THE LOGIC BEHIND SB 163.

This law has MANY purposes:

1. To help the citizens and businesses of Kansas continue to carry affordable health insurance as opposed to the plans available in the Exchanges created by PPACA. Plans bought OUTSIDE of the exchanges are not required to be QUALIFIED plans. That is, they do not HAVE TO meet benefit requirements. The result should be a reduction in the number of uninsured Kansans.
2. To allow Kansas consumers – **both individuals and groups** – to custom design their own health insurance plans using a Major Medical base plan and then selecting from a **menu of benefit choices** so that they can have the coverage that **meets their needs.**
3. To develop health plans that will help attract new consumers – individuals and businesses – to reside in Kansas because they CAN purchase affordable health care within the state.
4. A potential reduction in the number of Kansans on Medicaid since self-designed affordable Major Medical plans will be available in the market place.
5. By making the purchase of **fully insured** health plans sold to both the small and large group employer market **more attractive and less costly** it is probable that companies currently using **self-funded ERISA** plans will change to fully insured plans that bring them back under the state regulations pertaining to insurance.
6. According to the Kansas Labor department more than 80% of all employers in Kansas employ less than 10 employees and many of them do not offer health insurance due to the cost. Estimates are that more than 50% of these employers would begin to offer group health insurance.
7. By increasing the number of health insurance policies sold inside Kansas the state **general fund** will see in influx of **revenue** due to the increase in the portion of the **2% premium tax** collected that is rolled into the fund each year by the DOI.
8. Finally, by reducing health insurance premiums, employers will **have more money to hire new employee, expand and grow their businesses, increase wages and offer more fringe benefits.**
9. **KANSAS AND OUR ECONOMY WINS!!**

Affordable policies will not include all the PPACA Essential Benefits mandated but will allow the consumer to make choices in coverage that fits themselves, their families and/or their businesses. Each insurance company will offer "MENU" of benefits consumers can choose from.

Where will people buy this health coverage? OUTSIDE OF THE EXCHANGES.

Consumers always migrate to the best value for their dollar. If that value can be purchased for less than they would pay for a product sold inside the exchanges, but is designed to fit the needs of themselves and their family, even when adding in the cost of the penalty they are required to pay, then **THEY WILL BUY OUTSIDE OF THE EXCHANGES**. The base health plans all begin with **MAJOR MEDICAL**, not limited benefit plans.

"Mandate Lite" legislation is needed at the STATE LEVEL. **Consider the following:**

1. This is a law that will enable insurance companies to market products that can be custom designed to fit the needs of the consumers. These products must be free of all

state mandates, but must allow the consumer to choose those benefits they feel fit their family's or business' needs. A build your own castle, if you will. Each policy has basic major medical coverage a company chooses to offer, then each insurance company decides and prices the options they wish to make available to the buying public. **A MENU OF CHOICES!** The goal is to come in with a premium, when the package is complete, including the PPACA penalty, which will be less than the premium of the packages available within the Exchanges. These plans will NOT need to include the Essential Benefits as defined by ObamaCare since they are outside of the law!

2. I have attached a copy of that section or PPACA allowing this to happen in states.
3. Although parts section 2 of HB 2243 are NOT NEEDED, I sought to add clarity to how the insurance is built
    a. Section 2 (b) (1) and (2) and (c) state these policies can either be policies created before PPACA became law or policies created after PPACA became law and may be sold outside of any Exchange created under PPACA.
    b. (d) Allows insurers to offer policies that are mandate lite, to offer consumers a MENU of benefit choices for plans purchased outside of PPACA Exchanges.
    c. Section 2 (d) (1) (A) Requires the insurer to File with and receive approval of the MENU of benefits they will make available for the consumer to choose from for their policy.
    d. (i) (a) and (b) allow individuals and groups to choose benefits they want to include or exclude, while
    e. (ii) (a) and (b) require written acknowledgement of the benefits chosen with a copy to be kept on file by the insurance company.
    f. D (1) (B) requires minimum standard and basic coverage as previously noted for Mandate Lite Major Medical plans.
    g. (d) (2) addresses plans being renewable at policy holder option.
    h. (d) (3) Allows the insured to add or delete benefits at the policy anniversary.
    i. (d) (5) (A), (B) and (C) allow rate adjustments for increase and decrease in benefits.
4. NOTE: These provisions in combination with the Mandate lite provisions will provide both individuals and group consumers with wider choices for a significantly lower premium rate than projected by both the OMB and IRS.
5. At this point, all the information in **2** above would only be needed if further guidance is required from the legislature, should the insurance department not allow creation to take place as anticipated so **amending SB 165** to add this language should be delayed until 2014 and should be considered at that time if needed.

It is imperative that these laws be passed and signed prior to 2014 when PPACA kicks into full force!

THANK YOU,

DAVID J POWELL, CLU, ChFC, CFP, RHU