Approved: April 3, 2007
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairman Susan Wagle at 1:30 P.M. on February 12, 2007 in Room 231-N of the Capitol.

Committee members absent:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee:
Mr. Ken Wilkie, Assistant Director, Kansas Legislative Research Dept.
Senator Barnett

Others in attendance: Please see attached Guest List

Approval of Minutes

Upon calling the meeting to order, the Minutes of January 22 and 30th were distributed to the Committee. Chairperson Wagle asked that the Committee contact Ms. Cianciarulo with any changes and if none are received by Friday, February 16, 2007, these Minutes would stand approved.

Handouts

The Chair then called the Committee's attention to the two sets of handouts in front of them:

1) The first set is requested information by the Committees in the joint meeting held on January 30, 2007 including:

A.) The full report from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on their 2006 survey of Larned state Hospital;

B.) Corrective actions taken by Larned State Hospital in response to the 2006 (JCAHO) survey;

C.) Deaths that have occurred since 2000 at Larned State Hospital.

2) The second set is information from Mr. Ed Haislmaier, Research Fellow, The Heritage Foundation including:

A.) A "Report on: Massachusetts Commonwealth Health Insurance connector Program" from the Kansas Health Policy Authority;

B.) An article from "Backgrounder" paper, published by The Heritage Foundation entitled, "The Massachusetts Health Plan: Lessons for the States;

C.) Two charts, one entitled "Coverage Instability Problem" and the other, "Subsidy Implications".

A copy of the handouts are (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

Review of SB309 - An act enacting the Kansas Health Care Connector Act

The Chair then called upon Mrs. Terry Weber, Kansas Legislative Research Department, to give an overview of her handout. Referring to the "Bill Worksheet", Mrs. Weber stated that this was for the

committee's use and that Research had gone through and identified each section of the bill, provided a title, and tried to summarize each of the 16 sections. A copy of the "Bill Worksheet" is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

As there were no questions of Mrs. Weber, the Chair called upon Mr. Ken Wilkie, Assistant Revisor, Kansas Legislative Research Department. She mentioned that he actually wrote the bill and asked him to give a detailed overview on the bill. Mr. Wilkie stated that he was requested by Senator Barnett to put the bill together based a state health insurance exchange model act, which was the basis for Mr. Ed Haislmaier's remarks during his visit last week, keeping in mind that this act is just a first pass or starting point.

He went on to explain:

1) Throughout the act, the word "exchange" and the phrase "health care connector"can be found. The word "exchange", defined in Sec.2 as being the "Kansas Health Care Connector", is used throughout the bill as a term of art so as not to keep repeating the phrase"health care connector";

2) Section 1 basically provides a name for the act;

3) Section 2 gets into definitions:

A) Re: "carrier", did not use the definition in the model as it is very similar to the term "health insurer" as defined KSA40-4602 (just cross referenced to an existing definition, something we already had as with "credible coverage");

B) COBRA - if you loose your health insurance and need to go somewhere else, you may ending up buying your insurance through them;

C) Eligible individual - set up in such a way as you can be:

1.) A Kansas resident, or if not,

2.) You are employed at least 20 hours/week at a Kansas location by a bonafide employer in Kansas and the employer does not offer a group health plan or is not eligible to participate in a group health plan;

D) Accepted benefits - generally not covered under major medical type plans, (Ex. Workers Compensation)

E) Subsection K - defined "exchange" as the Kansas Health Care Insurance Connector established by this act, also established in Sections 4 and 5;

F) Down at the bottom of page 2, (m) "Health benefit plan" is cross tied to KSA 40-2118, should have referenced to have the meaning of health insurance in that statute (which is any hospital or medical expense policy, hospital or medical service corporation contract, or contract provided by municipal group funded or health maintenance organization contract offered by an employer or any certificate issued under those policies. This is how health insurance is defined and also the definition of a health benefit plan under KSA40-2209d;

G) Line 30, page 3, which is part of the definition of "Producer", there is a printing error. The statute should read "K.S.A.2006 Supp. 40-4902. Also "Producer" is another name for insurance agent and is in a Uniform Act which was passed by this body about 5 years when "licensing insurance agent" was updated.

4) Section 3 creates the Insurance Connector within the Health Policy Authority (the model as drafted indicated two choices, as a free standing organization or within a state agency and the directions were to put this in the Health Policy Authority as they already had a lot of things in place);

5) Section 4 sets forth several duties for the Health Care Insurance Connector including establish procedures for enrolling individuals (see criteria) and establish & administer procedures for the election of coverage by the participating individuals (the criteria for that are set forth in Section 6). These "duties" or detailed policies decisions the Committee will have to deal with because this is the type of detail that will have to be developed in order to more fully flush out the concept that this bill contains;

6) Section 5 - there are several types of contracting (ex. Outsourcing), also regarding "set and collect fees" Subsection (e) allows them to seek grants from the US Government or other agencies of the state or philanthropic organizations;

7) Section 6 - deals with more how an eligible individual can apply to the connector and Subsection (a) basically sets it up; limitations are shown in Subsection (b) ex. enrollment period; Subsection (d) similar to many healthcare plans regarding "a waiting period" if a "triggering event" occurs;

8) Section 7 - puts some limitations on the types of plans (requirements are checked by the Commissioner of Insurance;) also:

A.) In Subsection (d) the certification is set up so that the validity of the plan is automatically renewable unless there a withdrawal by the commissioner or a discontinuation;

B.) In Subsection (f) a detailed description of benefits offered including limits (Ex. Exclusions for certain types of cancer treatments, this would have to be disclosed);

C.) Subsection (g) deals with the types of major medical coverage that has to be included (listed at the top of page 6. Mental health benefits was not really defined in the model but would include anything that you find now in your health plans);

D.) Subsection (j) line 21, the exchange cannot decline or restrict an offering to any participating individual or sponsor a plan that hasn't first been

9) Section 8 states the rules that fall upon the carriers for the companies that are offering the plans dealing with pre-existing conditions and imposes requirements on dealing with these issues (Ex. If a person who has BCBS in one year and changes to Travelers the next year, this provision says you cannot subject them to a pre-existing provision just because of changing carriers within the exchange.)

10) In Section 9, if you are a participating individual, you can continue with the connector as long as you are eligible, but it does allow a company to cancel for nonpayment of premiums or fraud. It does prohibit the carrier from cancelling or non renewing the coverage to another year, because of a change in employer, marital or employment status and some other factors. (Basically, once you get a policy through the connector, you have coverage even if you change employment, get divorced, remarried, etc. as long as you continue to see that the premium is paid; if you voluntarily quit your job you are still covered, if you are fired for gross misconduct you are not.)

11.) Section 10 deals with procedures imposed on the Insurance commission and resolves disputes arising from the operation of the exchange (ex. Eligibility, coverage on surcharges, etc.) This section may have a slight overlap with the policies of the KHPA. (This could be a concurrent jurisdictional issue as it is a procedural rule that the KHPA set or an insurance issue with respect to the policy being offered.) As the top of page 11, he stated, this section also covers the process of appeals.

12.) Section 11 explains what happens if an employer wants to apply to the exchange to be a sponsor of a participating plan:

A.) In subsection (b), they must enter into a binding agreement with the exchange and sections one through eight lists the various things that have to be included in this agreement (Ex. In paragraph one, "The exchange becomes the plan administrator.")

B.) In Section 2, the employer is basically saying they are only offering one plan and are getting it through the exchange and no place else;

C.) Paragraph three states that employees have a right to elect any product that is in the exchange, so the employee has, in effect, a cafeteria type plan to choose from, but the employer is providing the employee access "to the menu" and agrees not to restrict the employee's right to choose.

D.) In paragraph four it states that if the employer wants to offer additional benefits, other than what is offered through the connector, then the employer is the one responsible. The exchange does not become the plan's administer for these supplemental benefits. (Ex. A disability insurance policy that is not one of the coverages, listed on page 8, line 1-6. He said the policies coming through the connector are designed to deal primarily with major medical.)

E.) In paragraph five there is a "non competing clause" stating that the employer agrees to not offer any competing plan with another company or elsewhere that has the same benefits.

F.) In subsection (d) it basically states that the exchange has to be an equal opportunity provider of access, all the plans have to stay substantially the same.

G.) In subsection (e) it states what happens with the first year when the exchange gets into operation. NOTE: This does require that the Health Care Commission enter into agreement with the exchange that the state employee group goes into the exchange.

13.) Section 12 refers again to the insurance producers/agents in that, if they are going to enroll in the exchange, and there is a provision where there is a commission to be paid to the insurance agent and could be fixed on so much a policy or could be based on the amount of the premium.

14.) Section 13 deals with some filing requirements by each employee that is covered under the connector. (Mr. Wilkie noted that this has an interesting aspect to it, in that, if the employees are not covered through the exchange, then the employer has to file the employee's election to post a bond or other form of financial responsibility to show that they are able to cover their medical expenses as shown more in the next section.) Also, in subsection (d), there are some filing requirements by the KHPA.

15.) Section 14 deals with a situation that the carrier cannot issue or remove health benefit plans other than through the exchange (making the exchange an exclusive marketplace if you will, Mr. Wilkie stated.) Subsection (b) deviates slightly from the existing Kansas definition of "group" which would allow a single person business to fall in this situation. (Ex. A group of one, right now the groups are limited to two to 50.);

16.) Section 15 deals with the financial responsibility mechanism with the start date of January 1, 2009, basically stating that people between the ages of 18 and 65 must show proof of their ability to pay for medical care for themselves and/or their dependents and that they are not going through the connector. This type of responsibility if found in some of the licensing acts in the State.)

17.) Section 16 states the acts will be in effect after publication in the statute book.

The Chair thanked Mr. Wilkie and asked for questions from the Committee which came from Senators Palmer and Wagle ranging from the ERISA base plan; mandated coverages on the State's plan to:

- What is the cost involved of the connector and who will pay?

- Is there any legislative oversight besides the KHPA?

- Who is not eligible?

- How will employees be covered who work for large chains, like Boeing, and only allowed to work part time?

As there were no further questions of Mr. Wilkie, the Chair announced that she had originally planned for Senator Barnett to give an overview of the concept of the connector and the Committee is not going to get to this, but will cover next Monday. She did request a memo from the Legislative Research Department regarding ERISA since they are a company that is exempted from this bill and we need to know who they are.

Adjournment

As it was going on 2:30 p.m., Chairperson Wagle announced that the meeting was adjourned. The time was 2:29 p.m.

The next meeting is scheduled for February 19, 2007.