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**Testimony on:
Health Insurance Connector**

**presented to:
Senate Health Care Strategies Committee**

**by:
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January 29, 2008**

Health Insurance Connector

Marcia J. Nielsen, PhD, MPH, Executive Director Kansas Health Policy Authority

Good afternoon Madam Chair. I am Marcia Nielsen, Executive Director of the Kansas Health Policy Authority (KHPA). I would like to thank the Senate Health Care Strategies Committee for an opportunity to discuss our examination analysis of a health insurance connector to assist Kansans in accessing affordable health insurance. Four Kansas foundations: United Methodist Health Ministry Fund, Sunflower Foundation, REACH Healthcare Foundation, and the Health Care Foundation of Greater Kansas City generously financed the economic modeling of five different health insurance reform approaches. Three of those reform approaches integrated connector functions to accomplish various goals and I will discuss those today.

Background: Policymakers have long struggled with the issues faced by small employers trying to purchase affordable health insurance. Recent attention has focused upon the Commonwealth Health Insurance Connector established in Massachusetts, as a means to facilitate access to affordable health insurance among small employers and provide universal coverage to all citizens in Massachusetts. In an effort to assist states in understanding the development of a Connector structure, the State Coverage Initiatives Program issued a document entitled *Health Insurance Connectors & Exchanges: A Primer for State Officials* in September, 2007. That document delineates the various functions that different models of Connectors might provide including: creating a health insurance “clearinghouse”, standardizing administrative functions, facilitating the aggregation of premium payments (employer and individual), providing human resource capacity, applying subsidy payments toward the cost of premiums, assisting consumers in selecting health plan choice, and informing consumers. The Primer cautions that states carefully delineate the functions they are seeking when considering adoption of a connector design.

2006 Study on the Massachusetts Connector: 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.” On February 1, 2007 the KHPA presented to the Kansas Legislature its findings on the Massachusetts Connector. Results of that analysis indicated that due to multiple differences among Massachusetts and Kansas, a Health Insurance Connector faces many challenges if implemented in Kansas. Massachusetts was in a favorable position to implement a connector-type insurance model due to tight regulation of the small group and non-group health insurance markets, a reinsurance pool for both the small group and individual market, and the State’s large program that makes supplemental payments for uncompensated care (over \$600 million prior to the Connector). Kansas, on the other hand, faces challenges with implementing a Massachusetts-like Connector due to very limited Medicaid coverage of adults, a much more modest program of supplemental payments to providers for uncompensated care, and far fewer federal dollars dedicated to uncompensated care.

2007 Health Insurance Modeling of a Connector: In 2007, the Kansas Legislature requested in SB 11 that the KHPA analyze health insurance reforms and develop recommendations for the 2008 session. An independent economic analysis was conducted by SchrammRaleigh Health Strategy during the fall of 2007, which provided the KHPA Board and Staff information on multiple methods of health insurance reform for Kansas. Health insurance reform options were identified by SchrammRaleigh based on Kansas’s existing health care marketplace and state-specific characteristics on the uninsured population. Reforms across the participation spectrum (voluntary to mandatory) as well as the access mechanism (public to private) were all considered by the KHPA Board. SchrammRaleigh consultants provided a series of presentations to the KHPA

Board in public meetings through the summer and fall of 2007.

I will describe three of the five coverage models considered by the Board – those that contained a connector type function -- in more detail below. However, for background information it is helpful to note that the “baseline” modeling that was used by SchrammRaleigh to compare each of the new insurance models assumed implementation of the premium assistance program as authorized by SB11. In addition, a “reference” model assumed a straight Medicaid expansion for children and adults up to 250% of the federal poverty level (FPL).

Model 2: “Affordable Coverage Option – Voluntary Market Reform”: This model involved voluntary individual and small group market reform with the merging of the two markets. Community rating and guaranteed issuance were included to ensure uniform coverage access, the use of Section 125 tax benefits was required, and subsidized reinsurance was included to control adverse risk selection. An insurance clearinghouse was created for this combined market to provide a review and approval of insurance products and assistance to employers in accessing Section 125 tax benefits.

After full implementation (as compared to the Baseline Model), the Affordable Coverage option would cover an additional 50,000 individuals through coverage offered by small employers and purchased individually by sole proprietors. *All of the 50,000 individuals would have previously been uninsured.* Insurance costs for the Affordable Coverage Option would be borne by self-paid expenditures at \$134 million and the State at \$93 million. The federal government and large and small employers would see decreases in their health expenditures as a result of implementing the Affordable Coverage option of \$24 million and \$6 million, respectively.

Model 3: “Universal Coverage Option – Mandatory Health Insurance”: This model provided a mandatory health insurance reform through individual and employer mandates and most closely resembled the Massachusetts plan. This option included required access to Section 125 tax benefits and subsidized reinsurance to control adverse risk selection. A connector-like infrastructure would be established to maintain the insurance coverage mandates, assist employers accessing Section 125 tax benefits, set pay-or-play standards, establish affordability and minimum coverage standards and an exemption policy, and apply subsidies.

After full implementation (as compared to the Baseline Model), the Universal Coverage Option would cover an additional 247,000 previously uninsured individuals, and 66,000 individuals previously insured in the individual market would shift to large and small employer-sponsored coverage. Small employer coverage would increase 99,000, large employer coverage would increase 164,000, Medicaid coverage would increase 46,000, and Premium Assistance coverage would increase 4,000. The Universal Coverage Option would effectively eliminate the uninsured in Kansas. Insurance costs for the Universal Coverage Option would be borne primarily by large and small employers, which would experience an increase of \$608 million, with the State experiencing an increase of \$167 million in health care expenditures. Self-paid expenditures and the federal government would see a decrease in expenditures if the Universal Coverage Option were implemented of \$217 million and \$61 million, respectively.

Model 5: “Updated Sequential Option”: This model is comprised of three parts with specific policy approaches designed to reduce the rate of uninsurance among specific target populations; low-income children, low-income child-less adults, and employees working for small businesses. The policy options targeted for small businesses creates a voluntary health insurance clearinghouse which would assist very small employers to access health insurance, provide human resource capacity, facilitate use of Section 125 tax benefits by small employers, combine sole proprietors and small group markets, and utilize reinsurance to spread risk.

After full implementation (as compared to the Baseline), the Updated Sequential Option would cover an

additional 12,000 uninsured sole proprietors and employees of very small businesses. Compared to Baseline, the Updated Sequential Option would increase the individual market by 12,000 previously uninsured lives while the small employer and large employer market would stay relatively the same. Through the three other provisions of the Updated Sequential Model, coverage will also be extended to an additional 20,000 children (Medicaid), 39,000 low-income childless adults (SB 11 expansion of Premium Assistance program), and 15,000 young adults (new products targeting this population). The Updated Sequential Option will decrease the rate of uninsured in Kansas by 33% or by a total of 86,000 individuals while having minimal impact on the small- and large-employer health insurance markets. Insurance costs for the Updated Sequential Option would be borne by a mix of individual, State and Federal government. Employers would experience a \$1 million decrease in health insurance costs, individuals a \$10 million increase, the State a \$71 million increase and the Federal government a \$65 million increase. When compared to the previous two models (Model 2 and Model 3), the Updated Sequential Option still provides a significant decrease in the number of uninsured Kansans, yet will have the least impact on the private markets and the smallest increase in government and self expenditures for health insurance costs.

Summary: The insurance models described here provided the Board with an opportunity to have a deliberative public dialog about the most pragmatic and politically feasible strategies to expand access to affordable health insurance in our state. The Board ultimately recommended the “Updated Sequential Model” to promote a three-pronged approach to expanding access: (1) Targeted and aggressive outreach to Kansas children already eligible for Medicaid/HealthWave; (2) Expanded premium assistance for very low income Kansas childless adults; and (3) a Voluntary Connector/Clearinghouse, combined with small group market reforms. We encourage legislators and stakeholders to review the SchrammRaleigh report, “Kansas: Pricing the Roadmap to Health Insurance Reform Options”, which was generously funded by four Kansas foundations: United Methodist Health Ministry Fund, Sunflower Foundation, REACH Healthcare Foundation, and the Health Care Foundation of Greater Kansas City. The full report can be found at: http://www.healthfund.org/pdf/11012007fdn_report_khpa.pdf

Regarding the ScrammRaleigh report, as recently described in a recent article by former State Representative Tim Carmody in KCB Magazine:

For several years, most polls and surveys have shown that the issue of how to pay for health care is a high priority for the public. Yet, there is no consensus on how to address the issue. The schramm-raleigh study not only provides support for the actual legislative proposal, but also goes beyond it in providing it in an understandable format, the raw data upon which policy must be made. In other words, if you have a preconceived opinion on the solution, check out the study to see how your opinion squares with the facts.

Perhaps the most interesting thing to consider is the context in any given issue, position, or solution is framed. For example, one person’s “single payer system” is another’s “socialized medicine”. One person’s “business mandate” is another person’s “tax”. One person’s “full access to health care” is another person’s “Canada”. The study allows one to consider the economic and, to some extent, sociological consequences of choices without a lot of preconceived labeling. Labeling is the choice of the reader. Understanding and informed policymaking are opportunities awaiting the legislature.

Definitions

Massachusetts Health Insurance Connector: The Connector is a structure designed by policymakers in Massachusetts to facilitate the purchase of affordable, high-quality health insurance by small businesses and individuals without access to employer-sponsored health insurance. The Connector is an independent, quasi-governmental entity designed to facilitate the purchase of health care insurance at affordable prices by eligible individuals and small groups. The Connector is a self-governing, separate legal entity from the Commonwealth and is governed by a 10-member board consisting of private and public representatives.

Section 125 Plans: Section 125 of the Internal Revenue Code provides companies a vehicle to allow their employees to pay for certain qualified benefits on a pre-tax basis, which allow employers to establish tax-preferred benefit programs that can make health insurance more affordable. Section 125 qualified plans allow employees to pay for certain qualified expenses before taxes are deducted from their paycheck, thus maximizing an employee's take-home pay and minimizing an employer's payroll-related taxes. These qualified expenses can include health insurance premiums and certain out-of-pocket health care expenses.

Reinsurance: Reinsurance is a mechanism for distributing risk across a larger pool of people and can lower insurance costs for some consumers, protect the solvency of insurers, and stabilize the small group insurance market. By assuming unpredictable high cost risks, reinsurance can stabilize the volatility of premiums and allow purchasers to more accurately forecast costs.

Adverse Risk Selection: Adverse Risk Selection occurs when individuals voluntarily purchase health insurance because they expect to use health care services (i.e., they are sick and unhealthy) causing the groups to have high medical claims thus raising premium costs for all members, including those who are healthy.

Pay-or-Play Mandates: Pay-or-Play Mandates are essentially employer health insurance mandates. Employers are required to provide insurance for their employees or otherwise pay a fine or tax if an employer decides not to comply.