the entire state and most enrollees have the choice of two to three plans in

their coverage area.

Phase II. In early 2007, phase two of the implementation process will ensue, making Commonwealth Care available to persons with incomes of 100.1 percent to 300 percent of the FPL with premiums set on a sliding scale. Proposed premiums will range from $18 (1.7 percent) per member per month for individuals with incomes 100%-150% FPL, to $106 (4.7 percent) for individuals with incomes 250 percent – 300 percent of FPL. For persons with incomes between 200 percent -300 percent of FPL there are two cost sharing plans, one with higher premiums and lower co-payments and one with lower premiums and higher co-payments. The benefit package also includes co-payments for most services, and out-of-pocket maximums will range from $500 to $750 depending upon the plan selected and the income category of the enrollee.

Commonwealth Choice Health Plan

It is anticipated that the third phase of the Connector, Commonwealth Choice, will be implemented July 1, 2007. Commonwealth Choice is an array of health plans sold through the Connector for individuals with incomes greater than 300 percent of FPL. Commonwealth Choice health plans are not subsidized. Individuals participating on their own or through their employer will have an annual choice of three different levels of benefits and premiums. In addition, individuals aged 19 to 26 who do not qualify for group health benefits will be able to purchase lower cost "Young Adult Plans" through the Connector.

Feasibility of Replicating in Kansas

In assessing the feasibility of replicating the Massachusetts Connector in Kansas, it is important to examine the climate and extenuating circumstances which existed when this policy initiative was adopted in Massachusetts.

Massachusetts History. In 1995, Massachusetts received approval of a Section 1115 waiver from the U.S. Department of Health and Human Services. This waiver allowed Massachusetts to expand Medicaid (MassHealth) and receive federal matching funds for supplemental payments made to safety-net managed care organizations. Under the waiver, non-elderly adults below 100-133 percent of the FPL ($10,210 - $13,579 for an individual) and children below 200 percent of FPL were eligible for Medicaid. Since the demonstration began, the number of Massachusetts residents eligible for MassHealth increased by over 300,000 persons. Fifteen percent of the non-elderly population receive health care services through Medicaid in Massachusetts.

Massachusetts Demographics. Massachusetts is among the top tier of states with high rates of employer-sponsored health insurance, with sixty percent of residents having employer-sponsored health insurance. The high level of employer-sponsored health insurance coupled with Medicaid expansions have resulted in a relatively low rate of uninsured individuals. In 2004, eleven percent of the population in Massachusetts was insured. Twenty-nine percent of Massachusetts residents have household incomes below 200 percent FPL with 14 percent having incomes under the FPL and 16 percent having incomes in the 100-199 percent FPL range.

A powerful impetus for enactment of the Massachusetts health reform plan (H. 4065) was the pending renewal of that Medicaid Section 1115 waiver. The Centers for Medicare and Medicaid Services (CMS) were scrutinizing the safety net institutional payments in Massachusetts, stipulating that funds be shifted from safety net institutions and into health insurance coverage. Accordingly, $385 million in federal funds were at risk when their Medicaid waiver was set to expire in July, 2006.

Massachusetts "Assets" that Contributed to Reform. Three factors were instrumental in the passage of the Massachusetts health reform statute. First, the state had a long history and tradition of tightly regulating the health insurance small group and non-group market. Insurers were required to offer individual insurance if they

offered small group insurance, and they were required to do so on a modified community rating basis that did not permit health underwriting. Secondly, the state had a reinsurance pool for both the small group and the individual market. Third, since 1985, the state of Massachusetts has had a large ($600+ million) program to make supplemental payments to hospitals, health care centers, and certain insurers for uncompensated care and Medicaid underpayments. This program was financed by provider and insurer assessments and state and federal tax revenues. Federal matching funds for these supplemental payments were most recently approved through a health care reform waiver granted in 1997, but the federal government challenged the state's financing of that waiver, placing $385 million in federal funds at risk without significant restructuring. Under the newly approved waiver, previously-questioned sources of federal funds are redirected towards subsidies offered through the Connector. In addition to these redirected supplemental payments, funding for the Massachusetts reform plan will be drawn from new funding from employer contributions, $308 million in new state general funds, and premiums. The first three years of the Massachusetts health plan is estimated to cost $1.2 billion.

Kansas Demographics. Based on some demographic measures, Massachusetts is similar to Kansas. Kansas has a relatively low rate of uninsured individuals (11 percent) and a relatively high level of employer-sponsored health insurance (59 percent). Public health insurance is available to children in households with incomes up to 200 percent FPL. Kansas has a slightly higher percentage of low-income residents with 34 percent having household incomes below 200 percent FPL (15 percent having incomes under the FPL and 19 percent having incomes in the 100-199 percent FPL range).

In terms of health insurance regulation, Kansas has enacted small group health insurance legislation which establishes a mean premium and allows for a 25% variation above and below that mean health insurance rate. This represents a modified community rating model for the small group health insurance market, but there has been limited regulatory activity in the non-group market.

Kansas Business Health Partnership. In 2000, the Business Health Partnership (BHP) was established with the goal of expanding coverage through a linkage between the public and private sector by improving the affordability and quality of health insurance for low-wage workers in small businesses. It was the intended purpose of the legislation creating the BHP that there be available subsidies and/or tax credits to assist low-wage workers in purchasing health insurance. The Business Health Policy Committee membership is statutorily defined by K.S.A. 40-4702. Members include:

1) the secretary of the department of commerce and housing or the secretary's designee;
2) the secretary of the department of social and rehabilitation services or the secretary's designee;
3) the commissioner of insurance or the commissioner's designee;
4) one member appointed by the president of the senate;
5) one member appointed by the speaker of the house of representatives;
6) one member appointed by the minority leader of the senate;
7) one member appointed by the minority leader of the house of representatives; and
8) three members at large from the private sector appointed by the governor.

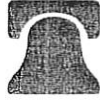
Challenges for Reform in Kansas. Unlike Massachusetts, Kansas has very limited coverage of adults in Medicaid. Eligibility is limited to participants in the Temporary Assistance to Families (TAF) program, who have incomes of no more than 29-36 percent FPL ($2961 - $3676 for an individual). Kansas also has a much more modest program of supplemental payments to providers, and far fewer federal dollars are dedicated to that purpose.

Conclusion

Kansas' relatively low rate of uninsured, moderately high level of employer sponsored health insurance, and level of Medicaid coverage for children provide a supportive climate for further policy initiatives to reduce the number of uninsured Kansans. The majority of the uninsured in our state are low-wage full-time workers employed in small businesses. Small employers struggle to find affordable health insurance for their employees and there are very limited options for those in the non-group market. An entity such as the Connector which serves as a clearinghouse to facilitate the pooling and purchasing of health insurance would facilitate access to health insurance products by small employers and individuals. The Business Health Policy Committee currently exists and could assume a similar role as the Connector.

Elements of the Massachusetts Commonwealth Health Insurance Connector program which appear to be crucial in improving access to health insurance for individuals and small employers include: subsidies for low income workers, a mechanism to pool payments from multiple payers, variation in plans, use of pre-tax dollars for health insurance purchase, plan quality verification, and establishment of an adequately financed infrastructure to perform the essential clearinghouse functions which are so burdensome for individuals and small employers. The inclusion of these elements could make health insurance more affordable and attainable for the majority of uninsured Kansans.

Backgrounder



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The Massachusetts Health Plan: Lessons for the States

Nina Owcharenko and Robert E. Moffit, Ph.D.

State officials can dramatically improve the functioning of their state health insurance markets, establish portability and personal ownership in health insurance coverage, and make major improvements in how they finance health care for the uninsured. Massachusetts, a state with a conservative Republican governor and liberal Democratic legislature, has recently enacted comprehensive health care reform. Not surprisingly, many state officials from around the country are carefully examining the Massachusetts health plan, trying to discern what is applicable to or appropriate for their own states.

The Massachusetts plan, signed into law by Governor Mitt Romney, is a complex mixture of specific policy initiatives aimed at providing residents with "access to affordable, quality, accountable health care."[1] Most notably, the new law:

- **Creates** a single consumer-driven marketplace for health insurance for small businesses, their employees, and individuals;
- **Promotes** "defined contributions" rather than the defined benefit system in employer-based health insurance that does not disrupt the current tax treatment of health insurance;
- **Redirects** public health care subsidies from hospital systems that serve the uninsured to low-income individuals to assist them in purchasing private health coverage;
- **Expands** Medicaid eligibility for children;

Talking Points

- States should consider both establishing a statewide health insurance exchange for health insurance in which individuals can choose and own their health care coverage regardless of job change or status and without losing favorable tax treatment and replacing the current provider-based subsidy structure for the uninsured with premium assistance to individuals in need.
- States should avoid provisions found in the Massachusetts plan that impose a health insurance mandate on employers or that expand dependence on the already overburdened public health programs such as Medicaid.
- Moreover, states should be more aggressive than Massachusetts in preserving an individual's right to self-insure, in deregulating their state insurance markets, and in opening access to and choice of private health plans through a statewide health insurance exchange.

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/bg1953.cfm

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- **Changes** the rules governing health insurance markets; and
- **Imposes** a mandate on individuals to buy coverage and penalties on employers who do not provide and subsidize coverage for their employees.

Several features of the Massachusetts health plan could revolutionize the traditional health care system by empowering individuals to buy and own their health insurance policies and keep these policies with them regardless of job or job status. However, officials in other states should shun the imposition of employer mandates and avoid public program expansions while making modifications and improvements to other significant components of the Massachusetts plan.

A Compromise

Given the partisan divide between the Romney Administration and the Democratic legislature, as well as the leftward political and regulatory climate in Massachusetts, the final language was not the ideal outcome for either the governor or the legislature. A key motivation for reaching an agreement was the expiration of an existing federal waiver. Massachusetts needed to restructure its waiver or risk losing federal funding for uncompensated care. Nonetheless, for the majority of the provisions, the final product was a genuine compromise on imperfect legislation.

The Achievements. There has been a great deal of media coverage of and commentary on the Massachusetts law. Regrettably, some of it has been inaccurate.[2] Regardless of ideological or partisan disagreements on specific provisions of the final bill, legislators in other states can learn a great deal from the Massachusetts legislation. Two of the new law's key achievements are:

1. Creation of a new market for health insurance in which individuals and families can buy private coverage of their choice, own it, and take it from job to job without losing the existing favorable tax treatment for employer-sponsored health insurance, and
2. Creation of a new system of premium assistance for lower-income individuals to purchase private coverage based on leveraging existing uncompensated care funds used to cover the cost of care for the uninsured.

These two components could revolutionize the traditional health care system by empowering individuals, including low-income persons, to buy and own their health care coverage, and they can be adapted to the unique conditions of other states.

The Shortfalls. At the same time, state legislators should avoid a number of troublesome provisions in the new Massachusetts law. These include the counterproductive employer mandate for providing health care coverage and the unnecessary Medicaid expansion. In reality, households, not employers, bear the burden of health care costs. Employer mandates constitute a regressive tax on workers and their families, usually in the form of reduced compensation or even job loss.

With regard to Medicaid, it is important to keep in mind that it is a welfare program. Ideally, the best Medicaid policy would "mainstream" individuals out of Medicaid and into the private health care coverage that is available to other Americans, just as the best welfare reform policy would mainstream

1. Acts of 2006, Chapter 58, Massachusetts Legislature, 2006 Session, April 12, 2006, at *www.mass.gov/legis/laws/seslaw06/sl060058.htm* (July 12, 2006).
2. For example, see Betsy McCaughey, "Romneycare's Fine Print," *The Wall Street Journal*, May 5, 2006, p. A16. McCaughey, former lieutenant governor of New York, states, "Moreover, under the new law, individuals purchasing their own insurance must buy HMO policies." In fact, any major medical plan of any type offered by any health insurance company, including a health savings account plan, may be offered through the Connector under the normal procedures of state approval for health insurance. For an accurate assessment of the Massachusetts legislation, see Edmund F. Haislmaier, "The Significance of the Massachusetts Health Plan," Heritage Foundation *WebMemo* No. 1035, April 11, 2006, at *www.heritage.org/research/healthcare/wm1035.cfm*. See also Robert E. Moffit, Ph.D., and Nina Owcharenko, "Understanding Key Parts of the Massachusetts Health Plan," Heritage Foundation *WebMemo* No. 1045, April 20, 2006, at *www.heritage.org/research/healthcare/wm1045.cfm*.

welfare dependents into jobs in the private economy. In effect, simple Medicaid expansions are an obstacle to the achievement of the broader goals of comprehensive welfare reform.

The Massachusetts law includes several impressive structural changes in the insurance market and health care financing, but states should improve other elements of the Massachusetts law. In adopting an individual mandate for the purchase of health insurance, the legislature adopted final language that dropped a crucial provision that would have enabled individuals to demonstrate personal responsibility by allowing them to self-insure and demonstrate their willingness and ability to cover their own health care costs without enrolling in an insurance plan. This was a serious mistake.

The Massachusetts law also created a new health insurance market for small-business employees and individuals, but businesses of all sizes should be permitted to access the new consumer-driven market, and all consumers should have access to the broadest range of policies and carriers. The goal of state insurance reform should be to create a robust, wide, and open market. While the law provided some regulatory relief from state rules governing insurance plan designs and benefits, it should have pursued more aggressive deregulation of the health insurance market.

Key Components That States Should Adopt

The Massachusetts health plan is the product of a bipartisan compromise in a political and cultural environment that is peculiar to Massachusetts. It also reflects the peculiarities of that state's health care delivery system. Massachusetts is burdened with high health care costs, a high level of uncompensated care costs, and an overregulated health insurance market. Relative to other states, it also has a higher concentration of "branded" medical providers accustomed to leveraging their reputations for quality to charge high prices and dictate reimbursement rates to insurers. Consequently, the legislation includes provisions to allow insurers more flexibility in contracting selectively with providers and constructing "value-focused" networks. Massachusetts also has a high rate of employer-based coverage and a relatively low number of uninsured—a feature not found in all states.

The plan enacted by the Massachusetts legislature and signed by the governor is not a program that can simply be replicated in other states. The political, economic, and social conditions of the states vary greatly, as do their patterns of health care delivery, including the number of uninsured, the pattern of health care costs, the ratio of public–private health care coverage, and the level of regulation and government control over the system. The true genius of the Constitution's federal system of government is its capacity for adaptation to local circumstances and the promotion of competitive policy innovation, enabling Americans to learn the best practices and avoid the most common mistakes of their fellow citizens.

However, officials in other states should note that several features of the Massachusetts health plan could be adapted to the unique conditions of their states. Two features of conceptual importance merit close attention.

Component #1: Creation of a New Statewide Health Insurance Exchange

The Massachusetts plan creates a new consumer-driven marketplace (the Connector) where individuals and employees of small businesses can purchase health care coverage from a variety of competing health insurance plans. This is, in effect, a health insurance "exchange."[3] Conceptually, the Connector is like a stock exchange for health insurance—an administratively easy way for individuals to buy various health insurance products through an organized market, just as they would buy differ-

3. The idea of the health insurance exchange was developed by Alain C. Enthoven, professor of public and private management at the Graduate School of Business at Stanford University. See Alain C. Enthoven, "Employment Based Health Insurance Is Failing: Now What?" *Health Affairs Web Exclusive*, May 28, 2003, pp. W237–W248, and Alain C. Enthoven, "Open the Markets and Level the Playing Field," in Alain C. Enthoven and Laura A. Tollen, eds., *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice* (San Francisco: Jossey–Bass, 2004), pp. 227–245.

ent stocks, bonds, and mutual funds through an organized financial market.

In this specific case, the Massachusetts Connector is designed on The Heritage Foundation's version of a voluntary "health insurance exchange."[4] In this design, the health insurance exchange is not a regulatory agency. It does not supplant the authority of the state insurance department, nor does it impose a comprehensive standardized benefit package on health plan participation, such as Maine's Dirigo health care program.[5] It is not a purchasing entity like an association health plan or existing state-sponsored small-business purchasing groups. Moreover, this type of health insurance exchange is not intended to negotiate rates or benefits with health insurance carriers on behalf of its member employers, employees, or individuals. In this crucial respect, the health insurance exchange is not like the popular Federal Employees Health Benefits Program, which provides a broad range of health plan choice to federal workers and retirees.

Like a stock exchange for financial investments, a health exchange's primary role is to facilitate transactions among the government, employers, individuals, and health insurers, such as coordinating contributions and government assistance for premium payments to insurers and other related paperwork. In principle, of course, such operations do not have to be run exclusively through a government entity like the Massachusetts Connector. States could charter a nongovernmental agency to carry out such functions or contract with existing private-sector entities to administer the essential functions of a statewide health insurance exchange.

Correcting Market Deficiencies. The rationale for the Connector is rooted in the deficiencies and complexities of the current individual and small group health insurance markets and the layers of state insurance rules that govern them. These deficiencies are common in all states. They are evident from the difficulties that small businesses and individuals have in getting affordable health insurance and staying covered over time.

The Massachusetts Connector is a mechanism to overcome these deficiencies by combining the small group and individual markets.[6] It expands choice for employees of small businesses who typically have few, if any, choices of health plans or carriers. Moreover, the Connector expands access by facilitating coverage for individuals and families who currently do not have coverage through an employer by creating a new way of easing access to coverage for these persons and extending favorable tax treatment.

Establishing Portability. The empirical data on America's uninsured are voluminous. Nationally, more than 80 percent of the uninsured are in working families. While they are an economically diverse group, the largest portion of this population is composed of lower-income working families. Moreover, they are heavily concentrated in small businesses that commonly do not offer health

4. The Massachusetts Connector was designed largely on the basis of a Heritage Foundation proposal to compensate for the deficiencies of federal regulations and tax law and to create a consumer-driven market for health insurance: a statewide "health insurance exchange." The earliest version of the Heritage Foundation exchange proposal was embodied in a health insurance market reform bill developed by the Department of Insurance Securities and Banking of the District of Columbia. For a discussion of the key elements of the D.C. proposal, see Lawrence H. Mirel and Edmund F. Haislmaier, "Doing It Right: The District of Columbia Health Insurance Market Reform," Heritage Foundation *Lecture* No. 936, May 15, 2006, at *www.heritage.org/research/healthcare/hl936.cfm*.

5. For an account of Maine's Dirigo health care program, see Tarren Bragdon, "Command and Control: Maine's Dirigo Health Care Program," Heritage Foundation *Backgrounder* No. 1878, September 16, 2005, at *www.heritage.org/Research/HealthCare/bg1878.cfm*. In variants of "managed competition," the standardization of health insurance benefits across health plans is a central principle, and market competition is thus based on quality and price. In contrast, this version of the health insurance exchange provides for a lot of different health plans and a multiplicity of benefit offerings through a single market, similar to the CarMax business model for selling consumers a wide variety of makes and models of automobiles.

6. The existing individual market is collapsed into the Connector. The small group market still exists, but small businesses can voluntarily opt out and participate in the Connector. The legislation also sets up a commission to study possibly folding the small group market into the Connector at a later date.

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insurance, and they are often found among part-time and contract employees that typically do not qualify for employer-based coverage.

The data also show that the uninsured population is constantly churning, with individuals and families going in and out of health insurance coverage, often because of changes in employment or employment status. In a detailed analysis of the empirical evidence over an extended period of time, Pamela Farley Short and Deborah R. Graefe of Pennsylvania State University found that the number of those who were "always uninsured" over the long term (defined as 48 months for the purposes of the study) amounted to no more than 12 percent of the uninsured population. The vast majority experienced gaps or frequent changes in coverage or were making the transition into and out of health insurance coverage.[7] Similarly, in a Commonwealth Fund study, Short, Graefe, and Cathy Schoen of the Commonwealth Fund observed: "To the extent that job turnover undermines coverage stability, designing ways for employers to contribute to the cost of coverage, without directly administering health insurance, could enhance continuity."[8]

The Massachusetts Connector makes coverage easier to purchase and to maintain. In other words, the Connector is intended to lessen the churning effect of the uninsured and general instability in coverage by providing an organized structure through which individuals and families can choose and purchase plans from competing insurers and maintain coverage regardless of job changes or employment status.

Preserving Tax Breaks. The federal tax code is a significant obstacle to achieving personal ownership and portability of health insurance. On one level, it is generous. It provides unlimited tax relief for the purchase of health insurance, but it largely confines that generosity to those who obtain health coverage through their places of work. Under current federal tax law, the total value of the employer-purchased health benefit is excluded from an employee's taxable income. On another level, it is stingy. Such lucrative tax preferences are not extended to workers who lack employer-based coverage. They must purchase coverage on their own with after-tax dollars.

This presents a dilemma: Buying a health plan in the individual market with after-tax dollars imposes a financial hardship, especially on individuals with lower incomes. The alternative—going without coverage—runs the risk of incurring high medical costs from serious or catastrophic illness. Without federal action to level the playing field, the policy challenge is to establish individual access to coverage in an inflexible federal tax system that almost exclusively privileges employer-based health insurance coverage.[9]

Through the Connector, the Massachusetts law resolves this dilemma and maintains the generous federal and state tax breaks for health insurance that are confined almost exclusively to coverage purchased by employers. In short, the new law establishes a defined contribution option for employers that they did not previously have. Specifically, an employer can designate the Connector as its employer-sponsored health insurance plan, allowing the employee to receive tax-free premium contributions from their employer. Thus, the Connector protects the current, favorable treatment of health insurance for employees and provides choice, ownership, and portability for them.

The Massachusetts reform also creates a new opportunity for employees to gain other tax advantages. The new law requires employers with 11 or

7. Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No. 6 (November/December 2003), pp. 247–249.

8. Pamela Farley Short, Deborah R. Graefe, and Cathy Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," Commonwealth Fund *Issue Brief*, November 2003, p. 10, at *www.cmwf.org/usr_doc/Short_churn_688.pdf* (July 12, 2006).

9. See Grace-Marie Arnett, ed., *Empowering Health Care Consumers Through Tax Reform* (Ann Arbor: University of Michigan Press, 1999).

more employees to set up a Section 125 plan so that their employees can pay their share of health insurance premiums with pre-tax dollars. This requirement will help all employees, but especially part-time and contract employees who may not receive any pre-tax contributions from their employers.

While critical of elements of the Massachusetts law, the editors of *National Review* nonetheless remarked:

> [T]he connector in the plan is genuinely innovative. The federal tax code encourages employers to provide health insurance rather than just giving people higher wages with which to buy their own insurance. The connector is a way of working around that problem. Employers would give workers a set amount of money, and they could use the connector to buy from one of several participating companies and the federal tax break would still apply.[10]

Component #2: Direct Assistance for Lower-Income Persons to Buy Private Coverage

The central issue in America's health care debate, aside from the rising cost of health care, revolves around the uninsured and helping them to get coverage. The correlative issue is how to finance additional assistance to help those who are without health insurance.

John C. Goodman, president of the National Center for Policy Analysis, notes that federal and state governments already spend tens of billions of dollars annually on a variety of programs for the uninsured, including Medicare and Medicaid funds for hospitals that serve a disproportionately large number of patients without health insurance coverage. Goodman has long argued that current government subsidies and tax incentives for the uninsured should be realigned and redirected to help the uninsured get coverage, primarily through health care tax credits.[11] The Massachusetts law puts this concept into practice by using existing government funding to help lower-income individuals purchase individually owned private coverage.

Governor Romney builds on Goodman's central insight. In Massachusetts, the costs of uncompensated care totaled $1.3 billion in 2005. In the traditional arrangement, hundreds of millions of government dollars, including federal funds,[12] were going to a few Massachusetts hospital systems to reimburse them for providing services to the uninsured—an arrangement that has often lacked accountability. With its uncompensated care waiver from the U.S. Department of Health and Human Services expiring, the Romney Administration proposed turning the massive uncompensated care subsidy structure upside down by using those funds to provide direct assistance to individuals and families rather than paying health care providers to provide services to the uninsured.

The direct subsidy will become a new premium assistance program, administered by the Connector and designed to help lower-income individuals and families buy private health insurance. Much like federal proposals for refundable health care tax credits or vouchers, the premium assistance program is designed as a sliding-scale system of financial help, based on the ability to pay, up to 300 percent of the federal poverty level ($30,480 for a single person and $60,432 for a family of four in 2005 dollars).

At the federal level, President George W. Bush has included a refundable tax credit for lower-income individuals and families in past budget proposals. While there are technical differences, the Romney income-based premium assistance program broadly covers the same uninsured populations that have been targeted by the Bush Administration's health care tax credit proposals.[13] The Bush Administration

10. "The Week," *National Review*, May 8, 2006, p. 4.

11. See John C. Goodman, "Solving the Problem of the Uninsured," *Thoracic Surgery Clinics*, Vol. 15, Issue 4 (November 2005), pp. 503–512.

12. State taxpayers provided 54 percent of Massachusetts' uncompensated care funds, and federal taxpayers provided the remaining 46 percent. Personal communication with Massachusetts Secretary of Health Timothy Murphy, May 31, 2006.

has consistently targeted its refundable health care tax credits on a sliding-scale basis to individuals earning up to $30,000 and families earning up to $60,000 per year.[14] Members of Congress have introduced similar proposals, but Congress has chosen not to enact these credits.

The adoption of this provision of the Massachusetts law amounts to a revolutionary change in health policy. It mainstreams low-income individuals and families into private health care coverage, and does this without new health care expenditures, by redirecting state health care spending from meeting the needs of providers to meeting the needs of patients and consumers. In sum, it converts the current *de facto* provider safety net into a consumer safety net.

Key Components for States to Avoid

To expand personal freedom and harness the power of competition through a more robust private market, states should resist certain features of the Massachusetts plan that obstruct this goal.

Imposing an Employer Mandate. The final language of the Massachusetts health law imposes new penalties on employers who do not provide health insurance to their workers, who do not make a "reasonable" contribution, or whose employees accumulate free care services.[15] However, employers in Massachusetts who provide coverage to their workers already pay a state health insurance premium tax. The existing premium tax is counterproductive, as are the new penalties. Governor Romney vetoed the new employer mandate provisions, but the Massachusetts legislature overrode his vetoes.

The underlying assumption behind an employer mandate—that employers pay for health insurance for their employees—is erroneous. In fact, households, not employers, pay 100 percent of health care costs. Health benefits, like wages, are part of the employees' compensation, and every increase in the payment for health benefits is routinely offset by decreases in workers' wages and other compensation.

Policymakers in other states should vigorously oppose employer mandates, regardless of how narrowly targeted or defined they may be.[16] Not only does an employer mandate provide an additional platform for further regulatory control over private health insurance contracts, but the additional

13. One of the major differences is that the Massachusetts subsidy program is based on a fixed pool of funds, whereas the Bush and congressional proposals are financed through general revenues. Federal officials have rarely proposed replacing the existing health care tax breaks—particularly the huge tax exclusion on employer-based health insurance—to fund a national health care tax credit system as many economists and conservative health policy analysts have recommended.

14. For the most comprehensive version, see U.S. Department of the Treasury, *General Explanation of the Administration's Fiscal Year 2006 Revenue Proposals*, February 2005, p. 20, at *www.treas.gov/offices/tax-policy/library/bluebk05.pdf* (July 12, 2006), and *General Explanation of the Administration's Fiscal Year 2007 Revenue Proposals*, February 6, 2006, pp. 25–26, at *www.treas.gov/offices/tax-policy/library/bluebk06.pdf* (July 12, 2006). The fiscal year 2007 version limits use of the tax credit to high-deductible health plans but maintains the same income eligibility standards.

15. The Massachusetts law levies a fee for uncompensated care on companies with 11 or more employees that do not offer health insurance coverage to employees. The fee is capped at $295 annually per employee and is calculated based on the use of free care by uncovered employees. A free rider surcharge is also applied to any firm with uncovered employees who together consume more than $50,000 in "free care" annually. However, the special fee would not be levied if the firm makes a Section 125 plan available to its employees. For a detailed description of the Massachusetts employer mandate, see Moffit and Owcharenko, "Understanding Key Parts of the Massachusetts Health Plan."

16. Perhaps the most notable is the "Wal-Mart Bill," which the Maryland legislature enacted over Governor Robert Ehrlich's veto. The bill requires private employers in Maryland that have more than 10,000 employees to spend 8 percent of their payroll on health insurance for their employees or pay a tax to the state to help fund the state's share of the Medicaid program. The Maryland bill has spawned copycat legislation in numerous states. For a description of the Maryland employer mandate, see Edmund F. Haislmaier, "Covering the Uninsured in Maryland: Futile Gestures or Real Reforms?" Maryland Public Policy Institute, *Maryland Policy Report* No. 2006–2, January 17, 2006, at *www.mdpolicy.org/docLib/20060117_PolicyReport20062.pdf* (July 12, 2006).

costs of a mandate make it even more difficult for entrepreneurs to start and maintain a small business, and these higher costs are passed onto workers and their families through lower wages and even job loss.

Expanding Medicaid. The Massachusetts law expands Medicaid eligibility to children of working families up to 300 percent of the federal poverty level. As a general rule, expanding Medicaid or other public health programs, such as the State Children's Health Insurance Program (SCHIP), is not the best option for families or state policymakers. In surveys, the overwhelming majority of uninsured families expressed a preference for enrolling in private coverage, not public programs.[17] For state officials, Medicaid is consuming ever-greater portions of state budgets, crowding out other important services (e.g., education, transportation, and homeland security), and jeopardizing the quality of care for those whom the programs were intended to serve.

Instead of expanding eligibility for these struggling government-run public programs, states should pursue innovative alternatives for working families and protect the public program for the truly indigent. Building on new market mechanisms such as a health insurance exchange like the Massachusetts Connector and providing direct assistance to lower-income families so that they can afford private health coverage are far better alternatives than simply enrolling them in Medicaid or other public health programs. Moreover, states would do well to begin mainstreaming many of their working individuals and families out of public coverage and into affordable private health insurance options.

Key Components for States to Improve

As noted, the Massachusetts plan is the product of a bipartisan compromise in a political, cultural, and health system environment that is peculiar to Massachusetts. A number of provisions in the law need improvement, and states looking at the Massachusetts model should consider these modifications.

Removing the Legal Restriction on a Person's Right to Self-Insure. The Massachusetts health plan imposes a simple "pay or play" mandate on the individual by requiring an individual to purchase coverage or pay a state fine.[18] This simple mandate is not the ideal option for dealing with the "free rider" issue—the very real problem of individuals seeking and getting health care at hospital emergency rooms or other health care facilities and then leaving the taxpayer to pay the bill. These costs are incurred either directly through taxation or through higher private insurance premiums. In Maryland, for example, caring for the uninsured cost an estimated $713 million in 2005, raising family premiums by $948.[19] In Massachusetts, as noted, uncompensated health care costs reached a stunning $1.3 billion in 2005.

A far better option would be to adopt Governor Romney's original proposal, which would have protected an individual's right not to purchase health insurance coverage. His "personal responsibility" proposal would simply have required everyone who could afford health insurance either to purchase coverage or to self-insure by posting a $10,000 bond or

17. According to a 2002 Commonwealth Fund survey of uninsured adults, only 12 percent said that they would like to enroll in Medicare or Medicaid if they had the option, but a strong majority said they would prefer to enroll in private group or individual health insurance plans. See Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, "The Erosion of Employer Based Health Coverage and the Threat to Workers' Health Care: Findings of the Commonwealth Fund 2002 Workplace Health Insurance Survey," Commonwealth Fund *Issue Brief*, August 2002, p. 7, at *www.cmwf.org/usr_doc/edwards_erosion.pdf* (July 12, 2006).

18. Under the terms of the new Massachusetts law, beginning on July 1, 2007, all Massachusetts residents will be required to have health insurance and must indicate proof of purchase on their state tax returns. Anyone refusing to purchase a health insurance policy will lose his personal tax exemption in the first year. Continuing to refuse to purchase a health insurance policy will incur a monthly fine equal to 50 percent of the cost of an "affordable" health insurance product.

19. Regina E. Herzlinger, "Health Policy in Maryland and Massachusetts: A Study in Contrasts," Heritage Foundation *WebMemo* No. 1037, April 13, 2006, at *www.heritage.org/research/healthcare/wm1037.cfm*.

equivalent of a bond, which would demonstrate a willingness and ability to pay for any future hospital care. The $10,000 figure was taken from the Massachusetts auto insurance law, which also requires the posting of funds if one does not wish to purchase auto insurance. This is simply a tangible demonstration of a person's willingness to pay his own way and eliminates the option of obtaining expensive health care services and then skipping out, leaving the taxpayers to pay the medical bills.

The current debate over the individual mandate to purchase health insurance in Massachusetts must be understood against the backdrop of a simple fact: Federal law prohibits hospitals from turning away patients because of their financial inability to pay for care. In effect, the *status quo* imposes a mandate on taxpayers, and the burdens of that mandate are steadily increasing. These burdens are not relieved by resorting to new funding for public hospitals for the poor and the indigent, shifting bad debt elsewhere, or fruitlessly chasing down the unpaid bills of high-cost patients who are simply incapable of paying high health care bills. Governor Romney's original approach would protect individual taxpayers from paying the uncompensated care costs for free riders while preserving the individual's freedom to decide how best to pay for care.

Accelerating the Deregulation of the State Health Insurance Market. Massachusetts has a highly regulated health insurance market, especially for small businesses. Much of the recent criticism of the Massachusetts plan from conservatives is that the plan did not deregulate enough, and especially that it did not eliminate the guaranteed issue requirements for health insurance.[20]

In fairness, the Massachusetts law does make some important changes in health insurance regulation, including a two-year moratorium on new mandated benefits. It also introduces new flexibility for products in the Massachusetts health insurance market, such as tiered networks, expanded health savings account options, the factoring of tobacco use into health insurance ratings, and more affordable mandate "lite" health plans for younger populations between 19 and 26 years of age.

Projecting future health care costs or savings is extremely difficult. Nonetheless, the governor's staff estimates, based on the available insurance data, that these regulatory changes in the health insurance market will reduce average individual premium costs by 20 percent to 50 percent.[21] The governor's staff has also calculated that the new provisions giving consumers greater information, including transparency in pricing, will stimulate greater market competition in cost and quality among hospitals and other medical professionals, which will result in larger statewide health system savings.

Nonetheless, the critics' basic point is well-taken. The Massachusetts health insurance market is overregulated, as are the health care markets in many other states. Much of today's state health insurance regulation is counterproductive and outdated. With respect to benefit mandates, while many legislators believe that they are necessary and socially beneficial, it is also true that enactment of these mandates (which now exceed 1,800 nationwide[22]) is too often driven by anecdotes and "hard cases," narrow political considerations, or the special financial interests of providers who want legally required coverage and reimbursement for their specialties.

State legislators should rigorously review existing rules and repeal those that impose unnecessary

20. For example, see Council for Affordable Health Insurance, "Massachusetts' Health Care Reform Plan: Too Many Sticks; Not Enough Carrots," May 2006, at *www.cahi.org/cahi_contents/resources/pdf/massachusetts.pdf* (July 12, 2006).

21. Personal communication from Cindy Gillespie, counselor to Governor Romney, May 25, 2006. The key changes that are expected to yield savings in the insurance markets include allowing companies to use "value-driven" networks instead of complying with the older "any willing provider" rules, expanded use of health savings accounts and high-deductible health plans, introduction of co-payments, and greater pharmacy benefit management. Timothy Murphy, Secretary of Massachusetts Health and Human Services, "Massachusetts Health Care Reform," May 16, 2006, PowerPoint presentation, p. 7.

22. Victoria Craig Bunce, JP Wieske, and Vlasta Prikazsky, "Health Insurance Mandates in the States, 2006," Council for Affordable Health Insurance, March 2006, at *www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf* (April 27, 2006).

costs on individuals and families. Specifically, states should provide greater flexibility as well as mandate and rating relief for carriers offering health insurance in the small group and individual markets. Better still, they should simply abolish the existing rules that govern these dysfunctional markets and start over with a clean slate: a single market and a common set of understandable rules focused on consumer information and protection.

Expanding Access to and Choice of a Statewide Health Insurance Exchange. The Massachusetts plan focuses primarily on providing relief to small businesses and their employees. Specifically, it creates an avenue for these individuals and families to take advantage of the generous federal tax breaks that accrue to employer-based health insurance while enabling them to own their own health insurance policies and keep them regardless of job change or status. The Massachusetts plan, however, restricts participation in the Connector to employees in businesses with 50 or fewer employees and individuals purchasing coverage on their own. Moreover, lower-income individuals receiving the new premium assistance subsidy are restricted in the types of products that are available to them through the Connector.[23]

Officials in other states who are interested in establishing statewide markets should consider expanding participation in a health insurance exchange to employers of all sizes, including state and local government employees. States should also fold public programs, such as certain enrollees in Medicaid and SCHIP, into the health exchange. In many instances, families involved with public health programs do not share the same coverage. Folding the public programs into an exchange would allow these families to maintain private coverage together under a single policy.

In establishing a health insurance exchange, state officials should also ensure that it does not and cannot become a barrier to entry for new and innovative insurance products or options. Therefore, consistent with consumer protection, it is equally important, that states should allow *any willing insurer* to participate in the health exchange arrangement and not restrict populations from choosing the product that best fits their needs, regardless of their income or level of financial help from the government. In the end, larger and more open participation in the statewide market will result in a more successful, competitive, and robust consumer-driven marketplace.

Conclusion

Massachusetts officials have made significant strides in reforming their health insurance market, and other states can learn from the Massachusetts experience. States should build on the solid features of the Connector: the establishment of a statewide health insurance exchange to allow individuals to buy and own health insurance without losing favorable tax treatment and direct assistance to low-income individuals and families for the purchase of private coverage using existing government funds. Likewise, states should reject certain problematic features of the final plan, such as the employer mandate and public program expansions, and improve other aspects of the plan.

Every state wrestles with the impact that rising health care costs and numbers of uninsured have on the economy and budget. Nonetheless, every state has its own health care delivery system that operates in a unique political, cultural, and legal, and regulatory climate. While the Massachusetts plan is clearly not perfect, it does make some crucial conceptual breakthroughs in health policy. Furthermore, the process itself illustrates that states, regardless of their differing characteristics, can tackle the difficult health care issues that thus far have stymied federal policymakers.

—*Nina Owcharenko is Senior Policy Analyst for Health Care in and Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation.*

23. Under the Massachusetts law, no deductibles are permitted for individuals getting premium assistance, which is available to uninsured people with incomes up to 300 percent of the federal poverty line. This is an unnecessary restriction on the market. Moreover, these individuals would be offered health plans exclusively through the Medicaid managed care organizations for the first three years of the program. This political compromise was included to ensure that the transition to the new system would not precipitate a financial crisis among the hospital systems that currently receive uncompensated care pool funding.

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Coverage Instability Problem

Coverage Patterns of Uninsured (48 month period)	Number (millions)	Share	Potential to Solve
Repeatedly uninsured	28.2	33%	Easiest (62%)
One coverage gap	24.4	29%	
Transition in or out of coverage	17.2	20%	Varied
Temporary coverage	4.8	6%	Hardest (18%)
Always uninsured	10.1	12%	
TOTAL	84.8	100%	

Source: 1996-1999 SIPP data as reported in: P. F. Short and D. R. Graefe, "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured," *Health Affairs* 22, no.6 (2003): 244-255.

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Subsidy Implications

Coverage Patterns of Uninsured (48 month period)	Income as % of FPL			
	<100	100-199	200-399	400+
Repeatedly uninsured	8.0%	12.1%	10.1%	3.0%
One coverage gap	4.5%	7.1%	11.5%	5.7%
Transition in or out of coverage	3.3%	6.7%	7.4%	2.9%
Temporary coverage	1.2%	2.4%	1.7%	0.4%
Always uninsured	2.7%	5.4%	3.0%	0.8%
Little or none = 41%	Some = 43%		Substantial = 16%	

43%
>41%
>43%
16%

SENATE BILL NO. 309
Bill Worksheet

Section Number	Description	COMMENTS
1 (pg. 1)	**Title** - Act to be known as the Kansas Health Insurance Connector Act.	
2 (pg. 1)	**Definitions** - defines act; applicant; carrier; COBRA; commissioner; creditable coverage; dependent; eligible individual; employer; excepted benefits; exchange; federal health coverage tax credit eligible individual; health benefit plan; HIPAA; participating employer plan; participating individual; participating insurance plan; plan year; preexisting conditions provision; producer; rate; self-funded health benefit plan.	
3 (pg. 3)	**Purpose** - establishes Insurance Connector within the Kansas Health Policy Authority for limited purpose of providing to residents of Kansas and other eligible individuals greater access to, and choice and portability of, health insurance products. The Health Policy Authority shall provide technical and clerical staff assistance as requested by the Insurance Connector. The Insurance Connector shall be subject to the Open Meetings and Open Records Acts.	
4 (pg. 4)	**Responsibilities** - Insurance Connector shall publicize its existence and disseminate information on eligibility requirements and enrollment procedures; establish and administer enrollment procedures; establish and administer procedures for the election of coverage; collect and transmit to participating plans all premium payments or contributions; issue certificates of previous coverage in accordance with HIPAA provisions; establish procedures to account for all funds received and disbursed by the Connector; and, following the end of the plan year, submit to the Commissioner of Insurance an independent audit report of the Connector's accounts.	
5 (pg. 5)	**Powers** - Insurance Connector shall have the power to contract with vendors to perform the functions set out in Section 4; contract with private or public social service agencies to administer the application process and related functions for specified groups or populations; contract with employers to act as the plan administrator for participating employer plans and to undertake the obligations of a plan administrator as required by federal law; set and collect fees from participating individuals, employer plans, and insurance plans sufficient to fund the cost of administering the Connector; seek and directly receive grant funding to defray the costs of operating the Connector; establish and administer rules and regulations governing the operations of the Connector; establish one or more service centers within the state to facilitate enrollment; and sue and be sued or otherwise take any necessary or proper legal action.	

Senate Health Care Strategies Committee
Date: February 12, 2007
Attachment 2

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(pg. 6)	**Enrollment and Coverage Election** - any eligible individual may apply to participate in the Connector and an employer, labor union, educational, professional, civic, trade, church or social organization that has eligible individuals as employees or members may apply on their behalf. Individuals determined by the Connector to be eligible to participate may enroll, or be enrolled by the individual's parent or legal guardian, in a participating insurance plan during the next open enrollment or, when applicable, at other times as specified. The Connector shall administer an open enrollment period and, subject to underwriting rules, eligible individuals may enroll without a waiting period and may not be declined coverage. Eligible individuals may enroll at times other than the annual open enrollment period if one of eight triggering events occurs and the individual does so within 63 days of the triggering event. The triggering events include lose of coverage due to death of a spouse, parent, or legal guardian; a change in employment status; divorce, separation, or other change in familial status; individual achieves an age at which coverage lapses; the individual becomes newly eligible by becoming a resident or the place of employment has changed to a location in Kansas; the individual becomes newly eligible by becoming the spouse or dependent by reason of birth, adoption, court order or change in custody arrangement, of an eligible individual; individual becomes subject to a court order, or enters into a new custody arrangement, requiring the provision of health coverage to certain dependents; or the individual loses coverage because a plan terminates participation in the Connector prior to the end of the plan year.	
7 (pg. 7)	**Participation of Plans** - no health plan may be offered through the Connector unless the Insurance Commissioner has first certified that the carrier is licensed and in good standing and the plan meets all applicable requirements. No plan shall be certified that excludes from coverage any individuals otherwise determined by the Connector as meeting the eligibility requirements. Certification of plans to be offered through the Connector shall not be subject to any state law that requires competitive bidding and each certification shall be valid for a uniform term of at least one year. Certifications may be automatically renewed unless withdrawn by the Insurance Commissioner or discontinued by the plan or carrier. Withdrawal of certification requires notice to the carrier and opportunity for hearing. Each certified plan shall contain a detailed description of benefits offered and shall provide major medical coverage. The plans are to include standard rates based on age, geography and family composition; are to be actuarially sound in the judgment of the Insurance Commissioner; and are to comply with state insurance law. Rates may be adjusted in each plan year based on experience and modifications to plan benefits provided the adjustments are made in advance of the plan year and on a basis which, in the judgment of the Insurance Commissioner, is consistent with the general practice of carriers that issue health benefit plans to large employers. The Connector shall not decline or refuse to offer any plan that has obtained, in a timely fashion, certification by the Insurance Commissioner. The Connector shall not sponsor any plan, or contract with any carrier to offer any plan, that has not been certified by the Insurance Commissioner and shall not impose any terms or conditions beyond those terms and conditions established by the Insurance Commissioner. The Insurance Commissioner shall adopt rules and regulations for certifying plans to participate in the Connector.	

(pg. 8)	**Underwriting Rules** - rules governing the imposition by carriers of any preexisting condition provisions and rating surcharges shall include: except for individuals with less than 18 months of creditable coverage, during open enrollment periods, participating individuals and participating dependents choosing a different plan shall not be subject to any preexisting condition provisions and shall be charged the standard rate for persons of the same age and geographic area. New participating individuals with 18 months or more of creditable coverage shall not be subject to any preexisting condition provisions and shall be charged the applicable age and geographically adjusted standard rate New participating individuals with two to 17 months of creditable coverage may be subject to one or more preexisting condition provisions (not to exceed 12 months) and/or charged a premium not to exceed 125% of the applicable age and geographically adjusted standard rate (not to be applied in third or subsequent years). New participating individuals with two months or less of creditable coverage may be subject to one or more preexisting condition provisions (not to exceed 12 months) and/or charged a premium not to exceed 150% of the applicable age and geographically adjusted standard rate (not to be applied in third or subsequent years). For newly eligible dependents, carriers shall not impose any preexisting condition provisions or any change in rate, unless the insurance plan's standard rates reflect the addition of new dependents. Periods of creditable coverage shall be established through certifications or other means specified in federal and state law. For new participating individuals without creditable coverage, or with limited creditable coverage, carriers may elect to waive the imposition of preexisting condition provisions and instead extend the applicable rate surcharge for an additional year. Individuals participating through an employer plan or who have any federal health coverage tax credit shall be deemed to have 18 months of creditable coverage.	
9 (pg. 10)	**Continuation of Coverage** - any participating individual may continue to participate in a plan as long as the individual remains eligible, subject to the cancellation rules of the carrier for non-payment of premiums or fraud, and shall not be canceled or non-renewed because of any change in employer or employment status, marital status, health status, age, membership in any organization, or any other change that does not affect eligibility as defined by the Act. An individual who is not a resident of the state of Kansas and ceases to be eligible due to a qualifying event, shall be deemed to be eligible for 36 months if the qualifying event is a voluntary or involuntary termination of employment, other than for reasons of gross misconduct, or loss of dependent status for any reason. The individual must elect to remain a participating individual and must notify the Connector of such election within 63 days of the qualifying event.	
10 (pg. 10)	**Dispute Resolution** - the Commissioner of Insurance shall establish procedures for resolving disputes arising from the operation of the Connector including disputes of eligibility, imposition of a coverage surcharge, and imposition of a preexisting condition. A participating individual disputing the imposition of a preexisting condition exclusion or a premium surcharge by a participating carrier may request the Commissioner to issue a determination as to the validity of the exclusion or surcharge. The Commissioner shall issue the determination within 30 days of the request being filed with the Insurance Department. If the individual or carrier disagrees with the outcome, either party may submit a request to the Insurance Commissioner for a hearing under the Kansas Administrative Procedures Act.	

(pg. 11)	**Participating Employer Plans** - any employer may apply to the Connector to be the sponsor of a participating employer plan. As a condition of participation, the employer must enter into a binding agreement with the Connector that includes the following conditions: (1) employer designates the Connector to be the plan's administrator for the employer's group health plan and the Connector agrees to undertake the obligations required of a plan administrator under federal law; (2) only the coverage and benefits offered by participating insurance plans shall constitute the coverage and benefits of the participating employer plan; (3) any individuals eligible to participate under the employer's plan, regardless if they would otherwise qualify to participate in the Connector, may elect coverage under any participating insurance plan and neither the employer nor the Connector shall limit the choice of coverage; (4) the employer reserves the right to offer benefits supplemental to the benefits offered through the Connector but any supplemental benefits shall constitute a separate plan(s) under federal law, for which the Connector shall not be the plan administrator; (5) the employer agrees that, for the term of the agreement, the employer will not offer to individuals eligible to participate under the employer plan, any separate or competing group health plan offering the same or similar benefits as those provided by insurance plans through the Connector; (6) the employer reserves the right to determine the criteria for eligibility, enrollment, and participation in the employer plan and the terms and amounts of the employer's contributions to that plan so long as, for the term of the agreement with the Connector, the employer agrees not to alter or amend any criteria or contribution amounts at any time other than during the annual period designated by the Connector; (7) the employer agrees to make available to the Connector any of the employer's documents, records, or information that the Commissioner of Insurance reasonably determines are necessary for the Connector to verify that the employer is in compliance with the terms of the agreement, with applicable laws relating to employee welfare benefit plans, and eligibility of the individuals enrolled in the employer plan; (8) and the employer agrees also to sponsor a "cafeteria plan" as permitted under federal law for all employees eligible for coverage under the employer's plan. The Connector may not provide the participating employer plan with any additional or different services or benefits not otherwise offered to all other participating employer plans. Beginning with the first plan year, the Kansas State Employees Health Care Commission shall enter into an agreement with the Connector to be the sponsor of a participating employer plan on behalf of all individuals eligible for health insurance benefits under the State Health Care Benefits Program, except for individuals eligible only for benefits consisting solely of coverage of excepted benefits.	
12 (pg. 13)	**Insurance Producers** - when a producer (agent) enrolls an eligible individual or group in the Connector, the plan chosen by each individual shall pay the producer a commission in an amount to be determined by the Health Policy Authority. The amount can be a fixed amount or based on the amount of the premium. When a membership organization enrolls eligible members, or eligible members of its member entities, in the Connector, the plan chosen by each individual shall pay the organization a fee equal to the commission specified by the Authority. Membership organizations are not required to be licensed as insurance producers but may not provide any other services requiring licensure as an insurance producer without first obtaining a license.	

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13 (pg. 13)	**Statement of Coverage Form** - each employer in the state shall annually file with the Insurance Commissioner, a form for each employee within the state indicating the health insurance coverage status of the employee and dependents including the source of coverage and name of insurer or plan sponsor. If no coverage for the employee is indicated, the employer shall file the employee's election to post a bond or establish an account in lieu of insurance coverage; apply, or not apply, for coverage through the Connector; and be considered, or not be considered, for any publicly financed health insurance program or premium subsidy program. The form shall be signed by the individual. Self-employed individuals shall annually file the same form with the Insurance Commissioner. The Health Policy Authority shall file the same form with the Insurance Commissioner on behalf on behalf of individuals receiving benefits under the Title XIX (Medicaid) and Title XXI (Children's Heath Insurance) programs. The Insurance Commissioner shall prepare and distribute the required forms.	
14 (pg. 14)	**Insurance Market Consolidation** - no carrier shall issue or renew an individual health benefit plan, or a group health benefit plan to a small employer with 50 or fewer employees, other than through the Connector after the first regular open enrollment period conducted by the Connector. This section does not apply to any health benefit plan that consists solely of one or more excepted benefits.	
15 (pg. 14)	**Personal Responsibility** - on and after January 1, 2009, residents of the state between ages 18 and 65 shall offer proof of ability to pay for medical care for themselves and dependents either by indicating coverage under a health plan offered through the Connector or by demonstrating proof of financial security to pay for medical expenses. Proof of financial security can be demonstrated by presenting a $10,000 bond to the Health Policy Authority or depositing $10,000 with the Authority to be placed in an escrow account. If individuals fail to comply in any calendar year, the Authority shall establish an escrow account in the name of the individual and retain and deposit in the account any overpayment of state taxes by the individual and/or obtain an order for the attachment of wages not to exceed $10,000. The money held in escrow shall be disbursed by the Authority only to pay for medical claims for healthcare services provided to the individual during the period the individual was not in compliance. The Authority shall close the account and remit the remaining funds to the individual within six months of receiving notification that the individual has submitted proof of insurance coverage or is no longer a legal resident of Kansas. If the Authority determines that an individual has not been a legal resident for 36 months or more, the Authority shall close the account and remit the remaining funds to the individual. If the individual cannot be located, the Authority shall dispose of the funds in accordance with state law. Judgments payable by an individual to a hospital, physician or other healthcare provider during a period when the individual is not in compliance shall include an order permitting the attachment of wages of the individual to satisfy the judgment.	
16 (pg. 15)	**Effective Date** - publication in the statute book.	