Approved: March 4, 1998
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on February 19, 1998 in Room 529-S of the Capitol.

All members were present except:

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Representative Melvin Neufeld
Kathleen Sebelius, Insurance Commissioner
Melissa Ness, Kansas Childrens Service League
Dawn Reid, Kansas State Nurses Association
John Holmgren, AARP
Jerry Slaughter, Kansas Medical Society
Bob Williams, Kansas Pharmacists Association
Rochelle Chronister, Secretary of SRS

Others attending: See attached list

Hearing on SB 424--Kansas insurance coverage for kids

Senator Praeger introduced the bill to the Committee and walked them through the sections which will provide administrative simplicity, seamless coverage for children as they move from Title XIX to Title XXI eligibility, and the continuity of care these children will receive (Attachment 1). A key component of the plan is education of families in order for them to access the available care and participate in healthy lifestyles for their children. Premium sharing by families where appropriate will be a way of transitioning families off public assistance and encouraging them to take responsibility for their own care. Senator Praeger expressed concern about the success of the current Medicaid program or the combination of Title XIX and Title XXI programs if there is not an increase in rates being provided for health care services.

Representative Neufeld said he saw this legislation as an opportunity to educate the targeted population through an outreach system. This plan will involve parents in the health care of their children.

Senator Praeger presented **Sub SB 424** to the Committee as a product of the work of the Governor's Task Force (Attachment 2). She reiterated how the hope for this program would be to encourage personal responsibility of parents for the health care of their children.

A letter from James M. Verdier, Director of State Health Policy of Mathematica Policy Research,Inc., to Ann Koci, SRS, was given to the Committee (Attachment 3). The letter summarizes the Medicaid physician reimbursement fee schedule issues, its relationship to managed care, and options for changing the fee schedule. Also included is the Title XIX plan for the proposed legislation.

Kathleen Sebelius, Kansas Insurance Commissioner, explained that this program would be available for the children of the working poor who do not qualify for Medicaid and cannot afford the cost of insurance premiums (Attachment 4). She remarked on the interesting federal structure of this program in that no penalties for non-compliance and the generosity of the matching funding was noted. The main requirement of the federal program is that the states must have a comprehensive insurance plan with the implementation, features, outreach, and measuring of outcomes left up to the states.

Melissa Ness, Kansas Children's Service League, reviewed the success of their first conference on the explanation of the program which would make insurance available for Kansas children. Two hundred eighty persons attended to learn of the outreach, affordability, and application of the plan. Information between the states regarding the successes, problem areas, and outcomes will be shared via such inter-state conferences. There will be in-depth study of Medicaid and private providers and reports made at these conferences. Insuring Kansas Children, a white paper produced by Kansas Children's Service League and Kansas Action for Children, was presented to the Committee and is on file in the office of Committee of Financial Institutuions and Insurance, Room 128 South (Attachment 5).

Dawn Reid, Kansas State Nurses Association, reminded the Committee of the need to apply by July of 1998 as there is a 90 day turn around (Attachment 6). If the plan is not approved, the state will receive no funding for that year.

John Holmgren, AARP, praised the section of the bill which classifies all covered children as one group with no distinction between their funding source (Attachment 7) He urged serious consideration be given to the consumer complaint and advocacy aspect of the HMO contracts to be negotiated as many of the people who will be enrolling will have had no experience with HMO insurance.

Jerry Slaughter, Kansas Medical Society, questioned the adequacy of reimbursement. No Medicaid provider profits but those who serve in lowest income areas are stressed about the current rate. Perhaps incremental increases could be considered.

Bob Williams, Kansas Pharmacists Association, recommended that the drug benefit portion of the bill be cared out and administered by SRS (Attachment 8). He explained the procedure used by Managed Care Organizations in subcontracting with a Pharmacy Benefit Management Company (BMC). This provides the drug benefit for the lowest possible cost but with no regard for outcomes, access to drugs/providers or ease of participation by health care providers/patients. The state has very little oversight of PBMs so he recommended the drug benefit portion of the program be handled by SRS so the state will be able to monitor and track the prescribing and dispensing of medication by providers.

Rochelle Chronister, Secretary of SRS, voiced the support of SRS for the proposed legislation.

The meeting was adjourned at 10:00 a.m. The next meeting is scheduled for February 20, 1998.

SENATE FINANCIAL INSTITUTIONS & INSURANCE
COMMITTEE GUEST LIST

DATE: 2/19/98

NAME	REPRESENTING
Chip Wheelen	KS Psychiatric Society
[illegible]	KMS
Rochelle Chronister	SRS
Ann Koci	SRS
Susan Anderson	Hein + Weir
Mary Ellen Conlee	Via Christi Health System
Michelle Peterson	Peterson Public Affairs Group
[illegible]	SRS
[illegible]	[illegible]
Amanda L Jones	Student Nurse
Loretta L. Miller	Student Nurse
Rebecca D. Helwig	Student Nurse
Melissa L Ness	Ks Children's Service League
Robin Lehman	Kansas Action for Children
Dawn Reid	KSNA
Bob Harder	MPS
Robert Epps	HCEA
Ken Ott	DPS
E. Pickelhaupt	Assoc. of Comm HCS

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/19/98

NAME	REPRESENTING
Danielle Noe	Governors Office
Scott Knoer	KPhA
Kathleen Selsdies	KID
Bob Williams	Ks. Pharmacists Assoc
BOB ALDERSON	KPhA
Tom Wilson	KID
Kathleen Selsdies	KID

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TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: PUBLIC HEALTH AND WELFARE
VICE CHAIR: FINANCIAL INSTITUTIONS AND INSURANCE
MEMBER: ASSESSMENT AND TAXATION
ELECTIONS AND LOCAL GOVERNMENT
HEALTH CARE REFORM LEGISLATIVE OVERSIGHT COMMITTEE
JOINT COMMITTEE ON CHILDREN AND FAMILIES
SRS TRANSITION OVERSIGHT COMMITTEE

Senate Financial Institutions and Insurance Committee

February 19, 1998

Good morning, Mr. Chairman, and members of the Committee.

Thank you for the opportunity to present testimony to the Committee regarding children's health insurance. I want to thank Rep. Neufeld and the House and Senate members of the task force as well as the executive branch members and members from the Insurance Department for their diligence in preparing this Senate Substitute for SB 424.

As I walk you through the bill I will try to explain the rationale which guided our decisions.

New Section 1. (a) The Secretary of SRS will develop and submit the plan for approval by Health and Human Services. The Department has the expertise in contracting for children's health and understands how to mesh the 2 programs. Title 19 & New Title XXI

(b) The plan will be developed as a capitated managed care plan for both

Senate FI&I
Attachment 1
2/19/98

the new eligible children and the current Title XIX eligible children. This is a key element of the plan because of the **administrative simplicity** of combining both groups of children. This makes both programs children and family-friendly and provider-friendly. For the health plans covering both groups of children creates a larger pool for more effective risk management and allows for **seamless coverage** as children move from Title XIX eligibility to Title XXI eligibility. For families this means that they will not have to change plans and providers as their family income changes. This **continuity of care** is another critical component of the plan.

(b) (1) This provision to use the same set of benefits for both groups of children also meets the goals of administrative simplicity, seamless coverage and continuity of care. The benefits covered under the Kansas KanBeHealthy program were developed by the Academy of Pediatrics and focus on wellness and prevention services. (see attached)

(b) (2) (E) Presumptive eligibility ensures that children can be easily enrolled in the program and receive necessary services if they meet these criteria.

(3) Continuous eligibility means that once a child is determined to be eligible they retain eligibility for 12 months. This provides continuity of care for the children and makes it more acceptable to the plans and providers who contract to provide services for an agreed upon number of children. This has been one of the concerns that health plans and providers have voiced with the current Medicaid program.

(4) Monitoring of the program will be very important. Contracts with health plans must include measurable outcomes and performance standards. The program must be able to demonstrate that appropriate care is being delivered and that children are receiving the services that they need.

(d) (1) We want health plans to work with existing community providers, whenever possible, to avoid duplication of services.

(d) (2) & (3) Outreach and enrollment will be an important part of the program if we are to be successful in providing health care services to the eligible children. Many existing community resources can be and should be utilized in this effort. Education is also a key component of the plan. To be successful families need to learn how to appropriately access care and how to participate in creating healthy lifestyles for their children.

(d) (4) Another criticism of the current Medicaid program is the "hassle factor " involved in enrollment. The current enrollment process will be simplified and be the same for both groups of children with enrollment taking place in a variety of locations, including phone and mail-in if appropriate. This addresses another problem with the Medicaid program by removing the stigma of enrollment through the "welfare" office.

(d) (5) Premium sharing will be used where allowed to begin to transition families off public assistance for health care. The premium sharing should not be a barrier to accessing health insurance coverage but used

more as a way of acknowledging that families should contribute something towards the cost of providing coverage. This is consistent with welfare reform and its goal of helping families become self sufficient.

(d) (6) The federal law limits eligibility to children who have not had health insurance. We wanted to be sure that children covered under the Caring Program for Children be eligible for this new program. We also included the high risk pool and any charity health program in this exemption.

(d) (7) This allows the state to apply for the same waiver that is currently in effect for Medicaid.

(e) This covers when children will not be eligible. We want to discourage families from dropping coverage by not paying their premium, but allow for reinstatement of eligibility if the back premiums are paid.

Sec. 3. This is a restatement of the federal law (Hyde amendment).

One final observation. No program, either the current Medicaid program or this combination of Title XIX and Title XXI, will be successful if we don't take a serious look at the rates we are currently providing for health care services. The Department commissioned a rate study which shows that our rates are considerably lower than the national average. This proposal eliminates many of the administrative problems with our current Medicaid program, but we need to encourage the appropriations committees to look seriously at increased reimbursement for health care services. Thank you.

PROPOSED SUBSTITUTE For SENATE BILL NO. 424

AN ACT relating to Kansas insurance coverage for children; duties of the secretary of social and rehabilitation services.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) The secretary of social and rehabilitation services shall develop and submit a plan consistent with federal guidelines established under section 4901 of public law 105-33 (42 U.S.C. 1397aa et seq.; title XXI).

(b) The plan developed under subsection (a) and amendments thereto shall be a capitated managed care plan covering Kansas children from zero to 19 years which:

(1) Contains benefit levels at least equal to those for the early and periodic screening, diagnosis and treatment program;

(2) provides for presumptive eligibility for children based upon, but not limited to, children who:

(A) Receive free or reduced school lunches;

(B) may be eligible for title XIX;

(C) received supplemental security income but lost such benefits under P.L. 104-193;

(D) receive services from headstart; and

(E) receive a preliminary determination of eligibility until a final determination is made.

Senate F.D.A.
Attachment 2
2/19/98

(3) Provides continuous eligibility for 12 months once a formal determination is made that a child is eligible subject to subsection (e);

(4) has performance based contracting with measurable outcomes indicating appropriate utilization of plan services to include, but not limited to, such measurable services as immunizations, vision, hearing and dental exams, emergency room utilization and annual physical exams; and

(5) will provide coverage to as many targeted low-income children, as defined under section 4901 of public law 105-33 (42 U.S.C. 1397aa, et seq.) and amendments thereto, subject to appropriations.

(c) The secretary is authorized to contract with insurance companies, health maintenance organizations or nonprofit hospital and medical insurance corporations authorized to transact health insurance business in this state to implement the health coverage plan in section 1, and amendments thereto, providing for several plan options to enrollees which are coordinated with federal and state child health care programs.

(d) When developing and implementing the plan in section 1, and amendments thereto, the secretary to the extent authorized by law:

(1) May include provisions that contracting insurers utilize and coordinate with existing community health care institutions and providers;

(2) may work with public health care providers and other

community resources to provide educational programs promoting healthy lifestyles and appropriate use of the plan's health services;

(3) shall plan for outreach and maximum enrollment of eligible children through cooperation with local health departments, schools, child care facilities and other community institutions and providers;

(4) shall provide for a simplified enrollment plan;

(5) shall provide cost sharing as allowed by law;

(6) shall not count the caring program for children, the Kansas health insurance association or any charity health care plan as insurance under subsection (e)(1); and

(7) may provide for payment of health insurance premiums if it is determined cost effective, taking into account the number of children to be served and the benefits to be provided.

(e) A child shall not be eligible for coverage and shall lose coverage under the plan developed under subsection (a), and amendments thereto, if:

(1) During the prior six months, the child was covered with a comprehensive health insurance policy by an insurance company, health maintenance organization or nonprofit hospital and medical insurance corporation authorized to do business in this state and such insurance is no longer available to the child; or

(2) such family has not paid the enrollee's applicable share of any premium due.

If the family pays all of the delinquent premiums owed during

the year, such child will again be eligible for coverage for the remaining months of the continuous eligibility period.

(f) The plan developed under section 4901 of public law 105-33 (42 U.S.C. 1397aa et seq., and amendments thereto) is not an entitlement program. The availability of the plan benefits will be subject to funds appropriated.

Sec. 2. The secretary of social and rehabilitation services shall adopt rules and regulations as necessary to implement and administer the provisions of section 1 through 4, and amendments thereto.

Sec. 3. (a) (1) None of the funds appropriated to implement this act shall be expended for any abortion.

(2) None of the funds appropriated to implement this act shall be expended for health benefits coverage that includes coverage of abortion.

(3) The term "health benefits coverage" means the package of services covered by an insurance company, health maintenance organization or nonprofit hospital and medical insurance corporation authorized to transact health insurance in this state pursuant to a contract or other arrangement entered into under sections 1 through 4, and amendments thereto.

(b) The limitations established in the preceding section shall not apply to an abortion:

(1) If the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical

disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Sec. 4. The secretary in contracting for capitated managed health care for children shall include in the pool of persons to be covered those eligible children covered by the Kansas medicaid program as law allows.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

MATHEMATICA
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January 8, 1998

Ann Koci
Commissioner of Adult and Medical Services
Department of Social and Rehabilitation Services
915 SW Harrison, Room 628-S
Topeka, KS 66612

Dear Commissioner Koci:

This letter summarizes the issues we have discussed regarding the Medicaid physician reimbursement fee schedule, its relationship to managed care, and options for changing the fee schedule.

SUMMARY

In the aggregate, Medicaid physician reimbursement in Kansas is substantially below that of most state Medicaid programs, Medicare, and private insurance. Kansas rates are especially low for many primary care services, such as hospital and office visits and immunizations. The rates are substantially above average, however, for many lab, x-ray, and surgical services, and for maternity care. While HMOs are not required to use the Medicaid physician fee schedule to reimburse physicians, many of them do. Further, HMO capitated rates derived from the low Medicaid fee schedule may not be sufficient to induce participation in the Medicaid program by as many experienced and capable HMOs as the state would like. Thus, revising the fee schedule to increase reimbursement for primary care physician services could increase access to this kind of care in both the fee-for-service and managed care portions of the Kansas Medicaid program.

The cost of increasing rates for primary care services could be offset by reducing physician fees in other parts of the fee schedule where Kansas rates are substantially above the average of other state Medicaid programs, such as labs, x-rays, surgeries, and maternity care. Myers and Stauffer has developed a model that compares Kansas physician fees to three different benchmarks: an average of the Medicaid rates in Missouri, Iowa, Indiana, and Nebraska; Medicare fees in Kansas; and a limited sample of private insurance fees in Kansas.

Senate Ways & Means
Attachment 3

2/19/98

Kansas Medicaid physician fees could be set at 84 percent of the four-state Medicaid average at no increase in cost above the current physician reimbursement expenditure level of $62 million a year -- a "budget neutral" change. For an additional cost of $11 million a year, the Kansas fees could be set at 100 percent of the four-state Medicaid average. Setting Kansas Medicaid fees at 100 percent of Kansas Medicare physician fees would add about $40 million a year to current Medicaid physician expenditures. Setting Medicaid fees equal to private insurance fees could cost up to $70 million a year above the current level.

Modifying Medicaid physician fees to bring them more in line with those paid by other state Medicaid programs, Medicare, and private insurers could be a useful first step toward adoption of the Resource-Based Relative Value System (RBRVS) for physician reimbursement that is used by Medicare as well as about half of state Medicaid programs and an increasing number of private insurers.[1] Even without going to a full-scale RBRVS system, a fee schedule that matched the four-state Medicaid average would significantly increase the incentives for physicians to provide primary care services. In addition, because hospital outpatient reimbursement in Kansas is tied to the physician fee schedule, a revised physician fee schedule would increase outpatient reimbursement -- a goal you mentioned in our initial meetings.

BACKGROUND

The Center for Health Care Strategies (CHCS) conducted a managed care "Readiness Assessment" in Kansas in February 1997. In the course of that assessment, you expressed the concern that the capitated rates Kansas has set in its HMO managed care program (PrimeCare Kansas) may not be adequate to assure access to care by Medicaid recipients. You indicated the need to compare the Kansas Medicaid rates to those of other payers. Many Medicaid physician reimbursement rates, for example, had not been changed since the 1970s, and providers complained that they were well below market rates. Since federal regulations require that the costs of Medicaid managed care programs not exceed the costs of fee-for-service Medicaid, states have only a limited ability to increase capitated rates without at the same time increasing fee-for-service rates. You also expressed the concern that low Medicaid fee-for-service physician reimbursement rates could threaten access in Kansas' planned children's health insurance expansion, to the extent it relies on the Medicaid program.

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[1] The RBRVS payment methodology was phased on for Medicare from 1992-96. It raised reimbursement levels for primary care services and lowered reimbursement levels for certain specialty services.

Based on its readiness assessment, CHCS agreed to provide Kansas Medicaid with technical assistance in further assessing the relationship between its fee-for-service physician reimbursement system and its HMO capitated rates, and in making appropriate recommendations regarding the physician reimbursement system. I visited Kansas on October 22-23 for discussions with you, your staff, the Kansas Medical Society, and several HMOs. Since then, with extensive assistance from Myers and Stauffer and your staff, I have prepared the analysis and options that are set out in this memo.

PHYSICIAN REIMBURSEMENT REFORM OPTIONS

Myers and Stauffer has constructed a model of the Kansas Medicaid physician reimbursement system that permits your staff to experiment with a wide range of modifications to the current physician fee schedule. The model will calculate the net fiscal impact of changes in any one or more of 600 procedure codes. The model permits easy comparisons on a code-by-code basis to three main benchmarks:

- The average rate paid by Missouri, Iowa, Nebraska, and Indiana ("four-state Medicaid average")
- The Kansas Medicare fee schedule
- The rates paid by two large Kansas private insurers (one HMO and one Preferred Provider Organization (PPO))

As a starting point, I would recommend using the four-state Medicaid average. The states are similar to Kansas both geographically and demographically, and their rates are reasonably close to the national average for state Medicaid programs. The other benchmarks can be used for purposes of comparison, especially if Kansas decides to depart from the four-state Medicaid average for particular procedure codes.

The remainder of this section highlights some comparisons of the fiscal impact of the three main benchmarks, and describes in more detail the impact by type of procedure that would result from moving from the current Kansas Medicaid fee schedule to the four-state Medicaid benchmark.

As shown in the table on the next page, setting Kansas Medicaid physician fees at 84 percent of the four-state Medicaid average would be a "budget neutral" change. There would be no net increase

in expenditures. Setting fees at 100 percent of the four-state average would cost about $11 million per year more than the current system.[2]

Fiscal Impact Of Potential Modifications To Kansas Medicaid Physician Fee Schedule ($ in Millions)

	Annual Expenditures	$ Increase	Percent Increase
Current fee schedule	62	0	0
84% of 4-state Medicaid avg.	62	0	0
100% of 4-state Medicaid avg.	73	11	18
100% of KS Medicare	102	40	65
100% of private PPO/HMO	120-130	60-70	100-110

SOURCE: Myers and Stauffer

As shown in the table on the next page, setting Kansas physician fees at 100 percent of the four-state Medicaid average would result in increases for most types of procedures. The rates for some radiology and surgery procedures would be reduced, while others would be increased. The biggest overall dollar reductions would come in maternity procedures, where Kansas in recent years has substantially increased physician reimbursement. For all maternity procedures combined, the reduction would be about 15 percent.

[2] Because the Myers and Stauffer model on which these fiscal estimates are based does not include all physician reimbursement procedure codes, the actual fiscal impact of the changes could be about 10 percent above or below the estimates derived from the model.

Selected Major Changes In Expenditures From Setting Kansas Physician Reimbursement Fees At 100% Of Four-State Medicaid Average, By Type Of Procedure

Code Range	Type Of Procedure	$ Change (In Millions)	% Change
99217-99238	Hospital care	3.0	114
99201-99215	Office visits	2.7	27
99280-99285	Emergency room visits	1.6	147
90700-90745	Immunization	0.5	174
99250-99255	Inpatient consultations	0.4	77
99240-99245	Outpatient consultations	0.4	76
70010-79999	Radiology	-0.1	-2
33010-37799	Cardiovascular surgery	-0.1	-8
59000-59899	Maternity	-2.0	-15

SOURCE: Myers and Stauffer

More Selective Modifications To The Physician Fee Schedule

Once the state decides on the overall dollar amount that is available to fund modifications to the physician fee schedule, it would be useful to consider more selective changes to the fee schedule, rather than setting all rates at some percentage of a benchmark such as the four-state Medicaid average. The Myers and Stauffer model is set up so that the fiscal impact of any combination of changes can be quickly calculated.

If, for example, the state is reluctant to make major reductions in reimbursement for maternity procedures, some of the increases in other procedures that would result from using 100 percent of the four-state Medicaid benchmark could be scaled back. Representatives of the Kansas Medical Society and the HMOs with whom the Medicaid program has contracted could likely provide valuable advice on potential trade-offs of this sort. In addition, because many of the increases from setting rates at 100 percent of the four-state Medicaid average would go to hospital based physicians and to outpatient hospital reimbursement, hospital representatives should probably also be involved in the discussions.

Longer-Term Physician Reimbursement Reform Options

The RBRVS physician reimbursement system that Medicare is now using throughout the country is also used by about half of state Medicaid programs and a steadily increasing number of private insurers.[3] The RBRVS system is scientifically based and carefully constructed. It is continually being refined and improved by the Health Care Financing Administration. The system is designed so that states can adjust the so-called "conversion factor" in the system to achieve whatever fiscal impact they wish, without modifying the rest of the system's structural features.

One of the main purposes of the RBRVS system is to shift reimbursement resources from surgical to primary care services, or from "procedural" to "cognitive" physicians. Moving the current Kansas reimbursement fee schedule in the direction of the four-state Medicaid average would have a similar effect, although it would be less thorough and more systematic than the RBRVS system. It could therefore set the stage for a move to an RBRVS system at a future point. Developing an RBRVS system requires the investment of significant time and analytic resources, but there are models available in other state Medicaid programs that can provide good starting points. Myers and Stauffer is familiar with a number of these models, including the one now being used in the Indiana Medicaid program.

Problems With Using Currently Available Private Insurance Data As A Benchmark

As we discussed, Myers and Stauffer has received private physician fee schedule data from the Department of Health and Environment covering two HMOs and two PPOs. The data from one of the HMOs and one of the PPOs are very incomplete; only about 10-20 percent of the procedure codes overlap with the 600 physician procedure codes in the Myers and Stauffer model. There is about a 90 percent overlap in the data from the other PPO, and about a 65-70 percent overlap in the data from the other HMO. Even with these latter two fee schedules, however, there are many inconsistencies between the procedure codes in those schedules and the Medicaid codes, since insurers are not required in their commercial business to abide by the HCFA requirements for procedure code uniformity and consistency that apply to Medicaid and Medicare claims.

Nonetheless, it will be useful to have this private insurance benchmark as you look at specific procedure codes that may be especially sensitive because of their clinical or fiscal impact, such as the maternity codes. The private insurance rates have been loaded into the Myers and Stauffer model, so they are readily available for comparison to the Kansas Medicaid fee schedule.

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[3] Martin, Sean. "Increasingly, payers use Medicare's physician pay scale." *American Medical News*, December 1, 1997.

RELATED ISSUES

There are two related issues that are worth reiterating here: phase-in options and measurement of physician participation and recipient access.

Phase-In Options

There are some possibilities for phasing in or front-loading increases in physician reimbursement rates if budget or other circumstances warrant it. If there are funds available for increases in FY 1999, for example, but some uneasiness about the availability of funding in later years, a phase-in that limited the increase in expenditures in later years could be used. Some key physician rates could be increased in FY 1999, but offsetting reductions elsewhere in the physician fee schedule could be postponed until FY 2000 and beyond. Alternatively, savings could be sought in other parts of the Medicaid budget to offset the costs of physician fee increases in later years. In addition, it is worth noting that if there are no further increases in physician reimbursement rates in later years, their real value will be eroded by inflation over time.

Measurement Of Physician Participation And Recipient Access

Finally, you should be sure to track physician participation and recipient access to see whether the increases in physician reimbursement have the desired impacts on access to care:

- **Physician participation.** Your claims processing system should be able to track the number of physicians who submit a specified number of claims during the course of a year, so that you can see whether that number goes up following an increase in physician reimbursement. It would be especially helpful to track this by physician specialty, since the fee schedule increase options described above are likely to have their greatest impact on primary care physicians and those involved in providing maternity care. If there is concern about the potential impact of reductions in maternity care fees on access, for example, tracking and monitoring efforts could focus in particular on physicians who specialize in maternity care.

- **Recipient access.** Recipient access is a more direct measure of the results you would presumably like to achieve with physician fee increases. Your claims processing system should be able to track measures such as the percentage of Medicaid-enrolled children receiving any physician services, the number of physician office visits per enrolled child, and the number of physician office visits per enrolled pregnant woman. It would also be useful to track emergency room visits, since improved primary care usually reduces such visits. If emergency room fees are substantially increased,

however -- as they would be under most of the options discussed earlier -- that could result in an offsetting increase in emergency room utilization.

. . . . . .

I hope this is helpful. Please let me know if you have any questions, or would like me to develop any of this further.

Sincerely,

James M. Verdier

cc: Karen Brodsky, Stephen Somers, Scott Simerly

Title XIX Plan

Benefits	Title XIX	Benefits	Title XIX
Inpatient hospital ***Must be covered under law of categories of service.***	Covered when medically necessary.	**Laboratory and radiological services** ***Must be covered under law of categories of service.***	Covered when medically necessary.
Outpatient hospital ***Must be covered under law of categories of service.***	Covered when medically necessary.	**Prenatal care and prepregnancy family planning services and supplies**	Covered when medically necessary. This coverage includes prenatal health promotion and risk reduction when enrolled in a HMO.
Physician services ***Must be covered under law of categories of service.***	Physician or mid-level practitioner are covered when medically necessary.	**Inpatient mental health services**	Covered when medically necessary. This coverage includes psychiatrists, psychologists, Community Mental Health Center services, partial-hospitalization and mental health prescriptions. Prior authorization is required.
Surgical services ***Must be covered under law of categories of service.***	Covered when medically necessary.	**Outpatient mental health services**	Covered when medically necessary. This coverage includes psychiatrists, psychologists, Community Mental Health Center services, partial-hospitalization and mental health prescriptions. These services are limited to 32 hours a year unless the client participates in **Kan Be Healthy** and then the client is allowed 40 hours of service.
Clinic services	Covered when medically necessary.	**Enabling Services**	Title XIX requires that enabling services be provided by HMOs.

Benefits	Title XIX	Benefits	Title XIX
Prescription drugs	Covered when medically necessary.	**Home and community-based health services and home health services.**	Home and community based services are covered within these special children populations: technology assisted children, developmentally delayed children, head injury children (age 18-55), physically disabled children (age 16-64), and severely emotionally disturbed children. Home health aide services include skilled nursing services, and attendant care services are covered when medically necessary.
Over-the-counter medications	The following therapeutic classes of drugs are covered for **KAN Be Healthy** participants: antihistamine combinations, decongestants, cough and cold, vitamins and multi-vitamins.	**Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school or other setting).**	Covered when medically necessary.
Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).	Durable Medical Equipment is covered when it is ordered by a qualified health provider and it is needed for life support, employment or a child. Audiology and hearing services include the fitting and dispensing of hearing aids (every 4 years) and appropriate accessories (up to 6 hearing aid batteries per month--monaural or 12 per month--binaural). Vision services are covered. They include a complete eye exam every four years,**(Kan Be Healthy** participants every year), Eyeglasses are covered and contact lenses are covered when medically necessary. Eye prosthesis are covered when ordered by a health care provider.	**Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders**	Physical therapy services are covered when they are restorative for each injury or acute episode for a maximum of six months from the date of the first therapy. Occupational services are covered when they are restorative for each injury or acute episode for a maximum of six months from the date of the first therapy. Speech services are covered when they are restorative for each injury or acute episode for a maximum of six months from the date of the first therapy.

enefits	Title XIX	Benefits	Title XIX
Disposable medical supplies	Covered when medically necessary.	**Abortion**	Only when it is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
Outpatient substance abuse treatment services	Alcohol and drug abuse services are covered when it is medically necessary through community based services.	**Well child check-ups including immunizations** ***Must be covered under law of categories of service.***	Covered when medically necessary. **Kan Be Healthy** extended services are available.
Case management services	Provided.	**Premiums for private health care insurance coverage**	An option that is used when the private health care package is more affordable than Title XIX.
Care coordination services	Provided.	**Medical transportation**	Covered when it is medically necessary. Non-ambulance medical transportation can be provided to **Kan Be Healthy** participants.
Hospice	Hospice services are covered when ordered by a health care provider.	**Dental Services**	Covered dental services include dental medical history, oral hygiene exam, dental developmental exam, oral lesions, periodontal exam, dental caries, education, fluoride treatments, cleaning, x-rays, oral surgery, orthodontia, and space maintainers.
Abortion	Only when it is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	**Inpatient substance abuse treatment services**	Alcohol and drug abuse services are covered for medical detoxification only.
Any other health care services or items specified by the Secretary and not excluded under this section.	Title XIX requires that HMOs provide health care services or items specified by the Secretary that are not excluded by the contract.		

3-11

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions and
Insurance Committee

From: Kathleen Sebelius, Commissioner
of Insurance

Re: Senate Bill 424 (Children's Health Insurance)

Date: February 19, 1998

Kansas has a unique opportunity to extend health insurance to children in this state who currently do not have access to health care services. Recent studies indicate there are approximately 60,000 to 90,000 children in Kansas who do not have health coverage. Generally, these are children of "working poor" families whose parents do not qualify for Medicaid and who either do not have health insurance offered through their employer or who can not afford the cost of insurance premiums.

There is a clear link between health insurance coverage and the ability to access health care. Uninsured children receive fewer doctor visits and do not stay in the hospital as long as children in families with health insurance. Children without health coverage also have problems receiving necessary dental care, prescription drugs or eyeglasses. These preventative services are especially important for younger children, ages 0-5.

Congress recognized the national problem of extending health insurance coverage to children and last year approved the Budget Reconciliation Act which provides funding to states to establish health insurance programs for uninsured children. The money will be available for at least 10 years starting with fiscal year 1998 which started October, 1997. States are required to put up a portion of the money to fund the program and the

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2/19/98

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Topeka, Kansas 66612-1678

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federal act includes a number of coverage options for states to consider in designing a children's health insurance plan.

Kansas is eligible to receive $31 million in federal funding the first year of the program and a five year total of over $152 million. States must provide matching funds equal to 70% of the amount of the state contribution to Medicaid. Kansas' share of the first year (assuming all federal funding will be used) is $12.3 million. Governor Graves has authorized the matching Kansas share of the program funding in his 1998 budget submitted to the Legislature.

Senate Bill 424 outlines how the program will operate in Kansas. The legislation includes many of the recommendations made by two task forces which studied this issue last year - the SRS Kansas Insurance Coverage for Kids committee chaired by Senator Praeger and the Children's Health Insurance Action Group which I formed.

As you study and make recommendations on providing health insurance coverage for Kansas children, it is important to remember that every dollar which we spend on preventative care and basic health services saves us money in having to pay for serious medical conditions which have been untreated. Passage of legislation to provide health insurance coverage for children in this state is one of the best investments we can make for the future.

PROVIDING CHILDREN'S HEALTH INSURANCE COVERAGE IN KANSAS

A Report To The Kansas Legislative
Health Care Reform Oversight Committee

December 3, 1997

Kansas Insurance For Kids SRS Workgroup
Senator Sandy Praeger, Chair

Children's Health Insurance Action Group
Insurance Commissioner Kathleen Sebelius, Chair

Introduction

Children are our most valuable resource. How we treat children is a true measure of our society. It is important that we provide them with all of the necessary tools to prepare for their future.

For many Kansas families, access to health care remains out of reach. This is true despite the fact that most of those who can not afford health insurance are employed. This report outlines the scope of the problem in Kansas and provides a series of steps which can be taken to provide health insurance for the approximately 60,000 children of working poor families who do not have coverage.

According to a recent study by the U.S. Census Bureau, there are 73,000 children in Kansas under 18 years old, or 10.4 percent of all children in the state, without health insurance. These are children who are not eligible for public health assistance programs such as Medicaid. This compares with 13.8% of all children nationally (almost 9.8 million) who do not have health insurance coverage.[1] The Kansas Department of Social and Rehabilitation Services estimates that there are 60,000 children in the state whose families do not work in the public sector and who earn less than 200% of the federal poverty level ("FPL") who do not qualify for Medicaid.[2] These government statistics are supported by a recent survey by the University of Kansas which found that 9.4% of children in Kansas under 18 (64,215 children) currently do not have health coverage.[3]

Many uninsured children are in families who are employed in jobs which either do not provide health insurance or where the premiums are not affordable. The Health Affairs Journal reports that between 1987 and 1996, the national percentage of workers with health insurance coverage through their employer dropped from 64% to 60%. The decline in health insurance coverage is most apparent for working poor families and for black and Hispanic workers.[4]

There is a clear link between health insurance and access to health care. A 1994 National Health Interview Survey found that long term uninsured children receive fewer doctor visits and less in-patient hospital days. Uninsured children also have problems receiving necessary dental care, prescription drugs or eyeglasses. These are services that are critical for childhood development, especially in 0-5 years of age.[5]

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Federal Children's Health Insurance Legislation

This year, the Congress has provided state governments, including Kansas, with a unique opportunity to address the problem of children who do not have access to health insurance. In August, Congress approved funding for a state children's health insurance program as part of the 1997 Budget Reconciliation Act. The new law provides $48 billion in federal funds over 10 years for children's health coverage. Major provisions of the act include:

- The Federal government will invest $24 billion over the next five years and there is the possibility of an additional $24 billion over the following five years. Funds will go to children's health insurance, increased Medicaid costs and diabetes programs. The program is partially funded by increased tobacco taxes.

- In Kansas, the program can provide coverage for qualified children in families with incomes at or below 200% of the federal poverty level.

- Kansas is estimated to receive $31,433,507 in the first year and a five year total of over $152 million. Funding starts October 1, 1997. Any money not allocated by a state in a particular year may be used during the two following years. At the end of three years, any unallocated funds are redistributed to the other states.

- States must provide matching funds equal to 70% of the amount of the state contribution to Medicaid. Kansas share for the first year (assuming all federal funding will be used) is $12.3 million.

- The money may be used by states to (a) expand Medicaid and (b) provide comprehensive private health insurance through a state children's health insurance program. Funds can not be used to duplicate any other private or public coverage that is available. Up to 10% of the funds can be used for administrative and outreach costs and for funding other health assistance programs for children.

- Benefits under the private health insurance program must provide "benchmark coverage" of basic services. This coverage is equivalent to that provided by: (a) the standard Blue Cross plan for federal employees; (b) the largest commercial health maintenance organization with the largest insured, non-Medicaid enrollment or (c) health benefits offered to state employees.

- States are required to submit a plan of how the funds will be used to the Secretary of Health and Human Services for approval. State plans must include details of "outreach" efforts to expand coverage to targeted population.

- Families with incomes above 150% of the FPL can be asked to pay a portion of the premiums. Certain deductibles and co-pays are also permitted.

- States must adopt procedures to ensure that coverage under this program does not "crowd-out" or substitute for existing employer coverage.
- Eligibility for assistance may not be denied based on preexisting conditions. Group health plans may limit coverage of services for preexisting conditions.

One of the most important things for the 1998 Legislature to do is to take advantage of this program to provide assistance to those children whose families can not afford private health insurance, but who also do not qualify for Medicaid assistance from the state. The benefits of assisting Kansas working parents to provide health insurance coverage for their children include reduced medical costs and a healthier future for the citizens of Kansas.

Kansas Children's Health Insurance Proposal

There are two groups which have been looking at developing a program to provide health insurance coverage for children in this state based on the provisions of the Budget Reconciliation Act. In July, Insurance Commissioner Kathleen Sebelius formed the Children's Health Insurance Action Group to study ways to fund health insurance coverage for uninsured children in the state. This group includes many representatives from the Commissioner's Health Care Advisory Committee which has studies a number of health issues over the past three years.

In September, the Secretary of the Department of Social and Rehabilitation Services, Rochelle Chronister, established a committee to develop a plan to use the funding made available through the federal legislation. This Chair of this committee is Senator Sandy Praeger. The SRS group has looked at the issue as a way to redefine and change the identity of the existing Medicaid program while the Insurance Department's Action Group has focused on ways in which the private market can participate in providing health coverage for uninsured children.

Both groups include representation from a wide range of groups interested in children's issues such as advocacy groups, public health clinics, medical providers, legislators and insurance carriers. In many cases, members of the Children's Health Insurance Action Group were also represented on the Kansas Insurance Coverage for

Kids ("KICK") Workgroup. A list of the membership of the two committees is attached to this report as Attachment A. Minutes of the meetings of the groups and other meeting materials are included as Attachments B and C.

It is important to note that the two committees worked toward a common goal of designing a children's health program for Kansas that would maximize the resources available to the state. The Action Group and the KICK Workgroup were also committed to providing a plan that would utilize a public-private partnership to deliver services to children. Both groups came up with the same general outline of a children's health program for Kansas.

The operating principals developed by the Children's Health Insurance Action Group and the Kansas Insurance Coverage for Kids SRS Workgroup are as follows:

- The target population is the approximately 60,000 uninsured children in Kansas whose family incomes fall below 200% of the federal poverty level. The program should be designed to provide comprehensive health coverage for as many children as possible.
- The program should be sustainable with the expansion funding from the federal government (Title XXI).
- The program should be innovative and utilize the private market to provide coverage for uninsured children.
- The program should maximize the purchasing power of the state by pooling the eligible children with other groups which are provided insurance through the state such as the existing Medicaid program.
- The new insurance program for Kansas children should be designed to coordinate and compliment existing health services for Kansas children.
- The program will put the focus on the prevention of disease and illness in children and provide better health outcomes for children, reduce costs and reduce the documentation and paperwork for health care providers. A focus on wellness and prevention results in healthier children who have greater success in school.
- The program should equalize Medicaid benefits for all Kansas children at 150% of the federal poverty level. Currently, Medicaid covers 0-1 year olds up to 150% of

FPL; 1-6 year olds at 133% of FPL and 7-18 year olds at 100% of FPL. This equalization will allow households under 150% of the federal poverty level to have access to Medicaid regardless of the age of the children and will reduce the complexities of the current Medicaid program.

- The state will competitively bid a benefit package identical to Medicaid in the private insurance market to enlist insurance carriers to provide children's health insurance for families between 150% and 200% of the federal poverty level. This will allow the state to purchase health care for eligible children in the same way an employer purchases health care for their employees. The purchase of coverage will be done through a request for proposal issued by the state.
- One goal of the program is to remove the stigma of health care provided through Medicaid and assist the transition from welfare to full employment.
- The package of benefits to be offered will be the same for all children under the 200% FPL. This will allow for seamless coverage for families as they change income levels and will allow children to have access to the same set of benefits and providers as they change programs. As Kansas families move from welfare to work, health insurance for their children will be consistent.
- Insurance companies will be required to form partnerships with local community health systems including providers and community health departments for the delivery of services.
- The contract should include incentives for insurers to provide outreach efforts to meet specific outcome measures for the delivery of health services.
- Parents with incomes above 150% of the federal poverty level should share in the cost of the program through a sliding scale of premiums, provided that such efforts do not discourage access to health coverage.
- The program will use day care centers, public schools, hospitals, medical providers, health clinics and other community organizations for outreach efforts to enroll eligible Kansas children with a simplified enrollment form.
- The state may want to provide premium tax incentives for those insurance carriers which participate in the program.

The two working groups have a joint meeting scheduled for December 18 to continue to explore implementation issues. As with any proposal, there are a number of program details that remain to be worked out. Those issues include:

- Decide on the most appropriate administrative structure to oversee the private contracts. Options include the Department of Social and Rehabilitation Services, the State Employees Health Care Commission, or a new administrative agency.
- Reduce the potential "crowd-out" of existing employer based health insurance. The KICK group has proposed that there be a six month waiting period after someone loses private insurance before they qualify for the children's health insurance program.
- The design of the contract proposal for private health insurance coverage needs to be finalized. One issue is whether the state outlines in the proposal a list of benefits and asks carriers to bid a premium amount or, as an alternative, sets out a per child amount and requires insurance companies to indicate what benefits can be provided for that level of funding.
- The Caring Program For Children is a public-private partnership established by Blue Cross and Blue Shield of Kansas, the Kansas Hospital Association and the Kansas Medical Society and partially funded through state dollars. This program provides basic health care services for many children who are in the targeted population. The future of the Caring Program For Children needs to be decided and ideally can be focused on those uninsured children outside the target population..
- In addition, the program should be evaluated as a possible way to provide health insurance coverage for children in families above the 200% of FPL cut-off. These families would be required to pay full premiums for such insurance.
- Outreach efforts need to be further clarified and the application process needs to be designed so that it provides streamlined and efficient access to the program.
- The state should look at the current system for Medical Support Orders in domestic cases to see if access to the Title XXI program should be required in appropriate cases.

- The Legislature should use state dollars to provide comprehensive insurance for children of public employees in the targeted income level.

This Legislature has the opportunity to provide health insurance coverage for over 60,000 Kansas children who currently do not have access to regular health care. It is the best investment we could make in the future of Kansas.

---

[1] U.S. Census Bureau, 1995 Census Data.
[2] Kansas Department of Social and Rehabilitation Services, Division of Adult and Medical Services.
[3] Health Services Research Group, University of Kansas, KU Health Insurance Survey, September, 1997.
[4] "Poor Workers Turning Down Employers' Health Benefits," New York Times, 11/10/97.
[5] Ron Pollack, Cheryl Fish-Parchman and Barbara Hoeing, "Unmet Needs: The Large Differences In Health Care Between Uninsured and Insured Children," Families USA Special Report, June, 1997.

4-10

Kansas Insurance For Kids SRS Workgroup
Children's Health Insurance Action Group
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Graham Bailey
Caring Program For Children
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Susan Barrett
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Jim Bergfalk
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Tom Bowser
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4-11

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Kathleen Sebelius
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Andy Tompkins
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Joyce Volmut
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4-15

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the Voice of Nursing in Kansas

Debbie Folkerts, A.R.N.P.--C.
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February 19, 1998

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S.B. 424: CHILDREN'S HEALTH INSURANCE PROGRAM

Chairman Steffes and members of the Senate Financial Institutions and Insurance:

I am Dawn Reid representing the Kansas State Nurses Association, testifying in support of SB 424. I served on both the Insurance Department and the SRS task forces examining Title 21. What I learned during this process is while the provisions of this program are very complex and confusing, it has great potential for positive long-term benefits for Kansas children. Kansas has the potential to receive $30.8 million a year for the next ten years. With a state required match of $12 million per year, a total of $42.8 million would be spent on the provision of children's health insurance.

You have already been given an excellent overview of the federal requirements a few weeks ago by representatives from SRS and Insurance; I will not belabor you with programmatic requirements, HCFA interpretations or implementation specifics. I would like to point out some of the basic conclusions that the two task forces came to:

1. The program must be administratively simple, and be user-friendly for both consumers and providers.

2. The program should be sustainable and be available statewide.

3. The greatest number of income-qualified children should be served with quality medical care.

4. There should be ease of movement for the children between the Medicaid program and the CHIP program.

The most important point I would like to stress is that time is of the essence. Now is not the time to debate the minutiae

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program specifics or implementation. In order to access the FY98 funds - $30.8 million - the state must have their plan approved by HHS by October 1, 1998. As there is a 90-day turnaround period, states are being advised by HCFA to submit a plan for consideration and approval by July 1, 1998. If a plan is not approved, the state cannot draw down the federal dollars, or carry them over to subsequent years. Only until the state has an approved plan can the federal dollars be accessed.

The US Census Bureau estimates there are 60,000 uninsured children, which is how the federal money has been allocated. Not all of these children will be eligible for CHIP or have families willing to take advantage of this program. However, the majority of income-eligible families who are currently going without basic medical care services, who are using their school nurse as their primary care provider, or running to the emergency room at the last minute because they just cannot afford to access preventative medical services, will be greatly relieved. By intervening early and providing increased preventive services, this effort will go far in reducing long-term, high medical costs.

b:dlr/green/chip

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Feb 19

Testimony Before the Senate Financial Institutions and Insurance Committee on
Tuesday, ~~January 25~~th, 1998, at 9 AM
By the State Legislative Committee of the AARP

Good Morning: I'm John Holmgren with the State Legislative Committee of the American Association of Retired Persons. We have several other members present. We are here today to support SB 424, Kansas Insurance Coverage for Kids. This is important to us as well as other concerned citizens of Kansas.Our national President of the AARP, Margaret Dixon, has stated her support of uninsured children coverage, very powerfully.

The Act proposes a Medicaid managed care plan: we agree with the purpose of that decision. Whether the state should look for funds through Title 19 or Title 21 is an important question that we cannot give you as a suggestion at this time until further study. But we do support and appreciate the bill's wording in Section 1.(3) as it "classifies all covered children as one group with no distinction between their funding source...and..."contains benefit levels equal to those for the early and periodic screening, diagnosis and treatment plan currently existing under Medicaid".

We also support fees by parents determined by income as a fair way of approaching the cost problem to the state, even with the outright grant funds from the federal government. We urge the adoption of a funding source that will be continued at least 5 years to obtain continuity in program and medical care for uninsured children. Thus, we are aware that although funds are paid to providers in this program by privately managed care insurance companies, it is a public program with primarily public funds. You will want to ensure accountability and integrity of the expenditure of those funds, as I am sure you will do.

We recommend that serious consideration also be given to the consumer complaint and advocacy aspect of the HMO contracts to be negotiated. Because this will be a new program it will be one where many parents of the children covered may have little or no experience with HMO insurance. Thus there needs to be a built-in mechanism for an 800 telephone line as part of the HMO service, separate and apart from the other complaint

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or problem solving avenue, the state Insurance Department's Consumer Complaint Division.

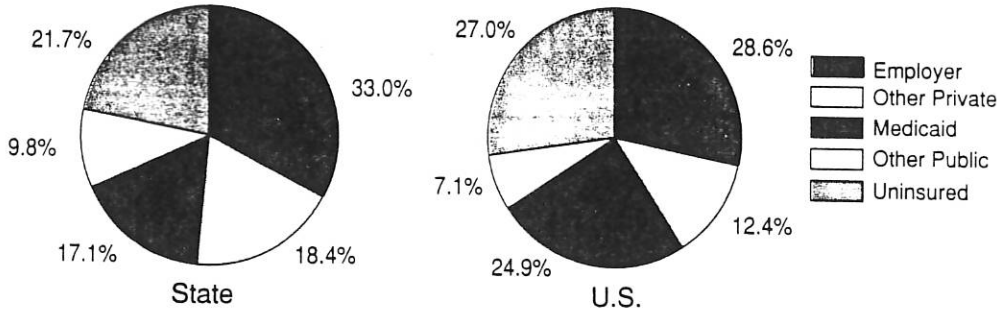
There are an estimated 6,000 uninsured children. This includes existing eligible Medicaids. Many are grandchildren living in grandparents homes. As we understand it, the upper limit with most states for coverage that can be financed with the new health block grant funds is 200 percent of the poverty level or $26,000 for a family of three. Most children would be covered because they are in income families very much below this cap. And we note that where children are provided low limited coverage in private plans, they are often not treated or preventively tested when they need to be. This then leads to poor health status and ulltimately, higher costs. These delays cost more in the long run, as studies have indicated. Medicaid 's comprehensive package may be the best answer to this problem, as you have decided.

We are attaching with our testimony a Kansas State Profile published by the Public Policy Institute, AARP, 601 E. St.,N.W.,Washington, D.C. 200498. This is one of the most recent Kansas health demographic reports published (1997). Chart Kansas/2 shows that 21.7% of all Kansas children are uninsured.

Our organization is respectful and appreciative of the Kansas Legislature's interest in medically insuring the uninsured Kansas kids. We thank your endeavors.

Health Care Coverage

Health Insurance Coverage for Children under Age 19 and Below 200 Percent of Poverty, 1995



	State	U.S.
Insurance Status:		
Uninsured full-time workers and dependents (%):		
1991	11.1	12.8
1995	11.1	14.3
Uninsured by race (%): White, 1995	10.8	11.5
Non-White, 1995	22.8	25.4

Health Insurance Coverage for Persons under Age 65, 1995

	Employer	Other Private	Medicaid	Other Public	Uninsured
State	63.9%	8.1%	7.4%	6.3%	14.2%
U.S.	63.7%	6.9%	10.1%	2.1%	17.3%

	State	U.S.
Medicaid:		
Medicaid beneficiaries (number in 1,000s), 1995	252	35,311
Non-elderly below poverty covered by Medicaid (as % of total non-elderly poor pop.), 1995	43.3	48.0
Children under age 11 without Medicaid (as % of eligible children), 1992-95 (4 yr. range)	25-50	32-39
Maximum income for Medicaid eligibility:		
AFDC criteria (as % of poverty level), 1996	40	N/A
Medically needy (as % of poverty level), 1996	44	N/A
SSI (as % of poverty level), 1997	73.6	N/A
Medicare and the Elderly:		
Medicare beneficiaries (number in 1,000s), 1997	386	38,115
Disabled Medicare beneficiaries (as % of Medicare enrollment), 1995	9.2	11.7
Medicare beneficiaries covered by Medicaid (as % of Medicare enrollment), 1993-94	7.8	12.5
Elderly with private health insurance (%), 1993-94	81.7	67.0

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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY

Senate Bill 424
Senate Committee Financial Institutions and Insurance
February 19, 1998

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee regarding Senate Bill 424.

For the past several weeks we have been listening to testimony regarding providing health care to Kansas children. It is the position of the Kansas Pharmacists Association that there are other issues which need to be addressed and that we want you to be aware of. Obviously, our concern is the providing of appropriate pharmaceutical care to these children. Those of you who were on the Task Force might recall some comments made by the Kansas Medical Society Executive Director, Jerry Slaughter. In his testimony, Jerry stated that if Kansas agrees to jump on the managed care band wagon, then the state must make the commitment, both financial and philosophical to providing managed care, that out-sourcing may make sense for some services, but not necessarily for all services and that private pay programs may not have the same commitment as the state may have in providing care.

It is the opinion of the Kansas Pharmacists Association that the drug benefit portion of the "Kansas insurance coverage for kids" be carved out and administered by SRS.

The pharmacy profession is somewhat unique among health care providers. The pricing of drugs is a very complicated process. Pharmacists have no control over the prices set by the drug companies nor do they have any control over the prescriptions written by physicians. They are the most accessible health care provider available to the public and have been voted the most trusted profession for 8 years in a row, above the clergy and physicians. Yet their skills and ability to provide huge cost savings to the overall health care market are underutilized.

As a rule, when a Managed Care Organization (MCO) provides a drug benefit, they subcontract with a Pharmacy Benefit Management Company (PBM). The sole purpose of the PBM is to provide the drug benefit for the lowest cost possible and, in our opinion, with very little regard for outcomes, access to drugs/providers or ease of participation by health care providers/patients. One method used by PBMs to control costs is a closed formulary or, what they now call a "preferred drug list." There are penalties for not using drugs on the list and they require time-consuming procedures on the part of busy pharmacists and physicians to obtain the prescribed drug for patients. A prime example is the PBM used by the Kansas Medical Society's Heartland Health, Managed Pharmacy Services (MPS), a PBM located in Missouri. We have received

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numerous complaints from our members regarding the difficulty they have in obtaining authorization to dispense the drug prescribed by the physician. In one such case, the patient went without their medication for three days. It took the pharmacist 12 phone calls to obtain the prescribed medication and then MPS "requested" the physician submit documentation regarding why he was prescribing that particular drug. It should be noted that this particular patient lived 60 miles round trip from their pharmacy which meant they ended up driving 120 miles to obtain their medication.

The State of Kansas utilizes Advanced Paradigm, a PBM out of Texas, for the state employee drug benefit plan. They too use a "preferred drug list". However, in addition to their formulary they have a "maximum allowable cost" (MAC) associated with most of the drugs listed on their formulary. MACd drug pricing is not unusual in drug programs. However, in this case, the MAC pricing is so low and on so many generics that pharmacies cannot purchase the drugs for what Advance Paradigm is reimbursing. This is forcing pharmacists and physicians to substitute other drugs which are not necessarily therapeutically equivalent--a dangerous practice. It should be noted that most PBMs take a dim view of DAW (dispense as written) prescriptions and in many cases, penalize pharmacists for dispensing DAW prescriptions. Drug delivery through PBMs is inhibiting physicians' and pharmacists' ability to properly manage patient care.

The Pharmacy profession was one of the first health care professions to be "managed". A decade ago MCOs began to cut reimbursement to pharmacists with the promise of increased volume to offset the loss of reimbursement. In response, the profession formed large volume purchasing organizations to make themselves more competitive. However, with reimbursement continually decreasing, pharmacists had no choice but to increase their volume--some would say to dangerously high levels which compromise patient care.

It should also be noted that the State of Kansas has very little oversight of PBMs. While they are required to register with the Insurance Department, few of them do and there are no penalties if they don't.

By managing the drug benefit portion of the "insurance coverage for kids" separately from the MCOs providing medical care, the state will be able to monitor and track the prescribing and dispensing of medication by providers participating in the various plans. This will provide invaluable data and oversight of the program.

With the number of potent drugs now available, and many more in the pipe line, today's health care system demands that patients comply with complicated drug therapy instructions. However, PBMs and some managed care organizations fail to provide the support and monitoring necessary to help them get well and avoid adverse drug reactions.

For these reasons, we believe the drug benefit portion of the "insurance coverage for kids" be carved out and administered by SRS. Thank you.

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