Approved: 3-18-08

Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 A.M. on February 18, 2008 in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Ken Wilke, Office of Revisor of Statutes
Bev Beam, Committee Secretary
Jill Shelley, Kansas Legislative Research Department

Conferees appearing before the committee:

Dr. Marcie Nielson, Kansas Health Policy Authority
Corrie Edwards, Kansas Health Consumer Coalition
Elaine Schwartz, KPHA
Ken Daniels, Midway Wholesale
Broderick Bremby, KDHE
Dianne Bricker, America's Health Insurance Plans
Ira Stamm, KHPA
Tim Witsman, Wichita Independent Business Association
Tom Bryon, Kansas Association of Health Underwriters
Marlee Carpenter, The Kansas Chamber
Larrie Ann Lower, Kansas Assn. Of Health Plans
Kerri Spielman, KAIA
Chad Austin (written only)
Linda DeCoursey (written only)
Peggy Johnson (written only)
Dan Morin, Director of Government Affairs, Kansas Medical Society (written only)
Brad Smoot, BCBS (written only)
James S. Watson, VP, UnitedHealth Group (written only)
Holly French, Chief Financial Officer, Newman Regional Health

Others attending:
See attached list.

The Chair called the meeting to order.

Hearing on:

SB 540 - concerning health insurance; establishing a voluntary health insurance clearing house; authorizing policies for young adults; defining very small employers; enacting the Kansas small business health policy committee act

Melissa Calderwood gave an overview of SB 540. She said SB 540 was introduced by the joint committee on health policy oversight at the request of the Kansas Health Policy Authority in response to 2007 SB 11 and its requirement. The bill would create new law to create a small business health policy committee, amend the coverage requirements for dependent children and, make other amendments to the state health insurance laws.

Sections 1 and 2 of the bill define the term "very small employer" and would establish the definition in the statutes governing individual and group accident and sickness insurance. She said for the purposes of this section, the term "very small employer" means an employer who employs at most 10 employees and shall also include a sole proprietor.

She said Sections 3 through 5 deal with young adult policies and dependent coverage. The bill would require insurers who issue individual and group accident and sickness insurance to issue young adult policies. A young adult would be defined by the bill as an individual who has attained the age of 18 but is not yet 26. The bill would also amend the statutory definition of dependent from 19 to 26 years of age for a resident spouse or a resident unmarried child and from 23 to 26 years of age for a child who is a student and financially dependent upon his parents.

Section 6 of the bill deals with the Kansas Small Business Health Policy Committee. "Health committee" means the Kansas small business health policy committee. "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical services corporation contract.

Section 7 establishes within the Kansas health policy authority the Kansas small business health policy committee. This committee shall consist of the secretary of the department of commerce or the secretary's designee, the commissioner of insurance or the commissioner's designee, one member appointed by the president of the senate, one member appointed by the speaker of the house of representatives, one member appointed by the minority leader of the senate, one member appointed by the minority leader of the house and three members at large from the private sector appointed by the governor and one member designated by the Kansas health policy authority.

Section 8 states the health committee shall develop a voluntary health insurance clearinghouse and in performing this duty shall assist small employers and very small groups in accessing health insurance and tax-preferred health insurance premiums through cafeteria plans; it shall develop a website designed to provide information for small employers, employees and very small groups on health insurance products and cafeteria plans.

Section 9 is amended to read "and sections 10 and 11, and amendments thereto, shall be known as the Kansas small business health committee act."

Section 10 is amended to read, "in order to encourage and to expand the use of cafeteria plans by small employers, there is hereby established the small employer cafeteria plan development program.

Section 11 is amended to read, "Kansas small business health policy committee is hereby authorized to make grants or no interest loans for the purpose of financing the initial costs associated with the forming and organizing of associations to assist members of the association to obtain access to quality and affordable health care plans.

Section 12 sets out the supplements that are repealed.

Section 13 states that this act shall take effect and be in force from and after its publication in the statute book.

Dr. Marcie Nielson, Kansas Health Policy Authority, testified in support of SB 540. She said Section 1 establishes very small employer group; Section 2 creates young adult policies; Sections 3-5 increases age of dependents on parent's health insurance; Sections 6-9 creates Kansas small business health policy committee and sections 10-11 transfer cafeteria plan promotion program from Department of Commerce to KHPA. Dr. Nielson said the purpose of the Small Business Health Policy Committee is to ensure stakeholder input and refined health insurance modeling to design affordable health insurance options for small business. She said the committee reports to the KHPA Board and Commissioner of Insurance. (Attachment 1)

Corrie L. Edwards, Kansas Health Consumer Coalition, testified in support of SB 540, stating that the bill proposes several important reforms. She said SB 540 looks to create a new market, merging sole proprietors and very small businesses. She said this is seen as a positive step that would greatly benefit groups-of-one since they tend to have higher health care costs than larger groups. She said this is an important change because generally a high percentage of sole proprietors or employees who work for very small businesses most likely are the Kansans who lack access to health insurance. (Attachment 2)

Elaine Schwartz, Kansas Public Health Association, testified that young adults make up the largest age group of uninsured Americans; nearly one in three of the uninsured are between 18 and 24 years old. She noted that

in Kansas, 20% of people between the ages of 19 and 25 do not have health insurance. She said for college students, health insurance options are limited. They may rely on their parents' coverage as a dependent, purchase their own school-sponsored coverage, or simply do without. She noted that most college students do not have a job where they can afford both rent and college tuition, and day-to-day living expenses, so health care takes a backseat to day-to-day expenses. (Attachment 3)

Kenneth Daniel, Midway Wholesale, testified in support of SB 540 with one important exception and some reservations. He said in his opinion, if the "very small group" is defined as 1-10 employees instead of 2-10, it may have grave consequences. He said it could virtually destroy the individual market in Kansas, including the non-employer portion. It could damage or virtually destroy the 2-10 market in Kansas and, the language seems to assume small business owners can participate in a cafeteria plan. They cannot. Only non-owner employees may participate, he said. He noted that the premiums would be extremely high for all 1-10 groups due to guaranteed issue for groups of one. It is possible no insurance companies will participate or that few small businesses will. He said it seems possible that the mere fact that insurance is "available" here may disqualify some people from the high risk pool. Mr. Daniel said if this concern is not fixed, then this bill should be killed. (Attachment 4)

Roderick Bremby, Secretary, Kansas Department of Health and Environment, testified in support of SB 540 He stated that as Secretary of the state's health and environment agency, he supports the reforms outlined in SB 540 and encourages strong consideration of this proposal. He said he is ready to assist the KHPA, Secretary of Commerce and Kansas Insurance Commission in achieving the new standards for health insurance that are outlined in KHPA's proposal. (Attachment 5)

Dianne Bricker, America's Health Insurance Plans, testified as neutral. She said legislation that is currently before the committee, namely, SB 540, has the laudable goal of increasing access to coverage for young adults and small employers. AHIP understands that increases in the cost of health care and low coverage rates among young adults and small employers pose a significant threat to the health and economy of the state of Kansas. (Attachment 6)

Ira Stamm testified on SB 540 as neutral, stating that the KHPA has documented that there are 300,000 Kansans without health insurance. The Institute of Medicine has estimated that in 2006, 22,000 Americans died because of the lack of health insurance. This means that in 2006, 198 Kansans died because of the lack of health insurance. He continued that approximately 198 Kansans without health insurance died in 2007 and another 198 Kansans will die in 2008. Over 400 plus Kansans without health insurance will have died in Kansas since Kansas initiated its program of health care reform.

Mr. Stamm continued that at any point in time 10% of the population have a medical condition that renders them uninsurable. This means that at any point in time, there are 270,000 Kansans who have medical conditions that make them uninsurable.

Mr. Stamm also noted that a study done in 2003 estimated that 16 million Americans were under insured. This means that in 2003 144,000 Kansans were under insured. He said adding together 300,000 Kansans who are uninsured, 270,000 Kansans with medical conditions that make them uninsurable, and 144,000 Kansans who are uninsured means that altogether 714,000 Kansas have problems with health insurance. He said this does not include the tens of thousands of Kansans who struggle daily with their insurance companies around problems of access to care. (Attachment 7)

Tim Witsman, representing the Wichita Independent Business Association and the Kansas Independent Business Coalition, presented neutral testimony on SB 540. Mr. Witsman told the Committee they can either set up an entirely new apparatus with no experience in working with small business or instead, utilize the existing resources that need only outreach money to accomplish most of the goals. He said rather than growing state government, Wichita Insurance Services could do the work and pay taxes on the income derived therefrom. He said the more successful the effort, the more income rather than expense the state would experience. (Attachment 8)

Tom Bryon, Kansas Association of Health Underwriters, testified in opposition to SB 540. Mr. Bryon stated the Kansas Insurance Department is the agency responsible for regulating health insurance plans and

handling consumer complaints. KID websites already have information used to educate consumers about the purchase of health insurance. Mr. Bryon said if more money is needed to expand the KID site, it would be money well spent and we would not be reinventing the wheel. He said members of the Kansas Association of Health Underwriters want to be a resource to the legislature as it works through the many complex issues of health reform. (Attachment 9)

Larrie Ann Lower, Executive Director, Kansas Association of Health Plans, testified in opposition to SB 540. She said KAHP trusts that the Committee will give very careful consideration to the concept of creating limited policies for young adults. She said young healthy individuals can currently purchase a comprehensive health policy for about $100 per month in the non-group market. She said in addition, it is young adults participating in the employer-based group insurance market that help subsidize and stabilize rates for the older Kansas workers. She said KAHP is concerned that this young adult policy idea not disrupt or damage existing markets. She said until this is more clear, KAHP asks that this section be removed or be optional. (Attachment 10)

Kerri Spielman, KAIA, testified in opposition to SB 540. She gave some ideas KAIA believes are worth exploring:

1. Broader use of Section 125 Plans or Premium Only Plans (POPS) to gain tax benefits for everyone who buys health insurance.

2. Encouragement to use Health Savings Accounts with qualified high deductible plans to move toward Consumer Directed Health Care (CDHC)

3. A single depository for individual medical records from all providers

4. Consumer access to their medical records and greater education of consumers to help them make informed medical care decisions with their providers

5. Experimentation with list billing of individual policies as an option for employers who have not offered health insurance for a year or more.

6. Consideration of a market-wide reinsurance mechanism for small group

7. Transparency of health care pricing to go with CDHC. (Attachment 11)

Marlee Carpenter, Vice President of Government Affairs, The Kansas Chamber, said the Kansas Chamber opposes SB 540. She said the Chamber believes it will add costs to already rising small group health insurance rates. She said the Kansas Chamber urges the committee to look at market-driven solutions that will help reduce costs to all businesses, especially small businesses looking to ensure their employees. She said the Chamber suggests an expansion of the current health care tax credit so it can be a real-time tool for small businesses to purchase health insurance, the enactment of a "mandate-lite" health insurance plan to help small businesses with the cost of health insurance and proposals such as Missouri's SB 818 which will allow individuals to purchase health insurance pre-tax through Section 125 Plans. (Attachment 12)

Submitting written testimony in support of SB 540:

Chad Austin, Vice President, Government Relations, Kansas Hospital Association (Attachment 13)
Linda DeCoursey, Senior Advocacy Director - Kansas, American Heart Association (Attachment 14)
Peggy Johnson, private citizen (Attachment 15)
Dan Morin, Director of Government Affairs, Kansas Medical Society (Attachment 16)

Submitting written testimony in opposition to SB 540:

Brad Smoot, Blue Cross Blue Shield of Kansas (Attachment 17)
James S. Watson, Vice President, State Affairs, UnitedHealth Group (Attachment 18)

MINUTES OF THE Senate Financial Institutions and Insurance Committee at 9:30 A.M. on February 18, 2008 in Room 136-N of the Capitol.

The Chair closed the hearing on SB 540.

Hearing on:

SB 563 - concerning health insurance; pertaining to utilization review

Holly French, Chief Financial Officer, Newman Regional Health, testified in support of SB 563. She stated SB 563 would prohibit a utilization review organization from requiring notification of admission prior to the next business day after a patient presents to a health care facility. She noted any admission done on nights, weekends, or holidays, is done only because it cannot be delayed. She said physicians are very busy people and especially during these times would not admit patients without a very real need. She said this is an inconvenience to our physicians and to patients and is avoided if at all possible. She continued saying it is difficult to understand how this notification will provide any benefit. She said the impact of requiring notification would cause (1) decreased reimbursement to providers, (2) increased cost of caring for patients, and (3) increased cost to patients. (Attachment 19)

The Chair closed the hearing on SB 563. She announced to those present that the hearing on SB 563 would continue Friday, February 21.

The meeting adjourned at 10:30 a.m.

SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE
GUEST LIST

DATE: 2-18-08

NAME	REPRESENTING
[illegible]	UHG
[illegible]	KHPA
Marci Nielsen	KHPA
Roderick L. Bremby	KDHE
[illegible]	"
Kerri Spielman	KAIA
Peggy [illegible]	BCBSKC
Cheryl [illegible]	Country Health Care
[illegible]	KHA
Chad Austin	KHA
[illegible]	KHA
Tracy Russell	KHPA
Tish Hollingsworth	KHA
[illegible]	Newman Regional Health
Patrick Patterson	HCA MIDWEST
Suzanne Wikle	KS Action for Children
[illegible]	SPF
Cynthia Smith	SCL Health System
Alex Kotoyantz	P.I.A.

SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE
GUEST LIST

DATE: 2-18-08

NAME	REPRESENTING
Thomas A. Bryon	Ks Ass of Health Underwriters
Sandy Braden	Ks Assoc of Hemodialysis
F. Tim Witsman	WIBA / KIBC
John Meek	KID
Bud Burke	Issues Mgmt Group
KEN DANIEL	KSSMALLBIZ.com
Bill Sneed	AHIP
Bruce Witt	Preferred Health Systems
Mike Hutfles	" "
Paula Marmet	KDHE
Carrie Edwards	Ks Health Consumer Coalition
Elaine Schwartz	Ks Public Health Assn. Inc
Lori Desch	PMCA of KS
Ron Seeber	HCA
Dan Rumsey	KHI

Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

KHPA Testimony on SB 540 to the Senate Financial Institutions and Insurance Committee

February 18, 2008

Marcia Nielsen, PhD, MPH
Executive Director
Kansas Health Policy Authority

1

KHPA

Objectives

- Background on Health Reform
- Description of SB 540
- Policy Recommendations
  - Young Adult Policies (YAPs)
  - Continuing eligible dependents through age 25
  - Health Insurance Clearinghouse for Small Businesses
  - Reinsurance Pool for Very Small Groups

2

FI&I Committee
February 18, 2008
Attachment 1

KHPA Reform Priorities

- **Promoting personal responsibility (P1)**
  - Responsible health behaviors
  - Informed purchase of health care services
  - Contributing to the cost of health insurance, based on ability to pay the cost of health insurance, based on ability to pay
- **Prevention and medical homes (P2)**
  - Focus on obesity, tobacco control, chronic disease management and incentives for primary care medical homes
- **Providing and protecting affordable health insurance (P3)**
  - Focus on small businesses, children, and the uninsured

3

Priorities: Systems Reform and Better Health

Transforming Medical Care	Improving Public Health	Expanding Affordable Insurance
•Transparency project: health care cost and quality •Health literacy •Medical home definition •Medicaid provider reimbursement •Community Health Record (HIE) •Form standardization	•Increase tobacco user fee •Statewide smoking ban •Partner with community organizations •Education Commissioner •Collect fitness data in schools •Promote healthy foods in schools •Increase physical fitness •Wellness for small businesses •Healthier food for state employees •Dental care for pregnant women •Tobacco cessation in Medicaid •Expand cancer screening	•Aggressive outreach and enrollment of eligible children (target population: 20,000) •Premium assistance for low income adults without children (target population: 39,000) •Small business initiatives (target population: 15,000 young adults and 12,000 employees of small businesses)

4

Provide & Protect Affordable Health Insurance Policy Options (P3)

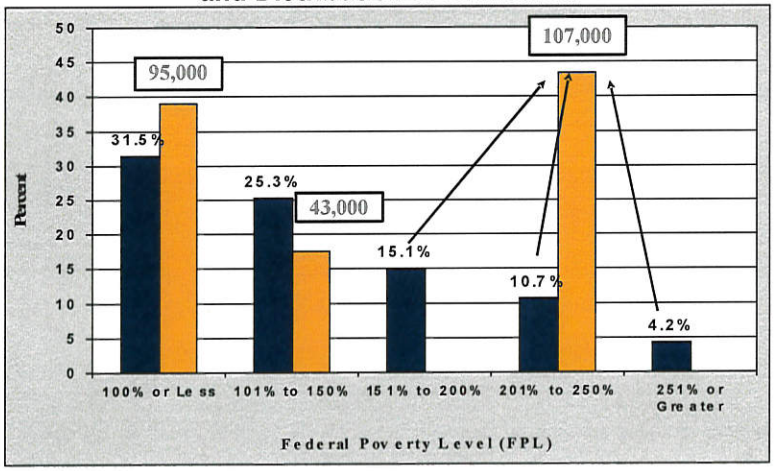
- **Premium Assistance *Expansion*:**
  - Increase private insurance coverage for low-income childless Kansans through premium assistance program expansion* **(Kansas Healthy Choices)**
- **Increased Enrollment:**
  - Improve access to coverage for Kansas children, with specific targets for enrollment
- **Small Businesses:**
  - Increase affordable coverage for solo business owners and other small businesses

* Please note that SB 111 Premium Assistance applies to low-income families only whereas the proposed expansion is to include low-income adults who do not have children (childless adults are currently not-eligible for medical assistance programs regardless of how poor they are).

5

Lower Income = More Uninsured

Uninsured Kansans under Age 65 by Income and Distribution of Uninsured

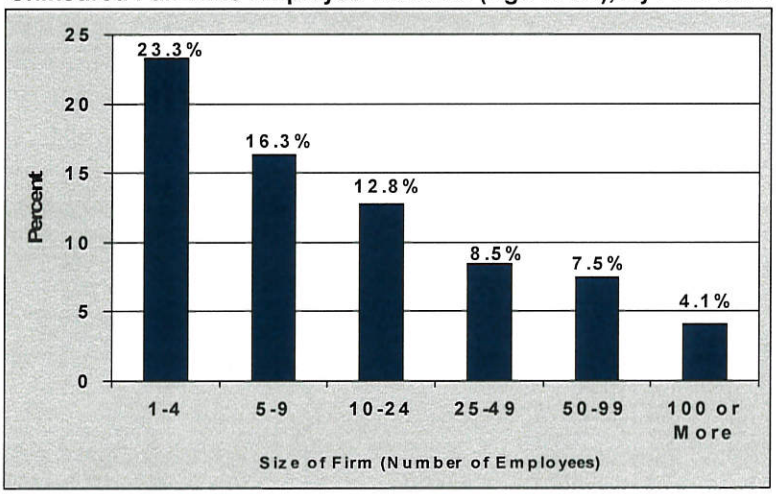


Sources: Kansas Health Insurance Study, 2001. Kansas Insurance Dept.

6

Smaller Businesses Have Higher Rates of Uninsured

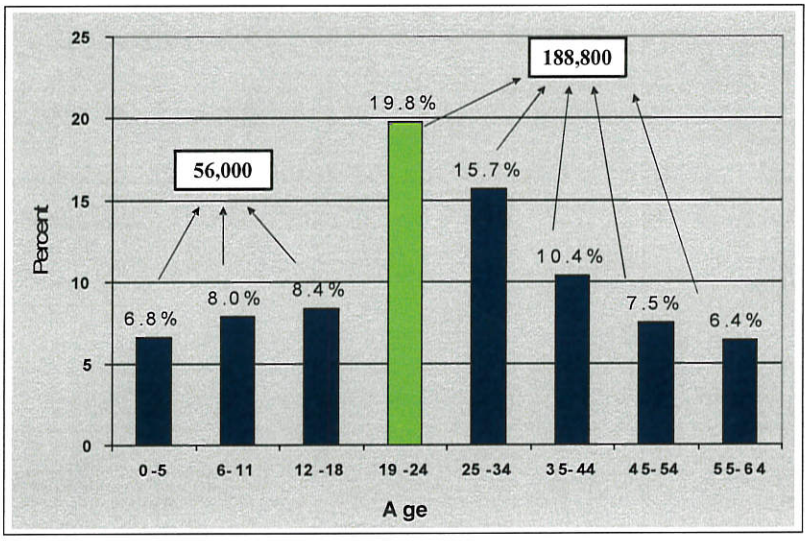
Uninsured Full-Time Employed Kansans (Age 18-64), By Firm Size



7

Source: Kansas Health Insurance Study, 2001. Kansas Insurance Dept.

Highest Rates of Uninsured Among Young Adults



8

Access to Health Insurance Among Young Adults

- **Lack of Coverage:**
  - Young adults (ages 19-29) are one of the largest segment of US population who are uninsured; nearly one in three are uninsured nationally
  - Increases in total uninsured in US largely due to rising rates of uninsured among young adults
- **Poor Health Care Access.**
  - Uninsured young adults face high out-of-pocket health care costs and more likely to:
    - not fill prescriptions
    - not have regular check-ups
    - skip follow-up treatments
    - not see a doctor when a health problem exists

Source: Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help. The Commonwealth Fund Issue Brief; Aug. 2007

Increasing Age of Dependency

State Laws That Increase Age That Young Adults Are Considered Dependents for Health Insurance Purposes (The Commonwealth Fund, 2007)

	Year Passed/Implemented	Age of Dependency	Applies to Non-Students
Colorado	2006	25	Y
Delaware	2006	24	Y
Idaho	2007	25	N
Indiana	2007	24	Y
Maine	2007	25	Y
Maryland	2007	25	Y
Massachusetts	2006	25	Y
Minnesota	2007	25	Y
New Hampshire	2007	26	Y
New Jersey	2006	30	Y
New Mexico	2005	25	Y
Rhode Island	2006	25	N
South Dakota	2005	24	N
Texas	2003	25	Y
Utah	1994	26	Y
Washington	2007	25	Y
West Virginia	2007	25	Y

SB 540: Health Insurance Reforms

- **Section 1: Establishes Very Small Employer Group**
  - Defines & creates group for very small employers (max of 10 employees; includes sole proprietors)
- **Section 2: Creates Young Adult Policies**
  - Defines & creates a special group (young adults ages 18-25) with goal to create more affordable health insurance policies for this population
- **Sections 3-5: Increases Age of Dependants on Parent's Health Insurance –**
  - Allows dependents on parent's health insurance policy extended through age 25
- **Sections 6-9: Creates Kansas Small Business Health Policy Committee:**
  - Create committee to establish voluntary Health Insurance Clearinghouse for small businesses
- **Sections 10-11: Transfer Cafeteria Plan Promotion Program from Dept of Commerce to KHPA**
  - Kansas Small Business Health Policy Committee to direct cafeteria plan promotion

11

Policy Options to Increase Affordable Coverage for Small Businesses

- Encourage utilization of **Section 125 Plans**
- Develop a **"Voluntary Health Insurance Clearinghouse"**
- **Define small group market and provide reinsurance**: obtain grant funding for further analysis
- **Young Adult Policies** - dependent coverage extension through age 25 and development of targeted young adult insurance products
- Pilot projects – support grant program in the Kansas Dept of Commerce for **small business health insurance innovations**

12

Small Business Health Policy Committee

Purpose:

- To ensure stakeholder input and refined health insurance modeling to design affordable health insurance options for small-business
- Reports to KHPA Board and Commissioner of Insurance

Continue function:

- Replaces Business Health Policy Committee and Partnership
- Assign new tasks such as developing insurance clearinghouse to provide consumers with information about health insurance and Section 125 plans

13

Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

http://www.khpa.ks.gov/

14

Testimony of the Kansas Health Consumer Coalition
Regarding SB 540: Concerning Health Insurance; establishing a voluntary insurance clearing house; authorizing policies for young adults; defining very small employers; enacting the Kansas small business health policy committee act
Presented to the Senate Financial Institutions and Insurance Committee
Submitted by Corrie Edwards
February 18, 2008

Thank you Chairperson Teichman for the opportunity to speak today in support of SB 540, concerning health insurance. My name is Corrie Edwards and I am the Executive Director of the Kansas Health Consumer Coalition (KHCC) based in Topeka.

The Mission of KHCC is to support state policies that will increase the availability of health care and health care insurance for all Kansans at affordable prices. SB 540 proposes several important reforms that we believe will assist in that Mission. We recognize that the reforms contained in the bill may not be the only way that health care coverage can be extended, but Kansans who don't have access to health care insurance need your support now. There's a time to debate the options and then there is a time to commit to a plan and move forward with it.

Unfortunately, time is not on the side of those without health care coverage. In just the past couple of years, the percentage of Kansans without health insurance has increased from about 10% to 11.5% in 2007. While our numbers are lower than many states, the trend is still alarming. The percentages reflect a 15% increase in the number of Kansans without health insurance in just a couple of years.

More Kansans are struggling to find affordable health insurance options. That's why passage of SB 540 is important. It addresses the needs of sole proprietors and young adults, and it creates a Clearinghouse where Kansas small business owners can easily access reliable information about insurance and cafeteria plans.

In this proposal, a very small employer group (VSG) is identified as an employer with one to ten employees. SB 540 looks to create a new market, merging sole proprietors and these very small businesses. We see this as a positive step that would greatly benefit groups-of-one since they tend to have higher health care costs than larger groups. This is an important change because generally a high percentage of sole proprietors or employees who work for very small businesses most likely are the Kansans who lack access to health insurance.

The recommendations of the Kansas Health Policy Authority were assembled after months of study and have been public since last fall. We urge you to move forward on this plan and recommend Senate Bill 540 favorable for passage. Thank you for considering this testimony.

Respectfully submitted,

Corrie L. Edwards, MPA
Executive Director
Kansas Health Consumer Coalition
534 S. Kansas Avenue, Suite 335
Topeka, Kansas 66603
(785) 232-9997

FI & I
February 18, 2008
Attachment 2

KANSAS PUBLIC HEALTH ASSOCIATION, INC.

Kansas Public Health Association, Inc.
Affiliated with the American Public Health Association
P.O. Box 67085
Topeka, Kansas 66667
Phone: 785-233-3103 fax: 785-233-3439
E-mail: director@kpha.us
Web Site: http://www.kpha.us

February 18, 2008

To: The Honorable Senator Ruth Teichman
Re: Testimony in support of SB540, An Act Concerning health insurance; establishing a voluntary health insurance clearing house; authorizing policies for young adults; defining very small employers; enacting the Kansas small business health policy committee act

Thank you, Madame Chair, and members of the Committee, for the opportunity to provide testimony in support of SB540. I am Elaine Schwartz, the Executive Director of the Kansas Public Health Association. I am here to speak on behalf of the almost 700 plus individuals from 145 organizations representing over 50 professions that belong to KPHA.

As one of KPHA's Top Legislative Priorities, KPHA is very supportive of SB540. It is listed on our Priority Platform as *# 4 Support legislative efforts to extend coverage of young adults on parents' health insurance plans*

Affordable health insurance is one of the hottest topics for our state and federal governments today. There is not one simple strategy for making health insurance available to everyone in Kansas. However, if we proceed to break down the barriers one by; one, the barrier to coverage for health insurance will be broken.

"With health care costs continuing to grow at double-digit rates, the number of those without health coverage will continue to escalate. Forty-five million Americans are uninsured already, and the number is expected to increase by 11 million more within the next decade. The Institute of Medicine attributes 18,000 deaths a year to a lack of coverage[1]. In addition, 42 percent of the uninsured have no usual source of care — they miss out on preventive screenings and care for chronic conditions such as cancer, diabetes, cardiovascular disease, mental illness, HIV and end-stage renal disease." (Aetna)

"The uninsured are not a homogeneous group. A comprehensive variety of solutions — both public and private — is necessary to bring low-cost, high-quality health care to a population that includes college students, small business and low-wage employers, and racial and ethnic minorities." (Aetna)

- **"Young adults make up the largest age-group of uninsured Americans; nearly one in three of the uninsured are between 18 and 24 years old." (Aetna)**
- **"In Kansas, 20% of people between the ages of 19 and 25 do not have health insurance. The demographic of people without health insurance cannot afford healthcare because they still depend on their parents for support." (affordable health-insurance.org)**
- **"For college students, health insurance options are limited. They may rely on their parents' coverage as a dependent, purchase their own school-sponsored coverage, or simply "go bare." Many employer-sponsored plans have age-based cut-offs for**

FI & I Committee
February 18, 2008
Attachment 3

dependents at either age 19 or 23, leaving part-time and graduate students with fewer health coverage choices." (Aetna)

- **Most college students do not have a job where they can afford both rent and college tuition, and day to day living expenses, so healthcare takes a back seat to day to day expenses.**

Therefore, It would be logical to begin to provide health insurance to one of the largest uninsured groups that could be simply remedied by requiring insurance companies to provide health insurance to dependents until they are twenty-five (Many college students do not graduate until they are 24-26 years of age) regardless of whether they are full or part time students.

Benefits of requiring continued insurance for dependents until they are 26:

- Extending coverage on parent's insurance could decrease uninsured by 20%
- Allowing students to complete their college degrees will allow them to be in a higher tax bracket, and will increase the tax base to fund future health programs.
- Providing health insurance to 19-25 years olds will begin a strong foundation for the health of our future senior citizens, thus reducing long term health care costs.

Step one of addressing the health care coverage is to provide health insurance to 19-25 year olds in Kansas.

U.S. Has Higher Rate of Preventable Deaths Than Any Other Industrialized Nation

According to a study published in Health Affairs, the United States "has the highest rate of preventable deaths among 19 industrialized nations," with more than 100,000 people dying each year due to "lack of timely, effective medical care," reports Bloomberg.

Source(s): Goldstein, Bloomberg, 1/8/08

According to a study published in *Health Affairs*, the United States "has the highest rate of preventable deaths among 19 industrialized nations," with more than 100,000 people dying each year due to "lack of timely, effective medical care," reports Bloomberg.

"There has been an increase in the past couple of years in the number of people in the U.S. who don't have access to insurance coverage," said Ellen Nolte of the London School of Hygiene and Tropical Medicine, one of the authors of the study. "People who don't have insurance tend to forgo, postpone or delay health care when they need it. It also leads to presentation at a later stage when less can be done."

Of all the 19 "market-based, democratic nations" involved in the study, the United States is the only one without universal health care coverage, according to the article. "101,000 fewer Americans would die annually" if the U.S. rate of preventable deaths were to reach the average rate of the top three nations--France, Japan and Australia. From 1997 to 2003, preventable deaths in the United States declined from 115 per 100,000 people to 110 per 100,000. But the other 18 nations improved at a higher rate.

I am also attaching to my testimony, an article from the State Health Policy Monitor, produced by the National Academy for State Health Policy. According to this article printed in December 2007, 19 states have passed laws that require some insurers to allow older dependents to remain enrolled in their parent's health insurance plans. Sixteen were passed in 2006 and 2007. Kansas should become one of the growing states to pass this law in 2008. In the long run, it will save lives, and money and it is the right thing to do.

Again, thanks for this opportunity to testify. I will be happy to stand for questions.

STATE HEALTH POLICY MONITOR

DECEMBER 2007

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

State Efforts to Extend Dependent Coverage for Young Adults

JESSICA KRONSTADT, SAFIYA MOJERIE, SONYA SCHWARTZ

Policy makers are becoming aware that young adults are the fastest growing group of uninsured in America. In fact, they are more likely to be uninsured than any other age group. Nearly one-third (30 percent) of young adults ages 19-29 are uninsured.[1] From 2004 to 2005, the number of uninsured adults ages 19-29 increased from 12.9 million to 13.3 million – an increase that accounted for 30 percent of the growth in the number of uninsured Americans under the age of 65 during this period.[2]

In an effort to address this issue, 19 states have passed laws that require some insurers to allow older dependents to remain enrolled in their parents' health insurance plans.[3] Sixteen of these laws were passed in 2006 and 2007 (see Figure 1 for a map of states with such laws and Table 1 for year of passage).

NATIONAL ACADEMY *for* STATE HEALTH POLICY

State Health Policy Monitor provides an overview of how a particular state health policy issue, policy, or practice is implemented in select states and across the country.

"State Efforts to Extend Dependent Coverage for Young Adults," State Health Policy Monitor, Vol. 1, Issue 5 (Portland, ME: National Academy for State Health Policy, December 2007), Publication No. 2007-111.

These laws typically require insurers who offer health insurance for dependents up to a specific age to increase that age threshold, often to age 24-26.[4] Many of the laws also apply to family coverage purchased through the individual market.[5] It is not clear how many young adults have gained coverage because of these laws, because many of the laws are new and data are not yet available.

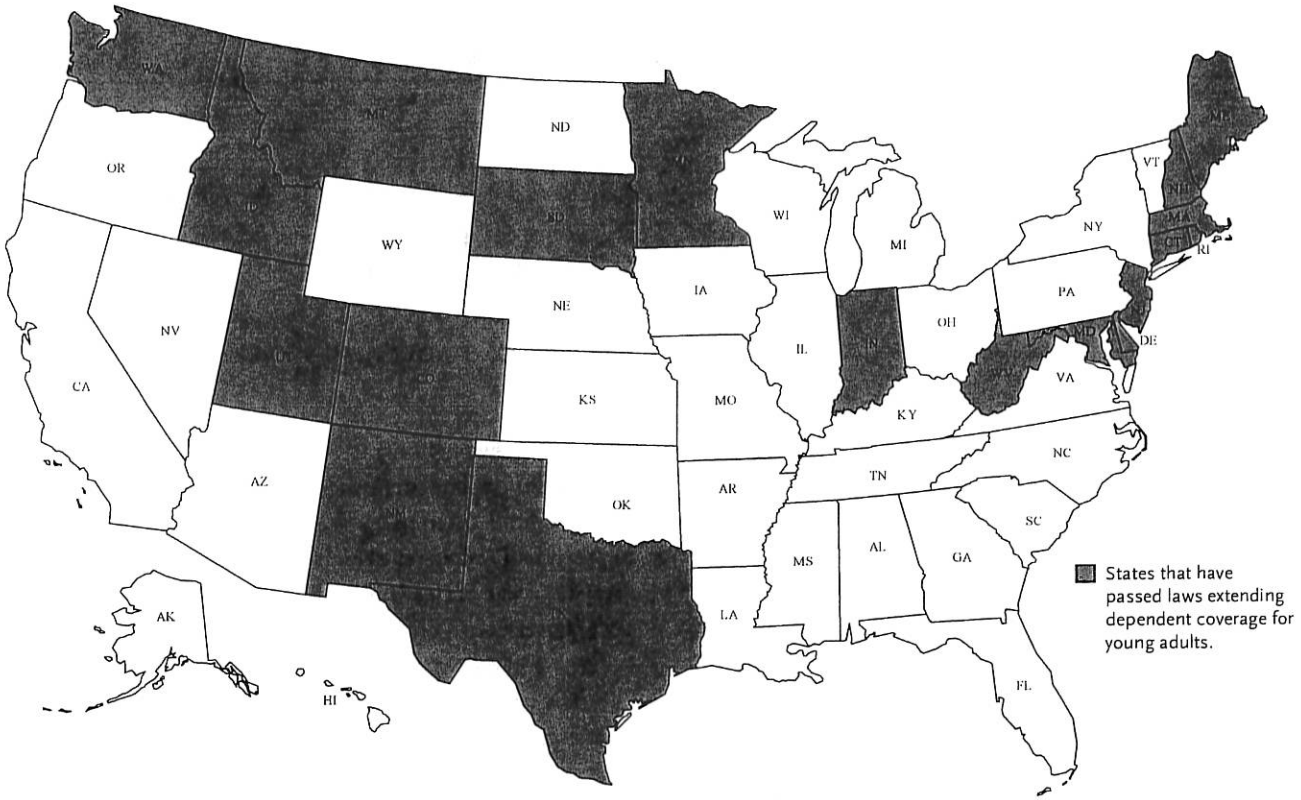
The growing number of uninsured and the lack of federal consensus about covering them has left states to develop options like these dependent coverage laws to fill gaps in coverage. These laws have emerged because of limited state options to cover young adults with federal Medicaid and State Children's Health Insurance Program (SCHIP) funds, and a shortage of affordable and comprehensive coverage options in the individual insurance market. This *State Health Policy Monitor* gives an overview of the key features of state laws designed to expand dependent coverage options for young adults.

Why Are Young Adults Likely To Be Uninsured?

There are many likely reasons for the large number of young, uninsured adults. Young adults often have entry level, part-time, or low-wage jobs where health insurance may not be an offered benefit.[6] Healthy young adults may be able to purchase private, individual insurance, but even the least expensive plans can be out of reach for them.[7] Forty-one percent of uninsured young adults had incomes below 100 percent of the federal poverty level (FPL) ($9,570 for a household of one in 2005) and 72 percent had incomes below 200 percent FPL in 2005.[8] Additionally, individual market plans may be inadequate for or unavailable to people with health problems.[9] Short-term coverage and student plans with limited benefits

3-3

FIGURE 1: STATES EXTENDING COVERAGE FOR YOUNG ADULTS (1994-2007)



Source: NASHP analysis of state laws, 2007, based on National Conference of State Legislatures, *The Changing Definition of 'Dependent': Who is Insured and for How Long?* and S.R. Collins et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York, NY: The Commonwealth Fund, 2007).

are options as well, but may not match the long-term needs and financial resources of this population.

In addition, young adults are likely to become disconnected from public and private coverage when they turn 19. Options are limited for extending Medicaid and SCHIP coverage to children once they reach their 19th birthday, unless they become pregnant or are parents. Medicaid allows states the option to extend coverage to older adolescents in Medically Needy and Ribicoff Programs,[10] but eligibility is limited to low- and moderate-income young adults under the age of 21.

Furthermore, not all states extend these programs to young adults ages 19-20. Only 15 states provide coverage under the "Ribicoff option" for individuals 19-20, and 16 use the Medically Needy Program to cover these young adults.[11] Likely because of these limitations, only a fifth of uninsured individuals ages 19-21 are estimated to be eligible but not enrolled in public coverage.[12]

Those who have private insurance through their parents' plans typically lose coverage at age 19, unless they are full-time students. Several federal laws give dependents who turn 19 and are insured under their parents' employer-sponsored insurance (ESI) the ability to temporarily extend that coverage.[13] COBRA allows children who are covered by plans sponsored by firms with 20 or more employees to continue to participate in the plan for 36 months.

Some states have created laws that mimic this federal policy (often referred to as "mini-COBRA") and also apply to firms with fewer than 20 employees. In addition, the Health Insurance Portability and Accountability Act (HIPAA) guarantees access to at least one insurance plan in each state for individuals who have exhausted COBRA and who have not experienced a break in coverage, but these plans may be more expensive because of adverse selection.

A Closer Look: Experiences with Implementation in New Jersey

Enrollment in New Jersey's new program for young adults (referred to below as the "under 30 option") began in May 2006. Approximately 7,000 young adults are currently covered under this option. Following are some implementation details that may be helpful for policy makers in other states.

- This law applies only to group plans issued in the state. Plans issued in states other than New Jersey and ERISA-exempt, self-insured plans are not required to offer this coverage.
- Individuals must have been enrolled in a plan covered by this law on the date they would have aged out in order to be able to take advantage of the under 30 option. Consequently, if an individual is covered under a student health plan or her own ESI during the period in which she would have lost dependent status, she would not have the option of gaining coverage under her parents' plan at a later date. However, if that individual is on her parents' plan when she ages out and she does elect the under 30 coverage, she may subsequently drop coverage and rejoin later, assuming she meets all the eligibility requirements.
- If a dependent decides to purchase coverage through the under 30 option, she is unable to receive COBRA. If an individual loses eligibility through the under 30 option – for example, if he moves out of the state of New Jersey and is not a full-time student – it will not count as a qualifying event that triggers the option to get COBRA coverage.
- Only dependents who are unmarried and who do not have dependents of their own qualify for this extended coverage. For example, a pregnant woman who is covered under her parents' plan can continue to receive coverage through delivery of her child and initial hospitalization. However, once she is discharged from the hospital she will lose her coverage.
- The state has released guidelines on the methods insurers can use to determine how much to charge older dependents. One recommended process involves calculating the difference between the premiums charged for employee-only coverage and the premiums for employee and child coverage and dividing that difference by the average number of dependents per employee. Insurers may then charge 102 percent of this applicable portion of the premium.

Source: NASHP summary based on correspondence with R. Neil Vance and Gale Simon of the New Jersey Department of Banking and Insurance, and Chanell McDevitt and Ellen DeRosa of the New Jersey Individual Health Coverage and Small Employer Health Coverage Programs, October 2007; New Jersey Public Law 2005, Chapter 375; and New Jersey Department of Banking and Insurance Bulletins 06-06 (http://www.state.nj.us/dobi/bulletins/blt06_06.pdf) and 06-14 (http://www.state.nj.us/dobi/bulletins/blt06_14.pdf). Further details about the program, including frequently asked questions, can be found at http://www.state.nj.us/dobi/dependentsunder30.htm.

Dependent Coverage Laws: Pros and Cons

State laws that require insurers to allow older dependents to stay enrolled in their parents' group or other private-market plans are one approach to address the low rates of insurance among young adults. Dependent coverage laws appeal to states because they:

- Offer privately insured families the option of retaining older children on their plans.
- Improve continuity of coverage for young adults as they transition from school to work and job to job in the early years of their professional development. Access to comprehensive, portable health care during this period of transition is critical given the increased risk of substance abuse, mental health issues, pregnancy, and sexually transmitted diseases in this population.[14]
- Offer needed coverage for young adults who might not otherwise find affordable, comprehensive coverage in the individual insurance market.
- Perhaps most important, generally allow states to expand coverage options without spending state dollars.

While these laws may help some young adults stay insured, they do have limitations. First, state dependent coverage laws offer no guarantee that affordable plans will be available. Some families may not have access to ESI or may have difficulty finding family plans that they can afford in the individual market. In 2007, workers are paying on average $3,281 toward the premium for family ESI,[15] which may be out of reach for some families.

It is also possible that these laws could increase the costs of health care. This could happen in one or both of the following ways. An employer could pass on the costs of these newly covered adults in the worker's share of the premium for family coverage. Additionally, because of the expense of insurance, even middle class families may be inclined to take advantage of these new coverage options only if their older dependents have serious health needs.[16] This

adverse selection could add to the insurer's cost of covering dependents. These additional costs, particularly for expensive services like maternity and mental health care, may lead to increased premiums for all beneficiaries if insurers pass along the cost of covering this population to employers and individuals.

Even families that could afford to enroll their younger dependents in ESI may not be able to keep older children on their plans if employers structure the benefit as a rider and cut back their contributions to the premiums for this newly covered population. Workers currently pay 28 percent of the full cost of the annual premium for family coverage ($12,106) in 2007.[17] However, if families must pay the entire cost of covering an older dependent, it may be too expensive.

Second, these state laws are unable to reach more than half of the individuals covered by ESI. The Employee Retirement Income Security Act (ERISA) prohibits states from regulating employer-sponsored plans directly. While ERISA does allow states to regulate insurance products that insurers sell to employers, it does not allow states to regulate employers that self-insure.[18] Therefore, these new dependent coverage laws do not reach the 55 percent of employees with ESI who in 2007 received coverage through a self-insured plan.[19]

Finally, many of these laws have additional eligibility requirements (see "Key Features of State Laws Extending Coverage to Young Adults"), so some young adults will not qualify even if their parents have insurance that is regulated by the state.

Key Features of State Dependent Coverage Laws

In drafting legislation to extend coverage to young adults, states have many policy options (see Table 1):[20]

- **Age Limits** – Although the majority of states with dependent coverage laws in place require commercial insurers in the fully-insured market to provide coverage to dependents until they turn 25, two states mandate coverage only until the dependent's 24th birthday. An additional six states have higher age limits, including New Jersey, which extends the requirement through age 29. Idaho sets a higher age threshold for students than for non-students.
- **Student Status** – Two states only require insurers to cover older dependents who are enrolled in school on a full-time or part-time basis. An additional four states only cover dependent children living out of state if they are students.
- **Family Status** – Rhode Island requires that older dependents not only be students, but also be unmarried if they want to remain on their parents' plans. Another 14 states limit the requirement to unmarried dependents. Three states limit coverage to those dependents who do not have dependents of their own.
- **Place of Residence** – In Colorado and Maryland at least some dependents must live with the policyholder to be covered by these laws. Connecticut's dependent coverage law for young adults only applies to individuals who reside within the state.
- **Other Restrictions** – Some states limit the coverage requirements to children who are financially dependent, according to various definitions, on the policyholder. Additionally, coverage mandates in some states do not apply to individuals who are enrolled in another insurance plan or who are eligible for another insurance plan at a comparable price. In at least one state, young adults must be covered under their parents' plan at the time they aged out of the program in order to take advantage of this extended coverage (see "A Closer Look: Experiences with Implementation in New Jersey" for more details).
- **Limitations on Premiums** – Many of the dependent coverage laws are silent on what premiums can be charged for coverage of older dependents. Other states tie the amount of the premium for older dependents to either 100 percent or 102 percent of the portion of the premium applicable to covered dependents (see "A Closer Look: Experiences with Implementation in New Jersey" for details on rate calculation in one state). States likely chose this way of limiting premiums in an effort to address affordability while trying to protect themselves from an ERISA challenge.[21] In fact, in order to guard against a potential ERISA legal challenge, several of these laws explicitly state that nothing in the law requires the employer to contribute to the premium.

Related Laws

Other states have adopted laws to extend dependent coverage to specific groups of young adults.[22] For example, in Illinois and Pennsylvania, insurers who offer coverage for full-time students up to a certain age also allow additional years of coverage for dependents who take longer to graduate because of

TABLE 1: KEY FEATURES OF STATE DEPENDENT COVERAGE LAWS

State	Dependent Coverage Until Age	Law limits premiums[a]	Restrictions			Year of Passage
			Must be full- or part-time student	Cannot be married	Cannot have own dependent	
Colorado	25			✓		2007
Connecticut	26	✓		✓		2007
Delaware	24	✓	FT*	✓	✓	2006
Idaho	21			✓		2007
	25		FT	✓		2007
Indiana[b]	24					2007
Maine	25		FT*	✓	✓	2007
Maryland[c]	25	✓		✓		2007
Massachusetts	26[d]					2006
Minnesota	25			✓		2007
Montana	25			✓		2007
New Hampshire	26		FT or PT*	✓		2007
New Jersey	30	✓	FT *	✓	✓	2006
New Mexico	25			✓		2003
Rhode Island	25		PT or FT	✓		2006
South Dakota	29		FT			2007
Texas	25[e]					2003
Utah	26	✓		✓		1994
Washington	25			✓		2007
West Virginia	25			✓		2007

* If not living in the state or not a state resident

Source: NASHP analysis of state laws, 2007: Colorado House Bill 05-1101; Connecticut Senate Bill 1484; Delaware House Bill 446; Idaho Senate Bill 1105; Indiana House Bill 1678; Maine Public Law, Chapter 115, Sec. 24-A; Maryland House Bill 1057; Massachusetts, Chapter 58 of the Acts of 2006; Minnesota House Bill 1078; Montana Senate Bill 419; New Hampshire House Bill 790; New Jersey Public Law 2005, Chapter 375; New Mexico House Bill 335; Rhode Island Senate Bill 2211; South Dakota Senate Bill 108; Texas Acts 2003, Chapter 1274; Utah Code 31A-22-610; Washington Senate Bill 5930; West Virginia House Bill 2940.

Notes:

a. Most state laws are silent on the question of whether insurers can charge higher premiums for older dependents than they can for other dependents. These five states either prohibit insurers from charging more or limit how much more they can charge.
b. Indiana's law only applies to the individual and small group market.
c. In this same law, Maryland mandated that, upon the request of group policyholders, insurers must offer the same coverage to domestic partners and their dependents who live with them that is available to other dependents.
d. In Massachusetts, the requirement extends until dependent children reach age 26, or two years after they lose dependent status under the Internal Revenue Code, whichever comes first.
e. In some cases, dependent students over the age of 25 may be able to retain coverage.

military service. Several other states, including Maine, Michigan, Vermont, and Virginia, require that insurers who provide coverage for students must extend that coverage at least temporarily to individuals who cannot enroll in school due to mental or physical disabilities. Other states have gone further and mandated that insurers who cover dependent children must cover children with disabilities regardless of age.

Conclusion

States have sought to expand coverage to older dependents by increasing the age at which children are eligible for coverage under their parents' plans. These laws attempt to solve a serious problem, since young adults make up the largest share of the uninsured population. While these laws may increase access to coverage for some young adults during a critical period of transition, they are limited in scope. Young adults living in low- and moderate-income households where employer-sponsored or direct purchase health insurance is not available or affordable are unlikely to benefit. Also, insurers or employers may pass on the cost of covering this group by increasing the cost of all health insurance premiums. Furthermore, these laws only apply to individual market and fully-insured ESI plans, yet 55 percent of covered employees are enrolled in some type of self-insured plan. While extending dependent coverage to young adults may help some young adults access health insurance, larger issues of access and affordability for this population remain.

Notes

1 S.R. Collins et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* [Issue Brief] (New York, NY: The Commonwealth Fund, 2007).

2 Ibid.

3 These laws typically extend to any entity providing health insurance in the state, including commercial insurers, nonprofit health service corporations, and HMOs.

4 In several states, prior to these new laws, insurers who offered coverage to dependents based on their age were required to do so up to age 19 for non-students and up to age 23 to 25 for students.

5 This *State Health Policy Monitor* does not focus on plans purchased through the individual market because only 6.6 percent of nonelderly Americans are covered by plans purchased in the individual market, compared to 62.9 percent who are covered by employer-sponsored insurance. (U.S. Census Bureau, Table H105, Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2006. Retrieved 15 Nov. 2007. http://pubdb3.census.gov/macro/032007/health/toc.htm.) Additionally, some states, like New Jersey, do not include insurers in the individual market in their law because there are already protections in the individual market that guarantee that all residents would have a plan offered to them (Correspondence with R. Neil Vance and Gale Simon of the New Jersey Department of Banking and Insurance, and Chanell McDevitt and Ellen DeRosa of the New Jersey Individual Health Coverage and Small Employer Health Coverage Programs, Oct. 2007).

6 Collins, op cit. Previous research suggests that insurance rates also vary by family structure, with unmarried young adults more likely to be uninsured. Among 19-29-year-olds in 1999, 41 percent of single childless adults not living with their parents were uninsured, while 28 percent of single parents, 25 percent of married individuals without children, and 22 percent of married young people with children were uninsured (Kevin Quinn, Cathy Schoen, and Louisa Buatti, *On Their Own: Young Adults Living Without Health Insurance* (New York, NY: The Commonwealth Fund, 2000)).

7 Premiums for such plans have a wide range in cost, from $1,200 to more than $4,200 annually. Cost estimates reflect average premiums among the plans designated as "best sellers" on ehealthinsurance.com for counties in Alabama and New York City, respectively. Estimates are based on a non-smoking, 22-year-old female without preexisting conditions. Plans are available that are both more and less expensive in both of those locations. Plans vary in the services they cover, their deductibles, and copayments.

8 Collins, op cit.

9 Individual market plans can have high deductibles or limited benefits, and in most states insurers can charge higher premiums, refuse to cover services related to a preexisting condition, or deny coverage altogether to people with health problems. Gary Claxton, *How Private Insurance Works: A Primer* (Menlo Park, CA: Kaiser Family Foundation, 2002). Retrieved 24 Sept. 2007. http://www.kff.org/insurance/2255-index.cfm.

10 Medically Needy Programs allow states to cover children with significant health costs by letting families spend down to income thresholds. Under the Ribicoff program, states have the option to extend coverage to children up to age 21 who meet asset and income tests but are otherwise ineligible.

11 H.B. Fox, S.J. Limb, and M. McManus, *The Public Health Insurance Cliff and Older Adolescents* (Washington, DC: InCenter Strategies, 2007).

12 Ibid. This is a much smaller share of the uninsured population than is the case for younger adolescents, where estimates are as high as 70 percent of uninsured individuals ages 17 and 18 are eligible for coverage.

13 Eliot Fishman, "Aging Out of Coverage: Young Adults with Special Health Needs," *Health Affairs* 20, no. 6 (2001): 254-266.

14 National Institute for Health Care Management, *Young People's Health Care: A National Imperative* [Issue Paper] (Washington, DC: 2006). Retrieved 3 July 2007. http://www.nihcm.org/pdf/YoungPeoples HCFINAL.pdf.

15 Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2007 Annual Survey* (Menlo Park, CA: 2007). Retrieved 24 Sept. 2007. http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf.

16 Presentation of Deborah Chollet, Mathematica Policy Research, Inc., at State Innovations in Health Coverage, A Workshop for State Officials, Aug. 3, 2007, Denver, Colorado.

17 Kaiser Family Foundation and Health Research and Education Trust, op cit.

18 ERISA's "savings clause" allows states to regulate insurance coverage if a company purchases the insurance through a third-party that assumes the risk of covering medical claims (fully-insured plans). Employers who self-insure, on the other hand, assume the financial risk of paying the medical claims of their employees, even though a third-party administrator or insurer usually administers the plan on contract. These self-insured plans do not fall under the "savings clause" of ERISA, and therefore states are preempted from regulating them. For more information about ERISA, see www.nashp.org.

19 Kaiser Family Foundation and Health Research and Education Trust, op cit. Some self-insured plans might follow the lead of the rest of the market and allow older dependents to stay enrolled, but states could not ensure it.

20 This section and Table 1 draw from state laws, as well as the following:

- Collins, op cit.

- National Conference of State Legislatures. *The Changing Definition of 'Dependent': Who is Insured and for How Long?* Retrieved 12 Sept. 2007. http://www.ncsl.org/programs/health/dependentstatus.htm.

- State Coverage Initiatives. *Matrix Glossary: Dependent Coverage Matrix.* Retrieved 7 July 2007. http://statecoverage.net/matrix/dependentcoverage.htm.

21 Under ERISA, states cannot directly require employers to provide coverage or to contribute a certain amount toward the premium. For more information about ERISA, see Pat Butler, "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision" (Portland, ME: National Academy for State Health Policy, Oct. 2006) and other ERISA resources at www.nashp.org.

22 National Conference of State Legislatures, op. cit.

Acknowledgments

This report greatly benefited greatly from the thoughtful consideration and input of Darcy Haber, Office of Wisconsin State Senator Kathleen Vinehout; Neil Vance and his colleagues at the New Jersey Department of Banking and Insurance; and NASHP's Alan Weil and Shelly Gehshan

Midway Sales & Distributing, Inc. d/b/a
MIDWAY WHOLESALE
Topeka • Salina • Lawrence • Manhattan • Elwood • Kansas City • Wichita

TESTIMONY ON SENATE BILL 540
SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE
By Kenneth Daniel
February 18, 2007

Kenneth L. Daniel is an unpaid volunteer lobbyist who advocates for Kansas small businesses. He is publisher of KsSmallBiz.com, a small business e-newsletter and website. He is C.E.O. of Midway Wholesale, a business he founded in 1970. Midway has eight locations and 115 employees.

Madame Chairman and Members of the Committee:

I speak in support of Senate Bill 540 with one very important exception and a couple of other reservations. In this testimony I will comment on those, but will be happy to answer questions about any portions of the bill.

In my opinion, if the "very small group" is defined as 1-10 employees instead of 2-10, it may have grave consequences:

- It could virtually destroy the individual market in Kansas including the non-employer portion.
- It could damage or virtually destroy the 2-10 market in Kansas.
- The language seems to assume small business owners can participate in a cafeteria plan. They cannot. Only non-owner employees may participate.
- The premiums should be extremely high for all 1-10 groups due to guaranteed issue for groups of one. It is possible no insurance companies will participate or that few small businesses will.
- It seems possible that the mere fact that insurance is "available" here may disqualify some people from the high risk pool.

If this concern is not fixed, then this bill should be killed.

FI & I Committee
February 18, 2008
Attachment 4

P.O. Box 1246 • 218 SE Branner Street • Topeka, KS 66601-1246 • (785) 232-4572 • Fax (785) 357-7794
www.midwaywholesale.com

Attached for your information is an outline I wrote entitled "Small Business Health Insurance Solutions." Note especially the higher costs of group policies.

Inndividual policies compared to group policies:

- Kansas single: $2363 vs. $3588 – saves $1225
- Kansas family: $5011 vs. $9420 – saves $4409

The remainder of this bill is at least palatable, but I would like to express one more concern.

The bill provides that "children" up to 26 years of age must be included as dependents, and disabled adults of any age if they are dependent upon the parent. Possible repercussions are:

- Fewer small employers will establish insurance plans.
- Current plans will be dropped if this pulls in people with expensive needs.
- Employers will not offer dependent coverage if they can avoid it.
- Employers will discontinue paying for dependent coverage.
- The bill estimates the cost for each new dependent to be $2,573 per year.
- Many employers are already providing insurance for another employer through spousal coverage. Now they will be responsible for additional employers. Whether they pay for dependents or not, their own plan will be impacted by the health care costs of those additional adults. This may render the insurance unaffordable for other employees as their share of costs go up to cover the children of other employees.
- I think this coverage is already available at prices I believe will be lower than with this scheme.
- I am already providing insurance to many 18 to 25-year-olds, with the employee portion fully paid at a cost to me of $178.83 per month. Am I now going to be forced to pay for the young employees of other employers, or even pay to have them covered twice?

Note that this bill will not apply to the 60% of insureds covered by large self-insured firms and unions. It only applies to those who buy insurance in Kansas. And, of course, the taxpayer will bear the costs for many public employees.

Thank you. I would be happy to answer any questions.

SMALL BUSINESS HEALTH INSURANCE SOLUTIONS

December 14, 2007

To get businesses with 1-10 employees to buy health insurance, there are four key issues:

- GET COSTS REDUCED.
- SIMPLIFY THE PROCESS.
- REDUCE RISKS – COST INFLATION AND LEGAL.
- GET MORE MONEY INTO THE PROCESS.

GET COSTS REDUCED

Move to individual policies from group policies:
- Kansas single: $2363 vs. $3588 – saves $1225
- Kansas family: $5011 vs. $9420 – saves $4409

Move to high deductible policies from full coverage policies:
- Saves 40% ± on insurance portion
- Saves some or all administrative costs on non-insurance portion
- Saves 40% ± of premium taxes.
- Saves 40% ± of high-risk pool assessment
- Saves 40% ± of defunct companies assessment

Use consumer-directed health care plans to get consumer involved in saving on health care expenditures:
- HSAs
- HRAs
- FSAs
- Shared-pay plans

Promote costs transparency,

Promote prevention and wellness.

SIMPLIFY THE PROCESS

On-line sales of health insurance.

Small business associations or others to provide assistance, services.

Universal health data form to remove red tape from application process.

REDUCE RISKS – COST INFLATION AND LEGAL

Revise (weaken or eliminate) small group reform laws.

Policies with multi-year inflation caps?

Provider agreements with inflation caps?

Indemnify small employers against lawsuits over health care.

GET MORE MONEY INTO THE PROCESS

Force consumers to have "skin in the game", preferably percentage co-pays and not fixed-dollar co-pays.

Allow employers to contribute to costs of individually-owned policies without triggering small group laws.

Allow individuals and owners of small businesses to purchase health insurance and perhaps health care with pre-tax money.

Governments provide subsidies, vouchers, or tax credits.

Debit cards with multiple sources of money to pay for health care costs.

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on SB 540

To
State Financial institutions and Insurance Committee

Presented by
Roderick L. Bremby
Secretary
Kansas Department of Health and Environment

February 18, 2008

Chairperson Teichman and members of the Committee, my name is Roderick Bremby. I serve as Secretary of the Kansas Department of Health and Environment and am very pleased to appear before you today in support of SB540 that proposes to implement health reform recommendations related to health insurance coverage proposed by the Kansas Health Policy Authority.

As Secretary of KDHE, I participate as a non-voting ex-officio member of the Kansas Health Policy Authority. In that role I have had the opportunity, along with the other Board members, to hear directly from consumers, medical providers and payers related to the health care crisis we are facing in Kansas. I am impressed with the due diligence of the process facilitated by KHPA staff as the Board reached consensus on a set of 21 recommendations to begin the health reform process in Kansas. Input to the process was extensive, with more than 1,000 individuals and organizations involved in the discussions throughout the past year.

Health care expenditures in the United States have grown at slightly more than twice the pace of the national gross domestic product (GDP) in recent years. Between 1980 and 2010, the portion of the nation's GDP spent on health is projected to roughly double. Simultaneously, public funds are paying for a larger share of theses costs through Medicaid, Medicare and other publicly funded programs. This means that every year, health care costs will consume more and more public funds, leaving less funding for other needed programs. Just as federal and state health care budgets are being squeezed, families, too, are feeling the burden of higher out-or-pocket costs.

Chronic conditions such as cardiovascular disease, cancer, diabetes, arthritis and respiratory diseases are leading killers in Kansas and a major source of illness,

FI&I Committee
February 18, 2008
Attachment 5

hospitalization, health care costs and long-term disability. Until recently, state policy makers have tried to control rising health care costs primarily through cost-containment measures. Now, however, states are paying more attention to the root causes of skyrocketing medical expenditures. SB540 outlines a select group of insurance reforms to provide earlier intervention, especially aimed at young Kansans and those employed by small business. Costly, debilitating and preventable chronic diseases are among the key contributors to the increased costs that states and uninsured populations face. Without aggressive intervention to provide early access to medical screening, treatment and disease management, these trends are expected to continue to worsen.

As the Secretary of the state's health and environment agency, I support the reforms outlined in SB540 and encourage your strong consideration of this proposal. I stand ready to assist the KHPA, Secretary of Commerce and Kansas Insurance Commissioner in achieving the new standards for health insurance that are outlined in the KHPA's proposal.

Thank you for your consideration of this important step towards health reform in Kansas. I will be pleased to stand for any questions you might have.

America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

February 15, 2008

The Honorable Senator Ruth Teichman
The Kansas Senate
Kansas State Capitol, Room 241E
300 SW 10th Street
Topeka, KS 66612

Re: Kansas Senate Bill 540

Dear Senator Teichman,

On behalf of America's Health Insurance Plans (AHIP), we want to thank you for your commitment to expanding access to health insurance coverage in the State of Kansas, and for your leadership as Chair of the Senate Financial Institutions and Insurance Committee. AHIP is the national association representing the private sector in health care, and its nearly 1,300 member companies provide health, long-term care, dental, vision, disability, and supplemental coverage to more than 200 million Americans.

Legislation that is currently before your committee, Senate Bill 540, has the laudable goal of increasing access to coverage for young adults and small employers. AHIP understands that increases in the cost of health care and low coverage rates among young adults and small employers pose a significant threat to the health and economy of the State of Kansas. However, the measure as currently written has the potential to negatively impact the individual and small employer markets while increasing premium rates. AHIP members are specifically concerned about the requirement to provide the new young adult policies in the group market, as well as the guarantee issue mandated imposed in the individual market for the expanded dependent coverage mandate. We appreciate the opportunity to engage in a dialogue about these concerns.

Requirement to Offer Young Adult Policies

S.B. 540 requires health insurers in the individual and group markets to provide young adult policies with benefit packages and premiums tailored to the needs of 18 to 25 year olds. While AHIP believes that health insurers need the flexibility to offer products that are targeted to the specific needs of their members in various markets; we are confused about the application of this requirement in the group market. Employers hire individuals who would fall within and outside the young adult population, and they generally select a single health insurance plan for their respective employees. As a result, it is unclear how this benefit package would fit in this market. Employers with a mixed population would be unable to select this benefit option as it would not be appropriate for, nor meet the needs of, their employees above the age of 25. We therefore suggest that this requirement should be modified to only apply in the individual market.

FI&I Committee
February 18, 2008
Attachment 6

We further respectfully note that any time a health insurer is required to provide specific types of policies it has the real potential to increase costs because of the additional resources that will be needed to create and administer these new policies. In addition, some health insurers may not have the capability to design, offer and administer a unique major medical policy for young adults in a cost-effective manner. Therefore, we suggest amending the legislation to make this section permissive, rather than compulsory, to better guarantee that the young adult population has access to these new benefit options that provide high-quality benefits at a reduced cost.

Expansion of Dependent Coverage Mandate

In addition to expanding the age of dependent coverage, this legislation also requires health insurers in the individual market to guarantee issue dependent coverage upon application. AHIP members are concerned about the application of this requirement to policies that are issued, underwritten and rated to insure only one person, as opposed to family policies that extend coverage to two or more eligible members of the family. In addition, a guarantee issue requirement is generally troublesome as it encourages individuals to delay obtaining coverage until the onset of a serious illness, which would eliminate many of the benefits of health care coverage, including preventive and primary care. Creating an environment that allows the young adult population to exit and reenter the market whenever coverage is needed eliminates incentives to maintain coverage, which ultimately removes these traditionally healthy individuals from the risk pool and increases premiums for those that maintain coverage in a responsible manner. For these reasons, we request that the proposed language for *Kansas Statutes Annotated § 40-2218(b)(1),* as outlined in section five of the legislation be modified as follows:

> *(1) Not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent reaches the age of 26* ~~*and shall, upon application, provide coverage for all unmarried dependents up to age 26*~~*.*

Kansas Small Business Health Policy Committee

Finally, we also suggest transferring the Kansas Small Business Health Policy Committee from the KHPA to the Kansas Insurance Department (KID). We respectfully note that the primary goal and purpose of the committee is to expand private market coverage options to small employers and believe that the KID's specific private market knowledge and experience would be particularly helpful to successfully achieve this objective.

Thank you for the opportunity to comment on this legislation and for the continued dialogue between the KHPA and the Senate Financial Institutions and Insurance Committee. We look forward to continuing to work with you to extend affordable, quality health care coverage to

working Kansans and their families. Please feel free to contact me at (202) 861-6378 or by email at dbricker@ahip.org.

Sincerely,

Dianne L. Bricker
Regional Director - State Advocacy

Written Testimony for SB 540 and SB 541
Senate Committee on Financial Institutions and Insurance
Senate Committee on Health Care Strategies
February 18, 2008

Uninsured Kansans

The Kansas Health Policy Authority has documented that there are 300,000 Kansans without health insurance.

The Institute of Medicine has estimated that in 2006 22,000 Americans died because of the lack of health insurance.

This means that in 2006 –198 Kansans died because of the lack of health insurance.

Approximately 198 Kansans without health insurance died in 2007 and another 198 Kansans will die in 2008.

Over 400+ Kansans without health insurance will have died in Kansan since Kansas initiated its program of health care reform.

Uninsurable Kansans

- At any point in time 10% of the population have a medical condition that renders them uninsurable (see attached list). Kansas has a population of 2.7 million. This means that any point in time there are **270,000** Kansans that have medical conditions that make them uninsurable.
- Individuals with these medical conditions cannot obtain individual health insurance at affordable prices.
- Individuals with these medical conditions who currently have insurance – cannot obtain individual insurance should their current insurance be terminated for any reason.
- The Kansas High Risk Pool requires that the individual show two letters of rejection from insurance companies in order to be eligible for the high risk pool. Premiums for this high risk coverage are beyond the reach of most Kansans.

Assuming that 10% of the 300,000 uninsured also have uninsurable medical conditions, about **540,000** Kansans or 20% of the population of Kansas either have no insurance or have medical conditions that make them uninsurable.

Underinsured Kansans

A Commonwealth Fund study estimated that in 2003 16 million Americans were underinsured. This means that in 2003 **144,000** Kansans were underinsured.

Adding together 300,000 Kansas who are uninsured, 270,000 Kansans with medical conditions that make them uninsurable, and 144,000 Kansans who are uninsured – means that altogether **714,000** Kansas have problems with health insurance. This is

FI&I Committee
February 18, 2008
Attachment 7

26.4% of the population of Kansas. This does not include the tens of thousands of Kansans who struggle daily with their insurance companies around problems of access to care, utilization review, etc.

Proposed Solution

To remedy this situation – SB 540 and SB 541 should be amended as follows:

Amendment A – The Kansas Health Policy Authority is directed to produce a plan to offer affordable health insurance to all those Kansans who are currently uninsured.

Amendment B – The Kansas Health Policy Authority and the Kansas Insurance Department will develop rules and regulations that

- prevent insurance companies from denying any Kansan health insurance because of a pre-existing medical condition and
- allows the individual to retain his/her insurance coverage from the employer at the group rate even when the employee is no longer employed by the company. The former employee would pay the group rate the employer offers to current employees.
- simplify the insurance process by requiring insurance companies to offer three basic levels of coverage to all Kansans.

Amendment C – Insurance companies doing business in Kansas would pool all insureds for that company into one risk pool for the company. Individuals, small companies, and larger companies would be in the same risk pool.

- This will bring health insurance in Kansas closer to its original concept as social insurance than the actuarial insurance model that it has become. The social insurance model of health insurance benefits the consumer; the actuarial insurance model of insurance benefits the insurance company and shareholder.

Respectfully,

Ira Stamm, Ph.D., ABPP

3600 SW Burlingame Road – Suite 1A
Topeka, KS 66611
913 706-8831
istamm@cox.net

Attachments:

Uninsurable Medical Conditions (OPIC) – (www.opic.state.tx.us)
2007 Individual Health Insurance Underwriting Guidelines (OPIC)
Actions Taken by the Insurance Companies for Selected Conditions (OPIC)

UNINSURABLE MEDICAL CONDITIONS

Many health conditions are considered uninsurable due to the high cost of treatment and medications. When such conditions are listed on the application, many health insurance companies will decline coverage without further review of medical records. These conditions include but may not be limited to the following: [1]

[1] List of medical conditions taken from Texas Health Insurance Risk Pool Qualifying Medical/Health Conditions.

- Cancer
  - Malignant Tumor within 4 Years (except skin cancer)
  - Metastatic
- Cardiovascular
  - Artificial Heart Valve
  - Cardiomyopathy
  - Coronary Artery Disease
  - Polyarteritis Nodosa
  - Peripheral Vascular Disease
- Endocrine/Exocrine
  - Diabetes Mellitus
  - Cystic Fibrosis
  - Addison's Disease
- Gastrointestinal
  - Intestinal
    - Crohn's Disease
    - Ulcerative Colitis
  - Liver
    - Cirrhosis (non-alcoholic)
    - Wilson's Disease
    - Hepatitis
- Hematopoietic
  - Anemia
    - Sickle Cell
    - Splenic (True Banti's Syndrome)
  - Hemophilia
  - Leukemia
  - Thalassemia
- Hodgkin's Disease
- Immunological
  - AIDS or HIV Positive
  - Lupus
- Musculoskeletal
  - Dermatomyositis or Polymyositis
  - Muscular Atrophy or Dystrophy
  - Myotonia
  - Rheumatoid Arthritis
  - Still's Disease
  - Legge-Perthes Disease
- Neurological - Central Nervous System
  - Cerebral Palsy
  - Cerebral Vascular Accident (CVA)
  - Epilepsy
  - Gullian-Barre Syndrome
  - Huntington's Chorea
  - Hydrocephalus
  - Lead Poisoning with Cerebral Involvement
  - Lobotomy
  - Parkinson's Disease (if treatment within 3 years)
- Neurological - Periphal Nervous System
  - Amyotrophic Lateral Sclerosis
  - Friedrich's Ataxia
  - Myasthenia Gravis
  - Paraplegia or Quadriplegia
  - Sclerosis, Multiple
  - Syringomyelia
  - Tabes Dorsalis (Locomotor Ataxia)
- Psychotic Disorders
- Pulmonary
  - Silicosis (Black Lung)
- Renal
  - Polycystic Kidney
- Other
  - Brain Tumor
  - Down's Syndrome
  - Scleroderma
  - Transplants

Produced by the Office of Public Insurance Counsel
www.opic.state.tx.us

2007 Individual Health Insurance Underwriting Guidelines

UNDERWRITING GUIDELINE	USED TO DENY COVERAGE	USED TO CHARGE A HIGHER RATE	USED TO OFFER LESS COVERAGE	TOTAL PERCENT OF MARKET SURVEYED USING GUIDELINE FOR UNDERWRITING PURPOSES
MEDICAL CONDITION The company examines the medical history of each applicant, using questions on the application, follow-up phone calls, and a review of medical records. Applicants with certain medical conditions are considered uninsurable and are routinely denied coverage. Click here for a list of uninsurable diseases and conditions as compiled by the Texas Health Insurance Risk Pool. For many common health conditions, applicants may be accepted, denied, charged a higher rate, or offered less coverage. For a breakdown of the actions taken by the insurance companies for selected conditions, click here.	100%	100%	100%	100%
HEIGHT/WEIGHT The company increases premiums or deductibles based on Body Mass Index (BMI). Premium increases can be between 25-50% of the standard (acceptable) rate. If applicant's BMI is higher than 35, the company will reject the applicant According to the National Institutes of Health: 18.5 – 24.9 NORMAL 25.0 – 29.5 OVERWEIGHT 30.0 – 39.9 OBESE 40.0 and higher – MORBIDLY OBESE	100%	86%	14%	100%
MORALS/LIFESTYLE The company asks if the applicant has had any convictions including DWI/DUI, number of speeding tickets, and whether the applicant has used illegal substances/drugs or abused prescription medications. In most cases, if an applicant answers "yes", a further investigation is done, and most likely the applicant will be declined.	76%			76%
AVOCATIONS The company underwrites based on the hobbies of the applicant and considers whether the hobby is professional or amateur. Some examples include SCUBA, Sky Diving, Parachuting, and Rodeo.	52%	24%	48%	67%
INFORMATION FROM CONSUMER REPORTING AGENCIES The company must ask applicant for permission to obtain these reports.				
MEDICAL INFORMATION BUREAU (MIB) REPORT- These reports provide data that is collected by approximately 500 member insurance companies. Information on medical conditions, driving records, criminal activity, and participation in hazardous sports, and aviation activity is contained in these reports.	67%	67%	67%	67%
CREDIT REPORT – A record of an individual's past borrowing and repaying history, including information about late payments and bankruptcy	67%	67%	67%	67%

Produced by the Office of Public Insurance Counsel
www.opic.state.tx.us

2007 Individual Health Insurance Underwriting Guidelines

UNDERWRITING GUIDELINE	USED TO DENY COVERAGE	USED TO CHARGE A HIGHER RATE	USED TO OFFER LESS COVERAGE	TOTAL PERCENT OF MARKET SURVEYED USING GUIDELINE FOR UNDERWRITING PURPOSES
PRESCRIPTION DRUG HISTORY Each company has a separate list of declinable medications. Some examples include: regular insulin for diabetes treatment, Plavix for treatment of clots, and Aricept for Alzheimer's Disease. If a patient is currently taking medications on the unacceptable drug list, the company may decline the applicant. An insurer can also increase premiums or deductibles based on certain medication usage. Also, some insurers require the applicant to purchase endorsements excluding or limiting coverage.	52%	24%	24%	67%
RESIDENCY Some insurers require United States residency of 12–24 months before an applicant can apply for coverage. Other insurers will decline an applicant who is on Visa status.	67%			67%
OCCUPATION The insurer will have a list of occupations that will result in declining the applicant or will ask the applicant to purchase endorsements excluding or limiting coverage based on his/her occupation.	48%		19%	52%
REPUTATION The company asks an insurance agent and in some instances, conducts personal interviews with friends, neighbors, and associates, regarding the general reputation and characteristics of the applicant. A sample question for an agent is, "Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk?"	38%	38%	38%	38%
BLOOD TEST OR ATTENDING PHYSICIAN STATEMENT (APS)				
BLOOD TEST - In order to process an application, the company requires a blood test.	5%	5%	5%	5%
APS- In order to process an application, the company requires an Attending Physician Statement regarding the applicant's health. In most cases, this is the insured's physician.	33%	33%	33%	33%
DOMESTIC VIOLENCE The company underwrites impairments caused by domestic violence.	10%	10%	10%	10%

Produced by the Office of Public Insurance Counsel
www.opic.state.tx.us

7-5

7-5

ACTIONS TAKEN BY THE INSURANCE COMPANIES FOR SELECTED CONDITIONS

	ACTIONS				DETERMINING FACTORS			
MEDICAL CONDITION	**USED TO DENY COVERAGE**	**USED TO CHARGE A HIGHER RATE**	**USED TO OFFER LESS COVERAGE**	**TOTAL PERCENT OF MARKET SURVEYED USING GUIDELINE FOR UNDERWRITING PURPOSES**	[illegible]	[illegible]	[illegible]	[illegible]
Breast Cancer Survivor	38%	62%	48%	100%	10%	90%	14%	24% [i]
Drug/Alcohol Abuse	100%	38%		100%		29%		10% [ii]
Maternity	86%		14%	100% [iii]				
Prostate Cancer Survivor	48%	52%	57%	100%	14%	81%		57% [iv]
Back Injury	38%	48%	62%	90%	62%	57%	19%	10% [v]
Arthritis	38%	62%	43%	86%	43%	14%	24%	
Asthma	43%	48%	52%	86%	38%	33%	67%	10% [vi]
High Cholesterol	29%	62%	33%	86%			33%	52% [vii]
Ulcers	33%	48%	48%	81%		43%	29%	
Depression	33%	43%	24%	76%	29%	14%	67%	
Osteoporosis	38%	57%	38%	76%	19%	14%	29%	24% [viii]
Hypertension	48%	57%	67%	71%	5%	24%	52%	33% [ix]
Thyroid	24%	38%	43%	67%		19%	52%	
Allergies		43%	24%	62%	24%	29%	52%	10% [x]
Fibrocystic Breast Changes	10%	29%	24%	48%	10%	19%		14% [xi]

[i] Medical records, lab reports, and mammograms
[ii] Blood test required.
[iii] 33% of the companies decline the entire family if one applicant is pregnant.
[iv] Prostate-Specific Antigen (PSA) test results.
[v] Medical records are required for further underwriting.
[vi] Age of applicant when last episode of asthma occurred is considered.
[vii] HDL/LDL lab results are needed for consideration.
[viii] Bone Density test results.
[ix] Current blood pressure reading is required for underwriting.
[x] Allergy testing results.
[xi] Medical records

Wichita Independent Business Association

THE VOICE OF INDEPENDENT BUSINESS

Senate Committee on Financial Institutions and Insurance
February 18, 2008
Neutral Testimony on Senate Bill 540
by Tim Witsman

Chairman Teichman and honorable committee members:

Thank you for the opportunity to appear before you today. My name is Tim Witsman and I am representing the Wichita Independent Business Association and the Kansas Independent Business Coalition. I am pleased that all of us are attempting to improve the quality, access, and cost of health care in Kansas. As a representative of small businesses, I am particularly pleased that HB 540 focuses on companies of fifty employees or less. Reduced premium plans for young adults, expanding dependent coverage, development of cafeteria plans, creation of a website, provision of grants and no interest loans for the development of cafeteria plans, as well as the development of marketing plans are all ideas our organization have been discussing since the KHPA released their recommendations.

The group that SB 540 focuses upon presents many challenges within the current health care system. Its premiums are higher because their size prohibits them the ability to negotiate lower premiums like larger business. It is difficult to aggregate. It has fewer resources with which to provide health insurance. As a consequence, it has a lower percentage of participation in health care coverage than larger companies. I understand why some see our state government as the means to improve the situation.

What you may not know is that there are options to the creation of a Small Business Health Policy Commission and a number of the other elements set out in this bill. This is, in all likelihood, because the Kansas Health Policy Authority did not know of these capabilities and, hence, did not include us in their deliberations.

I would not normally take your time to tell you about our organization, but what we are, do, and have done go to the heart of the issues raised in SB 540.

WIBA has been in existence for seventy-six years. We have been providing health insurance for the past twenty years to independent, mostly small businesses. Any non-publicly traded company in Kansas can be a member and access our health insurance options. We provide two High Deductible plans, two PPOs, and two HMOs. We are unique among Kansas associations in that our members are rated as a group rather than as individual companies. We offer coverage down to the sole proprietor and can quote six other companies if an individual does not like the rates in our six plans. Of the 591 companies taking insurance through WIBA, 121 are from outside Sedgwick County.

445 N. Waco Street / Wichita, KS 67202-3719
316-267-8987 / 1-800-279-9422 / FAX 316-267-8964 / E-mail: info@wiba.org / Web Site: www.wiba.org

FI&I Committee
February 18, 2008
Attachment 8

In addition, we provide a choice of four limited benefit plans. I have attached sheets displaying the coverage and rates for the plans we offer. We never try to convince anyone that these plans provide the same level of coverage as traditional insurance. We offer these products as a mechanism for a company that otherwise cannot afford to buy the traditional insurance products, but desires to provide a benefit and some coverage to their employees. This is especially important in getting a younger employee associated with a physician, or "medical home". Though the benefits are limited, they do include a wellness component. We also offer Section 125 plans.

My point is that we, and other organizations, can accomplish a great deal of what this bill intends without the State hiring additional staff or creating a new commission. If you are asking why we have not extended these offerings around the state, the answer is simply resources. We have a need for funds to make the outreach and travel around the state. While a website is helpful, it is not sufficient. We are in the process of making an application to the Department of Commerce for funds so we can accomplish our outreach goal. If the small employer market were more profitable the market would take care of it. Instead, we have reached a point where the State is considering stepping in. There are existing resources available in Kansas to carry out your intent without spending a great deal of money or creating new government bureaucracies. The fiscal note for SB 540 indicates the KHPA plans to hire of a person who will make 50% more than the person WIBA actually has handling our insurance plans.

We may not always agree with the Kansas Association of Insurance Agents, but in this case we are of similar mind. The Clearinghouse goal could be served by a combination of websites readily available today and managed through WIBA/KIBC, Kansas Insurance Department, Kansas Association of Insurance Agents, Kansas Chamber, Topeka Independent Business Association and NFIB.

As I close, I ask that you please consider this: you could set up an entirely new apparatus with no experience in working with small business or instead utilize the existing resources that need only outreach money to accomplish most of your goals. Rather than growing state government, our taxable entity that delivers our insurance products, the Wichita Insurance Services, could do the work ***AND*** pay taxes on the income derived therefrom. The more successful the effort, the more income rather than expense the State would experience. We think that makes good Kansas common sense.

I will be happy to answer your questions.

445 N. Waco Street / Wichita, KS 67202-3719
316-267-8987 / 1-800-279-9422 / FAX 316-267-8964 / E-mail: info@wiba.org / Web Site: www.wiba.org

Wichita Independent Business Association

Sterling Benefit Solutions™ Plans

Coverages	WIBA Plan A	WIBA Plan B	WIBA Plan C	WIBA Plan D
Combined Limited Medical Benefit Calendar Year Maximum	$100,000	$100,000	$100,000	$100,000
Deductible per person per calendar year	None	None	None	None
Outpatient Benefit				
Outpatient Physician Office Visit Indemnity Benefit (Bodily Sickness & Injury) Maximum 6 visits per person	$50 per visit	$50 per visit	$50 per visit	$60 per visit
Outpatient Testing/Diagnostic Procedures Indemnity Benefit Benefits are paid for X-Ray & Laboratory Testing. Maximum of 3 testing days per person per calendar year.	None	$100 per day	$100 per day	$100 per day
Wellness Benefit - Maximum $150 per person per calendar year	$50 per visit	$150 per visit	$150 per visit	$150 per visit
Ambulance Indemnity Benefit				
Calendar Year Maximum - 3 trips per person Lifetime Maximum - 5 trips per person	None	$100 per trip	$100 per trip	$100 per trip
Hospital Emergency Room Indemnity Benefit				
Accident Only Pays indemnity amount for treatment in an emergency room if performed within 72 hours of the accident.	$300 per occurrence	$500 per occurrence	$500 per occurrence	$1,000 per occurrence
Hospital Inpatient Benefit				
Hospital Admission Indemnity Benefit (Bodily Sickness & Injury) Requires a 24-hour hospital stay. Paid in addition to Daily Hospital Confinement Benefit. Maximum 1 benefit payment per person per calendar year.	None	None	None	$1,000 benefit
Daily Hospital Confinement Indemnity Benefit (Bodily Sickness & Injury) Requires a 24-hour hospital stay. Benefits are payable from 1st day of confinement.	$100 per day	$100 per day	$100 per day	$100 per day
Daily Intensive Care Confinement Indemnity Benefit Paid in addition to Daily Hospital Confinement Benefit. Maximum of 10 days per person per calendar year.	$100 per day	$100 per day	$100 per day	$500 per day
Mental or Nervous Disorders Daily Hospital Confinement Indemnity Benefit Requires a 24-hour hospital stay. $5,000 calendar year/$30,000 lifetime maximum	100% of HIP ($100 Per Day)	100% of HIP ($100 Per Day)	100% of HIP ($100 Per Day)	100% of HIP ($100 Per Day)
Substance Abuse Daily Hospital Confinement Indemnity Benefit Requires a 24-hour hospital stay. 30 days per person per calendar year maximum	100% of HIP ($100 Per Day)	100% of HIP ($100 Per Day)	100% of HIP ($100 Per Day)	100% of HIP ($100 Per Day)

8-3

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO

LM-110 03.27.07
WIBA

Sterling Benefit Solutions™ Plans

Coverages	WIBA Plan A	WIBA Plan B	WIBA Plan C	WIBA Plan D
Surgical Schedule Indemnity Benefit				
Inpatient Surgical Indemnity Benefit = the amount shown on the Surgical Schedule by procedure, with no benefit to exceed the inpatient maximum Outpatient Surgical Indemnity Benefit = 50% of scheduled Inpatient Surgery Benefit	None	None	Per person, Per Calendar Year Maximums: $1,000 Inpatient $500 Outpatient	Per person, Per Calendar Year Maximums: $2,000 Inpatient $1,000 Outpatient
Anesthesiology	None	None	20% of Surgical Benefits	20% of Surgical Benefits
Pregnancy Coverage				
Covered the same as any other sickness in all plans	Included	Included	Included	Included
Outpatient Prescription Drug Benefit				
Affordable RX (Catalyst) $10 Co-Pay Generic Formulary $15 Co-Pay Generic Oral Contraceptive Formulary Drugs $1,500 Annual Max per covered person Discount on all Name Brand Drugs	Included	Included	Included	Included
Term Life/AD&D Benefit				
$5,000/$5,000 Employee Only (Dependent Life – Not Included)	Included	Included	Included	Included
PPO Network Discount				
ProviDRs Care Network - Inpatient & Outpatient Discounts	Not Included	Included	Included	Included
COBRA Continuation Notification				
COBRA Administrative Services	Not Included	Included	Included	Included
MONTHLY RATES				
Employee	$39.51	$58.11	$ 76.25	$104.92
Employee & Spouse	$76.67	$110.02	$146.30	$203.64
Employee & Child(ren)	$71.13	$102.24	$136.34	$190.24
Family	$106.25	$151.16	$203.40	$285.97

GACHES, BRADEN, BARBEE & ASSOCIATES
PUBLIC AFFAIRS & ASSOCIATION MANAGEMENT
825 S. Kansas Avenue, Suite 500 • Topeka, Kansas 66612 • Phone: (785) 233-4512 • Fax: (785) 233-2206

Testimony of Kansas Association of Health Underwriters
Presented by Tom Bryon, Sr., Legislative Affairs Committee Chair
Regarding Senate Bill 540: Concerning Health Insurance
Presented to Senate Financial Institutions and Insurance Committee
Monday, February 18, 2008

Thank you Senator Teichman for this opportunity to discuss with your Committee our concerns about Senate Bill 540, one of the Health Reform recommendations of the Kansas Health Policy Authority. I am Tom Bryon with Association Benefits Advisor, Inc., and Chair of the Kansas Association of Health Underwriters Legislative Affairs Committee.

Before commenting about the specifics of the bill, I'd like to commend the Health Policy Authority for their efforts. They've covered a lot of ground in the past 10 months and have produced an impressive Health Reform package. There are many parts of their plan that we support and others where we think they are not going far enough, and still others where we think they are headed in the wrong direction. This morning I will limit my comments to the provisions of Senate Bill 540.

Section 1 of the bill redefines the small group insurance market to include sole proprietors. Groups of one to ten would be "very small employer" groups, thereby providing sole providers with the same group insurance opportunities as the current small groups size 2-50 employees.

While this change may seem simple and obvious it will result in significant increased costs to the small group insurance market. The current small group laws have a

FI&I Committee
February 18, 2008
Attachment 9

guarantee issue mandate as well as ratings cap that would apply to these new very small groups. That means that a sole proprietor that has pre-existing health conditions can not be denied access to a very small group health insurance plan; and it also subjects that plan to a cap on the rates it can charge.

The impact of this change will be to force companies offering small group insurance to accept the high costs of individuals with expensive pre-existing conditions without being able to price that small group plan accordingly. As a result, rates for all small groups will have to increase to make up the added expense for adding sole proprietors under guarantee issue. When this change was made in Colorado, four of the nine small group insurance carriers operating in the state left because they could not charge rates necessary to support their risks.

Under current law, the healthy sole proprietor can purchase an attractive individual health care policy at a reasonable cost, and many do. Thousands of these policies are sold every year in Kansas. Sole proprietor who have an existing health condition that prevent them from purchasing health care in the individual market currently have the state High Risk Pool as an option. But this is an expensive option.

We recommend that Kansas address the concerns of sole proprietors who are unable to purchase health insurance in the market by increasing the state subsidy of the High Risk Pool so it becomes a more affordable option for those with pre-existing conditions.

Section 2 of the bill creates Young Adult Policies that are limited benefit plans which "provide benefit packages limited to the specific needs of young adults." It is not clear in the bill who will decide what are the specific needs of young adults. In the opinion of our Association, young adult consumers don't need the State or Health Policy Authority telling them what benefits they need.

Still, KAHU has no objection to authorizing these Young Adult Policies but we want everyone to understand these are not health insurance. Limited Benefit Plans are already authorized by Kansas law and there are several firms that offer limited benefit plans for all Kansas residents, including young adults. Typically, these plans cover routine office visits but provide only limited or no coverage for catastrophic health care problems. For example, these plans would cover the occasion visit to the doctor for the flu but not cover care for a diagnosis of cancer or an injury that required a prolonged hospital stay like a major traffic accident.

It is also important to recognize that healthy young adults can already purchase regular health insurance at very low monthly costs; easily under $100 per month and often as low as $50 per month. Many young adults don't have health insurance, not because of the cost, but because they don't believe they will ever need it. We are concerned that young adults who purchase a Limited Benefit Plan might believe they have regular health insurance and only learn the disappointing truth when they need broader coverage due to catastrophic illness or injury.

Sections 3, 4 and 5 of the bill authorize young adults to be treated as dependents on their parents' health insurance plans up to age 26. It's worth noting that 80% of young adults in this age group already have insurance. Of the remaining 20% who are uninsured, many of them likely have insurance available through an educational institution or an employer and have simple chosen not to purchase it. Some part of the remainder are legitimately still dependents of their parents and could benefit from this provision. But we think this is a small number.

To the extent there are a significant number of young adult dependents who would be covered by this change it will increase health insurance rates for all families. But the change would be consistent with the recent changes in Missouri law.

We do have a specific question about the Young Adult Dependent language found on page six, lines 12-14, which reads, "(2) Provide that the cost of coverage for unmarried dependents from age 19 to age 26 shall be included in the premium on the same basis as other dependent coverage." It's not clear to us what that means. It seems to imply that there should be no change in rates for adding adult dependents, or that the rates should be determined "on the same basis." But the dependents being added are older than dependents currently covered, so the actuaries will want to do their work to determine what the rates should be for the additional risk.

Sections 6, 7, 8, and 9 of the bill create the Kansas Small Business Health Policy Committee and authorize the establishment of a "voluntary health insurance clearinghouse." This provision has generated great discussions within our organizations because we are aware of the desire of some policy makers to eventually replace the private health insurance market with a single payer government run program. Many of our members are concerned that the clearinghouse created here might evolve into a health insurance "connector" as used in Massachusetts, which has tried to replace the customer consultant role of insurance underwriters with a state run website that directs citizens to limited insurance choices.

Still, as currently proposed, this language is not objectionable. In fact, there are several state run health care information sites that are truly great tools for consumers. We particularly recommend the website run by the State of Florida – www.floridahealthfinder.gov

This excellent site not only includes information about maintaining health lifestyles and information about a broad range of health problems; it also contains performance and pricing information about every health plan operating in the state, and allows pricing and performance comparisons of hospitals, ambulatory surgery centers and nursing homes. It seems that the folks in Florida are busy measuring just about everything associated

with health care and share it all with their citizens. It is truly a great site. If this is what the Health Policy Authority has in mind for their clearinghouse, we support it.

Sections 10 and 11 of the bill transfer the cafeteria plan promotion program from Department of Commerce to the KHPA. We don't have any objection to the promotion and expansion in the use of 125 plans; however, we recommend instead of sending this program and new programs like the Clearinghouse to the Health Policy Authority, why not send them to the Kansas Insurance Department (KID).

The KID is the agency responsible for regulating health insurance plans and handling consumer complaints: its website www.ksinsurance.gov and the connected site run by the National Association of Insurance Commissioners www.insureuonline.org already have information used to educate consumers about the purchase of health insurance. If more money is needed to expand the KID site, it would be money well spent and we would not be reinventing the wheel. Adding responsibility for promoting cafeteria plans would seem to be a natural step.

Senator Teichman, thank you again for this opportunity to share our comments with your committee. The members of the Kansas Association of Health Underwriters want to be a resource to the legislature as you work through the many complex issues of health reform. Our national office is tracking health reform and Medicaid reform efforts across the country and can provide you with excellent resources as you work through these issues. I'm available to answer questions at your convenience.

Larrie Ann Lower
Attorney at Law
212 SW Eighth Avenue Suite 201
Topeka, KS 66603
785-640-2747
larrie_ann@yahoo.com

Testimony before the Senate Financial Institutions and Insurance Committee

SB 540

Kansas Association of Health Plans

February 18, 2008

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 enrolled in 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 540.

The KAHP commends the Kansas Health Policy Authority and the Kansas Legislature for continuing to examine and study ways to decrease the number of uninsured in Kansas. The KAHP shares that desire with the Authority and the Legislature. With all of us participating in the process, hopefully someday that goal will be realized.

The KAHP supports many of the sections of SB 540, but would like to express concerns with a few sections of the bill. New Section 1 allows insurers to provide coverage to "very small employers" which includes sole proprietors. Many sole proprietors currently have health insurance through an individual policy. Those that don't, either refuse to purchase the policy or don't qualify. Those that don't qualify in the in the individual market have access to health insurance through the Kansas High Risk Pool wisely created by this Legislature to guarantee every Kansan access to health insurance. The pool recently increased it's lifetime maximum to $2 million. Allowing groups of one to enter the small group market could very well cause rates for many others to rise as a result of adverse selection meaning more than likely the individuals that would choose to participate are the individuals that currently don't qualify through the individual market.

The KAHP is also concerned with the language of New Section 2. This section requires health insurance companies to offer limited benefit packages to young adults. It is unclear to the members exactly what is meant by "limited benefits packages" and it seems to require this new policy even if a health plan doesn't currently participate in the individual market. We trust

FI&I Committee
February 18, 2008
Attachment 10

that the Committee will give very careful consideration to the concept of creating limited policies for young adults. Please remember that young healthy individuals can currently purchase a comprehensive health policy for about $100.00 a month in the non-group market. In addition, it is young adults participating in the employer-based group insurance market that help subsidize and stabilize rates for the older Kansas workers. The KAHP is concerned that this young adult policy idea not disrupt or damage existing markets. Until this is more clear we ask that this section be removed or be optional. Again, thank you for allowing us to testify and I'll be happy to answer any questions you may have.

Kansas Association of Insurance Agents

Testimony on Senate Bill 540
Before the Senate Financial Institutions & Insurance Committee
By Larry Magill
February 18, 2008

Thank you madam Chair and members of the Committee for the opportunity to submit written testimony in opposition to Senate Bill 540. My name is Larry Magill and I'm representing the Kansas Association of Insurance Agents. We have approximately 520 member agencies and branches throughout the state and our members employ approximately 2,500 Kansans. Most of our agencies have a staff member who is licensed for life and health insurance and provide the coverage for their clients.

The Kansas Health Policy Authority, Dr. Nielsen and her staff are to be commended for the tremendous amount of time and effort put into their study of health care reform. We would have liked for agents to have had a seat at the table and for someone from the industry to be represented on the Board. Nevertheless the process generated a great deal of information about our health care system and health insurance that should be useful in the on-going effort to assure health insurance coverage is both available and affordable for all Kansans. You must not lose sight of the fact that Kansas ranks as the 6th lowest state in terms of its percentage of "uninsured" at just over 10% of the total population of the state.

Unfortunately, there is little in SB 540 that will promote the goal of affordable and available health coverage for all Kansans and here's why:

Very Small Group—Very Bad Idea
Taking Kansas' small group act down to groups of 1 simply will not work without a mandate. It will destroy the market for small group, as individuals will wait until they need surgery or have an illness diagnosed to buy coverage. It is analogous to allowing homeowners to wait until their house is on fire to buy insurance. Colorado did something similar only to see insurance carriers leave the state resulting in fewer market place options for its citizens.

Kansas has the Kansas Health Insurance Association to provide a market of last resort for an individual that cannot find coverage in the voluntary market. Its rates are subsidized by an assessment on all the health insurers. Thus there is already available health insurance coverage to "groups of 1", and the subsidy makes the coverage as affordable as possible.

FI&I Committee
February 18, 2008
Attachment 11

Young Adult Policies—Why?
Everyone agrees that a large number of the uninsured are young, healthy adults that for one reason or another, choose not to buy insurance. We do not believe they are choosing not to buy coverage because of the cost of individual coverage, which is age rated. Nor do we believe that the marketplace is not offering ample options to young adults in terms of coverage—aside from having to insure all the mandates.

Young adults that are covered on a group plan may pay more than they would under an individual policy, if the group is not age rated and the employer is not paying all the cost. But the group market needs to keep young adults in the risk pool to average out the cost for all Kansans. If you give the young, healthy adults a stripped down policy with cheaper rates, all you do is raise the rates for the remaining ones and cause more to go without coverage. In our view, a young adult policy is not going to cause the "bullet-proofs" to buy coverage. In addition, there is the problem of providing different coverage for different groups of insureds under a single group plan.

This is a mandate on all individual and group insurers to offer special coverage and rates to this market segment. It will simply raise the rates for everyone else and encourage more older adults to drop coverage.

Increase to Age 26
We question what this accomplishes. Universities can offer a student policy, a stripped-down low-cost policy that students can buy. If a child is working, they could have coverage available at their employment, yet this could require the parents employer to provide coverage under their group and expose their experience to a potential catastrophic claim. Further, some carriers already go to age 23 voluntarily and more are considering raising the age limit without a mandate to do so – the employer marketplace has asked for this extension to address the graduate student or dependent reliant on their parental coverage. We think the marketplace can handle it.

Clearinghouse Is Unnecessary
Section 6 converts the Kansas Business Health Partnership into a Voluntary Clearinghouse, a concept we are adamantly and unalterably opposed to. The KHPA in their 21 points envisioned that the Young Adult Policy and the Very Small Group policies would only be available through the Clearinghouse. While we cannot find language that accomplishes that in this bill, we fear it is still the ultimate goal.

To begin, the agent is the ultimate "clearinghouse". That is an agent's job: to find all the available markets, gather information from the insured about their coverage needs, their employees, their past experience and present it to the carriers and provide their proposals back to the client. And to suggest that the state needs to set up a "Clearinghouse" to provide consumers information or access to health insurance is a direct attack on agents and an effort for the state to take over the agent's role.

We would be happy to discuss with interested parties the perceived or alleged unmet needs of consumers and work with the Kansas Insurance Department to use their website and expertise to offer consumers a source for the needed information. The KID

website currently provides consumers with a list of "All Domiciles" Accident & Health and Life Companies. Further, consumers can review all of an agent's company appointments on the website.

Another significant concern is that the clearinghouse appears to extend the authority of KHPA beyond their legislative timeframe. Only after thoughtful review of the purpose and need of the KHPA should the legislature determine the future existence (including scope and funding) of the KHPA – it shouldn't simply be an outcome born out of legislation that didn't specifically address such extension.

There is a strong, viable market in Kansas for both individual and small group. We would be happy to work to attract new small group markets to the state but this will do the opposite. The experience in Maine, Massachusetts and elsewhere that a "Connector", "Exchange" or "Clearinghouse" has been tried, is that it drives markets out of the state. If it looks like a duck.....

Support Small Group Reinsurance Study

A continuing concern for small employers is the possibility that one large loss will drive up their group rates so high that they cannot afford to continue the coverage. The idea of a reinsurance mechanism for small group that smoothes out the peaks for small business through a spreading mechanism is worth exploring. This should allow smaller insurers to enter the small group arena and compete with the biggest players. We do not envision this as a taxpayer subsidy of small group rates. Rather, we see it as a way of leveling the premiums for all small groups. It will not save any costs in the health insurance system but it may save some small group plans from extinction. This can be done quite simply and without a clearinghouse.

No Silver Bullets, But....

Rather than leave you with only what we do not support, here are some ideas we think are worth exploring:

- Broader use of Section 125 Plans or Premium Only Plans (POPs) to gain tax benefits for everyone who buys health insurance
- Encouragement to use Health Savings Accounts with qualified high deductible plans to move toward Consumer Directed Health Care (CDHC)
- A single depository for individual medical records from all providers
- Consumer access to their medical records and greater education of consumers to help them make informed medical care decisions with their providers
- Experimentation with list billing of individual policies as an option for employers that have not offered health insurance for a year or more
- Consideration of a market-wide reinsurance mechanism for small group
- Transparency of health care pricing to go with CDHC

Senate Bill 564, which is patterned after Missouri Senate Bill 818, with amendments we will offer, will provide some positive changes for health insurance and health care.

We urge the Committee not to act favorably on SB 540. We would be happy to provide additional information or answer questions at the appropriate time.

Legislative Testimony

achieve more

SB ~~560~~ 540

February 18, 2008

Testimony before the Kansas Senate Financial Institutions and Insurance
By Marlee Carpenter, Vice President of Government Affairs

Chairman Teichman and members of the Committee:

The Kansas Chamber opposes SB 560 which, we believe, will add costs to already rising small group health insurance rates.

Businesses want to provide health insurance for their employees; however, the cost of health insurance is too high. The Kansas Chamber's 2007 Health Care Poll found that 88% of those surveyed agreed that "health insurance is available but high cost do not make it accessible." In addition, our 2007 Business Owners and CEO Poll revealed that managing health care costs was second only to lowering taxes on business when it came to concerns of business profitability. This survey polled 300 Kansas business owners and CEOs and of that 77% were small business owners with ten or less employees.

In addition, the Kansas Chamber talked to hundreds of small businesses from across the state during our 2007 Health Care Circuit this summer and fall. Small businesses from every corner of the state are looking for solutions and real-time help so that they can offer health insurance to their employees.

The Kansas Chamber opposes SB 560 because it will add cost to current health insurance programs and have a negative affect on the health insurance market in Kansas.

- The Kansas Chamber opposes establishing a very small group market because it will destroy the market for small group, as individuals will wait until they need surgery or have an illness diagnosed to buy coverage.
- The Kansas Chamber opposes young adult policies because the group market needs to keep young adults in the risk pool to average out the cost for all Kansans. If you give the young, healthy adults a stripped down policy with cheaper rates, all you do is raise the rates for the remaining ones and cause more to go without coverage.
- The Kansas Chamber opposes increasing the age to 26. We believe that there are better, more economical ways to cover this age group either though university policies or work related policies that will not have a negative affect on the group market.

KANSAS

FI & I Committee
February 18, 2008
Attachment 12

835 SW Topeka Blvd. **Topeka, KS** 66612 785.357.6321

- The Kansas Chamber believes that the clearinghouse is unnecessary. We believe that this information can be found in the current marketplace. This is an idea that the private sector is already doing and will be only an added government expense.

The Kansas Chamber would urge the committee to look at market-driven solutions that will help reduce costs to all businesses, especially small businesses looking to ensure their employees. We would suggest an expansion of the current health care tax credit so that it can be a real-time tool for small businesses to purchase health insurance, the enactment of a "mandate-lite" health insurance plan to help small businesses with the cost of health insurance and proposals such as Missouri's SB 818 which will allow individuals to purchase health insurance pre-tax through Section 125 Plans.

Again, the Kansas Chamber opposes SB 540 and urges the Committee to look at market-driven solutions that will reduce health care costs for all businesses. Thank you for your time and I will be happy to answer any questions.

Kansas Chamber, with headquarters in Topeka, is the leading statewide pro-business advocacy group moving Kansas towards becoming the best state in America to live and work. The Chamber represents small, medium and large employers all across Kansas.

KANSAS HOSPITAL ASSOCIATION

Thomas L. Bell
President

February 18, 2008

TO: Senate Financial Institutions and Insurance Committee

FROM: Chad Austin
Vice President, Government Relations

RE: SB 540

The Kansas Hospital Association appreciates the opportunity to provide comments in support of Senate Bill 540. This legislation consists of health reform provisions that have been recommended by the Kansas Health Policy Authority.

The Kansas Hospital Association supports the KHPA's three main goals: promoting personal responsibility, promoting medical homes and paying for prevention, and providing and protecting affordable health insurance. These goals provide a basis for broad health reform in Kansas and are consistent with KHA's *Principles of Health Reform* adopted by the KHA Board in June of 2007.

KHA believes that providing affordable and accessible health insurance to all is a critical piece of health reform. Senate Bill 540 begins to set the parameters that improve access to needed health care services that would otherwise be difficult, or impossible to obtain by Kansans. The young adult population seems to have the highest uninsured rate of any demographic population. Nearly twenty percent of Kansans between the ages of 19 and 24 are uninsured. Creating specific insurance options that are affordable for young adults and potentially increasing the age of dependents that may receive health insurance coverage on their parents' insurance plan makes coverage for these young adults more accessible.

Thank you for your consideration of our comments.

FI&I Committee
February 18, 2008
Attachment 13

Kansas Hospital Association
215 SE 8th Ave. • P.O. Box 2308 • Topeka, KS • 66601 • 785/233-7436 • Fax: 785/233-6955 • www.kha-net.org

American Heart Association®
Learn and Live™
Midwest Affiliate
Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin and two counties in Kentucky

February 18, 2008

TO: Senate Committee on Financial Institutions and Insurance

FROM: Linda J. De Coursey, Senior Advocacy Director – Kansas
American Heart Association

RE: Written Testimony on SB 540 - Health Reform: Establishing Very Small Employer definition; Creating Young Adult Policies; Increasing Age of Dependants on Parent's Health Insurance; Creating Kansas Small Business health Policy Committee and Transfer Cafeteria Plan Promotion from Commerce to KHPA.

Madam Chairwoman and members of the Senate Committee on Financial Institution and Insurance:

Early in January of 2008, the American Heart Association wrote a letter of support for the Kansas Health Policy Authority's recommendations. The AHA believes that the 21 recommendations are critical first steps to transform the health care system and improve the health of Kansans.

It is the mission of the American Heart Association to build healthier lives free of cardiovascular disease and stroke. Since heart disease and stroke are the No. 1 and No. 3 killers of our Kansas citizens, our efforts to build healthier lives are arranged among eight public policy priorities: Obesity Prevention; Tobacco Control; Funding for Heart Disease and Stroke Research & Prevention; Stroke; Quality and Availability of Care; Chain of Survival and Women and Heart Disease. In one way or another, these issues are addressed in the 21 health reform recommendations delivered by the Kansas Health Policy Authority (KHPA) board in November of 2007.

A major focus of the American Heart Association's advocacy efforts is to ensure that all U.S. residents have access to and coverage for appropriate and affordable quality care. The Association supports several principles: All U.S. residents should have prompt access to appropriate and affordable quality medical care. Any proposal to improve access should include enhanced support and coverage for preventive care, appropriate emergency care, diagnostic procedures, risk modification programs and heart and stroke rehabilitative services. The Association should participate in developing cardiovascular disease and stroke guidelines for appropriate patient care and support increased research into methods to measure quality, outcomes, and cost-effectiveness. The AHA will pursue public policy solutions to encourage hospitals to implement the quality measures monitored by the AHA's quality improvement initiatives and consider legislation and regulatory efforts to improve patient safety. The AHA supports the adoption of evolving health information technologies that translate science into evidence-based practice. AHA acknowledges that Health IT has the capacity to improve patient outcomes and patient care.

FI&I Committee
February 18, 2008
Attachment 14

The American Heart Association supports and endorses the 21 recommendations of the Health Policy Authority. We embrace the overarching goals of health reform:

promoting personal responsibility;
promoting medical homes;
paying for prevention; and
providing and protecting affordable health insurance.

It is American Heart Association's belief that the 21 recommendations are critical first steps to transform the health care system and improve the health of Kansans.

We would ask you to consider SB 540 favorably for passage. Thank you.

Peggy Johnson
Executive Director and COO
Wichita Medical Research & Education Foundation
Testimony provided to the
Financial Institutions and Insurance Senate Committee on Senate Bill 540

Thank you for the opportunity to provide to you comments concerning continuing health care coverage for young adults. I am Executive Director/COO of the Wichita Medical Research & Education Foundation located in Wichita. This past summer I served as the Chair of the Consumer Advisory Council to Kansas Health Policy Authority. But I am talking to you today as a mother of two young adults.

Senate Bill 540 would encourage health insurance companies to provide benefit packages limited to the specific needs of young adults and provide these policies or Young Adult Plans (YAP) at reduced premiums based on the limited benefits offered. SB540 would also allow young adults from the ages of 18-26 to continue to be covered under a parent and or parents' policy until the age of 26 if they continued to be dependent on the parent for support.

As the parent of a 22-year-old daughter enrolled as a student at the University of Kansas I implore you to seriously consider this bill. As more and more young adults work during college or make the hard decision to continue their education beyond a 4-year degree the U.S. and Kansas continue to see more and more young adults faced with no health insurance. The majority of health insurance policies today require young adult children to be dropped from the parents' health insurance at the age of 18, 21, or 22. Young adults and their families face tuition payments, housing and food costs, and many simply don't have the funds to purchase a quality health insurance policy in today's market place.

My daughter will be 23 in November, but will not graduate from KU until the following spring. As of December 1 she will no longer be eligible to be covered by our health care policy. My daughter's health is always precarious, by no fault of her own. She is a life long asthmatic and requires a number of prescriptions just to be able to carry on a normal life. Because of her asthma, her immune system is compromised and she is constantly fighting other health concerns. As of December she will be without health insurance and prescription coverage. In order to purchase a policy that would compare to the one we currently carry would cost our family or Molly at least $400 a month.

FI&I Committee
February 18, 2008
Attachment 15

My son recently graduated from law school with a debt the size of many homeowners. While he made the decision to go to law school and support himself, health insurance was not in his budget. Even though we continued to provide some support he lived on a shoestring. In order to have some peace of mind we purchased a school backed policy for him. If he had been seriously injured a portion of his injuries would have been covered; but little else was covered. There was little or no prescription coverage and while it did provide with some reimbursement the paper work required was more than most of his law school classes required. The youth of Kansas deserve better. Good health begins as a child and certainly doesn't skip the years until we are covered by insurance through our own employment.

We all know that many Kansans face terrible financial debt, but many of you may not know that many Kansans are in debt because of a long illness or the illness of a loved one. Many Kansans are simply too proud to ask for help. In today's market there isn't much chance to see if you're getting the best healthcare for your money. You simply seek healthcare close to home or where you can find it. Health care is not something we shop for, at least not yet.

It is estimated that in Kansas today there are 15,000 young adults without health insurance. Can you with clear mind continue to ignore this problem, when you have the opportunity to provide assistance? When my son turned 22 while still at Kansas State he was without insurance until we purchased the insurance opportunity provided through law school. Yet when he was dropped from your policy our premiums were not reduced. In December when our daughter turns 23 our insurance may be reduced, but certainly not by the $400+ a month it will take to replace her current coverage.

More and more young adults are taking longer to finish college for various reasons. More and more young adults are choosing public service after college, which should make us all proud. But unfortunately, more and more young adults are facing day-to-day life without adequate health care coverage and access to adequate preventive medicine. Many non-profits and community groups are unable to provide health care insurance because of the high cost, which leaves many without care, including our young adults. We all deserve better, but especially our youth as they start their adult lives.

As I started considering my testimony I heard from a number of friends who expressed the same frustration and fear for their adult children. Many, many families in Kansas are faced with these same concerns daily. This summer as the Consumer Advisory Council met and discussed many issues; this issue was one of concern for every member without exception. Yet the opportunity to right this concern is at your discretion to change. As you approach healthcare reform in this legislative session, few changes will be as easy as this can be. SB540 has a relatively low mark, but to so many families can really mean piece of mind for parents and children.

Understanding the value of health insurance and adequate health care is something that all Kansans should understand. Providing the opportunity to our young adults through YAPs would reinforce the need and the understanding of adequate health insurance and the value of preventive medicine. There will be some challenges in developing YAPs at an affordable cost for the industry, but by passing SB540 you can send a strong signal to the industry that the health of our young adults is important.

The Kansas Legislature has many tall tasks this session, but none more important than starting our state on the right track to healthcare reform. Thank you for taking on this challenge.

Again, thank you for this opportunity.

Peggy L. Johnson
28 Norfolk
Wichita, KS 67208
316-682-1662

KANSAS MEDICAL SOCIETY
KMS

623 SW 10th Avenue
Topeka KS 66612-1627
785.235.2383
800.332.0156
fax 785.235.5114

www.KMSonline.org

To: Senate Committee on Financial Institutions and Insurance

From: Dan Morin
Director of Government Affairs

Date: February 18, 2008

Subject: SB 540; AN ACT concerning health insurance; establishing a voluntary health insurance clearinghouse; authorizing policies for young adults; defining very small employers; enacting the Kansas small business health policy committee act.

The Kansas Medical Society appreciates the opportunity to appear in support of the health care reform proposals contained in SB 540, which were developed by the Kansas Health Policy Authority (KHPA). As we did when we commented on the proposed reforms at the meeting of the Joint Committee on Health Policy Oversight last November, we would like to commend the KHPA on the public process it undertook to identify and develop the reform recommendations contained in this legislation, as well as the other bills which contain the balance of the KHPA recommendations. The KHPA went to great lengths to obtain the input from stakeholder groups and the public prior to making its recommendations. In addition, the KHPA made a commitment to transparency in its development and deliberative process, and much of the testimony, data and reports which support their recommendations were promptly posted on their website throughout the process.

The KHPA developed its recommendations within the context of three core principles, which it utilized to guide its efforts. The three principles – 1) promoting personal responsibility, 2) promoting a medical home and prevention, and 3) providing and protecting affordable health insurance – represent a solid foundation upon which comprehensive health reform can be built in Kansas. As the health reform process moves forward in the coming years, these principles will be very helpful in framing the continuing debate and guiding policy changes.

It is important to recognize that the road to meaningful reform will take time, and a commitment to incremental change. While there are those who believe that health reform should be accomplished in one swift transformational change, experience has shown that fundamental change in large, complex systems such as this just take time. In addition, there is only so much that can be done to reform health care by individual states. There is much that states can do, but comprehensive reform will ultimately require the involvement of the federal government as well.

FI & I Committee
February 18, 2008
Attachment 16

The KHPA has estimated that if all of its recommendations for expanding insurance and access to care were adopted, approximately 86,000 Kansans would be removed from the ranks of the uninsured. Whether or not that is achieved will depend on many factors, but the prospect of accomplishing this without having to enact a coverage mandate on individuals or employers is significant. If Kansas were to reduce its uninsured by anything close to that number, we would have made an important step towards the ultimate goal of assuring that all Kansans have access to health insurance.

SB 540 increases the age of "dependents" for health insurance policies to include residents up to 26 years of age from 19. Approximately 300,000 Kansas do not have health insurance. Much of this number is due to young people between the ages of 19 and 34. Private health insurance could be more accessible for young adults if insurers made it standard practice to offer dependent coverage up to age 26. Accessing dependent coverage through a family plan is often cheaper than enrolling as an individual in the direct-purchase market. This new coverage option could help make coverage more affordable for families with young adult dependents, many of whom earn too much for public programs but cannot afford private coverage on their own.

The legislation also includes language allowing limited benefit coverage polices for young adults between 18 and 25. Unlike employer-provided insurance, the cost, availability and comprehensiveness of insurance purchased in the individual market depends on a person's age, health status and coverage history. The underwriting process (i.e. a review of all of the factors above) determines how much the policy will cost, what will and will not be covered or whether coverage will be offered at all. Younger and healthier workers are clearly advantaged in this market, compared to older persons or individuals with significant health risks.

SB 540 would also establish the Kansas Small Business Health Policy Committee to assist small groups and small employers in identifying and obtaining health insurance products and cafeteria plans through a voluntary health insurance clearinghouse, a website to provide such information, and provide grants or no interest loans to small employers to establish cafeteria plans. Small businesses and their employers struggle daily with the cost of health care insurance. The small business community pays, on average, 18 percent more in health insurance premiums for the same benefits as those in the largest firms, according to a Commonwealth Fund-supported study published in 2006. KMS supports a comprehensive approach to helping small businesses find affordable and quality health insurance and the steps included in SB 540 to increase the availability of health coverage information.

The recommendations included in SB 540 represent a solid start to meaningful health reform for the state of Kansas. We appreciate the opportunity to comment on these recommendations, and look forward to working on health reform with the KHPA and the legislature in the coming months and years.

BRAD SMOOT
ATTORNEY AT LAW

800 SW JACKSON, SUITE 808
TOPEKA, KANSAS 66612
(785) 233-0016
(785) 234-3687 (fax)
bsmoot@nomb.com

10200 STATE LINE ROAD
SUITE 230
LEAWOOD, KANSAS 66206

Statement of Brad Smoot
(Written Only)
Legislative Counsel
Blue Cross Blue Shield of Kansas
Senate Financial Institutions & Insurance Committee
Regarding 2008 Senate Bill 540
February 18, 2008

Madam Chairman and Members:

On behalf of Blue Cross Blue Shield of Kansas and its approximate 800,000 insureds, we appreciate this opportunity to comment on SB 540, and in particular, the portion of the bill that mandates expanded dependant coverage.

The topic of expanding the age for young adults to remain on their parents' health insurance policy as dependants is being discussed nationwide and being mandated in several states. It was a topic of discussion last session in connection with SB 117 and SB 243. To many, this is a method to increase the number of young adults who have health insurance coverage, a goal shared by BCBSKS and probably every health insurance company. Of course, adding anyone to the ranks of the insured, even young healthy individuals, brings with it the attendant risks, costs and premium impact to those who must pay for that coverage. To the extent that families opt to keep dependants on their family policies, employers and families will need to be prepared to share the cost of the extra three years of coverage mandated by SB 540.

SB 540, Section 5(b)(2) requires that the young adults between the ages of 23 and 26 insured under the dependant coverage of any policy must be "included in the premium on the same basis as other dependant coverage." BCBSKS traditionally uses four categories of coverage and dependants are included in two of those categories with no distinction between how many children might be on the policy or their ages. Consequently, unless a carrier uses age rating or prices dependant coverage according to the number of children in the family, they will have to price dependant coverage by spreading the costs of the young adults among all families with dependant coverage. In other words, the family with two children under five years old will share the cost of adding the young adult children between the ages of 23 and 26 of another family.

Last year, we estimated the premium impact of the increased dependant coverage mandate at about 1.3% or about $13 million for the affected BCBSKS policyholders. Statewide, we estimated that the impact might be three times that amount. It is most important to note that such estimates assume a lot of complicated factors, not the least of which is the estimate of how many young adults would opt for coverage on their parents' policy. The point here is not to declare a hard and fast estimate but to illustrate that this mandate, as with all mandates, comes with a price. As other states and employer groups gain more experience with the expansion of dependant coverage, we will all have a better idea how much additional premium we will need to collect for the 23 to 26 year olds and who will shoulder the added costs of this mandated coverage. Thank you for considering our views.

FI & I Committee
February 18, 2008
Attachment 17

UnitedHealth Group

James S. Watson, Vice President, State Affairs
8101 "O" Street
Lincoln, Nebraska 68510
Tel (402) 327-2446 Fax (402) 327-2453

Testimony in Opposition to SB 563
Financial Institutions and Insurance Committee
Monday, February 18, 2008

Senate Bill 563 seeks to prohibit a utilization review organization from requiring notification of admission to a health care facility prior to the next business day. UnitedHealth Group respectfully offers the following testimony in opposition to SB 563.

As the Committee is aware, UnitedHealthcare is currently conducting a pilot program, with 200 hospitals around the country – including Kansas hospitals – to obtain notification from those facilities within 24 hours after a UnitedHealthcare customer is admitted…seven days a week. The purpose of the pilot is to identify the operational issues, electronic submission issues and unique weekend holiday issues associated with each of our six notification transmission channels.

The Committee might also be interested to know that, contemporaneously with the hospital/facility notification program, we have also reduced the list of inpatient services requiring advance notification by physicians.

Why is notification so important? United's care management model is evolving to incorporate "best national practices" on a fully integrated basis. This includes focusing on outpatient and inpatient care, chronic disease and case management, coordination of care and the application of evidenced based medicine with systematic feedback to physicians and providers. Incidentally, this care management model does not impose a length of stay on providers.

FI & I Committee
February 18, 2008
Attachment 18

Specifically, notification facilitates UnitedHealthcare's ability to provide clinical support and education, such as:

1) Pre-op education for the patient and ensure adherence to nationally recognized guidelines in order to maximize quality and cost efficiency;
2) Facilitate post-op discharge planning to optimize clinical outcomes;
3) Refer patients to Centers of Excellence (e.g. congenital heart disease);
4) Refer patients to appropriate in-network physicians or other health care professionals to maximize customers benefits;
5) Refer patients to our case management and disease management programs

The "ultimate" goal is timely Physician and Consumer Engagement.

Is the new notification requirement burdensome? There are several ways a hospital facility can provide notification: 1) Unitedhealthcareonline.com 2) EDI (electronic 278 claim) transaction 3) telephone 4) VoiceCert 5) facsimile **or** facsimile of the hospital's UHC daily census logs 6) direct access by UHC to the hospital administrative system.

In closing, UnitedHealthcare respects the concerns of the Kansas Hospital Association, however we believe that the data driven processes being studied in our pilot program will get us to our mutual goal in a truly collaborative way.

Unfortunately, the pilot has just begun to produce the needed data for the pilot hospitals and UnitedHealthcare to make improvements to the process. Therefore, we respectfully suggest that this Bill at this time is premature, in that it attempts to address problems that both UnitedHealthcare and the hospital industry are working hard to ensure do not occur when the notification program is operational.

Newman
REGIONAL HEALTH
For your whole life™

February 18, 2008

TO: Senate Financial Institutions and Insurance Committee

FROM: Holly French
Chief Financial Officer
Newman Regional Health

RE: Senate Bill 563 – Notification of Admission

I appreciate the opportunity to speak in favor of Senate Bill 563 which would prohibit a utilization review organization from requiring notification of admission prior to the next business day after a patient presents to a health care facility.

Newman Regional Health is a Sole Community Hospital. The staff that is responsible for providing the notification to utilization review organizations is minimal even during the business week. We do not staff any of these administrative positions outside of the normal business day. To require this of an organization our size would be cost prohibitive.

We have been told by these utilization review organizations of ways that we can submit this information to them on a 24/7 basis. This does not change the fact that we must have the staff available at all times to provide technical information such as ICD-9 codes and physician tax identification numbers among other items required. This requires specialized staff to provide this information. These positions, especially qualified coding staff, are not easily recruited. This will again increase the cost to care for our patients and is an administrative burden required by these utilization review organizations with no perceived benefit.

We must weigh the increase in cost to provide the necessary staffing versus the loss of potential reimbursement to our facility. This may necessitate contract cancellations with these organizations due to the negative cost benefit analysis. This will impact our patients significantly by increasing the cost of healthcare. Patients will be forced to pay increased costs for out of network care. This is not something that we as a hospital provider take lightly. We know this will impact our patients and our community employers. We therefore make every effort to prevent this and that is why I am here today.

Providers struggle now to cover the cost of healthcare with the continuing reductions to reimbursement. We cannot afford to lose additional reimbursement for care that we provided in good faith to our patients.
Any admission that is done on nights, weekends, or holidays, is done only because it cannot be delayed. Physicians are very busy people and especially during these times would not admit

FI&I Committee
February 18, 2008
Attachment 19

patients without a very real need. This is an inconvenience to our physicians and to our patients and is avoided if at all possible.

It is difficult to understand how this notification will provide any benefit. In fact, we question whether these organizations will have the staff available to do anything substantive with this notification. I do very clearly understand the impact of requiring the notification: 1) decreased reimbursement to providers, 2) increased cost of caring for our patients, 3) increased cost to our patients.

I do hope the Senate Financial Institutions and Insurance Committee will place in statute the industry standard of next business day for admission notification policies. Your decision will impact not only rural communities and providers but healthcare in general. Thank you for your time and consideration of this issue.