Ascension
Via Christi

TO: **Members of the House Insurance Committee**
Rep. Jene Vickrey, Chair

FROM: **Bruce Witt**
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Date: **March 6, 2019**

Re: **Senate Bill 32**

Thank you, Chairman Vickrey, and members of the House Insurance Committee for allowing us to submit this testimony in opposition to Senate Bill 32. While we applaud Kansas Farm Bureau's interest in addressing the health coverage access needs of Kansans, we have concerns about the fiscal and health-related impacts this bill would have on the patients we serve. From our health system's own experience in Tennessee, we know that there is a high probability that SB 32 would:

- Segment the individual market, leaving the demographics of the ACA-compliant health insurance pool older in average age, and higher risk from health morbidity standpoint, thus resulting in both higher premiums and higher out-of-pocket costs for those individuals in the ACA-compliant market; and,
- Leave enrollees who choose to participate in this type of health plan subject to bare-bones coverage without financial protection or adequate benefits.

These health plans would segment the individual market to where it would significantly limit the ability of those with pre-existing conditions to obtain affordable, quality health insurance. Allowing the ability to underwrite applicants based on gender, health status, pre-existing conditions, age and other factors, working middle-class Kansans with pre-existing conditions would wind up with fewer affordable choices for health insurance, especially if they earn too much for subsidies on the ACA marketplace.

- In Kansas, 30% of non-elderly adults (545,000) have pre-existing conditions that medical underwriting would likely result in denial of coverage.[1]
- Based on Tennessee's experience, their individual market has seen annually higher premium increases than Kansas.[2] The higher premiums, and a destabilized insurance market that includes exits from high-profile insurance groups, is in part due to the existence of health plans provided by the Tennessee Farm Bureau.[3]

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[1] Claxton, G., Cox, C., Damico, A., Levitt, L., and Pollitz, K. (2016, December). *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*. Kaiser Family Foundation.
[2] Holahan, J. Wengle, E. Blumberg, L., Solleveld, P. (2017, January). *What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country?* Urban Institute.; Holahan, J., Blumberg, L., and Wengle, E. (2018, March). *Changes in Marketplace Premiums, 2017 to 2018.* Urban Institute.
[3] Lucia, K. and Corlette, S. (2017, April). *What's Going On in Tennessee? One Possible Reason for Its Affordable Care Act Challenges.* Georgetown University Health Policy Institute Center on Health Insurance Reforms

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- With the presence of Tennessee's Farm Bureau health plans, the Society of Actuaries found that Tennessee's ACA-compliant individual market evolved into having the sickest and most expensive enrollees in the entire country.[4]

Under the type of health plan allowed under Senate Bill 32, there is no requirement to cover costs related to extended hospitalizations, prescription drugs, cancer treatment, periodic preventative care, maternity and pregnancy care, or other essential health benefits. In addition, the Kansas Farm Bureau plan can choose to place annual or lifetime caps on enrollee benefit costs whenever they deem appropriate. Just as troubling, based on health plans we are aware of that are exempt from federal and state regulation, 62 percent do not cover treatment for behavioral health and substance abuse disorders.[5] At a time when our state system for treating these conditions is in crisis, this is a cause of great concern.

Previous experience elsewhere shows that these health plans typically turn a healthy profit for the association because they avoid risks of enrollees, at the enrollees' peril. On average only 67 cents of every premium dollar these health plans collect are spent on enrollees' claims. Comparatively, ACA-compliant plans must spend at least 80 cents of every premium dollar on claims.[6] Medical loss ratios (MLR) are a good proxy for whether insurers are avoiding risk rather than insuring for it, and these health plans have an MLR that is good for their bottom lines but bad for their insureds in need of care.

Given that these plans would be exempt from state oversight and solvency requirements, there is no established avenue for consumer and patient protection. If an enrollee has a complaint about their plan, or has a claim denied, there is no viable avenue for them to seek assistance with the Kansas Insurance Department. Instead, it is left up to the enrollee to pay for, acquire legal counsel, or seek assistance from the Kansas Attorney General. Very few Kansans will have the time and resources to avail themselves of these enforcement avenues.

If the Kansas legislature desires to help rural communities afford health care coverage, we encourage you to focus more on closing the coverage gap. An estimated 150,000 Kansans would gain coverage if the state expanded Medicaid (KanCare). Medicaid expansion states have lower premiums, by an average of 7%, and healthier risk scores in their individual markets.[7] Finally, a recent study found that since the passage of the ACA, uninsured rates for low-income adults in rural areas have declined three times faster in Medicaid expansion states compared to non-expansion states.[8]

For the reasons outlined in this testimony, we urge your opposition to Senate Bill 32, and support of a broader plan that not only addresses the true health coverage gap in this state but includes a fair and consistent regulatory structure.

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[4] Owen, R. (2016, August). *An Examination of Relative Risk in the ACA Individual Market.* Society of Actuaries.
[5] Kaiser Family Foundation. (2018, April). *Analysis: Most Short-Term Health Plans Don't Cover Drug Treatment or Prescription Drugs, and None Cover Maternity Care*.
[6] National Association of Insurance Commissioners. (2017, July). *2016 Accident and Health Policy Experience Report.*
[7] Antonisse, L., Garfield, R., Rudowitz, R. and Artiga, S. (2018, March). *The Effects of Medicaid Expansion under the ACA: Updating Findings from a Literature Review.* Kaiser Family Foundation.
[8] Hoadley, J., Alker, J., and Holmes, M. (2018, September). *Health Insurance Coverage in Small Towns and Rural America: The Role of Medicaid Expansion*. Georgetown University Policy Institute.