LeadingAge™ Kansas

To: Chairman Robert Olson and Members of
The Financial Institutions and Insurance Committee
From: Debra Zehr, President/CEO, LeadingAge Kansas
Date: January 30, 2019

Opposition to Senate Bill 36

Thank you, Mr. Chairman and Members of the Committee. I am Debra Zehr, President and CEO of LeadingAge Kansas, the state association for faith-based and other nonprofit long-term care and aging service providers. We have 160 members across Kansas, that provide a wide range of services, including include long-term care, short term rehabilitation, retirement communities, assisted living, homes plus, affordable housing, home health, home and community-based services, and PACE. Our members serve more than 25,000 older Kansans each day.

We strongly object to Senate Bill 36.

LeadingAge Kansas is not one of the seven associations to authorized to form an association health plan in KSA 40-2222 Section 1 (1) – (6). Rather than authorizing the Insurance Commissioner to oversee plans like ours, Senate Bill 36 will outlaw self-funded multiple employer plans altogether, by striking Section 1 (7) [lines 17-19 on page 2].

Two of LeadingAge Kansas' major priorities are to assist our members with financial sustainability and stewardship, and to grow, develop and support their workforce. Our members are experiencing increasing difficulty every year in obtaining good and affordable health insurance coverage for their employees. Some of our members have not been able to offer employees' health insurance.

In response to member need for more health insurance options, and in keeping with our priorities, LeadingAge Kansas embarked on 2 years of legal, actuarial and other due diligence which led to the creation of a self-funded Multiple Employer Welfare Arrangement (MEWA) in 2018. It is named LeadingAge Kansas Employee Benefits, Inc. (EBI for short.) EBI is the only such self-funded multiple employer plan formed since the 2014 Kansas Legislature overwhelmingly passed a bill to amend KSA 40-2222 to permit associations to form self-funded multiple employer welfare arrangements.

Our plan is working. The plan has exceeded our expectations for providing cost-effective, high quality coverage for members' employees. All EBI member employees have health insurance coverage. Ten percent of employees covered by EBI were uninsured previously. Every member offers at least three plan options from which employees can choose, including choices that meet the adequate and affordable criteria of the Affordable Care Act. Our member employers

have been very pleased with the plan and other members of the association have been looking to join the plan based on this success.

Our plan has built-in fiduciary and consumer protections. As a 501(c)9 trust owned and governed by member employers, it is regulated by ERISA. The trust funds the plan. The trustees and administrator are fiduciaries. VEBA assets must be used for purpose of paying benefits. EBI is also subject to Department of Labor regulations that outline grievance and appeals processes. (See attached.) In addition, the Association has an interest in making sure the plan serves members well.

Our plan is not designed to be a plan for everyone. It presents another option in an environment of limited options. EBI has more flexibility in designing a program to meet needs of members and their employees.

At a time when health insurance costs are skyrocketing and benefits diminishing, it is good public policy to permit options (including self-funded plans) for employers to come together to meet employee health insurance needs. Our plan has demonstrated how this type of coverage option can be successful in managing costs and providing high quality coverage.

Thank you, Chairman Olson and Members of the Committee for your consideration of our opposition to Senate Bill 36. I would be happy to answer questions.

Rights under ERISA

Your Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Member Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file

suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Procedures for Submitting Claims

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Individual's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Individual will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Individual who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Individual will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Individual for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the service was incurred. Written notice of claim given by or on behalf of the Covered Individual to the Claims Administrator, with information sufficient to identify the Covered Individual, will be considered notice. All claims must be submitted in a format acceptable to the Plan Sponsor.

Notice of Claim

Written notice of claim should be submitted to the Claims Administrator as soon as possible. All claims must be filed within one (1) year of the event on which the claim is based or payment will be denied.

Failure to furnish proof within the time provided in the Plan will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

Claim Procedure and Appeal Process

Following is a description of the time frames the Plan uses to process claims for benefits. A claim is defined as any request made by a claimant or by a representative of a claimant for a Plan benefit that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different types of claims and each one has a specific timetable for approval, payment, request for further information, or denial of the claim. If you have any questions regarding the procedure, please contact the Claims Administrator.

There are three types of health claims: urgent care claims, pre-service claims, and post-service claims. Most claims are post-service claims, which are requests for payment under the Plan for covered medical services already received by the claimant. An urgent care claim is one for medical care or treatment where an untimely determination may jeopardize the life or health of the claimant. A pre-service claim means any claim for a benefit under this Plan where the Plan requires advance approval for obtaining medical care.

You have a right to appeal any decision made by the Plan that denies payment of your claims or your request for coverage of a health care service or treatment. You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Request for appeal/explanation should be sent to:

Patient Advocate

Self Insured Services Company (SISCO)
P.O. Box 389
Dubuque, IA 52004-0389

You should contact SISCO for any of the following reasons:

- You do not understand the reason for the denial;
- You do not understand why the health care service or treatment was not fully covered;
- You do not understand why a request for coverage of a health care service or treatment was denied;
- You cannot find the applicable provision in your Summary Plan Description;
- You want a copy of the guideline, criteria or clinical rationale that was used to make the decision; or
- You disagree with the denial or the amount not covered and you want to appeal.

If a claim is denied due to missing or incomplete information, you or your health care provider may resubmit the claim with the necessary information to complete the claim.

All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent in writing to the address above within 180 days of the date you receive the denial. A full and fair review of the claims will be provided by individuals who were not involved in making the initial decision of the claim. You may provide additional information that relates to the claim and you may request copies of information that pertain to your claims. You will be notified of the decision in writing within 60 days of the Plan receiving your appeal. If you do not receive a decision within 60 days, you may be entitled to file a request for external review.

In the case of a post-service claim, the Claims Administrator will process your claims no later than 30 days after receiving it. An additional 15 days will be allowed in circumstances beyond the Plan's control, such as the need for additional information. You will be notified during the first 30 days of the need for additional information. You will have 45 days from receipt of the request to supply the information needed to complete the claim. Upon receipt of the requested information, the Plan will again review the claim and notify you within 15 days of the claim determination.

If your post-service claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your claim be denied (in whole or in part), or if there is a reduction of benefits or charge amount, you (or your provider) may have your claim reviewed based on the procedures stated above. You should supply any additional pertinent documentation to support the appeal of the claim. Within 60 days after receipt of your request for review, you will receive a determination from the Claims Administrator.

For an urgent care claim, notification of benefit determination must be provided as soon as possible, taking into account any medical exigencies, but in no case later than 72 hours after the Claims Administrator receives the claim. If there is insufficient information to make a determination, a request will be made for the additional information within 24 hours of receiving the claim. This request may be in writing or orally. The claimant will then have 48 hours to provide the missing information. After receiving the information or when 48 hours has passed, the Claims Administrator will respond orally or in writing as to the benefit determination. If an urgent care claim is denied, an appeal may be filed with the Plan Administrator within 180 days of the denial. This appeal may be orally or in writing. Upon receipt of the appeal, a claim determination must be made within 72 hours. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

You will receive notice of benefit determination for a pre-service care claim within 15 days of the Claims Administrator's receipt of the claim. An additional 15 days will be allowed in circumstances

beyond the Plan's control, such as the need for additional information, and you will be notified within five (5) days of receipt of the claim as to the need for additional information. You will have 45 days from receipt of the request to supply the information needed to complete the claim. Upon receipt of the requested information, the Plan will again review the claim and notify you within 15 days of the claim determination. If your pre-service care claim is denied, you may file a written appeal within 180 days of the denial. Upon receipt of the appeal, the Claims Administrator will have 30 days to make a benefit determination.

If the Plan has previously approved an ongoing course of treatment for a claimant to be conducted over a period of time, any reduction or termination of that course of treatment will be deemed to be an Adverse Benefit Determination. The Plan Administrator must then notify the claimant with a sufficient time in advance of the reduction or termination to give the claimant time to obtain a review on appeal of the adverse determination before the benefit is reduced or terminated.

If your request for the provision of or payment for a health care service or course of treatment has been denied, you may have a right to an external review by an Independent Review Organization (IRO), which has no association with the Plan, if the decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment. You may request the independent external appeal by submitting a request for external review within four (4) months after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The external review process is not available for questions of eligibility or rescissions of coverage. Requests should be submitted to SISCO at the address listed above. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five (5) business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether:

(a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(b) The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

(c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan must issue notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Plan must allow a claimant to perfect the request for external review within the four (4)-month filing period or within a 48-hour period following the receipt of the notification, whichever is later.

The Plan must assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan must take action against bias and to ensure independence. Within five (5) business days after the date of assignment of the IRO, the Plan will provide the IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one (1) business day after making the decision, the IRO will notify the claimant and the Plan. The IRO must provide written notice of the final external review decision to the Plan and the Covered Individual within 45 days after the request for external review is received. All decisions made by the IRO will be binding on the Plan. If the IRO reverses an Adverse Benefit Determination, the Plan must immediately provide coverage or payment for the claim.

Expedited Review Process

If the normal time frames set out above for an external review would seriously jeopardize the life or health of a Covered Individual or would jeopardize the individual's ability to regain maximum function, an expedited external review may be requested. Upon receipt of request for an expedited external review, the Plan will immediately determine if the request meets the guidelines for an external appeal and assign an Independent Review Organization (IRO) to review the case. Information regarding the appeal will be sent to the IRO electronically or by telephone or facsimile or any other expeditious method. The assigned IRO will review the claim information and return a decision within 72 hours after receiving the request for review. If the IRO notice is not in writing, within 48 hours after the date of providing the decision, the IRO must provide written confirmation of the decision to the claimant and the Plan.

Proof of Loss

The Plan Administrator will have the right and opportunity to have examined any individual whose Injury or Illness is the basis of a claim hereunder when and as often as it may reasonably require during the pendency of a claim, and also the right and opportunity to make an autopsy in case of death (where such autopsy is not forbidden by law).

Free Choice of Physician

The Covered Individual will have free choice of any legally qualified Physician or surgeon, and the Physician-patient relationship will be maintained.

Payment of Claims

All Plan benefits are payable to the provider of service, or subject to any written direction of the Covered Individual. All or a portion of any payments provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Covered Individual's option and unless the Covered Individual requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the Hospital or person rendering such services; however, if any such benefit remains unpaid at the death of the Covered Individual or if the Covered Individual is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Covered Individual: spouse, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan will not be required to see the application of the money so paid.