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 19, 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:
Ralph Ibson, VP of Government Affairs for Mental Health America
Kenneth Daniel, Midway Wholesale
Larry Magill, KAIA
Derrick Sontag, NFIB (written only)
Marlee Carpenter, Kansas Chamber of Commerce (written only)

Others attending:
See attached list.

The Chair called the meeting to order. Amy Campbell, Kansas Mental Health Coalition, introduced Ralph Ibson, Vice President of Government Affairs for Mental Health America, who spoke on "Federal Mental Health Parity."

Mr. Ibson said Mental illness and substance use have a huge impact on our society. He said mental disorders are the leading cause of disability in the U.S. for individuals ages 15-44. He noted they are also a leading cause of premature death, implicated in 90% of the more than 30,000 suicides annually in this country.

Mr. Ibson said the core principle of the House and Senate parity bills is the same, simply to require fairness in terms of treatment limitations and financial requirements. He said neither bill mandates mental health coverage and neither bill calls for any preferential treatment of mental health. He said both bills simply say health plans may not impose stricter treatment limits or financial requirements on mental health care than care for any other illness.

He continued that there have been many myths surrounding parity, the principle myth being that parity will be costly. He said what has become clearer with respect to arguments about the cost of parity is that the real costs lie in not treating behavioral health disorders rather than in establishing fairness in health coverage. He said failing to treat mental illness has other profound costs. He said without intervention, childhood disorders may persist and lead to a downward spiral of school failure, poor employment and poverty in adulthood. He noted no other illnesses damage so many children so seriously. He said while enacting parity legislation is fundamentally about achieving fairness in insurance practices, it is one important step toward solving a great many problems affecting virtually every community in this country. (Attachment 1)

Hearing on:

**SB - 564 - concerning health insurance; pertaining to employer provided cafeteria plans; pertaining to health savings accounts; pertaining to high deductible health insurance plans; pertaining to tax treatment of health insurance premiums**

The Chair asked Melissa Calderwood for an overview of SB 564. Ms. Calderwood said in Section 1, it states the act shall be known and may be cited as the smaller employer health care act.

Section 2 states A health benefit plan subject to the provisions of the small employer health care plan act shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, with some exceptions.

In new Section 3, it states beginning with the open enrollment period for the 2009 plan year, the administering carrier shall offer to all eligible individuals the option of receiving health care coverage through a high deductible health plan and the establishment of a health savings account. Such option may be offered through a cafeteria plan.

Section 4 is amended to read, "there is hereby created a nonprofit legal entity to be known as the Kansas Health Insurance Association. All insurers and insurance arrangements providing health care benefits in this state shall be members of the association."

Sections 5, 6, and 8 set out language from the existing bill.

Kenneth Daniel, Midway Wholesale, testified in support of SB 564. Mr. Daniel stated that this bill contains the provisions of the excellent plan passed in Missouri a year ago known as Missouri SB 181. The Missouri bill takes a step toward tax equity by establishing a state income tax deduction for net out-of-pocket health care costs; makes modifications to the high risk pool; it adds considerable language about Health Savings Account arrangements, including the high risk pool and state employees' health plan, and adds considerable language about Section 125 Cafeteria Plans. He told the committee they could consider adding most of the language from HB 2822, which picks up important parts of Missouri SB 818, makes it mandatory for Kansas businesses offering a health plan to establish a simple Section 125 Cafeteria plan, and upgrades Senator Barnett's 2005 tax credit for new small business health plans. (Attachment 2)

Larry Magill, Kansas Association of Insurance Agents, testified that it is his understanding that SB 564 is based on the provisions that would apply to Kansas in Missouri's SB 818. He said it appears that Section 2 enacts a requirement that all small group policies are guaranteed renewable unless the insured does certain things like fail to pay premiums, fail to meet participation requirements or commits fraud. He said there are provisions for discontinuing a plan and for exiting the small group market completely and a 5-year "lock out" if they do leave the state. He said there is a prohibition on page 2 on changing coverage of a small group plan but it does not seem to allow an insured to request changes in coverage terms unless it is changed for the entire book of business with that "plan." He said that is too restrictive. He said he is not aware of problems with carriers in the small group market that these provisions would address. He said they will certainly be a significant factor in determining whether a carrier stays in Kansas or enters the state. He said KAIA would rather encourage more competition in the small group market and are very concerned about any statute that might reduce it. He said for these reasons, he suggests that Section 2 be deleted and studied further.

He said whether you talk in terms of consumer directed health care, Health Savings Accounts or high deductible health plans, KAIA supports the concept that the consumer has to be brought back into the equation and given a stake in managing their health care expenses and their own wellness.

He continued that new Section 3 requires that the state's high risk plan offers a high deductible health care plan and health savings account through a Section 125 Plan. He said Section 8 allows an employer to qualify for the tax credit for offering insurance through an offer of health savings account, high deductible plan through a Section 125. Sections 9 and 10 extend it to state employees. He said KAIA supports all of those requirements.

He said KAIA further supports a requirement that all small group carriers offer a high deductible plan with a health savings account option at an actuarially justified savings through a Section 125 Premium Only Plan (POP).

He continued that individual policies have the advantage of decoupling the person's insurance from their employment, allowing them to take their coverage with them wherever they go.

MINUTES OF THE Senate Financial Institutions and Insurance Committee at 9:30 A.M. on February 19, 2008 in Room 136-N of the Capitol.

He said regarding mandatory POP, Premium Only Plans more than pay for themselves. He said with these changes, SB 564 takes some significant steps to encourage use of Health Savings Accounts, high deductible health plans, Section 125 POP Plans, individual rather than employer provided health insurance and greater consumer investment in their wellness and in the cost of their health care. (Attachment 3)

Derrick Sontag, NFIB State Director, presented written testimony only on SB 564. (Attachment 4)

Marlee Carpenter, Vice President of Government Affairs, The Kansas Chamber, presented written testimony only. (Attachment 5)

The meeting adjourned with the Chair leaving the hearing on SB 564 open.

Sen. Judman

Ben x67394

# SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE
## GUEST LIST

**DATE:** 2-19-08

| NAME | REPRESENTING |
|---|---|
| Susila Gabbert | |
| Michelle Powell | |
| Jennifer White | |
| Angela Walsh-Fisher | |
| Liz Maisberger-Clarke | KCASB |
| Karl Wagen | Kennedy & Associates |
| Alex Kotoyantz | P.I.A. |
| LARRY MAGILL | KAIA |
| KERRI SPIELMAN | KAIA |
| Jamal Jones | VHG |
| KEN DANIEL | KSSMALLBIZ.COM / TIBA |
| Bill Sneed | ADVP |
| Natalie Haag | Security Benefit |
| Lori Church | KAPCIC. |
| Cynthia Smith | SCL Health System |
| MaryEllen Conlee | Via Christi Health System |
| Bruce Linhardt | Overland Health Systems |
| Jay Hogen | Ks Ins Dept. |
| Rachel Smith | Kansas Health Institute |

**SENATE FINANCIAL INSTITUTIONS & INS. COMMITTEE**
**GUEST LIST**

**DATE:** _____

| NAME | REPRESENTING |
|---|---|
| [signature] | SCHF |
| Tara Hacker | KHPA |
| RICK CAGAN | NAMI Kansas |
| Pat Eakes | KCDC |
| Chad Austin | KHA |
| Dan Murray | Federico Consulting |
| Cheryl Dillard | Coventry Health Care |
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Briefing Statement
on
Mental Health Parity
Before the
Senate Financial Institutions and Insurance Committee

Ralph Ibson
Vice President for Government Affairs
Mental Health America

I'm honored to have the opportunity to speak to you today on Federal mental health parity legislation. Let me offer some context. Mental illness and substance use have a huge impact on our society. Mental disorders are the leading cause of disability in the U.S. for individuals ages 15-44. They are also a leading cause of premature death, implicated in 90% of the more than 30,000 suicides annually in this country.

Mental health and addiction disorders touch nearly every family in America. Some 54 million Americans suffer from mental health conditions, and another 26 million from addictions. These illnesses account for more than 20 percent of lost days of productive life.

Through our nation's investment in research we have made enormous advances in our understanding of mental illnesses. As the landmark 1999 Surgeon General report on mental health emphasized, mental illnesses are not only real, but diagnosable, and readily treatable with a range of effective evidence-based treatments. We know today that mental health is integral to overall health, and that mental health problems and so-called physical health problems are fundamentally intertwined. The science is irrefutable in documenting that mental illnesses have a biological basis, like other illnesses. There is no scientific foundation for policies or positions that approach behavioral health disorders as though they are somehow fundamentally different than other disorders. And yet some practices still reflect such outdated views.

Millions of Americans rely on employer-provided health insurance to get needed medical care. Yet many who experience a mental disorder confront formidable roadblocks when they turn to that insurance. The sad reality is that most employer-sponsored health plans set strict, arbitrary limits on mental health coverage, while imposing no limits, or much less strict limits, on coverage for other illnesses.

I'd ask you to imagine a friend who is undergoing treatment for cancer and learns part-way through a long course of chemotherapy that his or her insurance coverage for cancer treatment has maxed out because the health plan limits cancer care to 20 outpatient visits annually. Fortunately, people with cancer, heart disease, diabetes and other life-threatening illnesses don't encounter such barriers. But that's an everyday occurrence for people with mental illnesses, who often also face onerous cost-sharing requirements and may, for example, have to pay 50% of their costs out of pocket, while having far lower cost-sharing requirements for treatment of other illnesses.

Imagine an individual who has struggled for years with chronic depression so severe that she has attempted to take her life and whose health plan sets a LIFETIME limit of 75 outpatient visits for mental health care. I've spoken with people in just that situation; one of them explained to me that she would not be able to afford the continued treatment she needs once she reached the fast-

FI & I Committee
February 19, 2008
Attachment 1

approaching 75-visit lifetime limit. Given her history, she described this arbitrary limit as in the nature of a death sentence.

Few phrases more aptly describe these kinds of insurance practices than the words "arbitrary discrimination." Regrettably it continues to be routine for health plans to single out behavioral health disorders in this way and limit access to care. It's shocking that employers and insurers so blatantly discriminate against people on the basis of a specific class of illnesses. But it's more shocking, in my view, that -- more than 40 years after the passage of Civil Rights laws and some 15 years after the passage of the Americans with Disabilities Act -- federal law permits discrimination against health plan beneficiaries on the basis of mental illness.

Congress, in the Mental Health Parity Act of 1996, did in principle outlaw health-insurance discrimination by establishing that IF a health plan provides mental health benefits, that coverage should be "on par" with medical and surgical benefits. But the 1996 law only bars disparity as it relates to annual or lifetime dollar limits between mental health coverage and coverage of other illnesses. In other words, the 1996 act was limited in its reach. It ruled out a specific, narrow practice. But it left broad loopholes. And as the General Accounting Office reported in reviewing the Act's implementation, the vast majority of employers it surveyed complied with the 1996 law, but substituted new restrictions and limitations on mental health benefits, thereby evading the spirit of the law. As GAO documented, employers routinely limited mental health benefits more severely than medical and surgical coverage, most often by restricting the number of covered outpatient visits and hospital days, and by imposing far higher cost-sharing requirements.

This year Congress is close to passing bipartisan legislation that would close the loopholes in the 1996 law. The Senate unanimously passed its bill, S. 558, last September and the House is slated to take up a similar parity bill, HR 1424, within the next few weeks. House Speaker Pelosi has identified enactment of parity legislation as a high priority this year. And President Bush early in his first term signaled his support for parity legislation in a speech in New Mexico.

The core principle of the House and Senate parity bills is the same – simply to require fairness in terms of treatment limitations and financial requirements. Neither bill mandates mental health coverage. Neither bill calls for any preferential treatment of mental health. Both bills simply say health plans may not impose stricter treatment limits or financial requirements on mental health care than care for any other illness. Both would establish a simple equity standard to ensure that mental illnesses are covered under similar terms as other illnesses for the millions of Americans who currently receive health care through their employers. We describe that standard as mental health parity. Both bills would exempt health plans covering 50 or fewer employees. Both bills amend the Public Health Service Act and ERISA, the Employer Retirement Income Security Act of 1974, which allows employers to offer uniform national health benefits by preempting states from regulating employer-sponsored benefit plans. As such, the bills establish a parity standard applicable to both the 87 million individuals covered by self-insured plans and the 31 million employees covered by insured plans that are subject to state regulation. It's particularly important to note in this regard that both bills set a federal floor, not a ceiling. Under both bills, states would not be prohibited from establishing stronger requirements, and nothing in either bill would supersede any provision of state law which establishes any standard or requirement relating to health insurance coverage. In other words, neither bill would undercut state law, and states are free to move forward on parity laws of their own and establish stronger protections.

It is fair to acknowledge that there has been resistance to parity legislation over the years. But increasingly, as people have studied the issue, they have come around to support it.

Literally hundreds of organizations have endorsed federal parity legislation. This wide scope of organizational support, representing such diverse fields as criminal justice, education, health, public health, the faith community, and veterans reflect the many communities touched by mental illness.

One corporate CEO, who testified before Congress in support of federal parity legislation, cited the billions of dollars that clinical depression alone costs U.S. businesses each year in missed days and poor work performance. This CEO testified that "Too few businesses have really examined mental health parity – typically because of misunderstandings regarding mental illness, the erroneous belief that parity means additional cost, and misperceptions about the efficacy of treatment. I was one of those business leaders until my personal circumstances made me see what was going on in our own company. Today more than ever, managers of every business have the opportunity to support their employees while, at the same time, reducing the cost to their companies of mental health-related productivity losses. I do believe that in time, most business leaders will realize, as I have, that providing mental health benefits on par with medical and surgical care is good for the bottom line. But quite frankly, we cannot afford to wait for that time. Mental health parity is good for American workers and good for the American economy."

Importantly, in November 2005, the prestigious National Business Group on Health released a report that recommended that employers equalize their medical and behavioral benefit structures given evidence that parity yields significant clinical benefit without increasing overall healthcare costs.

Business leaders and insurers have in fact turned around on parity. The Senate parity bill, which was widely endorsed by mental health advocacy groups and hundreds of other organizations, also won the support of the US Chamber of Commerce, the National Retail Federation, the National Association of Manufacturers, the National Association of Wholesaler-Distributors, America's Health Insurance Plans, the American Benefits Council, Aetna, Cigna, and others.

Why has there been opposition to parity over the years? Frankly, there have been many myths surrounding parity. The principle myth is that parity will be costly. But as the National Business Group on Health observed in its 2005 report, study after study has found that equalizing specialty behavioral health and general medical benefits will either not increase total healthcare expenses at all or will increase them by only a very modest amount of total healthcare premium. The most recent and largest of these studies is the most powerful. It evaluated the impact of implementing parity under the Federal Employee HB program, which covers some 8 million federal workers and their dependents. That exhaustive study published in the New England Journal of Medicine **found that providing mental health and substance abuse coverage on par with other health coverage achieved improved insurance protection without increasing health care costs**.

What has become clear with respect to arguments about the cost of parity is that the REAL costs lie in <u>not treating</u> behavioral health disorders rather than in establishing fairness in health coverage. As the National Business Group noted, the indirect costs associated with mental illness and substance-use disorders – excess turnover, lost productivity, absenteeism and disability – commonly meet or exceed the direct treatment costs, and have been estimated to be as high as $105 billion annually.

Parity legislation is by no means a panacea that will assure that all insured Americans receive all needed mental health care. But ending arbitrary insurance discrimination against mental illness can help improve people's getting the treatment they need. And outlawing such discrimination will also help end the stigma surrounding mental illness, which is a major barrier to treatment. We know, for example, that one of every two people in this country who need mental health treatment do not get it, and too many people are reluctant to seek care because of the shame our society attaches to mental illness.

Failing to treat mental illness has other profound costs. Consider the impact on children. As President Bush's New Freedom Commission on Mental Health reported, in citing the importance of early intervention for children with mental health problems, "without intervention…childhood disorders may persist and lead to a downward spiral of school failure, poor employment and poverty in adulthood. No other illnesses damage so many children so seriously."

The costs of untreated mental disorders are borne by taxpayers and communities, and are felt throughout society – in the child welfare system, in emergency rooms, in prisons and jails, in safety net programs, and in overall healthcare costs.

While enacting parity legislation is fundamentally about achieving fairness in insurance practices, it is one important step toward solving a great many problems affecting virtually every community in this country.

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**TESTIMONY ON SENATE BILL 564**
**SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE**
**By Kenneth Daniel**
**February 19, 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 564 in its entirety.

This bill contains the provisions of the excellent plan passed in Missouri a year ago, known as Missouri 818, including:

- Takes a step toward tax equity by establishing a state income tax deduction for net out-of-pocket health care costs.
- Modifications to the high risk pool.
- Adds considerable language about Health Savings Account arrangements including the high risk pool and state employees' health plan.
- Adds considerable language about Section 125 Cafeteria Plans.

In addition, I would strongly encourage you to add other, very important parts of the Missouri 818 bill. Information about those are attached as Exhibit "A".

Or, you could consider adding most of the language from House Bill 2822, which picks up important parts of Missouri 818, makes it mandatory for Kansas businesses offering a health plan to establish a simple Section 125 Cafeteria plan, and upgrades Senator Barnett's 2005 tax credit for new small business health plans. A copy of HB2822 is attached as Exhibit "B".

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

FI&I Committee
February 19, 2008
Attachment 2

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EXHIBIT "A"

**Ken Daniel**

**From:** "Ken Daniel" <kdaniel@midwaywholesale.com>
**To:** "Senator Jim Barnett" <senatorjb@sbcglobal.net>
**Cc:** "Beverly Gossage" <beverly@hsabenefitsconsulting.com>; "Larry Magill" <larry@kaia.com>; "Kerri Spielman" <kerri@kaia.com>
**Sent:** Tuesday, February 12, 2008 11:29 AM
**Subject:** Changes to your bill

Dear Senator Barnett: Here is a first stab at changes to your bill. These will need to be put into statutory language.

1. Every employer in Kansas which sponsors an employee health benefit plan MUST set up and maintain a Section 125 premium-only plan. (Note that flexible spending arrangements and child care arrangements and other provisions can be put into a Section 125 plan, but it is only the basic premium-only plan provisions that are to be required here.)

2. Any Kansas employer who has not offered or sponsored an employee health benefit plan in the previous twelve months may contribute toward the premium costs of the individually owned health insurance policies of employees. Such employers shall establish a Section 125 premium-only plan to allow such employees to pay their share of premiums.

(Provisions need to be included that make it absolutely clear that this does not trigger the small group requirements or constitute or require an employer-sponsored plan. To be kosher with federal law, the contributions must be offered to all full-time employees, and must be the same dollars for every employee or the same percentage of premium for every employee.)

3. At the request of a new employee who already owns an individual policy, a Kansas employer with an employer-sponsored health benefit plan may contribute toward the premium for the employee's plan instead of the employer plan. Employer shall allow such employees to utilize the company Section 125 plan to pay the employee share of such premiums.

4. Kansas employers are authorized to enter into "list billing" arrangements with health insurance carriers whereby the employer, with the employee's instructions, withholds money from the employee's wages, then remits premiums to the insurance carrier. (We just need to be absolutely sure this is made clear. Another question is whether we should REQUIRE carriers to offer list billing.) *

5. The following language from the bottom of page 7 and top of page 8 in the SB564bill needs to stricken entirely. This apparently came from an early version of the Missouri bill. The first part may be needed somewhere, but the part I have underlined is incorrect and needs to be stricken entirely.

*Health benefit plan also includes a cafeteria plan authorized by 26 U.S.C. Section 125 which offers the option of receiving health insurance coverage through a high deductible health plan and the establishment of a health savings account. In order for an eligible individual to obtain a high deductible health plan through the cafeteria plan, such individual shall present evidence to the employer that such individual has established a health savings account in compliance with 26 U.S.C. Section 223, and any amendments and regulations.*

DROP THIS

~~6. Larry Magill thinks we need to consider requiring all health insurance quotations to include an option for an HSA-compatible plan.~~

This is where we are right now. Beverly Gossage is also doing an in-depth parsing of the draft you provided to me last week.

Ken Daniel 232-4590 x205 kdaniel@midwaywholesale.com

* THIS IS NOT MEANT TO OPEN UP FULL-BLOWN LIST BILLING — ONLY FOR #2 + #3.

2/12/2008
2-2

EXHIBIT "B"

Session of 2008

# HOUSE BILL No. 2822

By Committee on Insurance and Financial Institutions

2-11

AN ACT concerning insurance; relating to health insurance plans for small employers; amending K.S.A. 2007 Supp. 40-2246 and repealing the existing section.

*Be it enacted by the Legislature of the State of Kansas:*

New Section 1. (a) (1) For a period commencing on the effective date of this act and ending on June 30, 2010, any small employer which has not offered any health benefit plan to such employer's employees during the six month period next preceding the date upon which a health benefit plan is offered, may offer a health benefit plan under the provisions of this section. The health benefit plan shall be offered only to eligible employees, including dependents thereof, of such employer.

MANDATE LITE

(2) Any health benefit plan by a health insurer developed for a small employer under this act in accordance with paragraph (1) of subsection (a) which is delivered, issued for delivery, amended or renewed on or after July 1, 2008, may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. Except for preventative and health screening services, the provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2114 and subsection (i) of 40-2209 and 40-2229 and 40-2230, and 40-2,163, 40-2,164, 40-2,165 and 40-2,166, and amendments thereto, shall not be mandatory with respect to any health benefit plan developed under this act.

(b) No health benefit plan which is delivered, issued for delivery, amended or renewed on or after July 1, 2008, shall be required to provide for or include any additional benefit or coverage in addition to the benefit or coverages required by subsection (a).

(c) No provision of subsection (a) shall be construed to prohibit an employer from providing a health benefit plan containing any coverage or benefit in addition to the coverage required by subsection (a).

(d) No provision of subsection (a) shall be construed to prohibit any health benefit plan from providing any additional benefit or coverage in addition to the benefits or coverages required by subsection (a).

(e) No provision of this section shall be construed to prohibit any small employer from renewing any health benefit authorized by this section.

(f) For the purposes of this act: (1) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering such eligible employee and the dependent eligibility standards established by the board.

(2) "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 or more hours, and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer but does not include an employee who works on a part-time, temporary or substitute basis.

(3) "Small employer" shall have the meaning ascribed to it in K.S.A. 40-2209d and amendments thereto.

(g) "Health benefit plan" shall have the meaning ascribed to it in K.S.A. 40-4602 and amendments thereto.

New Sec. 2. (a) An employer that provides health insurance coverage for which any portion of the premium is payable by the employer shall not provide such coverage unless the employer has established a premium only cafeteria plan as permitted under federal law, 26 U.S.C. Section 125. The provisions of this subsection shall not apply to employers who offer health insurance through any self-insured or self-funded group health benefit plan of any type or description.

MANDATORY SEC. 125 PLAN

BIG GUYS OUT.

(b) Nothing in this section shall prohibit or otherwise restrict an employer's ability to either provide a group health benefit plan or create a premium only cafeteria plan with defined contributions and in which the employee purchases the policy.

ALLOW EMPLOYER TO PAY TOWARD INDIV. POLICY

Sec. 3. K.S.A. 2007 Supp. 40-2246 is hereby amended to read as follows: 40-2246. (a) *(1)* A credit against the taxes otherwise due under the Kansas income tax act shall be allowed to an employer for amounts paid during the taxable year for purposes of this act on behalf of an eligible employee as defined in K.S.A. 40-2239 and amendments thereto to provide health insurance or care and amounts contributed to health savings accounts of eligible covered employees.

*(2) Beginning July 1, 2008, a credit against any tax owed by the employer to the state of Kansas shall be allowed to an employer for amounts paid during the taxable period for the purposes of this act on behalf of an eligible employee as defined in K.S.A. 40-2239, and amendments thereto, to provide health insurance or care and amounts contributed to health savings accounts of eligible covered employees.*

EMPLOYER TAX CREDIT

(b) (1) For employers that have established a small employer health benefit plan after December 31, 1999, but prior to January 1, 2005, the amount of the credit allowed by subsection (a) shall be $35 per month per eligible covered employee or 50% of the total amount paid by the

NEARLY EXPIRED OR EXPIRED

employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75% of the lesser of $35 per month per employee or 50% of the total amount paid by the employer during the taxable year. In the fourth year, the credit shall be equal to 50% of the lesser of $35 per month per employee or 50% of the total amount paid by the employer during the taxable year. In the fifth year, the credit shall be equal to 25% of the lesser of $35 per month per employee or 50% of the total amount paid by the employer during the taxable year. For the sixth and subsequent years, no credit shall be allowed.

NEARLY EXPIRED OR EXPIRED

(2) For employers that have established a small employer health benefit plan or made contributions to a health savings account of an eligible covered employee after December 31, 2004, the amount of credit allowed by subsection (a) shall be $70 per month per eligible covered employee for the first 12 months of participation, $50 per month per eligible covered employee for the next 12 months of participation and $35 per eligible covered employee for the next 12 months of participation. After 36 months of participation, no credit shall be allowed.

CURRENT (SEN. BARNETT SB257-2005 SESSION)

*(3) For any employer that has established a small employer health benefit plan or made contributions to a health savings account of an eligible covered employee after December 31, 2007, the amount of credit allowed by subsection (a) shall be $100 per month per eligible covered employee for the first 12 months of participation, $75 per month per eligible covered employee for the next 12 months of participation, $50 per eligible covered employee for the next 12 months of participation and $25 per eligible employee for the next 12 months. After 48 months of participation, no credit shall be allowed.*

NEW

(c) If the credit allowed by this section is claimed, the amount of any deduction allowable under the Kansas income tax act for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with law. If the credit allowed by this section exceeds the taxes imposed under the Kansas income tax act for the taxable year, that portion of the credit which exceeds those taxes shall be refunded to the taxpayer.

(d) Any amount of expenses paid by an employer under this act shall not be included as income to the employee for purposes of the Kansas income tax act. If such expenses have been included in federal taxable income of the employee, the amount included shall be subtracted in arriving at state taxable income under the Kansas income tax act.

(e) The secretary of revenue shall promulgate rules and regulations to carry out the provisions of this section.

(f) This section shall apply to all taxable years commencing after De-

cember 31, ~~1999~~ *2007*.

Sec. 4. K.S.A. 2007 Supp. 40-2246 is hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

Kansas Association of Insurance Agents

Testimony on Senate Bill 564
Before the Senate Financial Institutions & Insurance Committee
By Larry Magill
February 19, 2008

Thank you madam Chair and members of the Committee for the opportunity to submit written testimony in support of Senate Bill 564. 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.

It is our understanding that SB 564 is based on the provisions that would apply to Kansas of Missouri's Senate Bill 818. However, we must confess that we are still trying to analyze and understand all the provisions of SB 564. Nor are we entirely certain that the bill does what its authors intended but those concerns can certainly be addressed through amendments.

**Guaranteed Renewable Small Group Troubling**
It appears that Section 2 enacts a requirement that all small group policies are guaranteed renewable unless the insured does certain things like fail to pay premiums, fail to meet participation requirements or commits fraud. There are provisions for discontinuing a plan and for exiting the small group market completely and a 5 year "lock out" if they do leave the state.

On page 2, there is a prohibition on changing coverage of a small group plan but it does not seem to allow an insured to request changes in coverage terms unless it is changed for the entire book of business with that "plan". That is too restrictive.

But perhaps more important, we are not aware of problems with carriers in the small group market that these provisions would address. They will certainly be a significant factor, we assume, in determining whether a carrier stays in Kansas or enters the state. We would rather encourage more competition in the small group market and are very concerned about any statute that might reduce it. For these reasons, we suggest that Section 2 be deleted and studied further.

**Strongly Support HSA's**
Whether you talk in terms of consumer directed health care (CDHC), Health Savings Accounts (HSA's) or high deductible health plans, we support the concept that the consumer has to be brought back into the equation and given a stake in managing their health care expenses and their own wellness. Today, all the incentives in our employer-

FI&I Committee
February 19, 2008
Attachment 3

based health care system are to spend as much as possible to receive the biggest "benefit" possible. Transparency of costs and informed consumers making wise health care choices is encouraged under CDHC.

New Section 3 requires that the state's high risk plan offer a high deductible health care plan and health savings account through a Section 125 Plan. And Section 8 allows an employer to qualify for the tax credit for offering insurance through an offer of a health savings account, high deductible plan through a Section 125. Section 9 and 10 extends it to state employees. We support all of those requirements.

Further, we support a requirement that all small group carriers offer a high deductible plan with a health savings account option at an actuarially justified savings through a Section 125 Premium Only Plan (POP). There are carriers today that are offering high deductible plans but the premium savings are nominal. They apparently do not want their customer base significantly reducing their premiums overnight. This appears to be the general intent of Section 5 that amends the small group act. In addition, Section 7 requires each small employer carrier to actively market all health benefit plans sold by the carrier. Since this is primarily aimed at presenting the HSA option to as many employers as possible and building momentum for CDHC, we suggest that a sunset on the mandatory offer be established of two years from the effective date. It could be extended if it was working and still necessary.

**Individual Coverage vs. Group**

One of the most intriguing reforms in Missouri's 818 were the provisions that allowed a person to pay for an individual health insurance policy through an employer provided POP. Missouri's and Kansas' HIPAA acts both allow this to occur.

Individual policies have the advantage of decoupling the person's insurance from their employment, allowing them to take their coverage with them wherever they go. This is the ultimate in portability. Employers in Kansas can still contribute to the cost of the individual policy through the Section 125 Plan.

We suggest that the legislation go a step further and specifically authorize the practice of "list billing" for employers who have not offered health insurance for the previous year. "List billing" is where employees purchase individual policies from one carrier and that carrier bills the employer for those policies monthly. Kansas does not currently allow the employer to pay any part of the cost of list billed individual policies. We are suggesting that it be allowed for this limited segment of the market to determine how it works. Again, this should be run through a POP to use pretax funds.

**Mandatory POP**

Premium Only Plans more than pay for themselves. The employer saves the cost of FICA and Medicaid taxes on amounts run through the Plan as does the employee. They are an immediate way to make health insurance more affordable. We are suggesting that it be mandatory that any carriers offering group health policies provide a POP, unless the employer already has one in place. We think that competition will

quickly drive the cost for the plan and the minimal administration down to the point of being inconsequential.

With these changes, SB 564 takes some significant steps to encourage use of Health Savings accounts, high deductible health plans, Section 125 POP Plans, individual rather than employer provided health insurance and greater consumer investment in their wellness and in the cost of their health care. It puts normal economic incentives in place that have been missing in the employee benefit world of group insurance where all the incentives have been on using as much benefit as you can and no emphasis on individual consumer cost control.

**Other Ideas Worth Considering:**
Here are some additional ideas we think are worth exploring:

- 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
- Consideration of a market-wide reinsurance mechanism for small group
- Transparency of health care pricing to go with CDHC

We urge the Committee to act favorably on SB 564. We would be happy to provide additional information or answer questions at the appropriate time.

NFIB

The Voice of Small Business®

**Legislative Testimony**
**Derrick Sontag, NFIB State Director**
**Senate Bill 564**
**February 19, 2008**

Madam Chair and members of the committee:

Thank you for the opportunity to provide testimony in support of Senate Bill 564.

Senate Bill 564 would assist small business owners and employees with controlling the cost of their health care policies. For many years now, small business owners have identified cost, not coverage as the principal health care issue facing their business today.

***In a recent NFIB poll, seventy-four (74) percent of NFIB members identified cost as the single most important problem facing the health system today.***

The issue of affordability of health care has had a dramatic impact on the number of small businesses able to offer benefits. The number of small businesses that offer health benefits continues to decrease, especially amongst start-up businesses. About forty-seven percent (47) of small businesses offer employee health benefits, of which 36 percent offer insurance to all or most full-time employees. Of these existing businesses, only about 1 - 2 percent drop health insurance on an annual basis. Thus, the reason for the continued decline in the number of small businesses offering employee health insurance plans appears to be that owners of new firms are increasingly reluctant to offer it.

Considering that a decreasing number of small businesses are offering group plans, new measures must be taken in order to directly address the cost of health care for these business owners and their employees. SB 564 assists these businesses by allowing individuals to purchase health insurance through Section 125 plans with pre-tax dollars. In turn, the employer may set aside a pre-defined contribution amount that would go towards the cost of the individual's health care policy. This allows small businesses to assist with the cost of health care for its employees while realizing stability in health care related budgetary items from year-to-year.

NFIB and its more than 4,500 members in Kansas have long supported equalizing tax benefits for those obtaining health insurance from employers and other sources. This legislation would help level the playing field by removing the competitive disadvantage small businesses face when they're unable to take part in small group plans.

Thank you for your time and consideration on this important matter.

Derrick Sontag
State Director
National Federation of Independent Business/Kansas

FI&I Committee
February 19, 2008
Attachment 4

National Federation of Independent Business – KANSAS
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# Legislative Testimony

achieve more

**SB 564**

**February 19, 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 supports SB 564 which will help provide additional health insurance options for employers in Kansas. Kansas businesses want to offer health insurance to their employees but believe that the costs are too high. SB 564 helps provide both short-term and long-term solutions for the rising costs of health insurance.

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 supports health care initiatives that are similar to Missouri's SB 818 which will allow individuals to purchase health insurance though Section 125 Plans (pre-tax). This would allow for individuals who work for companies that are not currently offering health insurance, a way to purchase health insurance with the same tax advantages afforded the employer. These provisions will also allow an employer to contribute to a Section 125 Plan for the purpose of helping employees purchase health insurance. This defined contribution will help employees purchase health insurance even if the employer does not purchase it for them.

In addition to the provisions in the bill, the Chamber would support several other provisions that help small businesses provide health insurance to their employees. The first would be real-time solutions for small businesses. Businesses need cash flow to make health insurance payments on a monthly basis.

THE KANSAS CHAMBER

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

FI&I Committee
February 19, 2008
Attachment 5

The bill amends the current health care tax credit so that employers can take the credit against any tax owed to the state. This will make the tax credit more of an incentive for companies as they begin offering health insurance to their employees. The bill also expands the current tax credit program—making it a four-year tax credit so that businesses have more of an incentive to offer health insurance.

The second would be to offer limited mandate plans that would be less expensive and make health insurance appealing for more businesses. There is conflicting data on the true cost of mandates in Kansas; however, when reviewing the information from the 1998 and 2003 interim studies on mandates, we believe that mandates add between 10%-15% to the total cost of health insurance in Kansas. Whatever the true number, mandates do add to the cost of health insurance.

Eighteen states have enacted similar legislation to allow for limited mandate plans or "mandate-lite" plans for small businesses. These "mandate-lite" or "no frills" products were never intended to be the solution to the uninsured problem. Rather, state officials viewed them as a positive step toward making coverage more affordable for small groups and/or individuals. I have attached a list of what other states are doing.

Again, the Kansas Chamber is supportive of SB 564 and solutions that will help small businesses offer health insurance to their employees. We believe that these measures will help with health insurance expenses and strengthen the current employer based health care system.

Thank you for your time and I will be happy to answer any questions.

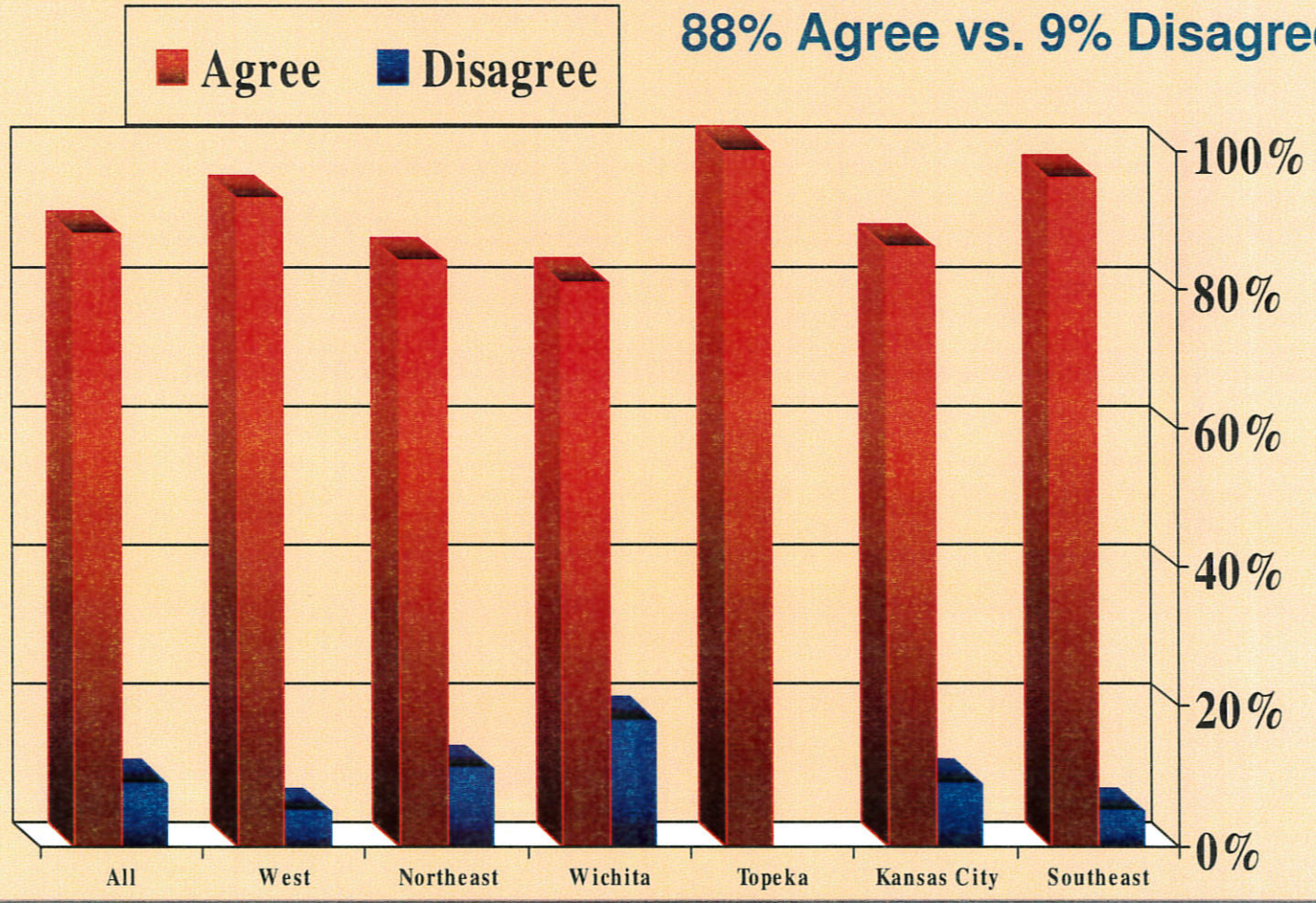
*Kansas Chamber, with headquarters in Topeka, is the leading statewide pro-business advocacy group moving Kansas towards becoming the best state in America to live and work. The Chamber represents small, medium and large employers all across Kansas.*

THE KANSAS CHAMBER

5-3

# Agree: Quality Health Insurance Available but Cost is Preventative

## 88% Agree vs. 9% Disagree



THE KANSAS CHAMBER

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5-4

# Ranking of Most Important Issues

| MENTIONED: | Nov. 07 | Nov.06 | Nov.05 | Nov. 04 |
|---|---|---|---|---|
| **Lower taxes on business** | **46%** | **46%** | **39%** | **38%** |
| **Managing health care costs** | **41%** | **47%** | **46%** | **42%** |
| Economic incentives | 21% | 20% | 20% | 15% |
| Stop friv. lawsuits/Tort reform | 18% | 22% | 21% | 21% |
| Decrease regulation/mandates | 18% | 18% | 14% | 13% |
| Workers' Compensation | 14% | 13% | 14% | 11% |
| Limit growth of state gov. | 12% | 7% | 10% | 8% |
| Unemployment Compensation | 4% | 4% | 9% | 5% |

**Arkansas – HB 1632, 2001 Laws**

"Every group accident and health insurer, hospital and medical service corporation, or HMO transacting health or accident and health insurance in this state may offer as an option, a group health benefits plan which, either in whole or in part, does not provide state mandated health benefits on group health benefits plans under state law." (Note: same language is included for individual products.)

**Colorado – HB 1164, 2003 Laws**

This law requires health plans to offer a new "mandate-lite" basic benefit plan that excludes coverage for the following mandated benefits: non-biologically-based mental illnesses, alcoholism treatment, mammography and prostate cancer screening, hospice care, and anesthesia for dental procedures for children with certain medical conditions.

**Florida – HB 1629, 2004 Laws**

Expands the existing Health Flex demonstration program statewide so that more uninsured, low-income residents can purchase "mandate-lite" products. This program is run by the DOI and the Agency for Health Care Administration and allows health plans to offer a product that: (1) limits or exclude benefits otherwise required by state law; (2) caps the total amount of claims paid per year per enrollee; and/or (3) limits the number of enrollees.

**Georgia – Sec. 33-51-3, 1991 Laws**

"The Commissioner shall develop a model basic health insurance plan which shall include, but not be limited to, the following features: …(3) Coverage for primary health care services designed to prevent the need for more expensive health care services;…"

**Illinois – Sec. 5/351B-2 to B-5, 1990 Laws**

"It is the purpose and intent of this amendatory Act of 1990 to authorize a program whereby small employers may obtain affordable group health insurance that will increase access to health care, assist in the reduction of the amount of uncompensated care, and reduce the number of uninsured people in this state.
…(**excludes** requirements to cover alcoholism treatment, cervical, prostate and colorectal cancer screening, clinical trials, diabetic supplies, IVF, mental health, off-label use of drugs, TMJ, chiropractors, optometrists, podiatrists)."

**Louisiana – HB 448, 2004 Laws**

Allows health plans to offer "mandate-free" or "mandate-lite" products in the small group and individual markets. When offering such a policy, an insurer must also offer, as an alternative, a product that includes all state mandated coverage's. Insurers must also provide a notice that the flexible benefits policy does not include all state mandated benefits.

**Mississippi – Sec. 83-63-1, 1992 Laws**

"Contracts of insurance coverage offered by approved carriers that are approved by the Commissioner of Insurance shall be exempt from all state mandated benefits and from the premium tax required by state law."

**Missouri - Sec. 376.995, 1990 Laws**

"Limited mandate health insurance policies and contracts shall mean those policies and contracts which cover individuals and their families and groups sponsored by an employer who employs 50 or fewer persons."

"No law requiring the coverage of a particular health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to limited mandate health insurance policies and contracts, except the following provisions: (**excludes** requirements to cover alcoholism treatment, ambulatory surgery, bone density screening, cervical, colorectal and prostate cancer screening, contraceptives, mental health care, chiropractors, optometrists, podiatrists)."

**Montana – HB 384, 2003 Laws**

This law allows health plans to offer a "no frills" basic benefit plan without certain state mandates (e.g., mental health treatments, emergency services and coverage for newborns). State regulators will approve such products for a 12-month demonstration period, with renewals possible for a total of five years.

Health plans who want to offer these products must meet the following criteria:
(1) offer a benefit package that includes significant outpatient services; and (2) limit eligibility to residents who have been uninsured for 90 days or longer.

**Nebraska – Sec. 44-4227/4228, 1991 Laws**

"Every uninsured access coverage policy or contract shall include: (a) in-hospital benefits for not less than 30 continuous days nor more than 90 continuous days for each spell of illness; and (b) surgical benefits for both inpatient and outpatient surgery." Notwithstanding any other provision of law, every uninsured access coverage policy or contract shall be exempt from any and all mandated benefits which require coverage of any type of services or conditions."

**New Mexico – Sec. 59A-23B-1, 1991 Laws**

"For purposes of the Minimum Healthcare Protection Act, "policy or plan" means a healthcare benefit policy or plan that the insurer, fraternal benefit society, HMO or nonprofit healthcare plan chooses to offer to individuals, families or groups of fewer than 20 members formed for purposes other than obtaining insurance coverage."

"Subject to a maximum limit on the cost of healthcare services covered in any calendar year of not less than $50,000, the policy or plan provides the following minimum healthcare services to covered individuals: inpatient hospitalization or home care not to exceed 25 days; prenatal care; obstetrical care; well-child care; mammograms; cervical cancer screening; a basic level of primary and preventive care (including no less than 7 physician, nurse practitioner midwife or PA office visits per calendar year, including any related ancillary diagnostic or lab tests;)"

**North Dakota – HB 1226, 2001 Laws**

"An insurance company, a nonprofit health service corporation, or an HMO may deliver, issue, execute, and renew a basic health insurance policy, health service contract, or evidence of coverage on an individual basis or an employer group, blanket, franchise, or association basis for employers with fewer than 50 employees."

"The basic health insurance coverage policy, contract or evidence of coverage under this section is not subject to sections: (**excludes** requirements to cover off-label use of drugs, substance abuse, mammograms, TMJ, prostate cancer screening, formula for metabolic disease, dental anesthesia, pre-hospital emergency medical services, optometric services). However, the insurance company, nonprofit health service corporation or HMO shall make the coverage required under these sections available at the option of the individual or employer and may charge an additional premium for each coverage provided."

**Oklahoma – HB 2350, 2002 Laws**

"Each Health Insurance Purchasing Group, in conjunction with a HIPG health carrier, shall make available a health benefits plan in the manner described in this section to all eligible employers and eligible employees at rates, including employers' and employees' shares, on a policy- or product-specific basis which may vary only as permitted under law."

"The HIPG may also offer a health benefits plan not subject to state-mandated health benefits which does not contain standard provisions or rights required to be present in a health benefits plan pursuant to law or regulations unrelated to a specific illness, injury or condition of the insured, for the provisions as may be determined by rules and regulations of the Commissioner."

**Tennessee – SB 3187, 2004 Laws**

This law urges health insurers to develop and market a product that provides only major medical coverage for catastrophic illnesses requiring in-hospital treatment. Such a product would not be subject to state mandated coverage requirements. Any new product must be approved by the DOI.

**Texas - SB 541, 2003 Laws**

This law allows health plans to offer a "mandate-lite" product without the following treatment mandates: substance abuse, reconstructive surgery, emergency care, immunizations and mammograms.

**Utah - HB 122, 2002 Laws**

"The Act permits a carrier to offer less or different coverage than the basic benefit package, the minimum standards required by the Commissioner of Insurance, or any other health insurance mandate required by state law when the Department of Health offers similar coverage as a part of a Medicaid waiver."

**Virginia – HB 2234, 2003 Laws**

This law allows health plans to offer a variety of new products in the small group market. For example, health plans can choose to offer state-regulated "essential" and "standard" health products that do not contain all of the state mandated benefits.

**Washington – HB 2460, 2004 Laws**

"A health care services contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health services."

"A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a licensed physician."