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 20, 2007 in Room 231-N of the Capitol.

Committee members absent: Senator Phil Journey- excused

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

Conferees appearing before the committee: Senator Chris Steineger
Dr. Ira Stamm, Clinical Psychologist
Mr. Marlon Donner, CEO ,
Preferred Health Services
Mr. Ken Daniel, Publisher,
KSSmailBoz.com
Mr. Bob Vancrum, Kansas Government Affairs Specialist,
Greater Kansas City Chamber,
Ms. Larrie Ann Lower, Executive Director
Kansas Association of Health Plans
Ms. Cheryl Dillard, Director of Government Relations,
Coventry Health Care
Mr. Brad Smoot, Legislative Counsel,
Blue Cross Blue Shield of Kansas
Ms. Cynthia Smith, Advocacy Counsel,
Sisters of Charity of Leavenworth Health System

Other in attendance: Please see the Guest List

Continued hearing on SB309 - An act enacting the Kansas Health Care Connector Act

Upon calling the meeting to order, Chairperson Wagle called on the first proponent of the day, Senator Chris Steineger who wanted to offer some comments about this bill, which he will support as a good first step, but also about health care in general which he feels is not an access problem but a cost problem. He cited:

A.) Last summer the heads of authority makers (Ford, GM, and Chrysler) went to meet with President Bush and none of them said that access was a problem but cost;

B.) Last year, Toyota was looking at building a factory that would cost more than 1billion dollars and narrowed their choice down to Michigan or Ontario, Canada and they chose Canada because they have lower health care costs (as written in the Wall Street Journal); and so when Fortune 500 companies are going to the President and Fortune 500 global companies are making decisions to invest in other countries rather than ours based on health care costs that we should be listening.

C.) In the US we spend about 16% of the GDP on health care or $5500 per person, our competitors (ex. Canada, Japan, or in Western Europe they spend about a third less or 10% of GDP or $3500 per person.

And finally, he stated, we do have our first ever cost study The Legislative GDP Post Audit Committee has ordered a cost analysis in Kansas and should be due out in about 6 more weeks (how much dollar amount of money is spent in Kansas on health care through all of these government programs and how we spend that money.) Senator Steineger did not offer written testimony.

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.

The Chair then called the second proponent, Dr. Ira Stamm, Clinical Psychologist, who stated his focus is on the process of change that underlies **SB309**. He offered :

A.) Statics about insurance populations in Kansas, citing the last line which read "Several hundred Kansas a year die from the lack of health insurance."

B.) Per Mr. Haislmaier regarding a 2003 study, over a four year period 1/3 of the uninsured go on and off again with insurance coverage, 20% had some and 18% remained uninsured and with 300,000 people in Kansas that means at minimum 54,000 people.

A copy of his power point is (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

As there were no more proponent conferees, written testimony was provided by Mr. David Monaghan from American Family Insurance Group. A copy of which is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

The first opponent conferee to testify was Mr. Marlon Donner, CEO, from Preferred Health Services in Wichita and:

A.) Called the Committee's attention to page 9 of his document stating that there are requirements for what he calls customerization (a process of moving our health insurance environment from employer based to the individual) and if not implemented will not solve the cost problems. He went on to say that for people to understand and buy health care services they will need to understand insurance pricing and physician and hospital pricing but the way the hospitals bill, the way the insurance company pays the hospital and the way individual buys their coverage for hospital care are all three different and no where is there similarities in that process for price comparisons.

B.) Would like to see competition among insurers based on price and services and same for providers.

C.) Called attention to the last page, under "Conclusions and Issues", which list what needs to be addressed regardless of it being in **SB309** or any other health bill.

A copy of his power point presentation is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

Chairperson Wagle recognized Senator Barnett who asked Mr. Donner if he was an opponent or proponent and asked him to tell the Committee a little bit more about his vision of a reinsurance model , or selected services, or what you would see as a mechanism that helps someone make these selections. Senator Wagle asked Mr. Donner, "Did he think there is success in this program depending on whether or not we get everyone involved in buying health insurance like we do with auto insurance?

As there were no further questions, the Chair called on Mr. Kenneth Daniel, Publisher, KSSmailBiz.com, who stated that the bill adopts many of the concepts of the unproven Massachusetts plan (Ex. Instead of the estimated $200 per month for a single employee policy, the costs are more in the neighborhood of $380 per month.); in Kansas, our average health insurance costs are some of the lowest in the nation, employing some of the lowest rates of uninsured (10.9%); and, self-insured big businesses will have to suffer a lot of new red tape and will harm our smallest and weakest businesses. A copy of his testimony is (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

The Chair called on the next opponent conferee, Mr. Robert Vanecrum, Kansas Government Affairs Specialist, Greater Kansas City Chamber, who stated they are in favor of programs to expand both the availability and afford ability of health care coverage, but recognize that these can be inconsistent goals

and although signed up as opponents, they are concerned about the plan reflected in this bill. He concluded by suggesting that a study be first commissioned from people with real expertise and start out with a pilot program. A copy of his testimony is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

The next opponent recognized by the Chair was Ms. Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP) who gave a brief history of KAHP and introduced two of its members: Mrs. Cheryl Dillard, Director of Government Affairs for Coventry Healthcare and Mr. Brad Smoot representing BCBS-KS and KC, would be explaining the association's opposition to the bill and Mr. Marlon Donner, CEO of Preferred Health Systems would be testifying to offer comments and potential alternatives. A copy of her testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

The Chair called first on Mrs. Dillard, who stated that the model is fraught with unintended consequences, the most important being that many Kansans will pay more for coverage, not less and urges the Committee to allow the Steering Committee to evaluate all the ramifications of this bill. A copy of her testimony is (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

Questions for Ms. Dillard came from Senators Wagle and Barnett including:

Can you explain the basics for the model which you ran 3,000 small businesses through it, why do you believe most of them have increased?

Aren't you insuring a larger pool of people and bringing in the young who currently don't get insurance?

Does this then represent an increase in competition among insurance companies?

The current system allows "cherry picking" to eliminate those patients you don't want to cover and is this is a concern that you could loose the ability to "cherry pick".

The Chair then called on Mr. Brad Smoot, who spent a couple of minutes describing mechanisms currently in place in Kansas that were designed to address these same issues in the Massachusetts playroom. He also offered two attachments:

A.) A chart designed to illustrate the means by which the connector addresses the problems of accessibility and afford ability as contrasted against the current statutory mechanisms in place to do the same thing;

B.) A document that describes the extent to which the current individual (non-group) and group insurance market address accessability and portability of coverage.

A copy of his testimony is (Attachment 8) attached hereto and incorporated into the Minutes as referenced.

Questions for Mr Smoot again came from Senators Barnett and Wagle including:

A.) Did you consider any impact of making all payments tax deductible?

B.) When you took this 36 year old female and saw a reduction, did you take other 36 year old females or did you put her in a group? And is she less expensive than the 70 year old male?

The Chair called on the final conferee, Ms. Cynthia Smith, Advocacy Counsel, Sisters of Charity of Leavenworth Health System and offered neutral testimony by providing a chart showing where their hospitals are located throughout the United States and they do not oppose the bill but are not yet ready to support the bill. She also referred the Committee to page 13, line 26 of the bill, where it makes reference

to a subsidy and the way it works in other states, these subsidy dollars come from federal programs that exist now by hospitals with resources that care for the poor and the vulnerable. If you dismantle those federal programs in order to create a subsidy pool of dollars they would like to see a plan in place addressing this. A copy of her handouts are (Attachment 9) attached hereto and incorporated into the Minutes as referenced.

Adjournment

As it was past 2:30, Senate session start time, Chairperson Wagle adjourned the meeting with a possibility of a meeting at the rail later in the day.

NAME	REPRESENTING
Austin Hayden	Sen. Brungardt
Derck Hein	Hein Law Firm
Cheryl Dillard	Coventry Health Care
Ira Stamm	Self
Dave Kemmerly	Humana
Sheldon Weisgrau	KHI
[illegible] Forbes	United Healthcare
William Sneed	AHIP
Marlon R. Danner	Preferred Health Systems
Larrie Ann Lower	KAHP
BRAD SMOOT	BCBS
Mike Huttles	KAMU
Bruce Witt	Preferred Health Systems
[illegible]	BCBSKS
Carolyn Smith	VCHS
MARK D. MARTZ	VIA CHRISTI HEALTH SYSTEM
Kerri Spielman	KAIA
Larry Magill	KAIA
Katie [illegible]	Kearney & Associates

45 min att

SENATE HEALTH CARE STRATEGIES COMMITTEE
GUEST LIST

DATE: Tuesday, February 20, 2007

NAME	REPRESENTING
Doug Wareham	Kansas Bankers Assn.
John Meetz	KID
KEN DANIEL	KsSmallBiz.com
Sandy Braden	NAIFA Kansas
Mike Shields	KHI News
Suzanne Wikle	Kansas Action for Children
Kathy Olsen	Ks Bankers Assn
Chip Wheelen	Asn of Osteo. Med.
Jim Turner	HeartLand Com. Bankers
PAT EAKES	KCDC
Michelle Peterson	Capitol Strategies
Michael White	Sen. President
Dan Murray	Federico Consulting

45 in att.

SENATE HEALTH CARE STRATEGIES COMMITTEE
GUEST LIST

DATE: Tuesday, February 20, 07

Senate Bill 309

Testimony to the
Health Care Strategies Committee
Kansas Senate
Topeka, Kansas
February 20, 2007

Ira Stamm, Ph.D., ABPP

Winston Churchill

- "Americans can always be counted upon to do the right thing, after all other possibilities have been exhausted."

Incremental vs transformational change

- Let's say you have a car built in 1947. To keep it running you keep replacing the parts: last year it was the generator and fuel pump; this year it is the timing belt and radiator; next year it may be an engine overhaul and new set of brakes – but it is still a 1947 car.
- A neighbor or friend may ask you – Would it not be more economical and smarter in the long run to replace the 1947 car with a 2007 car. The 2007 car has the latest design and materials and is built for today's world. That is the choice facing Kansans with regards to health care reform.

Type I and Type II Change

(Paul Watzlawick, Palo Alto Group)

- Type I change – you are in your car stuck in a snow drift. A Type I thinker steps on the accelerator – only to go deeper into the snowdrift.
- Type II change - you are in your car stuck in a snow drift. A Type II thinker invents four wheel drive. SB 309 is Type II change.

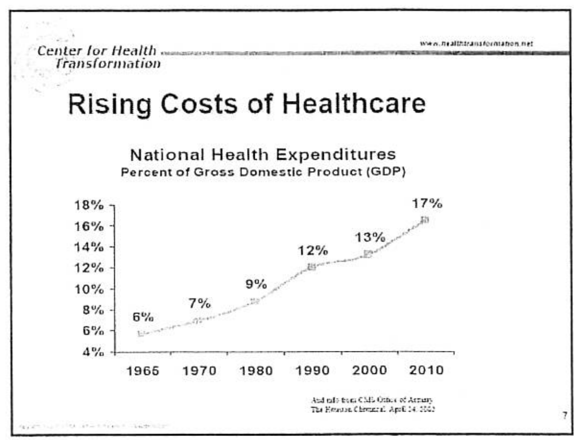
Insurance Populations

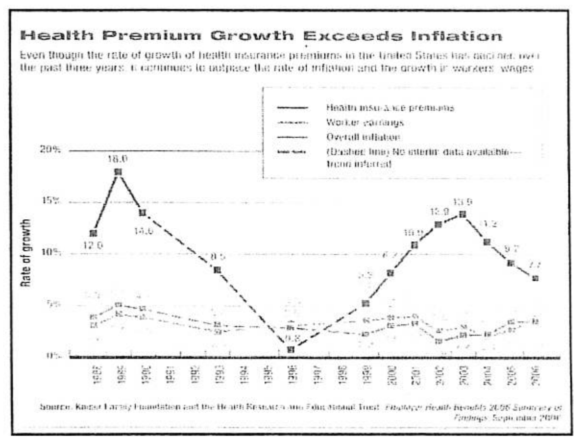
- 2.6-7 million – population of Kansas
- 263,000 Kansans use Medicaid
- 300,000 Kansans are uninsured.
- 394,000 Kansans are covered by Medicare
- 40,000 state of Kansas employees – some of who will be enrolled in a new Medicaid program
- 1.6 million Kansans covered by commercial insurance
- Several hundred Kansans a year die from the lack of health insurance.

The Perfect Storm/ The Coming Tsunami in Health Care

- My generation is headed towards Medicare
- The baby boomers – two years behind me are headed towards Medicare
- Together the two groups will bankrupt Medicare
- Medicaid provides health care for the poor and long-term nursing care for many Americans
- Medicaid is the fastest growing part of the State budget
- Medicaid threatens to bankrupt many States
- As my generation and the baby-boomers behind me require Medicaid for our nursing home care and Medicare for health care
- *The convergence of all the above will strain/bankrupt State and Federal treasuries*

Senate Health Care Strategies Committee
Date: February 20, 2007
Attachment 1





Center for Health Transformation

Saving Lives & Saving Money: State-By-State

Transforming Health and Healthcare in the States

Newt Gingrich
The Center for Health Transformation
www.healthtransformation.net
1301 K Street NW
Suite 800 West
Washington DC 20005
Contact: Vince Haley
vhaley@gingrichgroup.com
(202) 414-1514

Center for Health Transformation

Bottom Line

- The health and healthcare system is broken.
- Repairing and reforming won't work.
- The health and healthcare system must be transformed!

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Center for Health Transformation

Applying the Principles of Transformational Change in the States

Principle Three

Focus on Large Changes

- Lions, antelopes and chipmunks
  - Lions can't hunt chipmunks; they will starve to death. They must hunt antelopes and zebras to stay alive.
- Define the antelopes and don't get distracted by the chipmunks
- What achievements would decisively transform the health system in each state?

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Center for Health Transformation

Current System →	21st Century System
Provider-centered	Individual-centered
Price-driven	Values-driven
Knowledge-disconnected	Knowledge-intense
Slow diffusion of innovation	Rapid diffusion of innovation
Disease focused	Prevention and health-focused
Paper-based	Electronically-based
Third party controlled market (Patient - Provider - Payer)	Binary mediated marked (Patient - Provider)
Process focused government	Outcomes focused government
Limited choice	Increased choice
Predatory Trial Lawyer Litigation System	New System of Health Justice
Overall cost increase	Overall cost decrease
Quantity and price measured	Quality of care and quality of life

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The Uninsured
Ed Haislmaier – Heritage Foundation

- 2003 study –
- Over a four year period 1/3 of the uninsured go on again/off again with insurance coverage.
- 29% had some insurance coverage
- 18% remained chronically uninsured

The Uninsured
Ed Haislmaier – Heritage Foundation

- If we get insurance to "stick with the people, 40% of the uninsured problem goes away."
- If we can get insurance to stick to the person, instead of the job…"
- Getting everyone insured "is not an insurmountable problem, maybe we've been going about it the wrong way."

Massachusetts Health Care Reform

Presentation to the US Chamber of Commerce
Governor Mitt Romney
April 25, 2006

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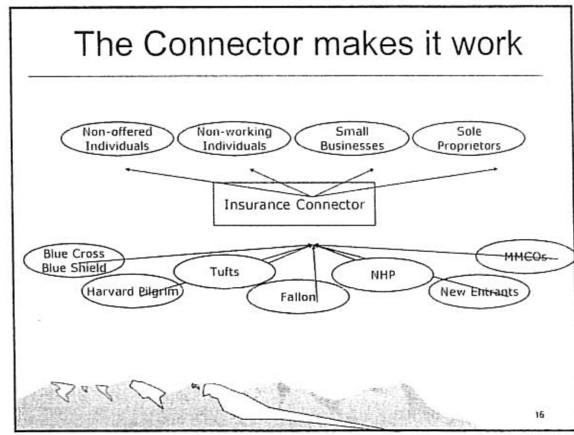
The Connector makes it work



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FPL Breakdowns

100 % Federal Poverty Level Examples (Gross Monthly/Annual Incomes)		300 % Federal Poverty Level Examples (Gross Monthly/Annual Incomes)	
Individual	$ 817 / $ 9,804	Individual	$2,451 / $29,412
Family of 2	$1,100 / $13,200	Family of 2	$3,300 / $39,600
Family of 3	$1,384 / $16,608	Family of 3	$4,150 / $49,800
Family of 4	$1,667 / $20,004	Family of 4	$5,001 / $60,012
Family of 5	$1,950 / $23,400	Family of 5	$5,850 / $70,200
Family of 6	$2,234 / $26,808	Family of 6	$6,700 / $80,400
Family of 7	$2,517 / $30,204	Family of 7	$7,551 / $90,612
Family of 8	$2,800 / $33,600	Family of 8	$8,400 / $100,800
(For each additional person add $284/month)		(For each additional person add $850/month)	

Commonwealth Care: Sliding scale premium assistance example

FPL	Single Person Income	Weekly Premium*	% of Income
<100%	$9,800	Free	NA
150%	$14,700	$6.92	2.4%
200%	$19,600	$11.54	3.1%
250%	$24,500	$18.46	4.0%
300%	$29,400	$32.31	5.7%

*All numbers assume **NO** pre-tax treatment and **NO** employer contribution

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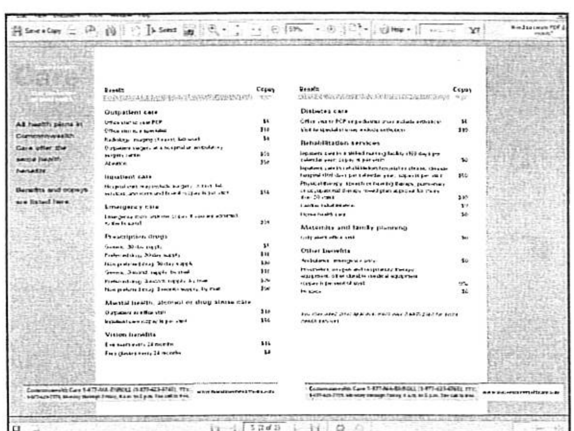


All health plans in Commonwealth Care offer the same health benefits.

Benefits and copays are listed here.

Benefit | Copay

Outpatient care

Inpatient care

Emergency care

Prescription drugs

Mental health, alcohol or drug abuse care

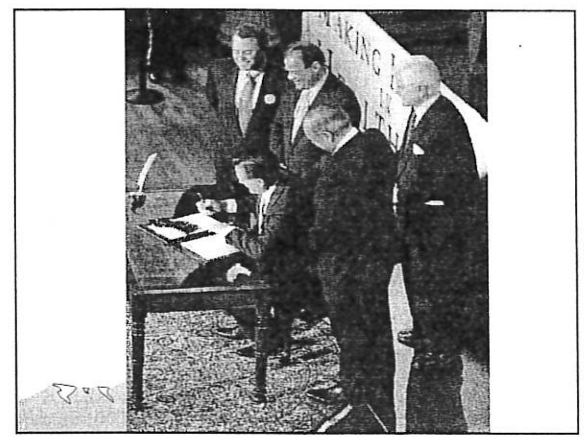
Vision benefits

Diabetes care

Rehabilitation services

Maternity and family planning

Other benefits



To conclude,
paraphrasing Newt Gingrich

- SB 309 is an important step on the path to Transformational Change in Kansas health care.
- Continue to think in terms of Transformational Change and leave the chipmunks alone.

Ira Stamm, Ph.D., ABPP
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Topeka, KS 66611
913 706-8831
istamm@cox.net

AMERICAN FAMILY INSURANCE GROUP
PO BOX 1786 • JEFFERSON CITY MO 65102-1786 • PHONE: (573) 893-5600

February 20, 2007

Senator Susan Wagle
Kansas State Capitol
Room 221-E
300 SW 10th Street
Topeka, KS 66612

Re: American Family Insurance's opposition to Senate Bill 309

Members of the Senate Health Care Strategies Committee:

American Family Insurance offers individual health insurance policies that provide comprehensive medical expense coverage for individuals and their families. We do not offer any small employer or large group health insurance policies.

We support many features and goals contained in Senate Bill 309. We support efforts to decouple insurance coverage from the individual's employer. As you know, not unlike auto, home, and life insurance, individual health insurance policies provide coverage for individuals and their families and such coverage is not dependent upon the policyholder's employment status. Further, we support state efforts to leverage the federal and state tax codes to provide health insurance to more individuals and families.

We believe that certain provisions in Senate Bill 309 are harmful for consumers and insurers in the individual health insurance market. These provisions will increase premiums for current policyholders and will likely lead many current policyholders to drop health insurance coverage.

Senate Bill 309 requires insurers offering individual policies to accept any applicant for insurance and incorporates new rating restrictions. Individuals who are medical uninsurable, including individuals who receive health coverage in the Kansas Uninsurable Health Insurance Plan, will be eligible to obtain individual policies under Senate Bill 309. Much of the expense of providing individual health policies for the medically uninsurable will be borne by individuals who currently purchase individual policies.

In the 1990s, a number of states adopted laws to guarantee issue of coverage and/or restrict rating in the individual health insurance market and such laws drove most insurers out of the individual market and increased premiums beyond the reach of all but the wealthy. When a state seeks to ensure access for the small percentage of the population

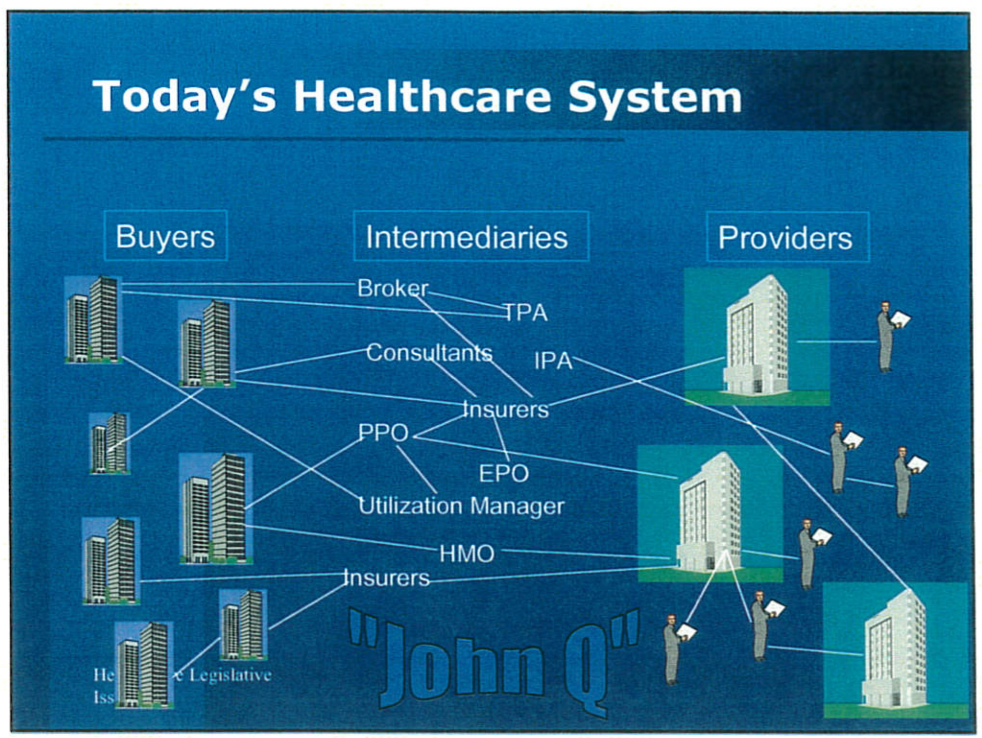
Senate Health Care Strategies Committee
Date: February 20, 2007
Attachment 2

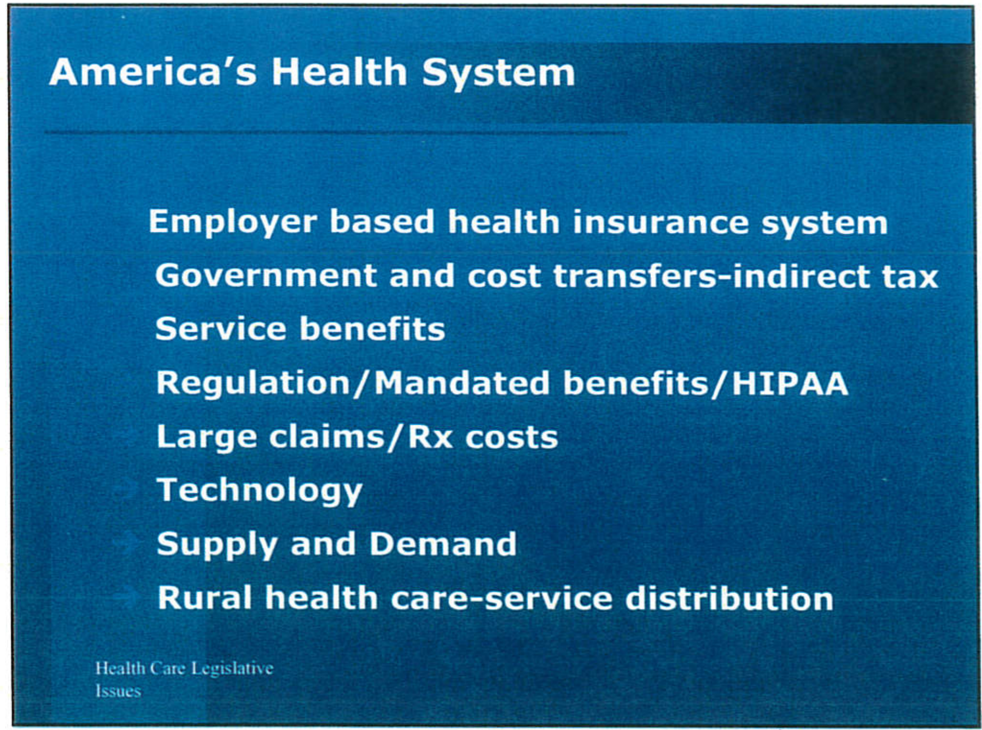
with significant health conditions, then it must be careful to tailor the program to spread the risk so it does not destroy the individual health insurance market for the rest of the population.

We appreciate the opportunity to offer testimony.

Sincerely,

David Monaghan





Senate Health Care Strategies Committee
Date: February 20, 2007
Attachment 3

Health Care Expenditures

$1.6 trillion in 2002

Projected to be $2.6 trillion by 2007

More than 15% of GDP

Prices increasing 2 x CPI

Use increasing

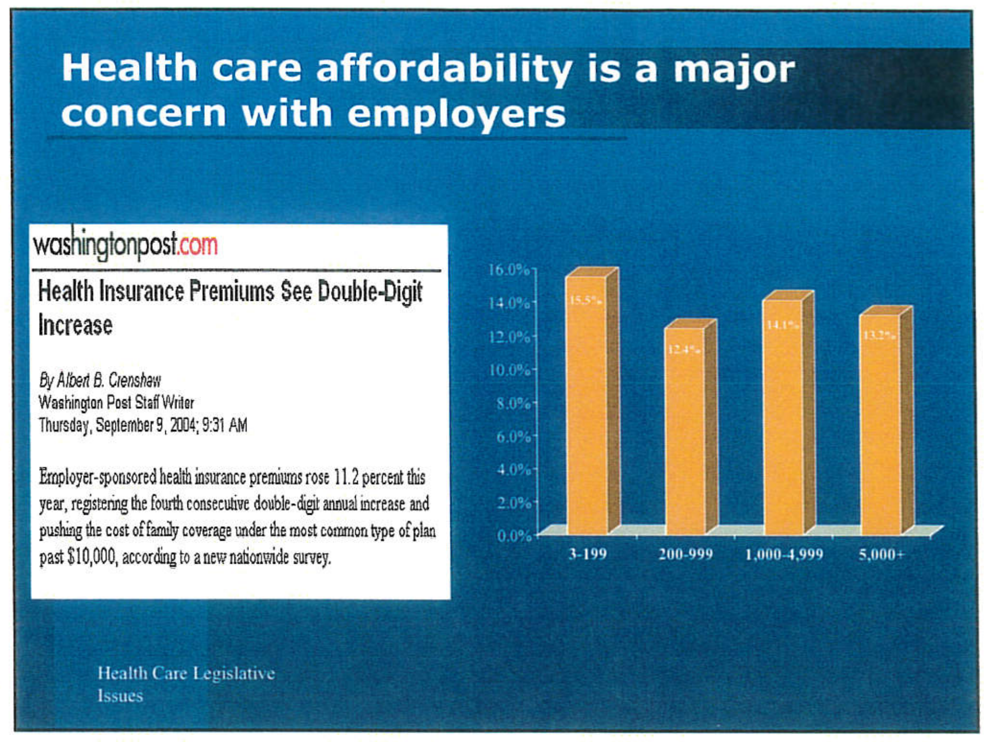
COST OF CARE IS THE CENTRAL ISSUE

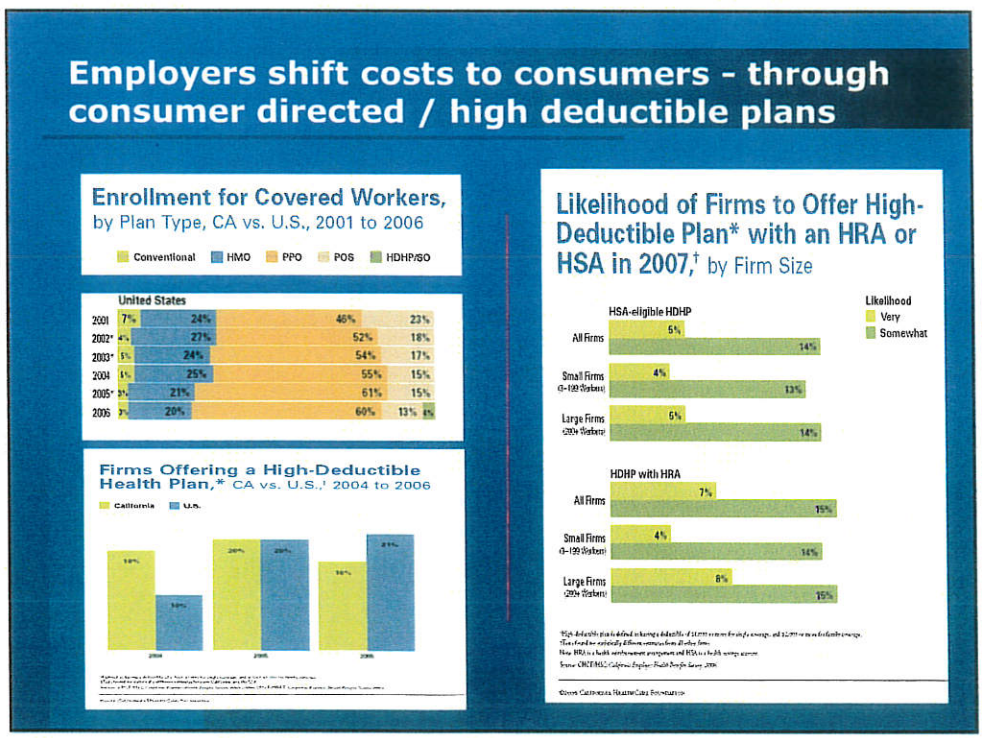
Health Care Legislative Issues

Kansas Premium Levels

- Family Coverage - $1,500 per month/$2,000
- Groups with maximum increase 75%
- Medical prices rising at 2 x CPI
- Lost more groups to no insurance than to competitors
- By region of country (5), second highest

Health Care Legislative Issues


Health care affordability is a major concern with employers
washingtonpost.com
Health Insurance Premiums See Double-Digit Increase
By Albert B. Crenshaw
Washington Post Staff Writer
Thursday, September 9, 2004; 9:31 AM
Employer-sponsored health insurance premiums rose 11.2 percent this year, registering the fourth consecutive double-digit annual increase and pushing the cost of family coverage under the most common type of plan past $10,000, according to a new nationwide survey.
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
15.5%
12.4%
14.1%
13.2%
3-199
200-999
1,000-4,999
5,000+
Health Care Legislative Issues


Employers shift costs to consumers - through consumer directed / high deductible plans
Enrollment for Covered Workers, by Plan Type, CA vs. U.S., 2001 to 2006
Conventional
HMO
PPO
POS
HDHP/SO
United States
Firms Offering a High-Deductible Health Plan,* CA vs. U.S.,† 2004 to 2006
California
U.S.
Likelihood of Firms to Offer High-Deductible Plan* with an HRA or HSA in 2007,† by Firm Size
HSA-eligible HDHP
HDHP with HRA
All Firms
Small Firms
Large Firms
Likelihood
Very
Somewhat

Consumer Driven Plans

- High deductible
- HSAs
- HRAs
- Higher coinsurance
- Benefit reductions

Health Care Legislative Issues

Impact of CDHP

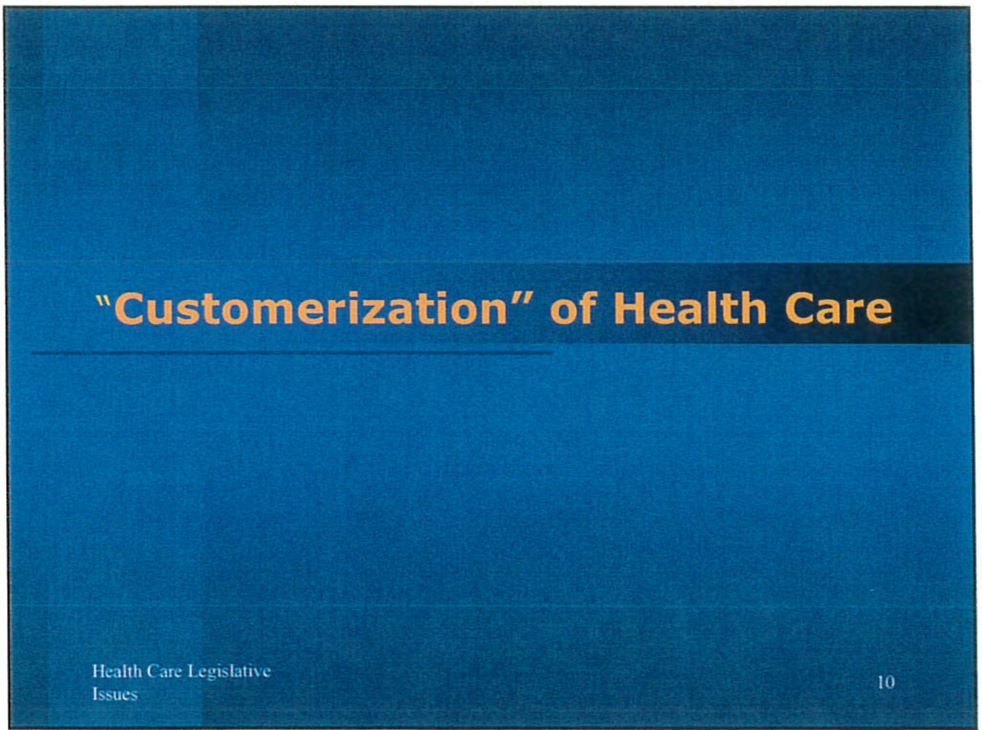
- Increased out-of-pocket expense
- Lower cost to employers, not lower costs
- Reinforcement of existing system
- Higher levels of bad debt
- Increased cost to insurance programs
- No improvement in transparency

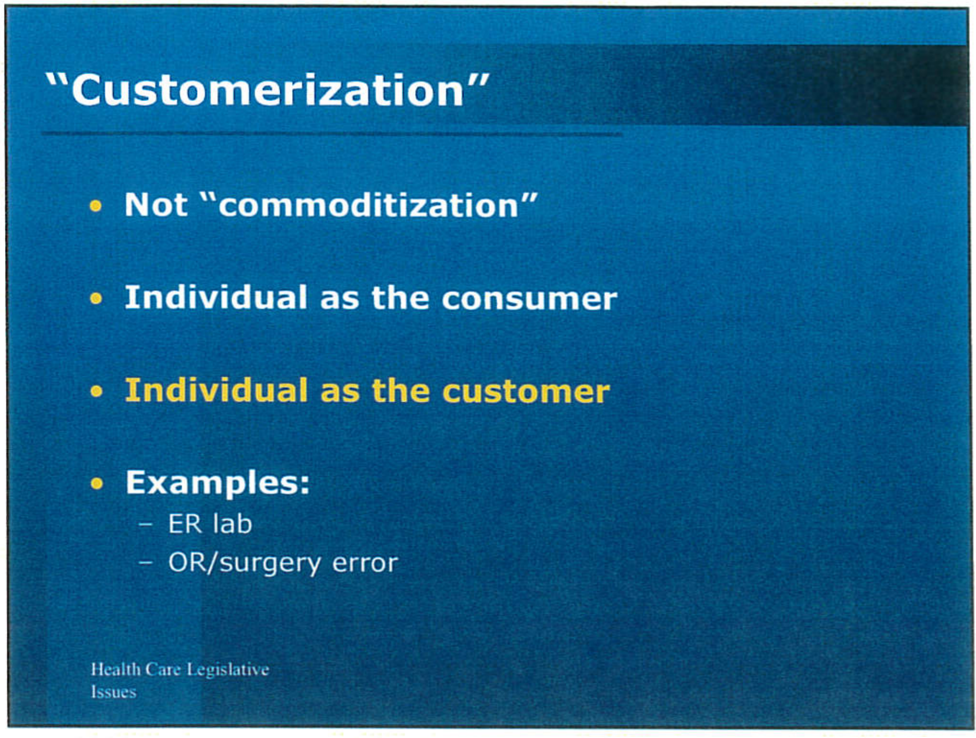
Health Care Legislative Issues

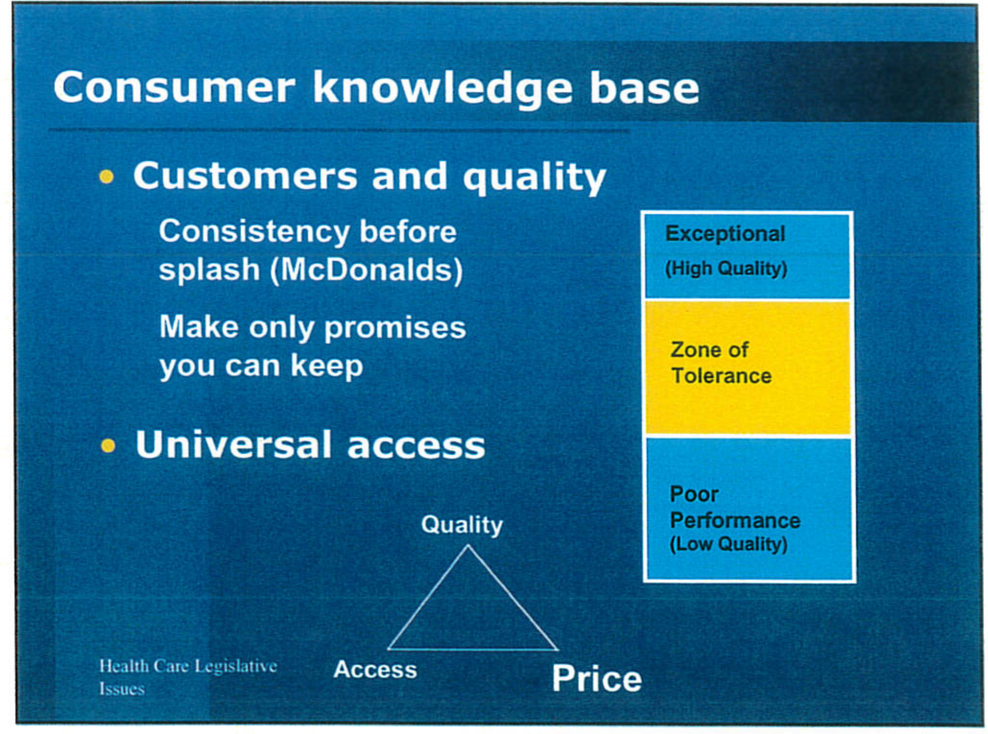
The Future Of Insurance

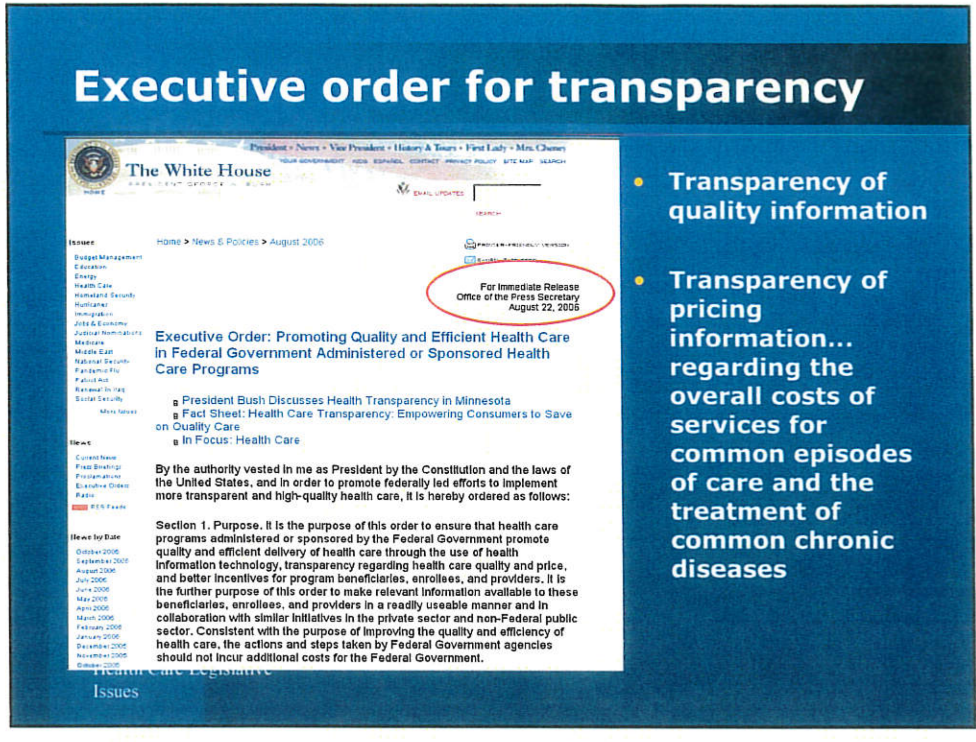
- Increasing cost/premium
- Reduced benefits
- Greater care management
- Continued support of broken delivery system
- Consolidation of insurers that lessens market competition for insurance services
- Abuse of market based executive benefits

Health Care Legislative Issues




"Customerization"
Not "commoditization"
Individual as the consumer
Individual as the customer
Examples:
– ER lab
– OR/surgery error
Health Care Legislative Issues


Consumer knowledge base
Customers and quality
Consistency before splash (McDonalds)
Make only promises you can keep
Universal access
Exceptional
(High Quality)
Zone of Tolerance
Poor Performance
(Low Quality)
Quality
Access
Price
Health Care Legislative Issues



What if customers...

...prior to purchasing their insurance coverage, could accomplish the following objectives through one web or "concierge" experience:

- Compare prices for the same benefit plan
- Know services and performance of insurers
- Choose from alternative structures that meet their needs (networks, benefits, costs)

Health Care Legislative Issues

What if customers...

...prior to receiving care, could accomplish the following objectives through one web or "concierge" experience:

- Learn about the disease or procedure
- Identify a physician based upon quality and price measures
- Know the quality and price of alternative facilities

Health Care Legislative Issues

Customerization/Transparency

Appendectomy

- Physician
- Hospital

Examples: (Market based, entry/exit)

- Toprol XL
- Open heart surgery

Health Care Legislative Issues

Requirements for Customerization

- Individual ownership of health plan
- HIE or Connector (private or quasi-public)
- Basic benefit plan-community rated
- Possible large employer exception
- Multiple insurer participation
- Mandated insurance coverage for all
- Mandated employer contribution
- Optional "buy-up" benefit plans
- Optional network configurations
- State payment for unemployed, poor

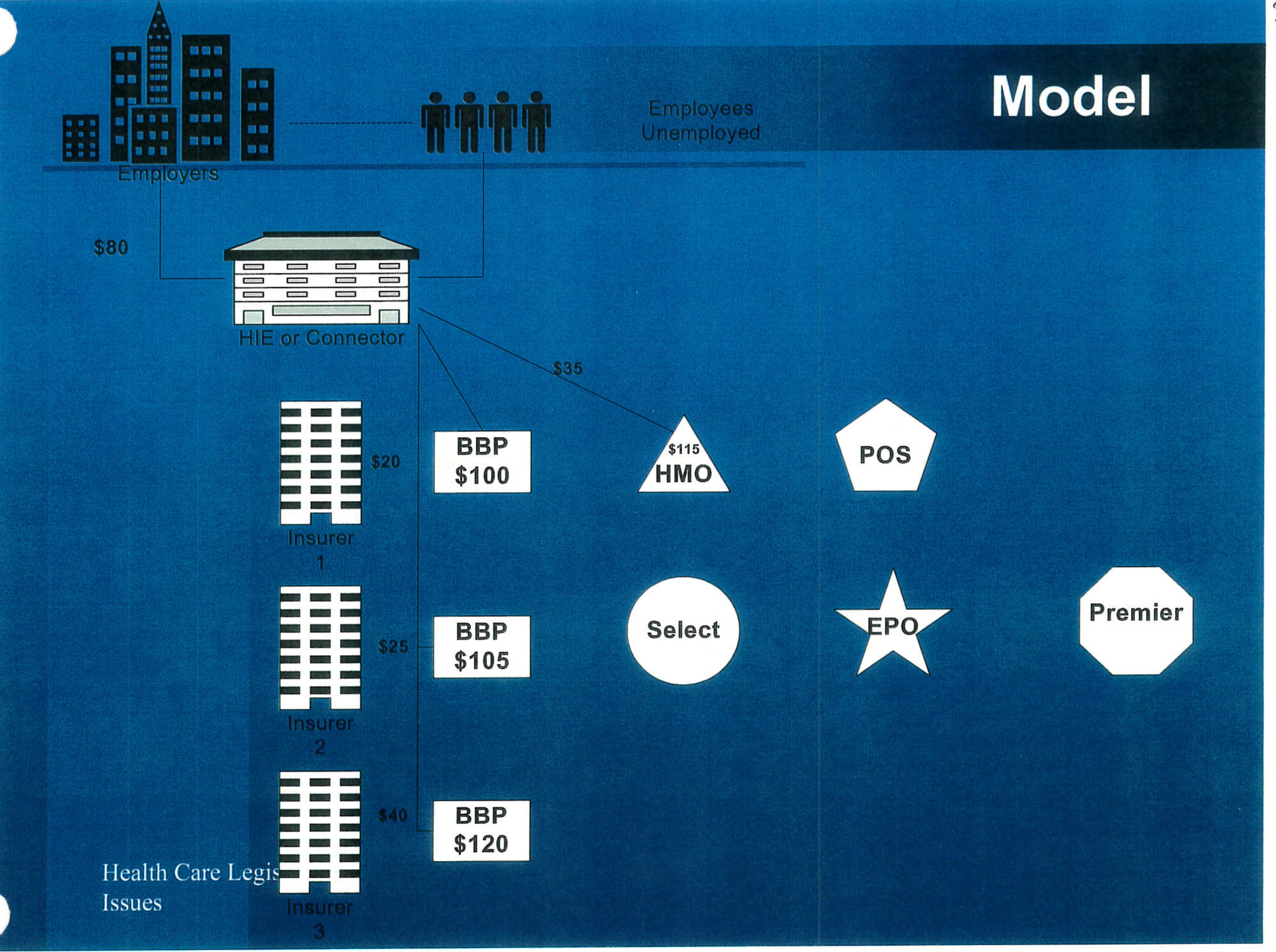
Health Care Legislative Issues

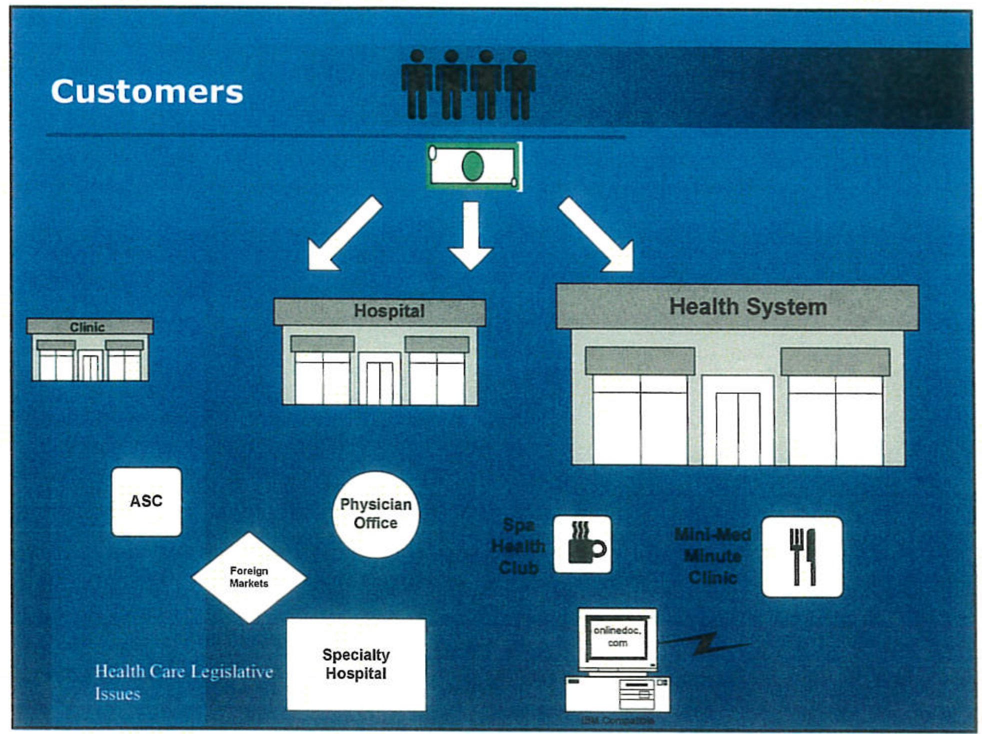
Requirements for Customerization

- Safety net provision
- DRG type hospital pricing (charges)
- State tax funded reinsurance for specified services or specified $ stop-loss
- Competition among insurers for individual customers based on PRICE and services
- Competition among providers for patients based on PRICE, quality, and access
- Exceptions for self-funded groups

Health Care Legislative Issues

3-10

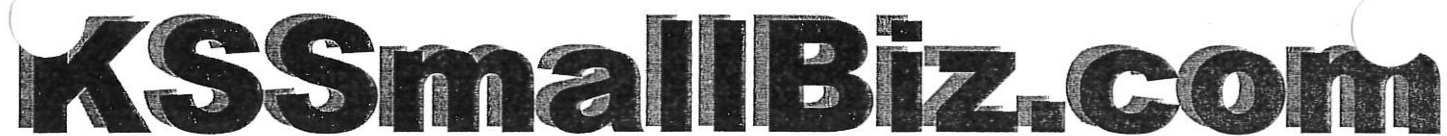




Conclusions and Issues

- Employer based vs individual customer based
- Portability
- Price – Quality – Access (Insurers/Providers)
- Brokers
- Associations
- Employers delivering care (self-funded)
- Reinsurance funding mechanism
- Funding premiums for the poor, etc
- Voluntary vs Mandatory (Compromising requirements diminishes success)

Health Care Legislative Issues



ADVOCATES FOR KANSAS SMALL BUSINESS

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TESTIMONY TO SENATE HEALTH AND WELFARE COMMITTEE
SENATE BILL 309

February 19, 2007
By Kenneth L. Daniel

Kenneth Daniel of Topeka is an unpaid volunteer lobbyist who advocates for Kansas small businesses. He is publisher of KsSmallBiz.com, a small business newsletter and website. He is C.E.O. of Midway Wholesale, a business he founded in 1970. Midway has seven Kansas locations and 110 employees.

MADAME CHAIRWOMAN AND MEMBERS OF THE COMMITTEE:

I am here to speak in strong opposition to Senate Bill 309. I have followed Governor Romney's Massachusetts plan closely and had high hopes that some or most of it would be workable in Kansas. Sadly, it is my opinion it will not.

Senate Bill 309 adopts many of the concepts of the unproven Massachusetts plan. That plan is already collapsing under its own wrong assumptions and unintended consequences:

- 200,000 small businesses that provide health insurance for their employees have discovered that their current policies don't comply with the new law.

- Instead of the estimated $200 per month for a single employee policy through the Mass. Connector, the costs are more in the neighborhood of $380 per month. Compare that to the $189.48 cost for a single employee on Midway's plan, and $179.55 for a single employee HSA plan.

In Kansas, our average health insurance costs are some of the lowest in the nation. We also enjoy one of the lowest rates of uninsureds. There is simply no reason for Kansas to be on the bleeding edge of any massive transformational change in health insurance.

The new red tape in Senate Bill 309 is breathtaking and unprecedented. It will do great harm to all Kansas businesses and negatively affect our competitiveness with other states. The Connector is only a small part of the massive changes in Senate Bill 309.

Self-insured big businesses will have to suffer a lot of new red tape. They won't have to buy the Connector policies or pay for the expensive new mandates.

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Businesses with more than 50 employees will have to suffer a lot of new red tape. They cannot buy insurance through the Connector. However, they very likely will have to pay for all the new mandates caused by the Connector.

Most of all, Senate Bill 309 will harm our smallest and weakest businesses. They will suffer disproportionate harm from the new red tape, and they will suffer huge cost increases for health insurance. It will likely drive many thousands of businesses out of providing health insurance, and it will likely drive many completely out of business.

The bill requires that employers annually collect highly personal information from each of the 1,200,000 employed people in the state, most of whom are already covered by insurance. Even the 175,000 self-employed individuals are required to submit their personal information.

If the employee, the self-employed person, or any of his or her dependents aren't covered, the employer must collect and submit a signed "election" to post bonds, buy insurance through the Connector, or agree or refuse to accept Medicaid or welfare.

Employees who don't sign or who give the wrong answers will have their income tax refunds seized and garnishments placed on their paychecks and other money they have coming.

This is going to create bad blood between employers and employees. Not only will employees resent being forced to sign documents, they will blame the employer for their having to post bonds or buy insurance or go on Medicaid.

Under this bill, it will quickly become illegal for insurance companies to sell any policies to employers of 2-50 except through the Connector. Kansas will quickly lose most of the competitiveness that holds down our premiums now.

This bill will kill off the insurance plans of the Wichita Independent Business Association, the Kansas Banker's Association, the Petroleum Marketer's Association, and the fledgling plans of the Topeka Independent Business Association and the Kansas Restaurant and Hospitality Association.

The main reason that Kansans are uninsured is that the insurance is unaffordable to employers and individuals. The money to post $10,000 bonds or buy expensive mandated policies or cover the uninsured with public funds is not going to fall out of the sky.

If this bill is enacted, we will see our small business health insurance premiums skyrocket, even for those that are larger than fifty employees. And, we will see Kansas' already miserable record in small business startups plummet.

NEW MANDATES AND RED TAPE IN SB309

- Kansas Health Policy Authority (KHPA) and the Connector dictate all insurance provisions, period, for employers of 2-50 and for the 175,000 self-employed Kansans.
- KHPA can dictate unlimited new, non-legislated mandates.
- KHPA dictates all rules and procedures for application processes and administration of insurance coverage.
- Greatly expanded and forced coverage of pre-existing conditions.
- Greatly expanded and forced open enrollment requirements.
- Greatly expanded and forced regular enrollment requirements.
- Limited insurance policies are outlawed. Only major medical policies with full mandates as approved by the Connector can be sold.
- Existing association health plans are outlawed. Can only exist by contracting with the Connector.
- Many new price controls on policies.
- Mandates forced coverage of non-Kansas workers, students, and dependents.
- All Kansas employers required to provide an annual report on every employee, showing insurance coverage of employee and dependents.
- All Kansas employers must force employees who show coverage gaps to sign a form electing to provide a bond, buy insurance, or enroll in a welfare plan.
- Employers forced to do payroll deductions and send to the Connector.
- Employers forced to adopt, provide and administrate a federal Section 125 "cafeteria plan".
- Employers forced to handle wage garnishments by the state for employees who refuse to post $10,000 bond or buy insurance.
- The Connector negotiates with all insurance companies, and uses employer and employee money to pay them.
- The Connector negotiates with administrators and other vendors, again using employer and employee money.
- The Connector uses employer and employee money to pay insurance agents.
- Employers must negotiate and enter into a binding contract with the Connector.
- Employer cannot offer any separate or competing plans.
- Employer must agree to provide Connector, upon request, any employer documents, records, information, federal and state tax and wage reports, etc.
- And much more…

STATISTICS and NOTES

(Size of Kansas Employer Firms, 2004, according to SBA using Census Bureau statistics. The following statistics31 are the latest published.)

Owners only – no employees: 174,635 self-employed individuals, no employees. Must submit paperwork to connector and be subject to having income tax refunds seized and income garnished by the state.

Employees, but not on snapshot date (2004, latest available): 6,994 firms. Most of these had only one employee. Many are start-ups or seasonal. 100% of these will be affected by the red tape in this bill, and will only be able to purchase insurance through the Connector.

One to Four Employees: 28,606 firms, 60,182 employees, average 2.1 employees. 100% of these will be affected by the red tape in this bill, and will only be able to purchase insurance through the Connector.

Five to Nine Employees: 10,600 firms, 69,589 employees, average 6.6 employees. 100% of these will be affected by the red tape in this bill, and will only be able to purchase insurance through the Connector.

Ten to Nineteen Employees: 6,563 firms, 87,279 employees, average 13.3 employees. 100% of these will be affected by the red tape in this bill, and will only be able to purchase insurance through the Connector.

Twenty to 99 Employees: 5,774 firms, 212,209 employees, average 36.7 employees. 100% of the "50 and under" employers will be affected by the red tape in this bill, and will only be able to purchase insurance through the Connector. The 51 and over employers will have to comply with the red tape, but will not be able to purchase insurance through the connector.

100 to 499 employees: 1,480 firms, 180,544 employees, average 122 employees. All of these employers will have to comply with the red tape, but will not be able to purchase insurance through the connector. The self-insured ones will not have to comply with any mandates or provisions of the connector.

500 or more employees: 1,821 firms, 506,474 employees, average 278 employees. (Important note: Most of these firms have employees outside of Kansas, but only the Kansas employees are shown here. This is true to a much lesser extent with the other size groups above.) All of these employers will have to comply with the red tape, but will not be able to purchase insurance through the connector. The self-insured ones will not have to comply with any mandates or provisions of the connector.

Testimony to Senate Health Care Strategies Committee
Robert Vancrum, Kansas Government Affairs Specialist
Greater Kansas City Chamber of Commerce

SB 309

February 20 ,2007

Chairman Wagle and Other Honorable Members of the Committee:

I appear today on behalf of the Greater Kansas City Chamber of Commerce. We are an organization with members throughout the Kansas City SMSA, but about 3000 member firms are based in Kansas. These member employers are of all sizes, but the preponderance are small businesses.

Our members typically list availability and affordability of health care insurance for their employees as one of their top priorities for legislative action, particularly in services concerning Congressional action items. We are therefore certainly in favor of programs to expand both the availability and affordability of health care coverage, but recognize that these can be inconsistent goals.

At the state level, our board last October adopted its 2007 Public Policy Agenda which includes as priority positions the following statements: ". Support adequate funding for Medicaid that ensures the ongoing viability of all health care providers who provide care to the uninsured and underinsured. " and " Oppose health care benefit requirements and provider mandates unless they meet rigorous, objective social and financial impact standards."

Although we signed up as an opponent, we are really just very concerned about the plan reflected in this bill. We will confess to lacking sufficient expertise to determine what the impact of SB 309 will be upon the affordability and availability of health care coverage in Kansas, but we are concerned about just that---- that none of us know well enough what those impacts will be. We do know that setting up a "health care insurance connector" or "exchange" within the Kansas Health Policy Authority is in effect giving a state agency the responsibility of determining which health care plan or plans will be offered through the exchange and the power to decree that the plan will be offered to all such individuals and employers and other groups as wish to apply for insurance, or portability of insurance. Notice this is to be done "without waiting periods" and " may not be denied coverage". It is my belief that this authority currently possesses neither the personnel nor the expertise to make such determinations Further, we don't know what additional state resources would be needed to carry out this task nor how or when such expense might be passed along to participating

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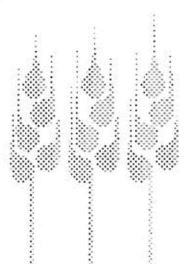
employers, participants, insurance carriers or providers, and we have no idea how or when KHPA would be ready to take on such task.

Yet this bill would prevent any health insurer from offering individual policies or group coverage to groups of fifty or less employees in Kansas as of the first open enrollment period set by KHPA, unless it is offered through KHPA. There is no way anyone can tell us that this mandatory plan will result in more affordable or available health insurance coverage, or in a mass exodus of companies from the Kansas market and / or a substantial increase in the cost of everyone's insurance. It is certain that it is forcing anyone currently in a group of 50 or less and anyone currently buying individual coverage to go through the experiment of purchasing through KHPA. I know a number of people there from Marci Nielsen and Scott Brunner on down and they are clearly well intentioned and very capable people , but I don't think we can yet say that the mandates provided in this bill have been subjected to rigorous impact standards. I'd respectfully suggest that such a study be first commissioned from people with real expertise , and even if it is favorable would be less concerned if you would first start out with a pilot project rather than jumping headlong into a mandatory government supervised program that also takes away the option for employers and individuals to go elsewhere during the course of the experiment.

I would be happy to try to answer any questions.



Kansas Association of Health Plans

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Testimony before the
Senate Health Care Strategies Committee
SB 309
February 20, 2007

Madam Chair and members of the Committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are associated with managed care. KAHP members serve most all Kansans with private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comment on SB 309.

The KAHP appears today in opposition to SB 309. Here today to explain the association's opposition to SB 309 is Cheryl Dillard, Director of Government Affairs for Coventry Healthcare and Brad Smoot representing BCBS-KS and KC. Marlon Dauner, CEO of Preferred Health Systems is also here today to offer comments and potential alternatives you may want to consider on this important issue of the uninsured.

Senate Health Care Strategies Committee
Date: February 20, 2007
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Kansas Senate Health Care Strategies Committee
Testimony from Cheryl Dillard, Coventry Health Care of Kansas
SB 309
February 20, 2007

Madame Chair and Committee Members—

I am Cheryl Dillard, Director of Government Relations for Coventry Health Care of KS. Coventry offers a full line of health insurance products throughout Kansas and Western Missouri. We are pleased to be one of the health insurance plans offered to Kansas state employees.

Thank you for the opportunity to provide comments on SB 309, the Kansas health care connector act. SB 309 is but one of many reform proposals being considered this session; some of them complimentary, others mutually exclusive. My colleagues and I at Coventry urge you to exercise caution as you consider each reform proposal, especially one with the far reaching impact of SB 309. We calculate that if Coventry's current book of almost 3000 small employer businesses was sold instead through the connector model, 28% of the employees will see a premium rate increase between 5% and 20%. Almost 35% of the employees would get 20% increase in their premium.

Last session, the Kansas legislature did a very wise thing. Under Dr. Barnett's leadership, you created the Kansas Health Policy Authority. A capable board was appointed and highly talented staff hired. You've asked them to run Medicaid, the children's health insurance program and the state employees health plan. You also assigned them the job of evaluating health reform policies for Kansans. They have started that task by creating the Health Insurance for All Kansans Steering Committee which includes Representatives, Senators and a number of KHPA Board members. The Steering Committee held its first meeting two weeks ago and is already considering over 30 proposals for reform, including SB 309. The Steering Committee wisely understands the necessity of an economic impact analysis to understand how different policy proposals affect the complex health care delivery and financing system in Kansas and already has two foundations interested in funding that analysis. That analysis is absolutely essential before any consideration should be given to the connector model, a model which represents a complete overall of the current health insurance market. The model is fraught with unintended consequences, the most important being that many Kansans will pay more for coverage, not less. We urge you to allow this Steering Committee to evaluate all the ramifications of SB 309.

Thank you for the opportunity to present these comments today.

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Date: February 20, 2007
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Statement of Brad Smoot
Legislative Counsel
Blue Cross Blue Shield of Kansas
Senate Health Care Strategies Committee
Regarding 2007 SB 309
February 20, 2007

Madame Chair and members of the committee,

I am Brad Smoot and I am pleased to have the opportunity to comment on Senate Bill 309 on behalf of Blue Cross and Blue Shield of Kansas. Blue Cross and Blue Shield of Kansas is a mutual insurance company based in Topeka providing health insurance benefits to approximately 700,000 Kansans in 103 counties.

Blue Cross Blue Shield of Kansas has been in the business of providing health insurance to Kansans since nearly the inception of the concept of health insurance. Health insurance is our business and we take very seriously the faults inherent in the current system. Faults that result in a relatively high cost product, which in turn have a great deal to do with the fact that we have approximately 300,000 Kansans without any sort of private or public health insurance coverage. We recognize that as costs continue to increase, more and more Kansans will be forced to decide between purchasing our product or other more pressing uses of their money, such as paying their rent. High cost health care and in turn health insurance, is not good for anyone, not for Kansans who are barely making ends meet and are paying the entire cost of coverage themselves, businesses that are trying to make payroll while contributing toward the cost of their employer sponsored health insurance plan, or Blue Cross and Blue Shield of Kansas. As such, we are keenly interested in and would be receptive to reforms to our system that hold real promise for controlling the cost of our products while at the same time providing more Kansans with access to health care.

Obviously, many of you recognize those same problems and your concerns are spawning a tremendous amount of activity for us this year here at the Capitol. In particular, SB 309 steals a page out of the Massachusetts playbook and seeks to establish an "insurance exchange" as a means to address the stated goals of enhancing accessibility and portability of coverage. While those are noble goals, I think it important to spend just a couple of minutes describing mechanisms currently in place in Kansas that were designed to address these same issues. I have attached to my written testimony a chart designed to illustrate the means by which the connector addresses the problems of accessibility and affordability as contrasted against the current statutory mechanisms in place to do the same thing. I have also attached a document that describes the extent to which the current individual (non-group) and group insurance market address accessibility and portability of coverage. In general these documents illustrate that everyone in the State of Kansas has access to some type of health insurance coverage, from those who enjoy

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Date: February 20, 2007
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the group coverage offered by their employer to those that don't have access through an employer sponsored plan and have to buy coverage in the individual market.

As for accessibility, in the case of those eligible for coverage through a employer group plan, insurers are prohibited from denying an individual coverage based on the persons health status and instead must accept everyone eligible through the plan. The individual market differs from the group market, as it is "underwritten", meaning insurers have the right to refuse coverage to those with significant health conditions. However, as a result of that underwriting, coverage available through the individual market is generally significantly less expensive than comparable coverage offered through a group. Those persons who are refused coverage in the individual market still have access to coverage through the state high-risk pool which offers a comprehensive set of benefits that are subsidized by both the tax payers and the insurance industry. Premiums are currently set for high-risk pool coverage at approximately 130% of comparable private market coverage, and while that does not speak to the issue of affordability, it is a mechanism that ensures "access" to coverage for all Kansans.

As for portability, employers offering a group health benefit plan to their employees have a guaranteed right to renew that policy, except for non-payment of premium and a few other specific conditions. Individuals who lose their group coverage have protections under state and federal law that depending on the situation, generally allow for a period of time ranging up to 36 months, during which the individual can continue to retain the same coverage they had under the group. Such individuals often also have a right to a non-group conversion policy that can be retained indefinitely. If all else fails, the high-risk pool is always an option. Persons who have purchased an individual policy have a guaranteed right to retain that policy indefinitely except for a few specific conditions such as non-payment of premium. As you can see, there are numerous protections currently in place that protect individuals from a loss of coverage linked to a job change or other life event.

SB 309 seeks to address the goals of accessibility and portability through a different approach. In particular, the concept is to establish a mechanism that provides comparable tax advantages to persons buying coverage through the exchange that are now available only to those persons who access their coverage through an employer sponsored plan. Indeed, the exchange itself would become the employer sponsored plan, and that is important to facilitate the purchase of coverage with pre-tax dollars. The trick here is that since current law requires insurance companies to accept every employee eligible through an employer sponsored plan (regardless of health status), turning the exchange itself into the employer sponsored plan requires that insurers accept every person purchasing coverage through the exchange without regard to health status.

In this way, the exchange guarantees "access" to coverage by forcing all insurers to accept persons purchasing coverage through the exchange regardless of health, and since the policies that are issued by participating insurers are in essence, individually owned

and controlled policies that cannot be cancelled except for failure to pay premiums, the exchange satisfies the portability issue.

Blue Cross and Blue Shield of Kansas believes there are several redeeming qualities in a carefully structured exchange model, HOWEVER we also believe if not structured properly, these mechanism could lead to serious unintended consequences that could raise the cost of coverage for many and in turn swell the ranks of the uninsured. In particular, the merger of the individual and small group markets as is called for under SB 309, coupled with the mandate that insurers accept everyone who purchases coverage through the exchange on a "voluntary" basis, is problematic. In such a "voluntary" market, where all persons (healthy and sick) are not required to buy coverage, it is highly likely a disproportionately high percentage of those purchasing coverage will have significant health conditions. The lack of an appropriate "spread of risk" (the number of relatively healthy persons enrolled as compared to the number of relatively less healthy persons enrolled) means that those enrolling in coverage will utilize a disproportionately high amount of health care services. High utilization results in high premiums and as premiums increase, those who are less inclined to need service will drop coverage putting even more pressure on premiums. This "death spiral" phenomenon has occurred in several states that have required insurance companies operating in the individual market to accept all applicants on a guaranteed issue basis, without a concomitant mandate that everyone buy coverage. I have attached a paper from the CAQH that describes the problems with guarantee issue requirements in the individual market when there is no corresponding mandate for persons to buy coverage.

Mr. Haiselmaier from the Heritage foundation, the architect of the Heritage Insurance Exchange Model upon which SB 309 is based, argues that by "priming the pump" so to speak, through inclusion of those persons currently covered by the state employee health benefit plan, there will be sufficient scale in the exchange to mitigate this adverse selection. While starting with the State employees would immediately make the exchange a very large pool, blending the rates of persons coming from an underwritten individual market, with those coming from a small group market where guaranteed issuance has been the norm, along with the mix of risk found in the state employee plan, and adding those folks who have been excluded from the private individual market because of health conditions will undoubtedly make for winners and losers in terms of changes in their current premiums.

To get a better understanding of the winners and losers and the extent to which they win or lose, we asked our actuarial staff to model the likely impact on premiums that would occur as a result of the move to an insurance exchange model. Our actuarial staff spent approximately 100 man-hours modeling the likely impact on premiums for the various populations that would be forced to access their coverage through the exchange. There will indeed be winners and losers. In fact we found that approximately 63% of the insureds that make up the individual, small group, and state employee groups would experience some degree of rate increase when moving to the exchange model, while

approximately 37% would experience a rate decrease. Of those that would experience a rate increase, the average increase would be approximately 63%. The highest rate increase would be just over 450%. Nearly 96% of those persons currently enrolled in the individual market would experience some degree of premium increase based on movement to the exchange, while 57% of the small group insureds and 46% of the state employees would experience a premium increase. Of those experiencing an increase, the average percent of increase for those currently in the private individual market would be approximately 80%, while those receiving increases in the small group market would see an average increase of 51% and those state employees experiencing an increase would see an average increase of nearly 59%.

As for the winners, of the 37% that would experience a rate decrease by moving to the exchange, the average decrease would be 25% with a maximum decrease of 70%. A little more than 4% of those persons currently covered in the individual market would experience a rate decrease, and the percentage of persons experiencing a decrease in the small group market and the state employee program are nearly 42% and 54% respectively. As for those receiving a decrease, the average decrease in the individual market would be approximately 11%, with the average decrease in the small group market coming in at 23% and for state employees 28%.

As you can see, there are many more winners than losers and losers lose to a much greater degree than the winners win. Obviously, SB 309 is no silver bullet but of course there are no silver bullets. Yes, the exchange model would address accessibility and affordability in a new way, but one of the fundamental questions you must ask yourself is whether the extent to which there will be rate disruption in the market and a possible increase in the number of Kansans dropping coverage entirely because of increasing premiums, is worth the marginal enhancements in accessibility and portability that an exchange approach offers.

Another fundamental question that should be considered in this debate is the extent of the urgency to act. One way to gauge this is to consider that while premiums are indeed high in Kansas and we do indeed have approximately 300,000 Kansans that have no coverage at all, when comparing average small group premiums to our four contiguous neighboring states our average is lower than 3 of the 4 by a minimum of 5% (with the highest difference being 21%). The one State that has lower average small group premiums is Missouri and even then, the difference is a little more than 2%. (These numbers were based on a comprehensive survey done by the American Health Insurance Plans "AHIP").

Another way to gauge the urgency of the problem is to compare the percentage of uninsured in our neighboring states. Based on US Census Bureau figures, Kansas has the lowest percentage of persons without insurance of the States in our five state region (Kansas, and the four contiguous neighboring states) with 10.9 percent uninsured, while

the other four State's percentages range from a low of 11.4% to a high of 19%. In fact Kansas has the 8th best uninsured percentage among all 50 States.

Remanufacturing the entire health insurance system in the State of Kansas is a serious and precarious undertaking, one that is fraught with the potential for serious and dramatic unintended consequences. We will leave it to your good judgment to decide whether the situation in Kansas is such that the risks associated with such a remake of the system in the time remaining in this session are more than offset by the rewards that might be realized through this course of action.

I would be happy to answer any questions you might have.

ALABAMA • ALASKA • ARIZONA • ARKANSAS • CALIFORNIA • COLORADO

CONNECTICUT • DELAWARE • FLORIDA • GEORGIA • HAWAII • IDAHO

ILLINOIS • INDIANA • IOWA • KANSAS • KENTUCKY • LOUISIANA • MAINE

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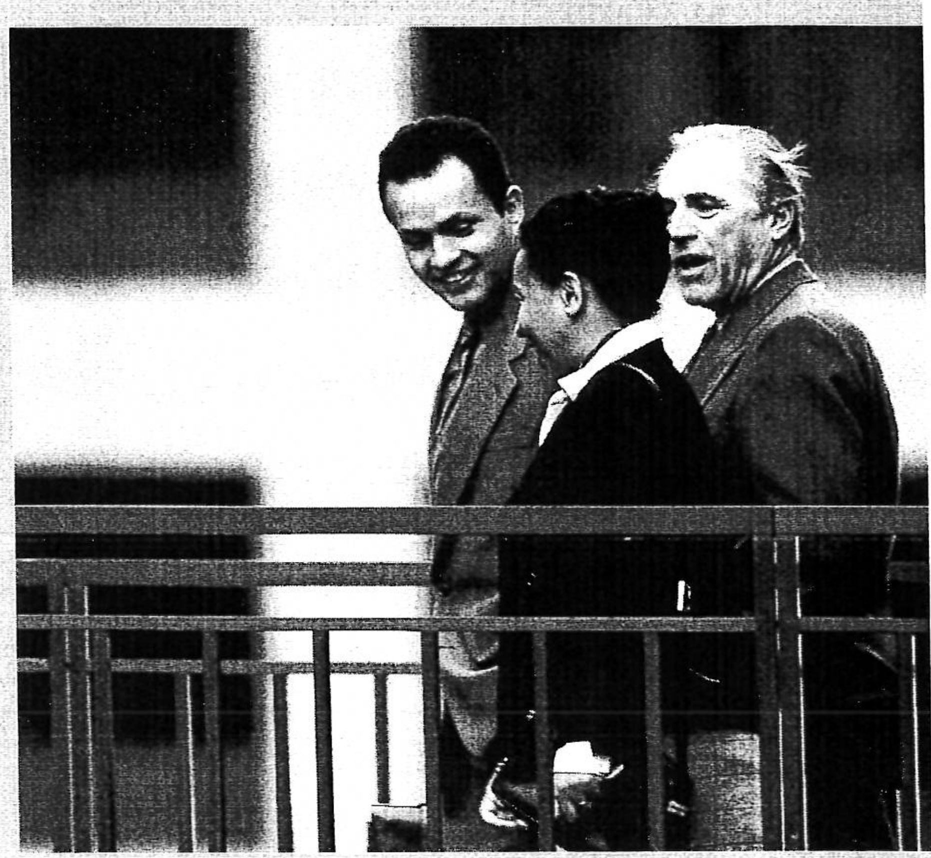
MISSOURI • MONTANA • NEBRASKA • NEVADA • NEW HAMPSHIRE

AHIP

Health Insurance: Overview and Economic Impact in the States

December 200[illegible]



NEW JERSEY • NEW MEXICO • NEW YORK • NORTH CAROLINA • NORTH

DAKOTA • OHIO • OKLAHOMA • OREGON • PENNSYLVANIA • RHODE ISLAND

SOUTH CAROLINA • SOUTH DAKOTA • TENNESSEE • TEXAS • UTAH

VERMONT • VIRGINIA • WASHINGTON • WEST VIRGINIA • WISCONSIN • WYOMIN

8-6

KANSAS

STATE HEALTH FACTS

STATE RANKINGS

People with Private Health Insurance Coverage

- People Covered by Private Insurance 2,075,000

Percent of Employers Offering Health Insurance

Average Annual Health Insurance Premiums

- Individual Market Single $2,260
- Individual Market Family $4,510
- Small Group Market Single $3,588
- Small Group Market Family $9,420

- Total State Premium Taxes Collected from Insurance Companies[1] $122,027,000

Jobs in Health Insurance Industry[2]

- Payroll Direct Jobs .... $197,516,000[h]
- Payroll Other Insurance-Related Jobs .... $379,156,000[i]
- Average Wage Direct Jobs $49,690
- Average Wage Other Insurance-Related Jobs $38,753

People with Private Health Insurance Coverage

- People Covered by Private Insurance 198,901,000

58% Self-Insured

42% Fully-Insured

Percent of Employers Offering Health Insurance

96% Large Employers

42% Small Employers

Average Annual Health Insurance Premiums

- Individual Market Single $2,268
- Individual Market Family $4,424
- Small Group Market Single $3,732
- Small Group Market Family $9,768

- Total State Premium Taxes Collected from Insurance Companies[1] $14,842,349,000

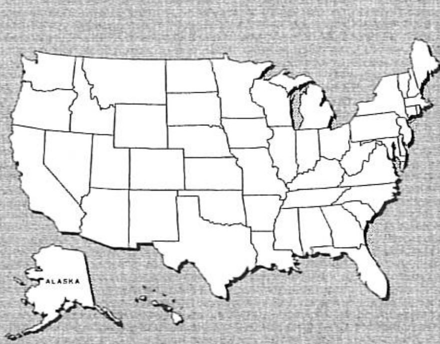
Jobs in Health Insurance Industry[2]

469,172 Direct Jobs

881,863 Other Insurance-Related Jobs

1,351,035 Total Jobs

- Payroll Direct Jobs $25,235,205,000
- Payroll Other Insurance-Related Jobs $43,465,937,000
- Average Wage Direct Jobs $61,409
- Average Wage Other Insurance-Related Jobs $50,119



UNITED STATES

U.S. Health Facts

16% Uninsured

Average Annual Medicaid Payment Per Enrollee $4,072

[1] Data from the U.S. Census Bureau. Includes state premium tax collected from all types of insurance companies, including health insurance.

[2] Data from the U.S. Census Bureau, NAICS reports. Direct jobs include those specifically found in the health insurance industry; other insurance-related jobs consist of those found in all insurance industries, including the health insurance industry. (see page 57 for a full description of job categories.)

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Health Insurance Exchange – Accessibility & Portability

Comparison to Existing Environment

Access to Coverage

Exchange	Current Environment
• The Exchange is designated the employer sponsored plan, the individual and small group markets are merged and coverage for small groups and individuals can only be obtained through the exchange. • Employers are required to establish a Section 125 plan to allow employees covered through the exchange to purchase coverage on a pre-tax basis. • Insurance companies are required to accept everyone coming through the exchange without regard to health status.	• Small Group Market – small employers (those with 2-50 employees) have a guaranteed right to coverage, meaning they cannot be denied regardless of the relative health of their employees. • Employers currently have the right to establish Section 125 plans to allow employees to purchase coverage on a pre-tax basis. • Individual Market – Private health insurance is underwritten and applicants with significant conditions can be rejected. Underwritten coverage is significantly less costly in general. • State High Risk Pool functions as insurer of last resort and must accept any Kansan who has been rejected by at least two private insurance companies. The pool offers comprehensive benefits and premiums that are set at approximately 130% of comparable private market coverage. Subsidized by private insurers and the State.
• Result – everyone has access to coverage	• Result – everyone has access to coverage

8-10

Portability of Coverage

Exchange	Current Environment
• Insurance purchased through the exchange is delivered via individually owned and controlled policies that cannot be cancelled except for failure to pay premiums.	• Insurance purchased through the private individual (non-group) market is delivered via individually owned and controlled policies that cannot be cancelled except for failure to pay premiums. • Employers offering a group health benefit plan to their employees have a guaranteed right to renew that policy, except for non-payment of premium and a few other specific conditions. • Individuals who lose group coverage have protections under state and federal laws that allow for a period of continued coverage ranging up to 36 months. During that time, individuals can continue to retain the same coverage they had under the group. • Persons losing coverage under a group plan often also have a right to a non-group conversion policy that can be retained indefinitely. • The high-risk pool is the insurance mechanism of last resort. High-risk pool coverage can be retained indefinitely, and can only be cancelled for certain specific conditions, such as non-payment of premiums.
• Result – the same coverage can be retained indefinitely	• Result – Individual market – the same coverage can be retained indefinitely. Group Market – mechanisms are in place to provide options for persons to continue coverage when group coverage is lost, and for guaranteed access to other coverage when the continuation period expires.

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Line of Business	Number Of Contracts	# of Contracts With Negative Rate Change	# of Contracts With Positive Rate Change
First Choice	30,918	1,317	29,601
SGRR	61,520	26,318	35,202
State	34,804	18,916	15,888
Total	127,242	46,551	80,691

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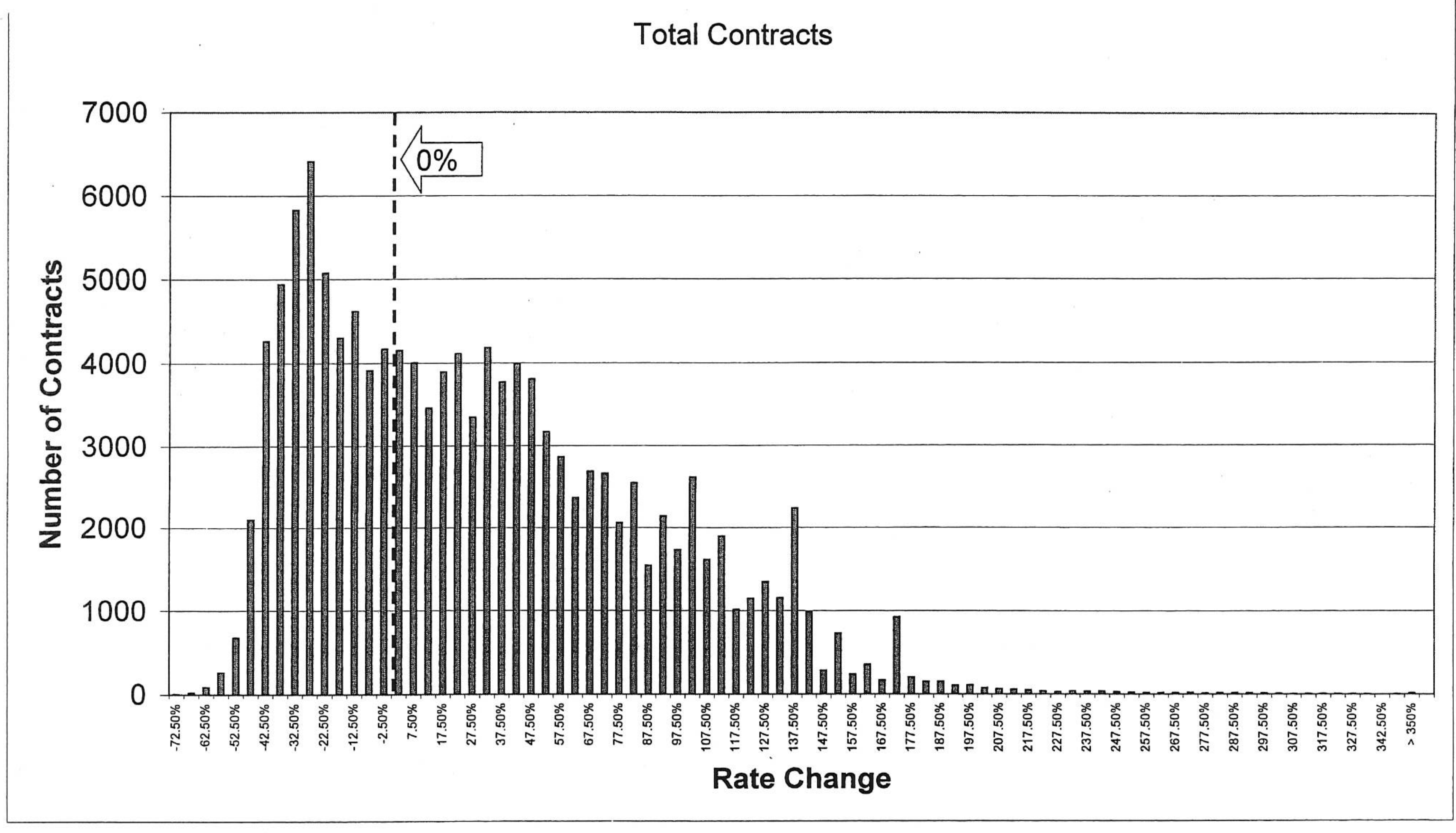


Number Of Contracts	127,242
Average Rate Change	31.0%
Max Rate Change	450.8%
Min Rate Change	-70.6%

% of Contracts With Negative Rate Change	36.7%
Average Decrease	-25.1%
% of Contracts With Positive Rate Change	63.3%
Average Increase	63.3%

Female age 36	SGRR Factor	Connector Factor
UT Factor	1.25	
Conversion	0.95	0.95
Industry	1.10	
Size	1.10	
Age Gender	1.577	
Age		0.61
Selection		1.15
RAF	2.26	0.66
Rate Change		-70.63%

Male Age 20	SGRR Factor	Connector Factor
UT Factor	1.24	
Conversion	0.96	0.96
Industry	1.10	
Size	0.95	
Age Gender	1.552	
Age		0.54
Selection		1.15
RAF	1.92	0.59
Rate Change		-69.01%

Female age 62	SGRR Factor	Connector Factor
UT Factor	0.75	
Conversion	0.91	0.91
Industry	1.05	
Size	0.95	
Age Gender	0.632	
Age		2.00
Selection		1.15
RAF	0.43	2.10
Rate Change		385.89%

Male Age 70	SGRR Factor	Connector Factor
UT Factor	0.75	
Conversion	0.95	0.95
Industry	1.00	
Size	0.95	
Age Gender	0.662	
Age		2.26
Selection		1.15
RAF	0.45	2.47
Rate Change		450.79%

Female age 51	SGRR Factor	Connector Factor
UT Factor	1.04	
Conversion	0.95	0.95
Industry	1.00	
Size	0.95	
Age Gender	0.790	
Age		1.02
Selection		1.15
RAF	0.74	1.11
Rate Change		51.00%

Male Age 29	SGRR Factor	Connector Factor
UT Factor	0.75	
Conversion	0.96	0.96
Industry	1.00	
Size	1.15	
Age Gender	0.528	
Age		0.60
Selection		1.15
RAF	0.44	0.66
Rate Change		51.01%

Female age 28	SGRR Factor	Connector Factor
UT Factor	0.93	
Conversion	0.95	0.95
Industry	1.00	
Size	1.15	
Age Gender	0.849	
Age		0.60
Selection		1.15
RAF	0.86	0.66
Rate Change		-23.60%

Male Age 38	SGRR Factor	Connector Factor
UT Factor	1.24	
Conversion	0.91	0.91
Industry	1.10	
Size	0.95	
Age Gender	0.724	
Age		0.62
Selection		1.15
RAF	0.85	0.65
Rate Change		-23.60%

The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 104 May 2002

What Were These States Thinking?

The Pitfalls of Guaranteed Issue

In recent years, several states have experimented with reforms intended to make health insurance more accessible and affordable. Some of the experiments such as the establishment of high-risk pools have indeed helped. Other reforms such as "guaranteed issue" have backfired in the worst possible way, as premiums have skyrocketed and insurers have fled the states.

What Is Guaranteed Issue? Guaranteed issue requires insurers to accept everyone who applies for health insurance, regardless of the condition of his or her health. This is comparable to allowing a person to purchase auto insurance *after* being involved in a car wreck.

What Happens When Guaranteed Issue Is Implemented? Guaranteed issue legislation leads to some very predictable outcomes.

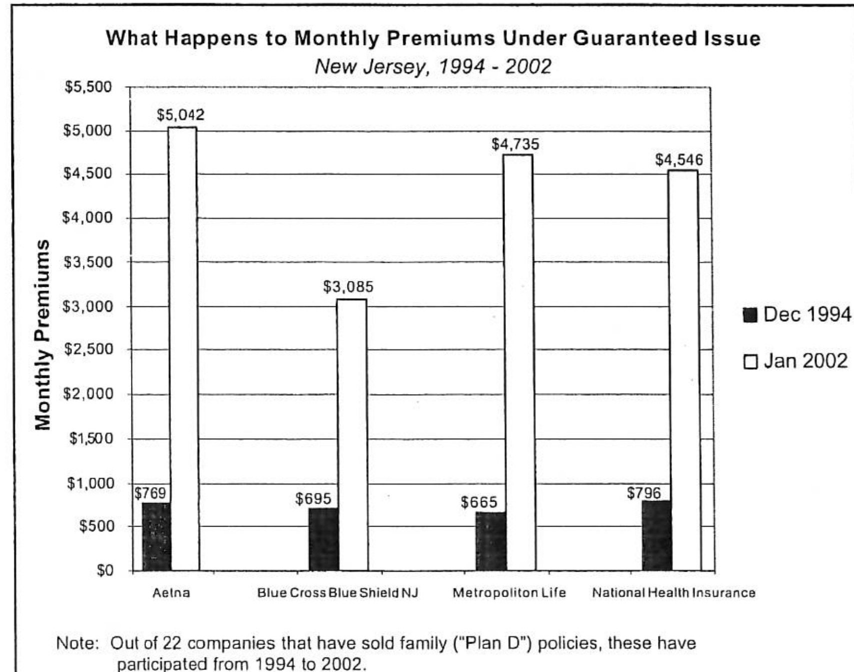
Premiums Begin to Rise — If people know they can get health insurance when they get sick, they won't buy it when they're healthy. Younger and healthier people cancel their polices — or decline to buy one in the first place. As the health insurance pool gets smaller and sicker, premiums go up, which forces even more people to drop out. This process is known as the "death spiral," as escalating premiums drive out all but the sickest people with the most expensive health care needs. Is there a way to avoid the death spiral? Two options are available:

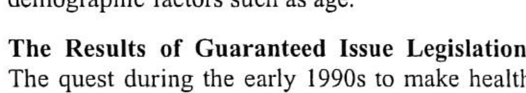
Mandating Coverage — One option is to force everyone — young and old, healthy and sick — to have health insurance, just as most states require drivers to have auto insurance, although many drivers choose to remain uninsured. The failed Clinton health care plan would have included such a provision, and several state legislatures have toyed with the idea. Only Hawaii requires employers to provide health insurance coverage.

The biggest problem with mandating coverage is that it is largely unenforceable at the state level. Employers who self-insure come under the federal law known as ERISA, so states can't regulate their coverage. In addition, many employers can move across state lines to escape the mandate.

Level Pricing — Perhaps the most common approach to ensure that premiums stay affordable, even in the death spiral, is to impose community rating.

What Is Community Rating? Community rating has two general forms. Under "pure" or "flat" community rating, insurers are required to charge every policyholder the same rate for coverage, without regard to individual risk factors such as health status or age. Modified community rating allows for small variations in rates due to health status, age or other factors. And while some states may prohibit the use of health status to set premium rates, they may allow the use of demographic factors such as age.





The Results of Guaranteed Issue Legislation. The quest during the early 1990s to make health insurance accessible and affordable for everyone led a number of state legislatures to pass guaranteed issue and community rating legislation in the individual (i.e., nongroup) health insurance market, which quickly collapsed under the weight of the reforms. Some of those states have spent much of the latter part of the 1990s trying to reform the reforms — with relatively little success. Here are a few examples.

New Jersey — New Jersey is the poster child for why a state SHOULD NOT implement guaranteed issue in the individual market. It passed the

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legislation in 1994, when the state's health insurance rates were already high. As shown in the figure on the previous page:

- In 1994, a New Jersey family policy (known as "Plan D") with a $500 deductible and a 20 percent copayment (i.e., the insurer pays 80 percent) cost as little as $504 a month and as much as $1,076, depending on which of the 14 participating insurers the family chose.
- By January 2002, that same policy purchased from one of the 10 remaining companies cost between $3,085 (Blue Cross Blue Shield) and $17,550 (Trustmark) per month — *that's $38,040 to $210,600 a year.*

Maine — Maine passed guaranteed issue and community rating in 1993, driving up rates and driving out insurers. A 2001 report notes, "Rates have risen sharply in the past three years, especially for HMO coverage, making coverage unaffordable for many." Maine Sen. Susan Collins recently noted, "Anthem Blue Cross Blue Shield — the single remaining carrier in Maine's nongroup market — has increased its rates by 40 percent over the past two years."

Kentucky — The state adopted guaranteed issue and modified community rating in 1994 and required carriers to offer a limited number of state-designed, standardized health plans. As a result, 45 insurers left the state, leaving only Anthem Blue Cross, Humana in a limited capacity and KentuckyCare, the state-run plan (now Kentucky Access, a high-risk pool). Legislation passed in 2000 to reform the reforms encouraged three insurers to return. But premium costs are still above average.

New Hampshire — New Hampshire passed guaranteed issue and modified community rating reforms in 1994. Within three years, three of the six insurers left the market and the number of individual policies declined by almost half, while premiums for the Blue Cross policy nearly doubled. By 1998, New Hampshire's Blue Cross Blue Shield, which had lobbied for the reforms, withdrew from the individual market and canceled those policies.

New York — Did New York's 1992 legislation imposing guaranteed issue and community rating create affordable health insurance for everyone? When the law was passed, a 55-year-old healthy male paid about twice what a 25-year-old healthy male paid for a policy. As a result of the reforms, the 25-year-old male paid about 60 percent more, while the 55-year-old paid about 30 percent less — a great deal for the older person, who on average will have a higher income, but a disaster for the younger. The death spiral started and within a few years, both young and old were paying more than the 55-year-old paid when the law was passed. The situation has continued to deteriorate.

Can Guaranteed Issue Be Made to Work? Legislators, having seen what guaranteed issue has done in other states, often think they can make it work by creating a longer waiting period before an uninsured person is eligible to enroll or by limiting the number and scope of those eligible to participate.

But guaranteed issue is not about closing loopholes, it's about offering bad incentives. It rewards people for remaining uninsured until they need coverage. Even trying to encourage young, healthy people to stay in the pool by providing a tax credit will not solve the problem if they have to pay something out of pocket for the insurance. Paying nothing to be uninsured is cheaper than paying something for coverage that they don't feel they need and that they can easily get when they do need it.

Ensuring Access to Affordable Health Insurance. State legislators pass guaranteed issue legislation in order to keep health insurance accessible and affordable for their constituents — *but it has never worked in any state.* Fortunately, there are better ways:

Consumer Choice — Consumers should have access to the widest possible number of health insurance options — from very basic to comprehensive coverage, low and high deductibles, different levels of managed care, or no managed care at all. Minimal government regulation allows consumers to choose the plan that best meets their needs and budgets.

Premium Assistance — Even though there are people who can't afford food, we don't try to regulate grocers or the price of groceries; we help low-income people by providing food stamps. Similarly, legislators should provide refundable tax credits to help people afford a policy.

A Workable Safety Net — Guaranteed issue tries to force health insurers to cover sick people who could not otherwise buy a policy. However, only governments can and should provide social safety nets. They can do so by establishing high-risk pools — public-private partnerships set up to provide insurance to the uninsurable at affordable prices.

Conclusion. State legislatures thought that passing guaranteed issue and community rating would make health insurance more accessible and affordable. Just the opposite happened. If Congress and the states refuse to learn from this experience, they will only decrease consumer choice and increase the number of uninsured.

Prepared by Victoria Craig Bunce, Director of Research and Policy, Council for Affordable Health Insurance.

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Our Mission

We will, in the spirit of the Sisters of Charity, reveal God's healing love by improving the health of the individuals and communities we serve, especially those who are poor or vulnerable.

Our Vision

SCLHS will realize its Mission through the unyielding pursuit of clinical excellence, strategic growth, and health care for all.

Health Policy Platform

Access to health care for all must be vigorously and thoughtfully pursued through meaningful reform in the way health care is delivered and paid for in this country.

Priority Advocacy Issues

FUNDING: Funding and Reimbursement policy should promote quality, continuity of care, fairness, and access for all.

TECHNOLOGY: Progress in the development of health information technology requires government action to support participation and investment, and to promote standardization to make technology as useful as possible.

TAX POLICY: Existing tax-exempt policy should be maintained for charitable health care organizations that demonstrate community benefit.

WORKFORCE: Ongoing efforts to identify, educate and develop the health care workforce are key to providing for current and future needs of the population.

PRESERVATION OF THE SAFETY NET: Community hospitals need the support of the government to prohibit physician self-referral to limited service facilities detrimental to the health needs of the community.

SHARED RESPONSIBILITY: Health care policy should promote shared responsibility for health and wellness.

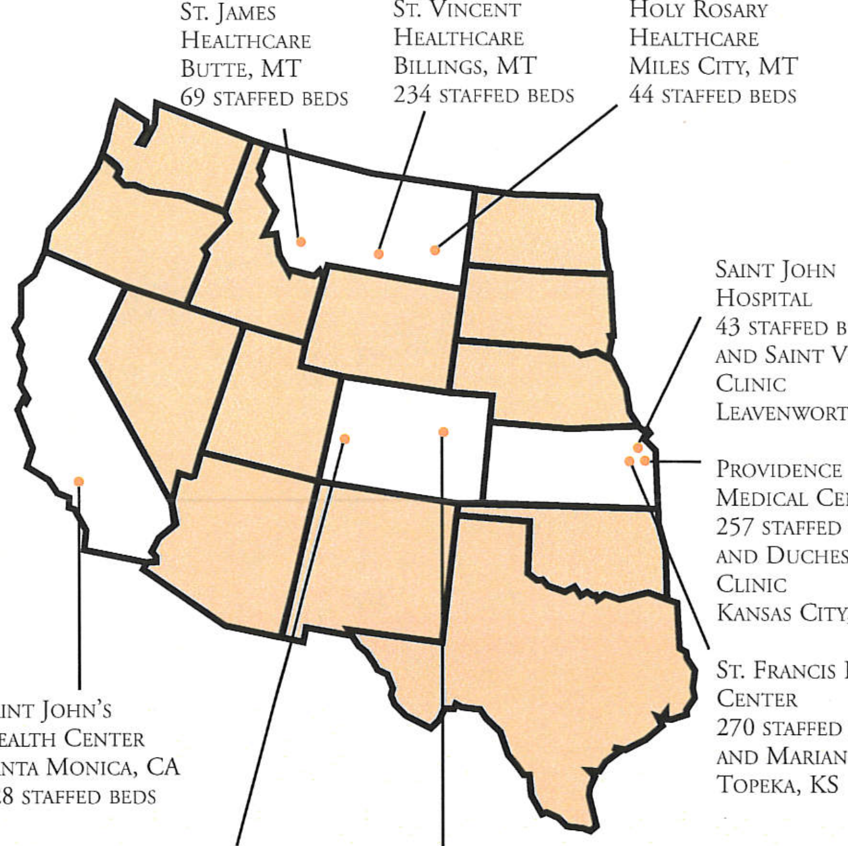
Senate Health Care Strategies Committee
Date: February 20, 2007
Attachment 9

About SCLHS

The Sisters of Charity of Leavenworth Health System (SCLHS) is a Catholic not-for-profit health system, composed of nine hospitals and four stand alone clinics in California, Colorado, Kansas and Montana. SCLHS is sponsored by the Sisters of Charity of Leavenworth.

SCLHS emcompasses nearly 11,000 employees and 2,200 staffed beds, in communities stretching across the western United States. Our staff are highly trained professionals dedicated to a culture that serves both the patient and the healer. The quality of our leadership, our unyielding pursuit of excellence and dedication to the communities we serve define us as a system.

Where We Serve



Mission

We will, in the spirit of the Sisters of Charity, reveal God's healing love by improving the health of the individuals and communities we serve, especially those who are poor or vulnerable.

Core Values

Excellence
We offer excellent and compassionate care.

Respect
We recognize the sacred worth and dignity of each person.

Response to Need
The health care we offer is based on community need, with a special concern for the poor.

Stewardship
We are mindful that we hold our resources in trust.

Wholeness
We value the health of the whole person—spiritual, psycho-social, emotional and physical.

Vision

SCLHS will realize its Mission through the unyielding pursuit of clinical excellence, strategic growth, and health care for all.

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www.sclhealthsystem.org

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