

Testimony on:

Senate Bill 309 - The Kansas Health Care Connector Act

presented to:

Senate Committee on Ways and Means

by:

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Senate Bill 309 – The Kansas Health Care Connector Act

Good morning Chairman Umbarger and members of the Committee. My name is Marcia Nielsen, and I am the Executive Director at the Kansas Health Policy Authority. Andy Allison, Deputy Director and Acting Medicaid Director, is here with me today. I appreciate you giving us an opportunity to provide a briefing on SB 309 and the overall need for health reform in Kansas.

First, I want to give you some background on the health reform process here in Kansas, and second, provide you with our perspective of the Connector plan with lessons learned from study of the Massachusetts Health Connector. A copy of our report is attached.

Health Reform in Kansas

Currently, 11% of Kansans are uninsured and without health care coverage. While we've made great strides in recent years to increase enrollment in Medicaid and the State Children's Health Insurance Program, and launched programs like HealthyKIDS that provide accessible and affordable health care, we can do better. Health reform requires making health and health care services accessible and engaging in effective outreach efforts that seek and invite Kansans to participate and lead healthy lifestyles. The Board has embraced these ideas as vision principles and they are reflected in the budget recommendations and policy initiatives the Health Policy Authority has advanced this year.

Kansas has a relatively low rate of uninsurance, moderately high level of employer sponsored health insurance and level of Medicaid coverage for children, which provides a supportive climate for policy initiatives to reduce the number of uninsured Kansans. The majority of the uninsured in our state are low-wage full-time workers employed in small businesses. Small employers struggle to find affordable health insurance for their employees and there are very limited options for those in the non-group market.

The Kansas Health Policy Authority Board has taken a number of initiatives to begin the process of health reform in Kansas. We recognize health reform and transformation must be thoughtful and careful in planning. Thus, we have created three Advisory Councils—Purchaser, Provider, and Consumer Councils—that will provide feedback to the Board in the reform process. We received 140 nominations for these 41 membership positions on these councils. The memberships were announced last week, and I am confident that these councils will serve as a quality venue to consider the impact of reform options on consumers, providers, purchasers and other stakeholders from around the state. They will be assisting the Board in the transformation of health in Kansas by looking at the long-term goals and vision.

Examining the possibilities of what we can do now with health reform in Kansas is the Health for All Kansans Steering Committee. In response to a request from the Governor, and following the direction provided by the Kansas Health Policy Authority Board, the KHPA has convened the Health for All Kansans Steering Committee, comprised of legislators, KHPA Board members, the Governor's staff and other key stakeholders to engage in the process of developing meaningful, practical, Kansas-based reform options. The Steering Committee has met twice now to discuss literally dozens of reform options, including the kinds of insurance market reforms represented by SB 309.

In our first two meetings, I have been impressed with the great energy put forward by the Committee to accomplish

something this Legislative session. While we are still looking at reform options and building consensus on what we can do in the 2007 legislative session, there is a true focus on health reform and providing accessible health services to Kansans. The committee's dedication to this endeavor is vital as we move forward in this process. We are looking forward to providing you with additional options in the coming weeks. Our next meeting is Monday, March 5. I anticipate at that meeting we will be able to determine out of the initiatives we have identified what we can do to greatly aid the people of Kansas in the coming months and year. Like I previously mentioned, insurance market reform such as the one presented in SB 309 is one we have discussed in the Steering Committee.

How a Connector can be implemented in Kansas

SB 309 would consolidate the individual, small group, and state employee insurance markets into a health insurance Connector operating under the Kansas Health Policy Authority. An entity, such as the Connector, which serves as a clearinghouse to facilitate the purchasing of health insurance, could facilitate access to health insurance products by small employers and individuals.

We have submitted an estimate of the administrative costs associated with the operation of the Connector. The costs are not insignificant, but I would also point out that the aims of the Connector are broad as well. The Connector would supplant some of the key administrative functions that carriers and businesses now bear, including marketing costs and the administration of an annual open enrollment process. The Connector is designed with the intention of enhancing competition in health insurance markets, and making enrollment and choice easier and more transparent for consumers. We would not presume to comment at this time on the net impact these changes would have on premiums. However, some carriers have expressed concerns with the effects the Connector would have on premiums – raised premiums.

Potential advantages of the Connector described in SB 309 include the extension of tax-advantaged health insurance for individuals in businesses that do not currently offer insurance, even when those employers do not contribute to the cost of insurance. Challenges include the maintenance of stable rates in the individual market, and maintenance of at least the existing level of employer contributions to the costs of insurance.

To gain a better picture of how the Connector model would be implemented in Kansas, we can look to the report KHPA released last month regarding the Massachusetts Health Connector. In this report, we assessed the feasibility of replicating the Massachusetts model in Kansas. We found certain elements of an insurance connector that appear to be crucial in improving access to health insurance for individuals and small employers. These elements include:

- subsidies for low income workers
- a mechanism to pool payments from multiple payers
- variation in plans
- use of pre-tax dollars for health insurance purchase
- plan quality verification,
- portability of insurance and
- establishment of an adequately financed infrastructure to perform the essential clearinghouse functions which are so burdensome for individuals and small employers.

SB 309 contains many of these elements, and we are committed to applying our full consideration to this proposal, and others, and to work with Senator Barnett, this committee, the Health for All Kansans Steering Committee, the Legislature, the Governor, and other stakeholders to develop practical options for health reform.

As you are well aware, the need for health reform in Kansas is great for our working families. We are looking

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forward to working with you on initiatives that will help us meet our mission and goal.

Thank you for the opportunity to present these comments. We would be happy to field any questions the Committee may have.

Report on:
Massachusetts Commonwealth Health Insurance Connector
Program

Presented to:
2007 Kansas Legislature

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2007 Kansas Legislature

February 1, 2007

Report on the Massachusetts Commonwealth Health Insurance Connector Program

The 2006 Kansas Legislature, as outlined in proviso, directed the Kansas Health Policy Authority (KHPA) to prepare a report about the Massachusetts Commonwealth Health Insurance Connector Program. The proviso specified that the KHPA "...study the Massachusetts commonwealth health insurance connector program and provide a report...on the feasibility of implementing a similar plan in Kansas."

Executive Summary

In 2006 Massachusetts enacted a law that would provide nearly universal health coverage to state residents. Key elements of that law include:

- An individual mandate requiring all state residents to purchase health insurance
- A requirement that employers offer health insurance or pay an assessment
- Creation of the Commonwealth Health Insurance Connector that links funding sources and health plans in a simplified market
- Provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance

In October, 2006 Massachusetts began the first phase of implementation, enrolling non-Medicaid eligible adults with household incomes at or below the federal poverty level (FPL) (\$10,210 for an individual) in the Commonwealth Care Health Insurance Program. This program is administered by the newly created Commonwealth Health Insurance Connector Authority. The Connector is an independent public authority established to facilitate the purchase of health insurance for individuals and small businesses (50 employees or less). The Connector is governed by a ten-member board. Funding for the Connector comes from the state, Federal Medicaid matching funds, employer contributions, and individual premiums.

The Connector is a private insurance purchasing pool designed to connect individuals and small employers with affordable, quality insurance products. Two sets of health insurance plans are to be offered through the Connector: Commonwealth Care plans and Commonwealth Choice plans. Commonwealth Care is a heavily-subsidized set of health insurance plans designed primarily for individuals below 300 percent FPL (\$30,630 for an individual). Commonwealth Choice is an array of health plans sold through the Connector for individuals with incomes greater than 300 percent of FPL. Commonwealth Choice health plans are not subsidized.

In assessing the feasibility of replicating the Massachusetts Connector in Kansas, it is important to examine the climate and extenuating circumstances which existed when this policy initiative was adopted in Massachusetts. The state has a high level of employer-sponsored health insurance and over the last decade has undertaken Medicaid expansions, so Massachusetts has a relatively low rate of uninsured individuals. In addition, the state had great incentive to undertake health care reform because \$385 million in federal funds were at risk when their Medicaid waiver expired in July, 2006.

Kansas too has a relatively low rate of uninsurance, moderately high level of employer-sponsored health insurance, and similar level of Medicaid coverage for children. The majority of the uninsured in our state are low-wage full-time workers employed in small businesses. Small employers struggle to find affordable health insurance for their employees, and there are very limited options for those in the non-group market. An entity

such as the Connector which serves as a clearinghouse to facilitate the pooling and purchasing of health insurance would enhance access to health insurance products by small employers and individuals. Certain elements of the Massachusetts Connector model, however, appear to be fundamental to that goal: subsidies for low-income workers, a mechanism to pool payments from multiple payers, variation in plans, use of pre-tax dollars for health insurance purchase, plan quality verification, and establishment of an adequately financed infrastructure.

Background

On April 12, 2006 the Governor of Massachusetts signed into law legislation (H. 4650) that would provide nearly universal health care coverage to residents of the state. Key elements of that law include:

- An individual mandate requiring all state residents to purchase health insurance
- A requirement that employers offer health insurance or pay an assessment
- Creation of the Commonwealth Health Insurance Connector that links funding sources and health plans in a simplified market
- Provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance

On October 2, 2006, Massachusetts began the first phase of implementation, enrolling non-Medicaid eligible adults with household incomes at or below the federal poverty level (FPL) (\$10,210 for an individual) in the Commonwealth Care Health Insurance Program. This program is administered by the newly created Commonwealth Health Insurance Connector Authority. By the end of 2006, over 28,000 adults had enrolled in one of the Commonwealth Care health plans.

Commonwealth Health Insurance Connector

Definition. The Connector is an independent public authority established to facilitate the purchase of health insurance for individuals and small businesses (50 employees or less). The Connector is governed by a ten-member board. Six directors come from the private sector: three appointed by the Governor (an actuary, a health economist, and a small business representative); three appointed by the Attorney General (an employee health benefits plan specialist, a health consumer representative, and a representative of organized labor); and four directors representing state agencies (Secretary of Administration and Finance, Secretary of Health and Human Services, Commissioner of Insurance, and the Medicaid Director). The stated mission of the Connector is “promoting health care coverage across the Commonwealth”.

Agency Functions. The Connector is a private insurance purchasing pool designed to connect individuals and small employers with affordable, quality insurance products. Larger businesses with more than 50 employees are not eligible to participate in the Connector, but may use the Connector to arrange for coverage for their employees who are not eligible for benefits. Plans that are purchased through the Connector are selected by individuals, rather than groups, and are portable, which means that individuals can maintain their insurance coverage regardless of where they work. There are numerous functions assigned to the agency, including: developing benefit guidelines for Commonwealth Care Health Insurance products; certifying the insurance products are “high value and good quality”; contracting with private insurers to provide health plans; collecting premium payments from multiple sources; determining the sliding scale subsidy guidelines for individuals with incomes less than 300 percent of FPL (\$30,630 for an individual); transmitting premium payments to insurers; and enrolling the individual in the health plan of their choice or auto-enrolling those who don’t select a plan.

The Connector allows multiple employers to contribute to an employee's premium purchase. For the 19-26 year old age population who as a group have high rates of uninsurance, the Connector is responsible for offering health insurance plans that are specifically designed to be affordable. The Connector is also charged with defining premium affordability standards and establishing an appeals process that allows individuals to be exempted from the law if they demonstrate they can't afford insurance.

Funding. Funding for the Connector comes from the state, Federal Medicaid matching funds, employer contributions, and individual premiums. Small businesses enrolling through the Connector are not required to make premium contributions, but they must adopt at a minimum a Section 125 "cafeteria plan" which permits workers to purchase health care with pre-tax dollars. Companies with 11 or more employees that do not contribute to their employees health insurance premiums will be assessed a "fair share" surcharge and may be assessed a free rider surcharge if their employees access free care. The free rider surcharge assessment is triggered if the employees access free care paid from the uncompensated care pool a total of five times per year, or if one employee accesses free care more than three times. The surcharge will exempt the first \$50,000 of free care used by employees but after that the employer will be charged between 10-100 percent of the cost to the state, the exact assessment rate to be determined by the Division of Health Care Finance and Policy.

Health Plans. Two sets of health insurance plans are to be offered through the Connector: Commonwealth Care plans and Commonwealth Choice plans. Commonwealth Care is a heavily-subsidized set of health insurance plans designed primarily for individuals below 300 percent FPL. Premiums and cost-sharing increase with income. Commonwealth Care has been implemented in two phases: the first phase was implemented in October 2006 and covers about 28,000 poverty-level adults; the second phase is being implemented this month and will cover individuals up to three times the federal poverty level (FPL). Commonwealth Choice is to be implemented in July of this year and is designed for participating groups as well as individuals with incomes above 300 percent FPL. A wider selection of health plans is planned for this arm of the Connector, including high-deductible plans for young adults. Each set of health plans is described in more detail below.

Commonwealth Care Health Insurance Plan

Definition. Commonwealth Care is a subsidized insurance program for individuals and employees of small firms who have incomes at or below 300 percent FPL. An individual is eligible to participate if they have been a resident of the state for six months, are Medicaid eligible, and the individual's employer has not provided health insurance in the last six months. Children of parents eligible for Commonwealth Care are covered through the Medicaid program.

Phase I. Commonwealth Care is being phased in over time for low-income individuals. For uninsured individuals with incomes at or below the FPL, Commonwealth Care is currently available and no monthly premiums are charged. Benefits include: inpatient hospital services; outpatient and preventive services; inpatient and outpatient mental health and substance abuse services; dental and vision care; and prescription drugs. The Connector has contracted with four nonprofit health insurance providers to offer Commonwealth Care. The four managed care organizations providing this insurance are; Boston Medical Center Health Net, Fallon Community Health Plan, Network Health, and Neighborhood Health Plan. The premiums paid by the state on behalf of low-income individuals for this insurance coverage range from \$280 to \$387 per member per month. The four providers cover the entire state and most enrollees have the choice of two to three plans in their coverage area.

Phase II. In early 2007, phase two of the implementation process will ensue, making Commonwealth Care available to persons with incomes of 100.1 percent to 300 percent of the FPL with premiums set on a sliding scale. Proposed premiums will range from \$18 (1.7 percent) per member per month for individuals with

incomes 100%-150% FPL, to \$106 (4.7 percent) for individuals with incomes 250 percent – 300 percent of FPL. For persons with incomes between 200 percent -300 percent of FPL there are two cost sharing plans, one with higher premiums and lower co-payments and one with lower premiums and higher co-payments. The benefit package also includes co-payments for most services, and out-of-pocket maximums will range from \$500 to \$750 depending upon the plan selected and the income category of the enrollee.

Commonwealth Choice Health Plan

It is anticipated that the third phase of the Connector, Commonwealth Choice, will be implemented July 1, 2007. Commonwealth Choice is an array of health plans sold through the Connector for individuals with incomes greater than 300 percent of FPL. Commonwealth Choice health plans are not subsidized. Individuals participating on their own or through their employer will have an annual choice of three different levels of benefits and premiums. In addition, individuals aged 19 to 26 who do not qualify for group health benefits will be able to purchase lower cost “Young Adult Plans” through the Connector.

Feasibility of Replicating in Kansas

In assessing the feasibility of replicating the Massachusetts Connector in Kansas, it is important to examine the climate and extenuating circumstances which existed when this policy initiative was adopted in Massachusetts.

Massachusetts History. In 1995, Massachusetts received approval of a Section 1115 waiver from the U.S. Department of Health and Human Services. This waiver allowed Massachusetts to expand Medicaid (MassHealth) and receive federal matching funds for supplemental payments made to safety-net managed care organizations. Under the waiver, non-elderly adults below 100-133 percent of the FPL (\$10,210 - \$13,579 for an individual) and children below 200 percent of FPL were eligible for Medicaid. Since the demonstration began, the number of Massachusetts residents eligible for MassHealth increased by over 300,000 persons. Fifteen percent of the non-elderly population receive health care services through Medicaid in Massachusetts.

Massachusetts Demographics. Massachusetts is among the top tier of states with high rates of employer-sponsored health insurance, with 60 percent of residents having employer-sponsored health insurance. The high level of employer-sponsored health insurance coupled with Medicaid expansions have resulted in a relatively low rate of uninsured individuals. In 2004, 11 percent of the population in Massachusetts was insured. Twenty-nine percent of Massachusetts residents have household incomes below 200 percent FPL with 14 percent having incomes under the FPL and 16 percent having incomes in the 100-199 percent FPL range.

A powerful impetus for enactment of the Massachusetts health reform plan (H. 4065) was the pending renewal of that Medicaid Section 1115 waiver. The Centers for Medicare and Medicaid Services (CMS) were scrutinizing the safety net institutional payments in Massachusetts, stipulating that funds be shifted from safety net institutions and into health insurance coverage. Accordingly, \$385 million in federal funds were at risk when their Medicaid waiver was set to expire in July, 2006.

Massachusetts “Assets” that Contributed to Reform. Three factors were instrumental in the passage of the Massachusetts health reform statute. First, the state had a long history and tradition of tightly regulating the health insurance small group and non-group market. Insurers were required to offer individual insurance if they offered small group insurance and they were required to do so on a modified community rating basis that did not permit health underwriting. Secondly, the state had a reinsurance pool for both the small group and the individual market. Third, since 1985, the state of Massachusetts has had a large (\$600+ million) program to make supplemental payments to hospitals, health care centers, and certain insurers for uncompensated care and Medicaid underpayments. This program was financed by provider and insurer assessments and state and

federal tax revenues. Federal matching funds for these supplemental payments were most recently approved through a health care reform waiver granted in 1997, but the Federal government challenged the state's financing of that waiver, placing \$385 million in federal funds at risk without significant restructuring. Under the newly approved waiver, previously-questioned sources of Federal funds are redirected towards subsidies offered through the Connector. In addition to these redirected supplemental payments, funding for the Massachusetts reform plan will be drawn from new funding from employer contributions, \$308 million in new state general funds, and premiums. The first three years of the Massachusetts health plan is estimated to cost \$1.2 billion.

Kansas Demographics. Based on some demographic measures, Massachusetts is similar to Kansas. Kansas has a relatively low rate of uninsured individuals (11 percent) and a relatively high level of employer-sponsored health insurance (59 percent). Public health insurance is available to children in households with incomes up to 200 percent FPL. Kansas has a slightly higher percentage of low-income residents with 34 percent having household incomes below 200 percent FPL (15 percent having incomes under the FPL and 19 percent having incomes in the 100-199 percent FPL range).

In terms of health insurance regulation, Kansas has enacted small group health insurance legislation which establishes a mean premium and allows for a 25% variation above and below that mean health insurance rate. This represents a modified community rating model for the small group health insurance market, but there has been limited regulatory activity in the non-group market.

Kansas Business Health Partnership. In 2000, the Business Health Partnership (BHP) was established with the goal of expanding coverage through a linkage between the public and private sector by improving the affordability and quality of health insurance for low wage workers in small businesses. It was the intended purpose of the legislation creating the BHP that there be available subsidies and/or tax credits to assist low-wage workers in purchasing health insurance. The Business Health Policy Committee membership is statutorily defined by K.S.A. 40-4702. Members include:

- 1) the secretary of the department of commerce and housing or the secretary's designee;
- 2) the secretary of the department of social and rehabilitation services or the secretary's designee;
- 3) the commissioner of insurance or the commissioner's designee;
- 4) one member appointed by the president of the senate;
- 5) one member appointed by the speaker of the house of representatives;
- 6) one member appointed by the minority leader of the senate;
- 7) one member appointed by the minority leader of the house of representatives; and
- 8) three members at large from the private sector appointed by the governor.

Challenges for Reform in Kansas. Unlike Massachusetts, Kansas has very limited coverage of adults in Medicaid: eligibility is limited to participants in the Temporary Assistance to Families (TAF) program, who have incomes of no more than 29-36 percent FPL (\$2961 - \$3676 for an individual). Kansas also has a much more modest program of supplemental payments to providers, and far fewer federal dollars are dedicated to that purpose.

Conclusion

Kansas' relatively low rate of uninsurance, moderately high level of employer sponsored health insurance, and

level of Medicaid coverage for children provide a supportive climate for further policy initiatives to reduce the number of uninsured Kansans. The majority of the uninsured in our state are low-wage full-time workers employed in small businesses. Small employers struggle to find affordable health insurance for their employees and there are very limited options for those in the non-group market. An entity such as the Connector which serves as a clearinghouse to facilitate the pooling and purchasing of health insurance would facilitate access to health insurance products by small employers and individuals. The Business Health Policy Committee currently exists and could assume a similar role as the Connector.

Elements of the Massachusetts Commonwealth Health Insurance Connector program which appear to be crucial in improving access to health insurance for individuals and small employers include: subsidies for low income workers, a mechanism to pool payments from multiple payers, variation in plans, use of pre-tax dollars for health insurance purchase, plan quality verification, and establishment of an adequately financed infrastructure to perform the essential clearinghouse functions which are so burdensome for individuals and small employers. The inclusion of these elements could make health insurance more affordable and attainable for the majority of uninsured Kansans.