Approved: 3-30-09
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 p.m. on February 12, 2009, in Room 784 of the Docking State Office Building.

Committee members were all present except Representatives Gordon and Morrison, whom were excused.

Committee staff present:
Norm Furse, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Reed Holwegner, Kansas Legislative Research Department
Janet Grace, Committee Assistant

Conferees appearing before the Committee:
Beverly Gossage, HSA Benefits Consulting (Attachments 1, 2, 3, 4, 5, 6)
Natalie Bright , Wichita Independent Business Association (Attachment 7)
Scott Day, Day Insurance Solutions (Attachment 8, 12)
Dan Murray, National Federation of Independent Business (Attachment 9)
Linda Sheppard, Kansas Insurance Department (Attachment 10)
Michael Gross, Kansas Association of Health Underwriters (Attachment 11)
Dr. Marcie Nielsen, Kansas Health Policy Authority

Chairman Landwehr called the meeting to order. The meeting began with the hearing on **HB 2287**.

HB 2287 - Health reimbursement arrangements.

Beverly Gossage, HSA Benefits Consulting, provided testimony and information as a proponent for **HB 2287** (Attachments 1, 2, 3, 4, 5, 6). This bill is similar to **HB 818** in Missouri, allowing the Missouri business owners not to be mandated. Most small businesses do not offer group health insurance due to multiple reasons including administration and costs. One of the primary strategies used within the consumer-directed health care approach is to offer Health Savings Accounts (HSA's). HSA's can help the small business owner and the employee with affordable health care, cost savings, and less administrative costs.

Natalie Bright representing the Wichita Independent Business Association (WIBA) presented proponent testimony for **HB 2287**. (Attachment 7) The members of WIBA support this bill because it proposes another tool that may be used by employers to assist their employees in obtaining health care insurance. Health Reimbursement Accounts (HRA's), under current law, are attractive to employees because they deposit pre-tax dollars and use those dollars to pay for health care expenses. Under existing law, employers are denied the option of contributing dollars to their employees HRA's. **HB 2287** would remove this restriction and allow employers to deposit dollars into an employee's HRA account, affording the employee the benefit of leveraging both contributions towards the premium of an individual health care policy. It also fosters additional individual choice and control over one's health care insurance, which is a necessity in reducing health care costs.

Scott Day with Day Insurance Solutions provided a broker's perspective during his proponent testimony for **HB 2287**. Through the establishment of a Health Reimbursement Arrangement (HRA) the employer can make pretax contributions to individual premiums, thus giving them both an incentive to contribute. (Attachment 8) This would equalize the tax discrimination that has favored those purchasing health insurance through group plans. This bill helps small business owners spend less administrative time dealing with health insurance. The employees will be allowed to select their own individual plans, and choose from a marketplace of carriers and plan designs for the one that best meets their personal needs. The employer determines the amount of contribution, if any, that they want to provide. This will help lower the cost of health insurance for the uninsurable without creating additional tax burden.

Dan Murray, National Federation of Independent Business (NFIB), is a proponent of this bill. The primary tools available to small business owners, their employees and their families include health savings accounts (HSA's), health reimbursement arrangements (HRA's) and flexible spending accounts.

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

(Attachment 9) These plans provide the consumer with the choice to control and spend health care dollars as they see fit. This tool will help lower their health care costs.

Linda Sheppard from the Kansas Insurance Department provide testimony as an opponent to **HB 2287** (Attachment 10). One of the criteria used by health insurers when they are marketing small employer health plans is the percentage of participation by employees. This requirement permits the health insurers to spread the risk across all of the small employer's employees and impacts the cost of the coverage provided. If some employees elect to obtain their own individual coverage paid for, in part, by their small employer, the employer may be unable to obtain small group coverage for the remaining employees because they no longer have a sufficient number of eligible employees to participate in the small group plan. **HB 2287** would result in healthy eligible employees, who are able to qualify for an individual policy, to exit the small group market place.

The Kansas Insurance Department is concerned about Lines 19-22; small group market rate reform. The concern is about 40-2209B-refer to line 21; that small group rates will increase. The balance is the employer contributes to a health care program, so it gets the group market rate. The trade off is having healthy people balance out the unhealthy to keep costs lower. The purpose of the bill is to not trigger health insurance for a single person due to high insurance risks. It is against the law to raise premiums for someone who goes from being healthy to becoming ill. Discussion on the bill allows people to be insured as opposed to being unisured.

Kansas Health Policy Authority is neutral on this bill and available for questions.

The hearing is closed **on HB 2287.**

HB 2259 - Health care act providing for a medicaid waiver to offer health opportunity accounts and a pilot premium assistance plan program for small employers.

Michael Gross from the Kansas Association of Health Underwriters (KAHU), supports the provision of Section 1 that gives the Kansas Health Policy Authority (KHPA) authority to apply for a waiver or waivers from the CMS, in an attempt to lower the cost of health care under the Kansas Medicaid program by offering Health Savings Accounts (HSA's). HSA's are underutilized and help lower health costs. KAHU opposes the opportunity account (last line in Section 1) because it has not been defined in this act. (Attachment 11) KAHU supports the provisions of Section 2 that gives the KHPA the authority to develop and implement a pilot premium assistance plan to the eligible employees of small employers to purchase an employer-sponsored health benefit plan. KAHU opposes the last line of Section 2 because there is no clear definition of the criteria of what a "state approved" individual health plan might be. The KAHU is in support of offering additional plan designs for the Kansas Medicaid participants. The KAHU hopes the choices offered will be private sector products which help to lower the cost of health insurance. KAHU supports **HB 2259** because it offers choices and provides the opportunity to lower health costs.

Scott Day, Day Insurance Solutions, favors **HB 2259**. This Kansas program Medicaid is in dire need of reform to promote personal responsibility for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing. Oklahoma has a premium assistance plan known as Insure Oklahoma. This program has proven that Premium Assistance can work, if designed correctly. The key to this success is the Medicaid waiver that Oklahoma applied for to allow private market small group and individual plans to be offered in the program. The waiver allows plan designs that are almost identical to the private market plans already in Kansas. Scott Day supports the Premium Assistance if the Oklahoma model is used. The current Kansas Medicaid programs cannot be sustained unless personal responsibility must be introduced to these programs.

Beverly Gossage, HSA Benefits Consulting, provided more insight to **HB 2259.** HSA's offer more choice. They cannot be used for children for the Health Opportunity Accounts (HOA's) can be used for children. HOA's offer someone their own policy and funds in an account that can be used to pay toward the premium. This is a way to get people off the Welfare Healthcare program.

Minutes of the House Health and Human Services Committee at 1:30 p.m. on , in Room 784 of the Docking State Office Building.

There were no opponents to **HB 2259**.

Dr. Marcie Nielsen, Kansas Health Policy Authority provided written neutral testimony (Attachment 13).

The hearing was closed for **HB 2259.**

The next meeting is scheduled for February 13, 2009.

The meeting was adjourned at 2:45 p.m.

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

HOUSE HEALTH & HUMAN SERVICES COMMITTEE

DATE: 2/12/09

NAME	REPRESENTING
Lisa McCall	Newman University
Annette Newell	Newman University
Joe Mosimann	Hein Law Firm
Kim Tanner	Southwestern
Nicole Bell	Newman University
Shanna Payne	Newman University
DeRon Disney	Newman University
Gina Maree	KHI
Suzanne Cleveland	KHI
Robin Barrett	Barton Com. College
Angel Bates, RN	Webster University
Barbara Cavanaugh RN	Webster University
Julie Holmes	Kansas Insurance Dept.
Craig Van Aalst	KID
Linda Sheppard	KID
Barbara Torkelson	KID.
Bill Sneed	AHIP
Tom O'Connor	KAHU
Mike Gross	KAHU

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HOUSE HEALTH & HUMAN SERVICES COMMITTEE

DATE: 2-12-09

NAME	REPRESENTING
Mike Floodman	Broker
Scott Day	Day Ins. Solutions
Beverly Gassage	HSA Benefits Consulting
[illegible]	KU School of Nursing
Amy Biggs	Wichita State University
[illegible]	self
Julie Evans	NCCC
Andrea E B [illegible]	NCCC
Mallory Koontz	Pittsburg State University
Vanessa Rivas	Newman University
Zulema Martinez	" "
Jeff Mitzner	" "
Michelle English	Cloud County Community College
John Meetz	KID
Todd Fleischer	Ks Optometric Association
Patrick Vogelsberg	Kearney and Assoc.
Crystal Walker	Newman University
Cindy Jacobi-Williams	Newman University
Cassie Drummond	Newman University

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HOUSE HEALTH & HUMAN SERVICES COMMITTEE

DATE: 2/12/09

NAME	REPRESENTING
Natalie Bright	KAHP, WIBA
Michelle Butler	Capitol Strategies
[illegible]	KGC

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Chairperson Landwehr and Members of the Health and Human Services Committee:

Thank you for this opportunity to support HB 2287 and HB 2259.

I am Beverly Gossage, a consumer driven health care specialist, the director and founder of HSA Benefits Consulting, a research fellow for Show Me Institute, a health board member for Flint Hills Public Policy, and a member of the KHPA At Large Advisory Council.

I would first like to address HB 2287. This wording is similar to the wording from MO HB818. I have written a paper on the benefits of this bill. You should have it before you. I have also attached two other documents. One is a bulleted version of that paper that was prepared for Chambers of Commerce in Missouri to distribute to their members. The other is an example of a small business owner that used the provisions that are offered in HB 818 to lower his health care costs and to cover the 3 formerly uninsured individuals with his company.

Here are just a few of the comments that have been made about MO HB818:

Greg Scandlen of Consumers for Health Care Choices
"Missouri's (HB 818) is so good and such a model for other states that it should change its motto from 'The Show Me State' to 'The Show Us (How to do it) State.'"

Representative Jeb Hinserling's office in Texas
has been talking to Cheryl in Roy Blunt's office because they would like to do an 818 model in Texas (see policy paper below)

From page 35 of Pacific Research Institute's John Graham's paper attached:
A year ago, a colleague and I tentatively recommended a "connector," although we were concerned that it was not possible to avoid guaranteed issue and community rating through a connector. This is because HIPAA requires that any employer contribution to a health plan define the employee as in the small group, and therefore subject to HIPAA's provisions.133 This was not relevant to Massachusetts's connector, because the Commonwealth had already destroyed its market for individual health insurance through these regulations.134

Today, there is a simpler way to achieve the goal of eliminating job lock. IRS regulations issued last August have clarified that an employer can make pre-tax payroll deductions via a Section 125 "cafeteria" plan, and use those deductions to pay a premium for an employee's individual health policy.135 Missouri is taking advantage of this new regulation to free employees to buy individual health insurance, thus reducing the bureaucratic burden on small businesses. Instead of creating a connector or insurance exchange, Missouri House Bill 818 contained the Small Employer Health Insurance Availability Act. This act empowers a Missourian who already has an individual health plan to carry that health plan to a new job, where his employer can use a Section 125 cafeteria plan to pay the premiums for the policy. The employer can also make a contribution to the employee's insurance premiums as long as he makes the same contribution for all employees.

Governor Blunt and the legislators believe that this avoids the burden of HIPAA. Importantly, the Missouri bill does not compel a death spiral of small-group health insurance. Employers and carriers who want to continue with the status quo are free to do so, and carriers can require employers who enter small-group contracts to deliver up to three-quarters of their employees to the small-group plan, a standard precaution to reduce selection bias. Missouri HB 818 does not fully solve the problem of employer-sponsored health care. Indeed, because the U.S. Department of Labor (DOL), which regulates HIPAA, has not commented on the IRS regulations, there is a risk that the DOL might look unfavorably upon HB 818. Nevertheless, a California version of HB 818 would be a far easier, simpler, and voluntary way to eliminate job lock where it is most needed—without spending $14.4 billion on new government programs.

Minnesota

HEALTH AND HUMAN SERVICES
DATE: 02/12/09
ATTACHMENT: 1

From: Craig Westover [mailto:CraigW@mnfmi.org]
Sent: Tuesday, October 23, 2007 11:15 AM
To: beverly@hsabenefitsconsulting.com
Cc: David Strom
Subject: RE:HB818

Bev --

It was nice meeting you and, YES, put Minnesota down as interested in an 818 model. Just getting my head above water, but will get back to you soon about how the Minnesota Free Market Institute might leverage your expertise to help us implement this.

Craig Westover
Minnesota Free Market Institute

Jim Frogue and Newt Gingrich group on 818

-----Original Message-----
From: Jim Frogue [mailto:jfrogue@gingrichgroup.com]
Sent: Friday, June 22, 2007 1:03 PM
To: Beverly Gossage; 'Jim Frogue'; jason.hannasch@showmeinstitute.org
Subject: RE: follow up

Beverly,
I passed out the longer version of your article on HB 818 to the health committee at NCSL and suggested that health chairmen look to the Missouri model rather than the Massachusetts model

Show Me Institute—VP Jason Hannasch

Although we could make pretax contributions to the health savings accounts, I found that the Show-Me Institute, as a small employer, was at a disadvantage when it came to the premiums. We couldn't contribute directly to policy premiums of employees' HSA health plans, and pretax contributions couldn't be made, either — not for the Institute or for employees.

Considering all the red tape we were up against, it's no wonder that only 42 percent of Missouri's small businesses offer health coverage.

Because we couldn't meet those requirements, our only option was to give employees bonuses for them to use toward paying premiums. HB 818 was the bipartisan solution to this health policy dilemma. This law puts employees in charge, freeing them to choose their own insurance policies. Employers can now contribute directly to employees' plans without the burden of mandated contribution.

Links to papers on HB818

http://www.policyguy.com/pubs/SPLL/SPLL-MissouriPlan.pdf

http://www.khi.org/resources/Other/1186-HealthReform.pdf

http://www.khi.org/s/index.cfm?aid=834

Texas Public Policy paper on HRAs and individual policies

http://www.texaspolicy.com/pdf/2008-02-PP06-HRA-kh-mks.pdf

Now I would like to address HB 2259

Currently if a recipient is on a welfare health plan, he is on a government controlled, government constructed health plan. Few choices, few providers.

The goals of any health care reform should include an emphasis on wellness, individual accountability for a healthy lifestyle, and wise consumption of health care. Subsidies should be reserved for the truly needy, with a system in place for a smooth transition away from the welfare health program.

A simple step toward reaching these goals would be to convert subsidies for all welfare health programs, such as Medicaid and SCHIP, into income-based vouchers that can be used to purchase private policies or to join an employer's plan.

HB 2259 would authorize a request for a waiver from CMS to permit government assistance for low income individuals to purchase individual policies or apply the assistance to their portion of an employer's group health plan. These plans would include an HSA or HOA opportunity.

The advantages would be many.

Choice of plan. Voucher recipients would be free to purchase any of the many plan options on the open market or participate in their employer's group plan. They could add their own funds to buy a more expensive traditional plan, or purchase a lower premium plan high deductible health plan and put the balance of their vouchers into an HSA or health opportunity account (HOA). Those funds can be used for routine health expenses, such as pain relievers, doctor's visits, and prescriptions. This encourages consumerism, and promotes wellness and responsibility.

A wider choice of providers, **decreased wait times**, and **shorter driving distances.** Since many providers no longer accept Medicaid/SCHIP patients because reimbursement rates have been lowered, private plans would provide health welfare recipients with more choices because they would be on private plans. Children and parents could go to the same family physician. I know of families in which Mom drives many miles to a doctor that will accept her children because they are on the SCHIP plan and her physician won't see them.

Could lower rates for everyone. Subsidizing this primarily healthy, young group would add their premiums to private insurance plans and reduce overall risk by adding more people to the pools of the private plans.

Families can get discounts. Vouchers would also allow families to take advantage of discounts for private family plans or add the family to an employer's plan. Premium assistance for children on SCHIP, for example, can be used to put them on their parents' policy.

Portability. Currently, if while on a government health care assistance program, an individual should develop an "uninsurable" health condition, but the income of the family no longer permits that person to stay on the government plan, that individual's choices for health insurance are limited. He must go on his or his spouse's employer's health plan (if one is offered) or go on the high risk pool. If he had used the funds (thanks to HB 2259) to purchase a private plan, he would still be insured with the plan that he selected. He would not have to look for a new policy; he would just be responsible for that portion of the premium that the government assistance used to pay. His rates could not be raised nor could his policy be cancelled due to his personal claims.

My only caution about HB 2259 is authorizing the KHPA to phase in any waiver it receives and to develop and implement a pilot assistance plan. We want to put safe guards in place that would assure that the program permits the benefits as described above.

Currently a healthy 25 year old could choose to a pay as little as $37-$60 per month for a plan that includes a free annual physical and a defined out of pocket. If he is low income HB 2259 would permit him to receive premium assistance to help him pay the premium on his policy and to put the remainder of the funds in a health use only HSA or HOA account. If we couple this bill with HB 2287, his employer could contribute to the premium on his individual policy and/or put money in his pretax health savings account (HSA) — which grows with interest. While staying budget neutral, the state could remove barriers and increase the ranks of the insured. We should let it take effect before adding new layers of bureaucracy and centralized control.

Rather than veering off on a path that leads to government-controlled health care, Kansas is forging ahead on the road to personal responsibility and free-market health care reform with HB 2287 and HB 2259.

Beverly Gossage is a consumer-based health care expert and research fellow for Show Me Institute

KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #8
Health Opportunity Accounts (HOAs)

Background

The Health Savings Account

In recent years, consumer-directed health care has increasingly been used as a means to encourage people to make informed, cost-effective decisions about their health care.[1] One of the primary strategies used within the consumer-directed health care approach is to offer Health Savings Accounts (HSAs). The HSA was authorized through federal legislation in 2003 and is a type of medical savings account that allows consumers to save for medical expenses on a tax-free basis. Both individuals and employers can contribute to the HSA; the contributions are tax-deductible if made by the consumer and tax-exempt if made by the employer. In order to establish an HSA, the consumer must be enrolled in a high deductible health plan (HDHP). Typically, HDHPs are characterized by greater out-of-pocket spending, lower premiums, and higher deductibles. Advantages of establishing an HSA include providing the consumer with a mechanism to save for their health care costs, ownership of the account, rollover of unused funds from one year to the next, and portability (i.e., the consumer may keep their account if they switch jobs or are no longer enrolled in an HSA-eligible plan). Because consumers must pay for most of the medical costs out-of-pocket until they reach the plan's deductible, however, they face increased financial risks. One of the premises behind the HSA is that consumers will be financially motivated to contain their health care costs in light of the financial responsibility they assume.

Basic Features of the HSA

- A savings account that allows the owner to save for medical expenses on a tax free basis.
- In order to establish an HSA, the consumer must choose a high deductible insurance plan; the deductible being the dollar amount at which the insurer begins to cover some or all of the medical bills.
- Funds in the HSA are to be used to pay for the consumer's share of health care costs and generally cannot be used towards the cost of premiums.
- After the deductible is met, health insurance plans typically require additional cost-sharing in the form of co-payments and co-insurance.

Source: Kaiser Commission on Medicaid and the Uninsured www.kff.org/uninsured/7568.cfm

The Health Opportunity Account

While consumer-directed health care approaches were first introduced into the commercial and Medicare markets, state Medicaid agencies have also begun testing these strategies.[2] Health Opportunity Accounts (HOAs) are among the strategies being explored. HOAs were established as part of the Deficit Reduction Act of 2005 (DRA). Like the HSA, HOAs function as a type of medical savings account and are linked to a high deductible version of Medicaid. Unlike the HSA, however, contributions to the account are made using state funds and federal matching dollars, and may also include contributions from charitable organizations.

The HOA provision established in the DRA became effective on January 1, 2007, and allowed the Centers for Medicare and Medicaid Services (CMS) to approve demonstration projects in up to 10 states. The purpose of the demonstration projects is to determine if HOAs, in combination with high deductible insurance plans, are an efficient way to deliver health care benefits to Medicaid beneficiaries. The Medicaid HOAs incorporate key components of HSAs into the Medicaid demonstration program.

Elements of the HOA demonstration programs include:

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1 Greene, Jessica, *State Approaches to Consumer Direction in Medicaid.* Center for Health Care Strategies, Inc. July 2007.
2 *Ibid.*

- Participants must have both an HOA and coverage for medical items and services that are available under the existing Medicaid state plan or Section 1115 waiver authority, after an annual deductible is met.
- The HOA requires the consumer to pay for health care expenses out of the account and then out-of-pocket until the deductible is met.
- Contributions may be made by the state (not to exceed $2,500/adult and $1,000/child including federal match) or others (including charitable organizations).
- Deductibles may not apply to preventive care.

Certain eligibility components are outlined in the DRA, including:

- Eligibility is determined by the state although people who are aged, disabled, pregnant, or receiving terminal or long-term care are ineligible.
- Individuals may continue to make withdrawals from their HOA, under state-specified conditions, for up to three years after Medicaid eligibility termination (no additional account contributions will be made thereafter and balances will be reduced by 25%).
- For individuals who participate in a demonstration for at least one year and later become ineligible, funds from the account can be used for health insurance, job training, or educational expenses.

Source: Joint Commission on Health Care

HSA Implementation

Because the HOA is very similar in design to the HSA, and the HSA was established and implemented prior to the HOA, reviewing outcomes and issues associated with HSA implementation is helpful. As reported in a 2006 issue brief published by the Kaiser Commission in October 2006, "high deductible health plans that meet the HSA requirements are still relatively rare."[3] The statistics presented in a 2008 General Accountability Office (GAO) report support this observation. Findings in the GAO report are based upon industry and Internal Revenue Service (IRS) data and include the following:

- Between September 2004 and January 2007, the number of individuals covered by HSA-eligible plans increased significantly, from about 438,000 to approximately 4.5 million. Despite this growth:
  - Many of the HSA eligible plan enrollees (42 percent to 49 percent) reported they had not opened an HSA (findings were obtained from nationally representative surveys conducted in 2005, 2006, and 2007), and
  - Only a small share of individuals with private health care coverage was represented by these plans (approximately 2 percent in 2006).
- Additionally, tax filers who reported HSA activity in 2005 had higher incomes on average than other tax filers; among the tax filers between the ages of 19 and 64, the average adjusted gross income was approximately $139,000 compared with about $57,000 for all other filers. These income differences were observed across all age groups.

Source: GAO-080474R Health Savings Accounts

Other key findings that were reported in the Kaiser 2006 issue brief included:

- The lower premiums associated with HSA-qualified health plans are lower in part because they shift more of the financial risk to individuals and families through higher deductibles;
- Premiums and out-of-pocket costs for HSA-qualified health plans will consume a substantial portion of a low-income family's budget;

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[3] Kaiser Commission on Medicaid and the Uninsured. *"Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?"* October 2006. http://www.kff.org/uninsured/7568.cfm

- Most low-income individuals and families do not experience a high enough tax liability to benefit in a significant way from the tax deductions associated with HSAs (e.g., according to data from the U.S. Department of Treasury, a family of four with an income of $20,000 would receive no benefit from contributing any amount to an HSA);
- People with chronic conditions, disabilities, and others with high-cost medical needs may face even greater out-of-pocket costs under HSA-qualified health plans (i.e., these individuals are much more likely to reach their deductible level each year, which is set at a much higher level in the HDHP);
- Research from the RAND Health Insurance Experiment found that people enrolled in cost-sharing health plans were significantly less likely to see a doctor for services (including general health, vision exams, and treatment for infections) than people enrolled in health plans with no cost-sharing (the gap was greater for those with low incomes - <200 percent of the poverty level); and
- HSAs and HDHPs are unlikely to substantially increase health insurance coverage among the uninsured:
    - Over two-thirds of the nonelderly uninsured are low income; because they earn so little over half have no tax liability;
    - As such, offering plans that offer tax deductions as an incentive will have limited impact on the number of uninsured; and
    - The out-of-pocket spending that is required will not offer the low-income uninsured enough financial protection to offset the premium cost.

Source: *Health Savings Accounts and High Deductible Health Plans: Are They an Option for Low-Income Families?.* Kaiser Commission on Medicaid and the Uninsured, October 2006.

HOA Implementation

Currently, two states offer an HOA to their Medicaid population. Below is a summary of each state's HOA program.

Indiana

Implementation Date	December 2007
Program Type	1115(a) Demonstration Waiver
Incentives	$500 in "first dollar" preventive benefits at no cost to members
Geographic Areas	Statewide
Eligibility	Adults meeting specific eligibility criteria
Benefits	Basic commercial insurance package provided by contracting insurance companies
Deductible	Up to 5% ($1,100) of gross family income
State Contribution	Gap between designated deductible and $1,100
Enrollment	Approximately 28,000

South Carolina

Implementation Date	December 2007
Program Type	State Plan Amendment
Incentives	Preventive care and appropriate ER services are not applied toward the deductible
Geographic Areas	Richland County
Eligibility	Adults and children that have been eligible for three months
Benefits	Traditional Fee-For-Service benefit package
Out of Pocket Expenses	$250 per adult, $100 per child if State Contribution is exhausted

(Deductible)	
State Contribution	$2,500 per adult, $1,000 per child
Enrollment	5

With respect to Indiana's plan (the Healthy Indiana Plan or HIP), it is helpful to note some of its more significant features. The HIP plan is:

- Open to any Indiana resident ages 19 to 64 who:
  - Earns less than 200 percent of the FPL;
  - Has been uninsured for at least six months;
  - Is a U.S. citizen;
  - Does not have access to employer-sponsored health insurance; and
  - Is not eligible for Medicaid or Medicare.
- Indiana's existing Medicaid program, Hoosier Healthwise, restricts income eligibility for non-disabled adults to no more than 22 percent of the FPL – nearly the lowest coverage limit in the U.S.
- The HIP is intended to fill the gap in coverage between Medicaid and private insurance.

Source: *States in Action: A Bimonthly Look at Innovations in Health Policy.* The CommonWealth Fund Organization, February/March 2008.

Internal Analysis of the HOA

Little state-specific information regarding HOA use for the Medicaid population is available. Available resources are most often regarding the availability of the alternative benefit package through the Deficit Reduction Act only. No articles evaluating the success of the HOAs used within state medical assistance programs were located.

The Healthy Indiana Program is very comprehensive and, by enrollment terms, appears to be successful. Indiana contracts with private insurance companies to provide medical services and opens a Personal Wellness and Responsibility (POWER) account where family and/or state contributions are deposited for use. They also complement the program by offering an Enhanced Service Plan to screen and enroll beneficiaries with high risk conditions into the State's high-risk pool.

Resources with the state report South Carolina's Health Opportunity Account enrollment has been very slow. Per the State Plan Amendment, enrollment is capped at 1,000. Although the application process began December 2007, the state just recently enrolled beneficiaries into the program and has not yet processed claims. To date, enrollment includes one family of four (adults, children) and one child. Marketing efforts have included two mailings and county-wide distribution of flyers regarding the program. A third mailing is being planned. State officials attribute the low enrollment to the recent transitioning of the Medicaid population to managed care and the beneficiaries' being less inclined to try this new option.

National Analysis of the HOA

There are few articles or summaries regarding Medicaid enrollment in Health Opportunity Accounts. The most recent are dated 2006. High deductible heath plans are relatively new to the insurance industry; therefore, only summations can be made about their impact on the Medicaid population. The following are conclusions drawn from the most recent literature found on the subject.

"By encouraging individuals and families to choose high deductible health plans and set up HSAs, it is assumed that consumers will eventually become more cost-conscious, enabling them to make more cost-effective decisions about their health and health care. However, most low-income individuals and families are already making these tougher cost-benefit decisions as each health need arises. And the research to date shows that unaffordable cost-sharing among the low-income population not only decreases access to needed care but, in some circumstances, can also lead to

poorer health. For low-income families in particular, HSAs and HDHPs may exacerbate, rather than alleviate, the problems they currently face in affording and accessing needed health care."[4]

"The Health Opportunity Accounts could leave some beneficiaries, particularly those in poorer health, responsible for out-of-pocket costs related to health services they need when they have exhausted their accounts but not yet met the deductible. These costs would be on top of the standard copayments that beneficiaries would have to pay once the deductible was exhausted, which themselves would be increased by other Medicaid provisions of the Energy and Commerce reconciliation package. Research indicates that increased cost-sharing particularly affects the ability of low-income individuals to access health care.

At the same time, the Health Opportunity Accounts would add to federal Medicaid costs. By allowing former beneficiaries to keep balances held in their accounts, the federal government would essentially be paying for benefits provided to individuals and families no longer eligible for Medicaid. The demonstration project also would permit, at state option, the use of federal Medicaid dollars to pay for health care services not covered under Medicaid and even for non-medical services." [5]

"Factors other than patient cost-sharing also will impact the development of consumerism in the Medicaid program. Compared to the general population, Medicaid beneficiaries have lower levels of health literacy, less familiarity navigating the health care delivery system, and less experience and support researching and evaluating medical options."

Conclusion
In addition to the local and national analyses on HOAs described above, during September, 2007, the Kansas Health Institute developed a summary of main issues for states to consider when implementing consumer directed health purchasing (CDHP). Listed below are some of the issues and considerations that were identified.

Savings
Within the context of Medicaid reform, there are some reasons to believe that cost-savings may not be as great as in the private sector. Since beneficiaries will be paying for the up-front deductible costs with Medicaid funds, instead of their own money, the financial incentives may not be as great. Furthermore, they may be motivated to spend larger portions of the deductible amount if the incentives for saving are not present (e.g., availability of funds after leaving the Medicaid program; federally required reductions in the account balance upon leaving the program, etc.).

Conversely, if Medicaid recipients are allowed to keep the unexpended funds in their HOAs for up to three years, even if discounted 25 percent (as specified in the DRA), and are able to use the money on future health care expenses, education costs, or job training, they may experience incentives that encourage cost-conscious health care spending.

Eligibility
If Kansas incorporated CDHP into the Medicaid program, most participants would be healthy children and adults as required by the DRA. Although these individuals make up a substantial

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[4] Catherine Hoffman and Jennifer Tolbert, Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families? (The Kaiser Commission on Medicaid and the Underinsured , October 2006)

[5] Edwin Park and Judith Soloman, Health Opportunity Accounts for Low-Income Medicaid Beneficiaries: A Risky Approach (Center on Budget and Policy Priorities, November 2005)

percentage of Medicaid beneficiaries, they are responsible for a much smaller portion of Medicaid costs. Most to the Medicaid expenditures come from coverage of other populations which would be excluded from participating in HOAs (e.g., the aged and disabled). Therefore, the net impact on Medicaid spending may be less than expected.

Administrative Costs

Administrative costs associated with implementation of CDHP would need to be considered within the context of the overall fiscal impact of the program. For example, the DRA requires states that implement HOAs to develop and electronic monitoring and funds transfer system for the use of monies in the accounts (i.e., cash is not involved).

Other

Within the context of CDHP, and given the demographics of Medicaid enrollees, experts recommend a heavy emphasis on education, outreach, and quality initiatives to help beneficiaries distinguish between necessary and unnecessary care. Many of the state plans that are emerging include the availability of health counselors to assist in the selection of health plans to better understand available services and incentives.

Source: Memo on Consumer Directed Health Purchasing in Medicaid. The Kansas Health Institute, September 2007.

HB818 and HSA Help Small Business Owner*

Former "health plan"

- 42 year old and (42) spouse $562 traditional individual policy (2 million lifetime coverage each)
    - *2 kids were on Medicaid —now uninsured due to slightly elevated income no longer qualifying for this at annual review*
- 25 yr old employee nephew $130 traditional individual policy
- 25 yr old employee $0 *uninsured* for 4 years
    - $692

New HSA qualified health plans

- 42 yr old/spouse /2 children $255 -Kids no longer on Medicaid (5 million coverage each)
- 25 yr old employee $67 -paid physical/discounts/HSA
- 25 yr old employee $67 -Now is Insured-paid physical/discounts/HSA
- Funds to HSA $30 mthly each $60 -Grows with interest, tax free
- Funds to owner HSA $200 -Flexibility(employer decides)

$649

- Employer jump started employees HSA with a full year's funds ($360 each)
- Paying less than before, everyone is insured with tax deductible premiums with tax free money in the bank to pay for expenses

Win Win Win

Win for employer. Win for employees. Win for the state.

*A small business owner in Kearney, Missouri, who owns a water delivery business.

Compiled by Beverly Gossage, a consumer-based health care expert and research fellow with the Show-Me Institute

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How Could HB818 Affect Your Business?

By Beverly Gossage

Governor Blunt signed a groundbreaking new health insurance bill which has caught the eye of the nation and can impact your company. Most of the uninsured work for small companies and over 50 percent of Missouri small businesses do not offer health insurance.

Employers cite these reasons:

- The hassle of selecting a plan each year
- Employer contribution and employee participation requirements
- The lack of retention among employees
- The high cost of group premiums

HB 818 addresses these concerns. Through this bill:

Your employees

- ✓ Will not be subject to a waiting period before applying for coverage
- ✓ Can do their own shopping for a personal plan
- ✓ Are free to select an HSA qualified plan
- ✓ Could have much lower health insurance premiums
- ✓ Could experience discounts when putting their family on one plan
- ✓ Can have convenience of payroll deducting their health insurance premiums
- ✓ Can save on taxes through a Cafeteria 125
- ✓ Are more likely to purchase health insurance
- ✓ Could be healthier, miss less work, and be more productive
- ✓ Could stay with your company longer

You

- ✓ Don't have to shop for a health insurance plan for your company
- ✓ Do not have to meet participation and contribution requirements
- ✓ Have the *option* of contributing to the premium
- ✓ May contribute to individual health savings accounts
- ✓ Will find it easier to budget health insurance expenses
- ✓ Could have the convenience of "list billing" individual policies
- ✓ Can save on taxes through a Cafeteria 125
- ✓ Could have more employees insured
- ✓ Could have healthier employees who miss less work and are more productive
- ✓ May experience higher employee retention and satisfaction levels
- ✓ May maintain your group plan (if you offer one) while contributing to individual plans

HB 818's provisions allowing for your contributions to individual plans with pretax advantages can turn uninsured employees into insured consumers.

Beverly Gossage is a consumer-based health care expert and research fellow with the Show-Me Institute.

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What Can be Done to Help Small Business Owners Deal with Rising Health Care Costs?

By Beverly Gossage, Consumer Driven Healthcare Specialist and Research Fellow for Show Me Institute

For small business owners, health insurance has become an expensive benefit to offer. That is the main reason 52 percent of small business owners in Missouri do not offer a group health plan, and those who do, want answers on how to reduce the rising cost of premiums. Fortunately, there are ways that these cash-strapped employers can help their employees acquire affordable health insurance.

One way to lower rates is by switching to consumer-driven health plans, which can reduce monthly premiums by about 35 to 50 percent, depending on the insurance carrier. By using these health insurance plans, which can be partnered with health savings accounts (HSAs) or health reimbursement arrangements (HRAs), employers—and employees—can contribute tax-free to employees' accounts. Fewer dollars allotted to premium and more dollars sheltered in pretax accounts help to mitigate the trend of sizable annual increases.

Even if small businesses can't afford to offer group health insurance, they can still contribute funds pretax to their employees' private health care plans thanks to a bill, HB818, which passed in June. This provision allows employees a broad choice of plan options at affordable prices (a family of four could purchase a private plan for about $250 per month), while reducing costs for the employers.

Small business owners can also help lower health insurance rates by educating employees about the benefits of wellness and good health. About 80 percent of health claims stem from unhealthy lifestyle choices. Informing employees of the local hospital's health fair, organizing weight loss and smoking cessation programs, and encouraging after-hours exercise groups can reap great rewards in the form of healthier employees, fewer sick days, and lower overall health insurance rates.

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Free-Market Health Care Reform in Missouri: A Primer

By Beverly Gossage June 3, 2007

A long-awaited free-market step on the path to cover those without health insurance came out of Jefferson City on Friday. Gov. Matt Blunt signed HB 818, making Missouri the first state to permit pretax contributions from small business owners to their employees' individually selected policies. Unlike other health care reform "solutions" that require more government intervention and bureaucracy — third-party or one-payer systems, employer mandates, tax hikes, and cost shifting — this law offers a common sense approach to health care reform.

The media has focused on a controversial midwife provision that was inserted into the bill at the last minute. But the real news here is the bill's revolutionary approach to health insurance reform — and the fact that the bill won such overwhelming bipartisan support in both chambers of the Legislature. There's a lot to be excited about in HB 818, so here's a primer you won't find in the press.

The standard employer-based model for health insurance coverage leaves a remarkable number of people out. Nationwide, about 30 percent of workers in firms with fewer than 25 employees are uninsured, and 88 percent of Missouri businesses have fewer than 25 employees. Many small companies no longer offer group health insurance. According to a study by America's Health Insurance Plans (AHIP), only 42 percent of Missouri small businesses offer health insurance. These employers' reasons include: the hassle of selecting a plan each year; employer contribution and employee participation requirements; lack of retention among employees; and the high cost of group premiums. The uninsured mention affordability and portability as barriers to health insurance.

HB 818 addresses these concerns:

The annual insurance renewal hassle. Shopping to determine which single carrier's one or two plans (if any) an employer will offer each year to attempt to meet the needs of all employees is every small business owner's nightmare. Employers would generally rather run their companies than be in the health insurance business. Since employees under HB 818 are allowed to select their own individual plans, they can choose from a marketplace of carriers and plan designs for the one that best meets their personal preference. The employee becomes the consumer and purchaser of insurance; the employer merely contributes a defined amount. HB 818 also allows the employer to continue to offer a small group plan and contribute to employees' individual policies.

Employer contribution requirements. Most small group carriers require that the employer contribute at least 50 percent of the premium for the individual employee. Many employers would like to contribute to their employees' health insurance, but would like to have the flexibility to determine their contribution amount. By allowing a defined

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contribution, HB 818 gives employers this option. Business owners may discover that individual policies can be less expensive than group plans, so their contribution, even at 50 percent, may be less than it was with a group plan.

Lack of employee participation and small group participation requirements. Most small group carriers require that at least 50 percent of employees participate in a plan. Although part-time employees are not counted in this participation requirement, and are frequently left without coverage, small business owners have found it difficult to maintain this standard. Employers can now contribute to premiums without this constraint. Previously uninsured employees are more likely to purchase individual plans if their employers are picking up some of the cost and they can pay for it through pretax payroll deductions.

The retention and portability issue. Small business owners understand that in a global society, employees come and go. With each new hire and termination, group dynamics change and insurance premiums can be drastically affected, making it difficult to budget costs and meet participation requirements. When health insurance is employer-based, a constantly transitional workforce will have a high percentage of temporarily uninsured workers. The federal government reports that 45 percent of those without health insurance are uninsured for only six months or less. Portability is important in helping to cover this group, and most employees would rather keep their selected benefits when changing employers and have a consistent health plan.

HB 818 affects both issues by authorizing employees to plug their individual policies into their new employers' cafeteria plans, and permitting those new employers to contribute to the premiums. This is an easier transition for newly hired employees, often eliminating doctor and benefit changes, or a waiting period to access new health insurance. When employees are terminated, they take their plans with them — no need to offer state continuance or COBRA. Changing jobs or being terminated will not be a cause for panic about health insurance loss.

The affordability issue. One-size-fits-all small group health plans, with their accompanying mandates, are often more expensive than individual plans. According to the AHIP, last year in Missouri the average small group single employee premium was $292, and family rates averaged $765. By contrast, the average premium was $192 for an individual, $332 for a family. The Council on Affordable Health Insurance (CAHI) reports that young "invincibles," age 19 to 34, represent 56 percent of the uninsured. Their premiums can be especially inexpensive on an individual policy. For example, a 25-year-old healthy, nonsmoking male could have an individual policy with a premium as low as $65, which includes a free annual physical. This is about the cost of an average monthly cell phone bill.

Competition. There are 18 million individual policies nationwide, and Humana expects that number to grow by 5 to 8 percent over the next five years. Other carriers known for being large group providers, such as Coventry and United, recognize this trend and have entered the individual market in recent years. This makes the rates even more competitive. Many carriers already offer convenient "list bill" options, which permit employers to payroll-deduct premiums for individual policies and pay one check or bank draft for all the employees who have policies with that carrier.

Family Discounts. With small group plans, often husband and wife are on separate plans with different employers, and the children may have individual policies. The family can be with as many as three different carriers. With HB 818, if both spouses work for small employers, the family can have one policy purchased independently and each spouse's employer can contribute to the premium. Families can stay together on the same plan. This is nice for several reasons: rates are often lower, because most carriers give a discount if the family is on one policy; there are fewer benefit rules and health cards to keep straight; and doctors can be chosen from one network. Health savings account plans are also growing in popularity, and because they have one family deductible, having the family together is a plus.

Tax incentives. As the popularity of individual plans has increased, the injustice of insurance taxes has become more pronounced. Until now, premiums were only tax-advantaged if purchased through an employer group plan. However, HB 818 permits funneling individual premiums through the Cafeteria 125, making the employee's portion pretax. This equalizes the tax discrimination. Since the employer's portion of the premium is also pretax, this will give an incentive for both employers and employees to contribute to health insurance, covering more uninsured. HB 818 also allows self-employed business owners a state tax credit for personal health premiums, since these cannot be funneled through the Cafeteria plan.

HSAs and Consumerism. When given free choice of an individual plan, many employees choose health savings accounts and the qualified health plans that accompany them, because the premiums are usually 35 percent to 40 percent lower than traditional plans. Employers and employees may both contribute to the health savings account, providing more tax advantages for both parties. These funds grow with interest, and employees may use them to pay health care expenses for the entire family — even save it for retirement, if not used. HB 818 also adds an HSA plan to the state risk pool and Missouri state employees' health benefit package. This provision will give a tax-advantaged, affordable option with a defined out-of-pocket expense for those who do not qualify for an individual plan from a private carrier, and for those who work for the state. This option exposes employees to the actual cost of their health care.

Employees with individual policies, particularly HSA plans, are not insulated from the true cost of the premiums, as well as the cost of care. They recognize that this is their portable plan, not the employer's plan. They are aware that their lifestyles affect premiums. This realization can affect unhealthy, sedentary choices. For example, when told that his premium could be 30 percent lower if he was not a tobacco user, an individual said that was the incentive he needed to stop smoking. This self-ownership provides for more judicious utilization of insurance benefits, and promotes wellness.

HB 818's provisions allowing for small employer contributions to individual plans with pretax advantages can turn uninsured employees into insured consumers. This benefits all of Missouri.

Beverly Gossage is a consumer-based health care expert and research fellow with the Show-Me Institute, which sponsored Gossage's March 5 presentation to the Missouri Legislature on HSAs and free-market approaches to health insurance reform. HB 818 incorporates many of the ideas Gossage presented.

Wichita Independent Business Association

THE VOICE OF INDEPENDENT BUSINESS

House Committee on Heath and Human Services
Testimony in Support of HB 2287
By: Natalie S. Bright

February 12, 2009

Chairman Landwehr and honorable committee members:

My name is Natalie Bright, and I am the governmental affairs consultant for the Wichita Independent Business Association (WIBA). As a representative of organizations charged with the mission to promote a strong business environment in Kansas, I am here as the voice for more than 1,000 business members from across the state of Kansas and can assure the rising cost of health care insurance is the top concern for our members. Thank you for the opportunity to submit testimony in favor of HB 2287, which provides for small employers not offering health insurance to their employees, the option of contributing to an employee's individual policy though a section 125 plan.

The members of WIBA support HB 2287 because it proposes another tool that may be used by employers to assist their employees in obtaining health care insurance. Health Reimbursement Accounts (HRA's), under current law, are attractive to employees because they deposit pre-tax dollars and use those dollars to pay for health care expenses. Under existing law, employers are denied the option of contributing dollars to their employees HRA's. HB 2287 would remove this restriction and allow employers to deposit dollars into an employee's HRA account, affording the employee the benefit of leveraging both contributions towards the premium of an individual health care policy. HB 2287 will give employers and employees an additional choice, which we believe is what is needed in the health care arena. It also fosters additional individual choice and control over one's health care insurance, which we believe is a necessity in ultimately reducing health care costs.

There is concern that passage of this bill might circumvent the small group market and we would offer that this is a legitimate concern. However, we also recognize that if we are going to reduce the cost of health care, we need to be willing to try new approaches.

As we have said in all the testimony we have presented to you this week, the 2009 Legislature has a tremendous opportunity to identify and explore market-driven solutions that will help keep health care costs down – and coverage rates up. WIBA is committed to working with Kansas Legislators to find market driven solutions that assist employers with providing health care to their employees and urge your support of HB 2287. We look forward to working with lawmakers in developing the best possible options and outcomes for all Kansans. Thank you for the opportunity to share our position with you.

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316-267-8987 / 1-800-279-9422 / FAX 316-267-8964 / E-mail: info@wiba.org / Web Site: www.wiba.org

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House Health and Human Services Committee

To: Chairperson Brenda Landwehr and the Honorable Members of the House Health and Human Services Committee

Subject: HB 2287: Health Reimbursement Arrangements

My name is Scott Day and I am a co-owner of Day Insurance Solutions, LLC, a health and life insurance agency located in Topeka, KS. I am here today to testify in favor of HB 2287.

HB 2287 would permit individual insurance premiums to run through a Cafeteria 125, which allows pretax contributions for employees. Through the establishment of a Health Reimbursement Arrangement (HRA) the employer can make pretax contributions to individual premiums, thus giving them both an incentive to contribute. This would equalize the tax discrimination that has favored those purchasing health insurance through group plans.

Shopping for group health insurance is a hassle. Employers would rather run their companies than be dealing with health insurance. Since employees under HB 2287 are allowed to select their own individual plans, they can choose from a marketplace of carriers and plan designs for the one that best meets their personal need. The employer determines the amount of contribution, if any, that they want to provide.

Since the employee owns the health insurance, it goes with them when they leave an employer. No more COBRA or State Continuation issues when an employee leaves. When health insurance is employer-based, a transitional workforce will always have a high percentage of temporarily uninsured workers. Portability is important in helping to cover this group.

Most small group carriers require that the employer contribute at least 50 percent of the premium for the individual employee. Many employers would like to contribute to their employees' health insurance, but would like to have the flexibility to determine their contribution amount. HB 2287 gives them this flexibility.

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Most small group carriers require that at least 50 percent of employees participate in a plan. If this requirement is not met the whole group loses the insurance and they are all uninsured. HB 2287 allows employers to contribute to premiums without this constraint.

HB 2287 opens many possibilities for the small business owner to provide affordable health insurance coverage to their employees. The advantages are many and can help to reduce the number of uninsured without additional tax burden to our citizens.

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The Voice of Small Business®

House Health & Human Services Committee
Daniel S. Murray: State Director, NFIB-Kansas
Testimony in Support of HB 2287
February 12, 2009

NFIB-KS advocates free-market reforms that allow small-business owners to decide which benefits they can and cannot afford to offer.

Madam Chair, Members of the Committee: My name is Dan Murray and I am the State Director of the National Federation of Independent Business-Kansas. NFIB-KS is the leading small business association representing small and independent businesses. A nonprofit, nonpartisan organization founded in 1943, NFIB-KS represents the consensus views of its 4,000 members in Kansas. Thank you for the opportunity to comment on HB 2287.

Since 1986, the National Federation of Independent Business' members have said that healthcare costs are their No.1 concern. For this presidential election, a national survey conducted by NFIB confirmed that healthcare remains a top issue in voters' minds. Nearly 81 percent of small business owners say that finding affordable healthcare for themselves and their employees is a challenge. Fifty percent of small business owners say they anticipate having difficulty keeping up with the cost of healthcare over the next four years. And, of the nearly 46 million Americans without healthcare, more than 26 million are small business owners, employees and their dependents.

So, with the rising cost of providing healthcare benefits, an increasing number of employers are looking for innovative ways to stretch their healthcare dollars. This includes market-driven reforms aimed at empowering individuals and employees to become better consumers by giving them the freedom to choose how they are spending their healthcare dollars.

The primary tools available to small business owners, their employees and their families include health savings accounts (HSAs), health reimbursement arrangements (HRAs) and flexible spending accounts. These plans provide the consumer with the choice to control and spend healthcare dollars as they see fit.

NFIB is a huge proponent of HRAs. An HRA is an employer-funded account that is designed to reimburse employees for their qualified medical expenses. Like an HSA, an HRA requires an employee to obtain an HDHP. However, unlike the HSA, the employer is solely responsible for funding an HRA and the HRA stays with the employer if an employee leaves.

Through an HRA, an employer sets aside a portion of funds to be used to reimburse employees for qualified medical expenses that are paid for out-of-pocket (deductibles, co-payments, doctors visits, prescription drugs, etc.). Like HSAs, in an HRA all of the up-front medical costs are paid for by the employee, thereby encouraging an individual to be thoughtful with their healthcare spending. Once those services have been paid for, the employee submits a request to be reimbursed through the HRA.

We believe HRAs will help reduce the number of uninsured Americans by allowing small businesses and their employees more choice in the current small-group market. Further, by allowing portability and more flexibility, HRAs will afford employers a better opportunity to offer employees health insurance at reasonable rates. HB 2287 allows employers to authorize small business employers to establish HRAs whereby they can contribute to the insurance premiums of their employees' individually underwritten health plans.

Kansas small businesses are facing real challenges—healthcare costs are of chief concern. NFIB ***strongly*** believes that HRAs are a key tool in addressing increasing healthcare costs. We ask that you support HB 2287. Thank you for your time and consideration.

National Federation of Independent Business – KANSAS
5625 Nall Ave., Roeland Park, KS 66202 • 785-217-3442 • Fax – 785-232-1703 • www.NFIB.com/KS

Kansas Insurance Department

Sandy Praeger, Commissioner of Insurance

TESTIMONY ON
HOUSE BILL No. 2287

HEALTH AND HUMAN SERVICES COMMITTEE
February 12, 2009

Madam Chair Landwehr and Members of the Committee:

Thank you for the opportunity to testify today on behalf of the Kansas Insurance Department regarding House Bill No. 2287 pertaining to health reimbursement arrangements. My name is Linda Sheppard and I am Director of the Insurance Department's Accident & Health Division.

Based on our understanding of this bill, which would permit small employers to contribute to the premiums of employees who have individually written health insurance, we believe that HB 2287 would result in negative consequences for some employees in the small employer marketplace and the small employer marketplace as a whole.

One of the criteria used by health insurers when they are marketing small employer health plans is the percentage of participation by the employees. This requirement permits the health insurer to spread the risk across all of the small employer's employees and impacts the cost of the coverage provided. If some employees elect to obtain their own individual coverage paid for, in part, by their small employer, the employer may be unable to obtain small group coverage for the remaining employees because they no longer have a sufficient number of eligible employees to participate in the small group plan.

420 SW 9th Street
Topeka, Kansas 66612-1678
785-296-3071 Phone
785-296-2283 Fax
Consumer Hotline
800-432-2484

Allowing eligible employees to purchase health coverage in the individual marketplace will result in those that are able to pass underwriting leaving the group for an individual product. Therefore, those employees who are unable to obtain coverage in the individual marketplace due to a health condition may no longer have their group coverage available to them because the small employer is not able to meet an insurer's participation requirements.

In addition, HB 2287 would result in healthy eligible employees, who are able to qualify for an individual policy, to exit the small group marketplace. When healthy lives leave a block of health insurance it leads to higher premium rates because those premium dollars are not there to spread the risk. Therefore, HB 2287 would weaken the small group market and create an atmosphere where costs would be increased for small employers that continue to offer group health insurance. With the cost of group health insurance already a burden on many small employers this increased expense could very well lead to lapsed group policies and more uninsured Kansans.

For these reasons the Kansas Insurance Department opposes HB 2287 and I would be happy to stand for any questions you may have regarding this testimony.

Linda J. Sheppard, Director
Accident & Health Division, Kansas Insurance Department

Janet Grace

From: Michael Gross [mgross@countryclubbank.com]
Sent: Wednesday, February 11, 2009 4:50 PM
To: Janet Grace
Cc: Ron Gaches
Subject: Testimony for HB 2259

Good afternoon Representative Landwehr, the members of the Committee on Health and Human Services and fellow conferees

I am Michael Gross; a licensed health insurance agent, immediate past president of the Kansas Association of Health Underwriters (KAHU) and Kansas resident, residing in Olathe KS.

I am here to represent the all the members of the KAHU.

We support the provision of Section 1 that gives KHPA authority to apply for waiver or waivers from the CMS, in attempt
to lower the cost of health care under the Kansas Medicaid program by offering a Health Savings Account . . .
we oppose the opportunity account because it has not been defined in this act,

We support the provisions of Section 2 that gives the KHPA the authority to develop and implement a pilot premium assistance plan,
to assist eligible employees of small employers to purchase an employer sponsored health benefit plan.
We oppose using the premium assistance plan to purchase a state approved individual health benefit plan
because there is no definition of the criteria of what a "state approved" individual health plan must be.
The state's criteria could limit participation if it is too specific or the states criteria could eliminate
the choice of private sector policies altogether.

The KAHU is in support of offering additional plan designs for the Kansas medicaid participants.
We simply wish for the choices offered to be private sector products which help to lower the cost
of health insurance.

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House Health and Human Services Committee

To: Chairperson Brenda Landwehr and the Honorable Members of the House Health and Human Services Committee

Subject: HB 2259: Medicaid Reform

My name is Scott Day and I am a co-owner of Day Insurance Solutions, LLC, a health and life insurance agency located in Topeka, KS. I am here today to testify in favor of HB 2259.

Section 1: Medicaid is in dire need of reform. We need to reform the Kansas Medicaid Program to promote personal responsibility for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing. Current plan designs promote medical utilization…a $3 co-pay for non-emergency use of an ambulance does NOT curb medical utilization. Kansas should pursue a Medicaid waiver allowing the restructuring of the Medicaid plan to include a Personal Opportunity Account (POA).

Though Medicaid POA accounts limit the exposure to Medicaid recipients, they do expose them to more of the costs than our current program. And like HSA accounts, many interested parties can contribute to the accounts: Government; Recipients; Family; Charitable Organizations; Employers; and etc.

Section 2: "Recognizing that many Oklahomans do not have health care benefits or health care coverage, that many small businesses cannot afford to provide health care benefits to their employees, and that, under federal law, barriers exist to providing Medicaid benefits to the uninsured, the Oklahoma Legislature hereby establishes provisions to lower the number of uninsured, assist businesses in their ability to afford health care benefits and coverage for their employees, and eliminate barriers to providing health coverage to eligible enrollees under federal law."

The above statement was taken from the landmark Oklahoma Medicaid Program Reform Act of 2003…SENATE BILL NO. 1546,

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which enabled small employers, and/or employed, uninsured adults with or without children to purchase employer-sponsored, state-approved private plans through a state premium assistance payment plan. This premium assistance plan was originally known as O-EPIC, but is now referred to as Insure Oklahoma. This program has proven that Premium Assistance can work, if designed correctly.

The key to this success is the Medicaid waiver that Oklahoma applied for to allow private market small group and individual plans to be offered in the program. The waiver allows plan designs that are almost identical to the private market plans we already have in Kansas. Employer Sponsored Insurance (ESI) plans are actually utilized in Oklahoma. The private market in Oklahoma was not changed at all in the implementation of Insure Oklahoma. Insurance carriers, agents, employers, the uninsured, & etc. all speak highly of the Insure Oklahoma program. Oklahoma implemented Premium Assistance and actually did no harm to the private market.

How did they accomplish this? There is NO Premium Assistance "State developed" plan. All "eligibles" are enrolled through private market plans…either ESI plans or individual plans. To this issue, I recommend that Section 2, line 29 delete the phrase "state approved" and be replaced with "eligible private market".

Conclusion: I support Premium Assistance if the Oklahoma model is used. The model that was passed in 2007, in my opinion, was an expansion of Medicaid…which I do not support. Our current Medicaid programs cannot be sustained. Personal responsibility must be introduced to these programs. POA accounts in Medicaid and private market plans (with actual deductibles) in the Premium Assistance model will provide insurance for those in need without continuing the unfettered abuse of these programs.