



March 18, 2015

Support for Expanded KanCare 2.0

Thank you for this opportunity to speak to you about this important healthcare matter. I do not represent the healthcare industry, but I represent a key Legislative Priority for the The Chamber of Lawrence, Kansas and also 43 years of owning and operating funeral homes in Lawrence, as well as eleven (11) other towns across Kansas.

With my previous business experience, I was in frequent contact with Medicaid recipients as well as those receiving State assistance through Social and Rehabilitation services, and federal assistance through SSI, in eleven Kansas communities from Leavenworth, KS, to Hill City, KS. I learned so much during these times including an appreciation for the recipients and how they struggle with health and life issues and sometimes eventually face life and death issues and/or financial ruin. I also gained an appreciation for the case workers and SRS administrators who are charged with administering the programs during difficult family situations.

I have literally watched the catastrophic effects of long term illnesses and death as a result. I have listened to many stories of how these illnesses have devastated family resources and wealth and the sometimes resorting to seeking State and Federal assistance, when they pride fully would rather not have to do that.

It was not too difficult during those days to see where we were headed with healthcare and end of life decisions, both emotionally and financially.

As Kansans, we know that we are in difficult times at every level of government. Resources are limited and we must find innovative ways to use our resources to benefit the most. We do have a joint concern about those people (estimated at 169,000 Kansans), who are uninsured with 100,000 of them being classified as the “working poor”. This number is unimaginable to me, but I am sure that it is climbing each year.

Expanded KanCare is also important as a bridge to receiving and estimated \$2.2B for federal health care aid between 2016 and 2020.

It is my opinion that in business, we make the best decisions that we can make at a given time with the best available information. I am sure that the Governor and the Legislature made the decision in 2013 to not ask for ACA State funding options, beginning in 2014, based on the known facts and projections at that time. But today, we must reassess that with the facts that we know and where we as a State are with multiple healthcare funding challenges.

My humble suggestion is that the 2015 Legislature begins the task of using the available facts and projections ahead to consider the development of a Kansas solution for the future of KanCare 2.0. A huge step forward would be the passage of HB 2319. There does not seem to be much news out of Washington, DC that calls for the repeal of the Affordable Care Act (ACA), so we must begin to deal with what we have to create our own supplement to the Federal law that will take care of these folks in our communities, who currently are not covered for whatever reason.

Kansas hospitals need a solution as they are assuming more and more of the responsibility for treating an aging population of Kansans with health issues. At our community hospital, Lawrence Memorial Hospital (LMH), they served 6,875 inpatients in 2014 and helped with the birth of 1,119 children in the same period. Add to that, 166,129 outpatients and 37,222 emergency room patients. In 2014, LMH served 12,000 charity care patients, which were up from 7,464 in 2010. We can see the trend just in this one hospital and can safely assume that the raw numbers and ratios are repeated in many other communities across Kansas.

I have read and followed the press articles on the subject and I continue to land on the Kansas Hospital Association Guiding Principles for KanCare 2.0 piece. I cannot find any more concise plans to address the reality “on the ground today”. I have attached that document as an addendum to my testimony for your review in the event that you have not received it before. It addresses a wide scope of Kansas issues.

Where do we go from here? I would hope at least the following:

- That the 2015 Legislature recognizes and appreciates the financial stability that increased funding would have on Kansas hospitals, especially the rural ones.
- That the 2015 Legislature would seriously debate House Bill 2319 in order to develop a “Kansas solution and formula” to help our economy and those who need expanded Medicaid the most.
- That the 2015 Legislature would create legislation that would empower the Governor and the Kansas Department of Health and Environment to lead the charge to develop our plan and not standby and allow the increasing millions of Federal dollars to be distributed to other states.
- Educate Kansas hospitals to support expanding the state KanCare program. We know that lack of insurance keeps people from receiving regular care.
- Education of consumers is also important so they know that they can get what they need, that they otherwise did not have.
- It is my hope that the 2015 Legislature will tackle this growing healthcare issue in America, and especially for Kansans. It is a very complex problem with far-reaching ramifications if we do not solve it.

Thank you for your time and attention.

By Larry K. McElwain, President/CEO



(Addendum)

Guiding Principles for KanCare 2.0

Core Principles:

It is significantly important to Kansas hospitals that a “Kansas-based” solution is reached on expansion.

KanCare 2.0 will be a statewide demonstration program that will provide coverage through the KanCare program for all individuals below 138 percent of the Federal Poverty Level.

KanCare 2.0 will utilize the 100 percent federal match through 2016. Beginning in 2017, the State of Kansas will be responsible for the state’s portion of KanCare 2.0.

Dedicated funding sources should be used to help offset the state's financial share of KanCare 2.0.

Key Policy Provisions in Concept Paper:

Use of Premium Assistance for those who have access to employer sponsored insurance;

Use of high deductible health plan model, in conjunction with a funded health savings account, to empower beneficiaries to become better consumers and access services at the right place and the right time;

Beneficiary contributions would be required for those individuals above 100% FPL, subject to a lock-out period for non-payment and optional for those below 100% of the FPL;

Cost-sharing for those who do not participate in the health savings accounts who fall under 100% FPL – again, to promote the use of services at the right place and right time;

Incentives for healthy behaviors – use of preventive services like prenatal care, blood sugar monitoring, and cholesterol monitoring, etc. – that include roll-over of health savings account balances to reduce the required contribution for the following year;

Incentives for participation in job search and training;

Incentives for participation in adult education for those who do not yet have either a high school diploma or GED;

Assistance and incentives for seeking a disability determination where appropriate and assistance with assistive technology where it is not;

Focus on continuing health delivery reform initiatives, such as improving health status and quality of care, promoting patient centered medical homes, reducing emergency department utilization, increase use of prenatal care, and reduced infant mortality rates;

Dedicated funding sources will be sought to help offset the state's financial share of KanCare 2.0.

A provision opting out of expansion if the federal match rate drops below 90%.