Approved: <u>February 3, 2004</u>
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairperson Patricia Barbieri-Lightner at 3:30 p.m. on January 29, 2004 in Room 527-S of the Capitol.

All members were present except:
Representative Broderick Henderson- excused
Representative Eber Phelps- excused
Representative Ray Cox- excused

Committee staff present:
Bill Wolff Legislative Research Department
Ken Wilke, Revisor of Statutes
Renae Hansen, Secretary

Conferees appearing before the committee:
Bill Wolff-Legislative Research

Others attending:
See Attached List.

Presentation by:
Dr. Bill Wolff, Kansas Legislative Research, Report of the Health Insurance Issues Working Group to the 2004 Kansas Legislature. (<u>Attachment #1</u>)

The Committee met only 5 days, but accomplished a tremendous amount during that time. They developed comprehensive study of health insurance affordability and availability to Kansas Citizens. Topics covered in this report are as follows: Health Reimbursement Accounts (HRAs), Association Health Plans, Business Health Partnership, Medicaid, Community Health Centers, Consumer Education (with emphasis on tobacco use, and obesity), and Value-Based Purchasing/Leveraging Market Forces in Purchasing Health Care. Dr. Wolff detailed each of these in his report.

Questions and/or comments were made by Representatives Huff, Kauffman, and Dillmore.

Representatives Dillmore and Huff introduced their interns to the committee.

Discussion on: **<u>HB2549.</u>**

<u>HB2549:</u> **<u>Health insurance; HIPAA technical changes.</u>**

<u>It was moved by Representative Stephanie Sharp to pass **HB 2549** to the house consent calendar, seconded by Representative Stanley Dreyer, passed unanimously.</u>

Discusson on: **<u>HR5027.</u>**

<u>HR 5027:</u> **<u>Concurrent Resolution urging the Insurance Department and Insurance Commissioner to pursue creation of interstate compact.</u>**

<u>It was moved by Representative Scott Schwab to pass **HR 5027** favorably, seconded by Representative Cindy Neighbor, passed unanimously.</u>

Meeting adjourned.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: January 29, 2004

NAME	REPRESENTING
Natalie Haag	Security Benefit
[illegible]	KID
Brad Smoot	BCBS / AIA
Bill Curtis	Ks Assoc of School Bds
Larrie Ann Lower	KAHP

Report of the Health Insurance Issues Working Group to the 2004 Kansas Legislature

CHAIRPERSON: Senator James Barnett

RANKING MINORITY MEMBER: Senator Janis Lee

OTHER MEMBERS: Senator Ruth Teichman; Representatives Rob Boyer, Nancy Kirk, and Jim Morrison

NON-LEGISLATIVE MEMBERS: Robert Day, Linda DeCoursey, Sandy Praeger, and Robert St. Peter

STUDY TOPIC

A Comprehensive Study of Health Insurance Affordability and Availability to the Citizens of Kansas

December 2003

House Insurance
Date: 1/29/04
Attachment # 1

Health Insurance Issues Working Group

A Comprehensive Study of Health Insurance Affordability and Availability to the Citizens of Kansas

Conclusions and Recommendations

- Regarding HRAs, since no statutory changes are required for the marketing and sale of the product, the Working Group has no recommendation for legislative action. However, the Group recommends that the Department of Administration, the State Employee Health Care Commission, and the Kansas Public Employees Retirement System explore further the many features of HRAs, both for health insurance purposes as well as for retirement benefits for state employees.
- Concerning the purchase of insurance by small employers, the Working Group encourages the Business Health Partnership to continue exploring ways to structure policies and benefits in order to make health care coverage available to their employees.
- The Working Group recommends that no further action be taken on Association Health Plan legislation, unless it can be demonstrated by proponents that such plans would have no negative impact on the existing small group marketplace.
- On the issues of smoking and obesity, the Working Group recommends that the interested parties continue their collaborative efforts on the development of statewide programs that will have positive impacts on the two health issues. Especially, the Working Group commends the Department of Health and Environment for its work in the area of chronic diseases and the Kansas Sunflower Foundation for its investment in programs and studies aimed at addressing the health concerns associated with both smoking and obesity. The Legislature should be informed of the results of the collaborations and the findings of studies and programs conducted by both the private and public sectors. Particularly, the Group recommends that the interested parties explore methods for financing programs, including the possibility of raising the necessary program funds through the issuance of bonds that would be redeemed at those time intervals when the greatest return on the original investments is received.
- Community health care centers can make health care both available and affordable for many Kansans. The Working Group recommends that the Department of Health and Environment, the Kansas Association for the Medically Underserved, the Sunflower Foundation, the United Methodist Ministries, and the Kansas Health Institute continue to explore ways of assisting local communities in becoming eligible for consideration for federal funding for additional centers. The Working Group encourages the stakeholders to participate in the informational and training meetings that are planned for early in 2004 and work toward a plan that can be brought to the Legislature for consideration in the 2004 Session.
- Long-term care insurance has some potential for reducing the state's Medicaid expenditures for nursing home care, albeit over an extended period of time. To remove any impediments to the purchase of such insurance, and to remove confusion that might exist in the marketplace, the Working Group recommends that the Insurance Commissioner modify existing rules and regulations to require that potential purchasers of the insurance be provided a Kansas specific shoppers guide.

  Further, the Group recommends that the Department of Social and Rehabilitation Services and the Legislature review existing Medicaid program laws to assure that the law serves to encourage Kansans to purchase long-term care insurance rather than serving to encourage

reliance upon the state for the future payment of long-term care. Additionally, the Group recommends that the tax committees of the Legislature explore tax incentives that would include a deduction for premium payments made for long-term care insurance, as well as other tax incentives that might be offered to encourage the purchase of long-term care insurance.

- Educating consumers about health care costs and their role in generating those costs need to be continued. Health insurers, health plans and governmental agencies are encouraged to continue their efforts with their subscribers and clients and with the public at large in informing consumers of the cost of health care and of the most appropriate usage of that care.
- The Health Insurance Issues Working Group recognizes the critical role health data play in making public policy, and realizes that Kansas policymakers are at a significant disadvantage because of the lack of usable data and personnel to process existing data into useful information. The Group recommends that the Kansas Data Governing Board review its role in order to be more current and more proactive in assisting policymakers in the health care arena. That review should include an assessment of the current laws that create the Board, establish the method of data collection, and provide the funding for the Board's collection activities. The goal of the review should be to identify the types of data to be collected and the barriers to the collection of that data and its conversion to useful information, The Department should report the results of its review along with its recommendations for change, including a fiscal note identifying the cost of the proposed changes.
- The Working Group requests that the Director of the Governor's Office of Health Planning and Financing keep the Legislature informed of that office's activities through reports to the appropriate standing committees during the 2004 Session. Included in that report should be an update on the implementation of the Maine program.
- In the course of its studies, the Working Group was reminded of legislation enacted some time ago that would assist in providing health care coverage for children of state employees who met all the qualifications for coverage under the HealthWave program, but were excluded solely because of state employment. The Working Group reviewed the report on that legislation required by the law and recommends that it be shared with the appropriate standing committees during the 2004 Session.
- The Working Group was informed that Kansas' ranking among the states for immunization of children has slipped considerably. One reason for that slippage, perhaps, is the manner in which many Kansas children receive those immunization. Since many immunizations are provided through local health departments, there is a greater likelihood that they are not reported. The Working Group recommends that the Department of Health and Environment and local health departments review where immunizations are provided and how those can be included in the count of Kansas children who have received age appropriate immunizations. Upon the completion of the agency review, a report should be made to the appropriate standing committees of the Legislature during the 2004 Session.

  Finally, the Working Group learned at its last meeting that the federal government has enhanced enforcement of the immunization programs it funds. As a consequence, there may fewer federal dollars available for immunizations that are generally provided through local health departments. The Group anticipates that the Department of Health and Environment will keep the appropriate committees of the Legislature apprised of the consequences of the federal action.

Proposed Legislation: None

BACKGROUND

The focus of the Health Insurance Issues Working Group was to do a comprehensive study of health insurance affordability and availability to the citizens of Kansas. The study included, but was not limited to:

- Consideration of Health Reimbursement Accounts (HRAs) for Kansas citizens, including state employees;
- Review of a possible state Medicaid waiver for low wage employees wherein the employer would pay the state match;
- Consumer education—Statewide educational program to address healthcare expenditures;
- Value-based purchasing—Directing dollars for optimum outcomes for disease or illness and quality of care;
- Long-term care insurance tax incentives—Study what kind of tax incentives might further enhance the sale of long-term care insurance; and
- Investigate the state's ability to leverage market forces in purchasing health care insurance, including consideration of changing the membership structure.

The Working Group was composed of three members from each house of the Legislature, the Insurance Commissioner, the President of the Kansas Health Institute, the State Health Benefits Administrator, and the Director of the State Medicaid Program.

COMMITTEE ACTIVITY

At the outset of its deliberations, the Working Group recognized that the underlying issue affecting the affordability and availability of health insurance was the cost of health care, which includes both the unit cost and utilization. Consequently, the Working Group decided to focus primarily on those issues that might more directly impact the cost of care and, thereby indirectly affect the insurance issues. However, the Working Group did review each of the insurance topics assigned, noting that health plans that emphasize consumer awareness and participation can impact the cost of those plans to employers, employees, and the state.

Health Reimbursement Accounts (HRAs)

HRAs refer to defined contribution health plans in which the employer contributes an amount of money for the health care costs of its employees and usually includes a high deductible health plan purchased at a lower premium rate. Recent decisions of the Internal Revenue Service allow both the contributions paid by the employer and the benefits received by the participant to be excluded from the taxpayer's gross income. Also, unused dollars allocated to employees can be rolled over from year-to-year. An added benefit is that the use of monies available is placed in the hands of the employee who is exposed to the high cost of health care and, therefore, encouraged to be a wiser consumer of that care.

Additionally, HRAs may have a component part that allows employees to convert unused sick and vacation leave upon retirement into a HRA for the purpose of paying health care costs into retirement. The Working Group was advised that such a use of HRAs has been marketed in several public employee settings and that a Kansas company, Security Benefit Group, has developed plans for this market. Apparently, no contact has as yet been made between the Department of Administration responsible for employee benefit options and the insurance industry on this type of coverage. The Working Group realizes that no legislation is necessary for the marketing and sale of HRAs in the Kansas marketplace.

Association Health Plans

In the 2003 Session of the Legislature, the Senate Committee on Financial Institutions and Insurance was asked to consider legislation to allow the Kansas Grain and Feed Association to form an association health plan (AHPs) for its members. Current Kansas law prohibits such plans. Proponents of the plan indicated it was difficult to obtain affordable coverage for small businesses. Amending Kansas law to allow AHPs, they argued, would allow the membership to retain savings in their plan rather than to have to share those dollars with other small employer groups that have not had the same good use experience as the Association. Further, authorizing self-funded AHPs would allow Associations to take advantage of their individual unique characteristics in the development of coverages for their members.

At the federal level, the National Federation of Independent Business has lobbied for a national exemption from insurance regulation for association health plans. That legislation has been heard in committee, but no action has been taken to move the legislation to passage. Locally, the NFIB representative spoke in favor of the Kansas bill to allow such self-funded plans to develop in Kansas.

The insurance industry, represented by Blue Cross and Blue Shield of Kansas, pointed out that the net effect of AHP legislation is to deregulate the insurance marketplace for associations. Insurers subject to all the state laws regulating the sale of insurance would be at a distinct disadvantage in the marketing of their products.

Finally, the Insurance Commissioner spoke strongly against the authorization of AHPs, not just in Kansas, but as the spokesperson for the National Association of Insurance Commissioners. She indicated that further segmenting the market undermines state reforms, especially for small groups, as well as the reforms put in place by the Health Insurance Portability and Accountability Act. As a regulator, she concluded, concern must be given to protecting consumers. Pooling, whether through associations or otherwise, may no longer be the best way to deal with health insurance availability or affordability issues. Any legislation to increase affordability and the number of choices must meet these criteria, she said: higher risk employee must not be forced out of the market; consumers must be protected from plan failures and fraud; and patient rights must be preserved.

Business Health Partnership

The Business Health Partnership was created by the Legislature to assist low wage employees of small employers in the purchase of health insurance. Central to the idea was the availability of money to subsidize the cost of that insurance. Since the creation of the Partnership, however, no funds have been available for subsidizing such plans. Nevertheless, the Partnership has continued to work with employers and insurers to develop plans that make health insurance available and affordable to both employers and employees. To date, plans are being marketed, without subsidy, to small employers. The current plan available provides multiple benefits, a fixed deductible, varying copayments, calendar year maximum benefit caps, and maximum lifetime benefits. Other plans are in the developmental stage that would provide only basic physician services coverage exclusive of major medical expenses. Discussions also have been held with interested insurers regarding plans that might be constructed with none or a limited number of the benefits mandated under current Kansas law.

Medicaid

Waiver. During the last days of the 2003 Legislative Session, an informal group working on health issues learned of an

Arkansas proposal to use employer dollars as the state match for Medicaid and thereby make employees of small employers eligible for coverage under the state Medicaid program. By the time the Working Group began to meet, it was known that the federal Department of Health and Human Services had rejected the Arkansas proposal. Based on that information, the Working Group chose not to pursue the issue further at this time.

On a related matter, the Group learned of recent legislation enacted in Maine, that has a similar funding mechanism to the Arkansas plan. The plan, referred to as Dirigo, is now in the implementation phase and has not yet received federal approval.

Long-Term Care Insurance. One issue before the Working Group was whether offering tax incentives for the purchase of long-term care insurance will have a favorable financial impact on the state, *i.e.*, reduce the number of persons who become clients of the state Medicaid Program. Some highly speculative calculations were provided based on the usage rate of state employees and data used by the Department of Revenue in drafting fiscal notes on bills proposing tax deductions for premiums paid for such insurance. The data indicate that, after a lengthy period of time, that is from the date of purchase to the date of use, the state might save approximately $9.3 million in the Medicaid Program for nursing home care, and $1.5 million in the Home and Community Based Services/Frail Elderly (HCBS/FE) waiver program.

The Working Group asked staff to continue exploring options that might minimize the loss to the state on the tax incentive side and maximize Medicaid and HCBS/FE waiver savings.

A second issue reviewed was the idea of the Silver-Haired Legislature to create a consumer guide patterned after the Insurance Department's Kansas Medicare Supplement Insurance Shopper's Guide. The Working Group recognized that the federal government has standardized the policy provisions for "Medigap" insurance and that no such standardization exist for long-term care insurance. While attempting some standardization in one state might drive insurers out of the Kansas market, the confusion over long-term care insurance benefits still must be addressed.

Having reviewed the issues associated with health insurance and insurers, the Working Group concentrated the remainder of its time on ways to provide care to those who are uninsured and on those issues that might impact health care costs directly.

Community Health Centers

A September 2003 survey of Kansans sponsored by the Kansas Health Institute found that 40 percent of people without insurance did not get the care they needed within the last year compared with nine percent for those with insurance. Additionally, 45 percent of the uninsured reported difficulty in paying their medical bills compared with 14 percent of those with insurance. These data translate into over 100,000 Kansans who either do not receive care or have difficulty paying for the care received. And, the statistics highlight the importance of insurance and illustrate the overall high cost of medical care and the difficulties Kansans experience in accessing that care.

Representatives of the Kansas Association for the Medically Underserved commented that Kansas has a weak safety net. The uninsured in Kansas tend to be chronically uninsured and are less likely to have a usual source of health care. Some of the health centers that make up the safety net receive neither state nor federal funding. Existing federally qualified health centers serve 36 communities in only 23 counties, barely one quarter of the state. These clinics serve only one in four of the uninsured. Three out of four of the uninsured cannot access any type of clinic because it is either not geographically available or the clinic in their

area is at capacity.

Staff of the Department of Health and Environment identified for the Group the various types of entities in Kansas communities that provide health care for persons who reside in underserved areas and who are uninsured or vulnerable. The federal Consolidated Health Center Program includes Community Health Centers (CHCs), Migrant Health Centers, Health Care for the Homeless, Public Housing Primary Care, and School Based Health Centers. Additionally, there are state-funded primary care clinics created to supplement local community initiatives to establish and operate clinics or health centers for low-income, uninsured, and underserved Kansans.

While pleased to hear of the state and federal programs currently providing funding for services, the Working Group was somewhat frustrated in the efforts to expand services to address the large unmet need for care. Particular attention was called to the federal Community Health Center Program. Kansas currently participates in that program with eight CHCs in operation and receiving $5 million in federal grants to support provision of health care in 21 locations. Knowing that federal funds in the amount of $1.6 billion were available nationwide, and recognizing a substantial unmet need for health care, the Working Group was interested in learning how the program could be expanded.

KDHE officials assured the Working Group that it shared the frustration related to expansion activities; however, they said every effort was being made to find ways to bring a larger share of the dollars available to Kansas. The Department, and its private sector partner, the Kansas Association for the Medically Underserved, are working to identify underserved areas, unmet medical needs, and community organizations that might be in a position to obtain funding for new CHCs. Much of what needs to be done rests with local communities and their willingness to do the things necessary to satisfy the requirements for participation in the program. Not every community is comfortable with all of the conditions and requirements. Nevertheless, all the interested parties, the state, the Kansas Association for the Medically Underserved, and the United Methodist Health Ministry Fund pledged their resources and energies toward supporting efforts to expand CHCs in Kansas.

Consumer Education

A briefing paper prepared by the Kansas Health Institute revealed there are three major areas in which consumer education can assist in reducing health care costs: appropriate use of the health care system, financially wise decisions regarding use of services, and lifestyle choices that promote health and prevent disease. To explore these areas, the Working Group called on representatives of several insurance, education, and governmental entities in order to identify what each might be doing to educate consumers of health care as to their role in controlling health care costs.

Representatives speaking for the State Employees Health Care Commission noted that the state plan encompasses the largest group in Kansas covering 95,000 lives by the end of FY 2004. The Commission defines and tracks quality measures related to the performance of providers and health plans that are a party to the state plan. The plan is revisited every three years and new methods of assuring patient safety and continued quality and cost effectiveness are incorporated. Further, the Commission provides employees annually and during the open enrollment period information on fitness campaigns, special training, *e.g.*, smoking cessation, health risk appraisals, and disease management programs. Finally, the Commission has taken actions to structure the plan to include more co-insurance rather than co-payments in an effort to inform the employee of the true cost of care. The point of all this is to help plan

participants become better consumers of health care by encouraging them to engage their health care providers in conversations about quality and cost.

Spokespersons for Blue Cross and Blue Shield of Kansas indicated the company provides education at two levels: for providers who are part of the Blue Cross network of providers and for subscribers of Blue Cross plans. On the first point, for example, provider profiles are developed to ensure accurate payment of claims, but also to enable practices to review patterns which can be compared to peer groups and thereby provide an opportunity to compare the relative efficiency of the provider's practice as well as discrepancies in practice from their peer group. Recent efforts also have been made to provide information regarding pharmacy utilization and demand for brand name drugs.

If providers are the educators of consumers of health care, the Working Group was interested in determining what, if any, education and training providers received to make them aware of the costs of their services. The Vice Dean and Senior Associate Dean for Educational and Academic Affairs of the Kansas University School of Medicine, noted that the School is in the early stages of a comprehensive review and revision of its undergraduate medical education curriculum. Students become familiar with the socioeconomic impact of the health care system. Their experiences include discussions of the direct costs of care as well as of the indirect cost of restricted access to care. At the graduate level, the core curriculum is being expanded to include teaching sessions and discussions focusing on the economic, social, and legal considerations arising in medical practice. Today, all physicians upon completion of training, must be able to assess the quality, efficiency, and cost effectiveness of the care they provide.

The Chairperson of the Department of Health Policy and Management, Kansas University School of Medicine, informed the Working Group that since this Department has been relocated to the medical center, the faculty is redesigning its curriculum centering it on a broad model of health and health care. For example, a course on the social basis of medical practice will include topics such as reimbursement, patient safety and systems thinking, and health policy. In a more informal way, the faculty is working with medical students to provide information about and an awareness of the health care system and their future role in it.

A private physician speaking on behalf of the Kansas Medical Society discussed the disconnect between perception and reality – what the patient expects and what the patient needs. He commented that, from his training, most diagnosis could be made from the patient's history and that tests were used to confirm the examination findings. Now, he said, tests are used to make the diagnosis and to make the patients feel that progress is being made in their care and treatment. Patients tend to feel as if nothing is being done if tests are not run, leading to increased health care costs.

A physician speaking for the Kansas Association of Osteopathic Physicians commented on the "use it or loose it" attitude of some. Since patients receive care through an employer policy or government program, they want to utilize it to its full potential, regardless of cost considerations. She noted that patients who do not adopt healthy lifestyles or are noncompliant with medical advice, typically are not concerned about utilizing the health care system in a cost effective manner. The most difficult question for policymakers, she suggested, is whether health care is a right or a privilege.

The representative of the Kansas Pharmacists Association explained that pharmacists spend a great deal of time explaining drug plans to patients, in addition to educating them about their prescriptions. He briefed the members on collaborative drug therapy management, which enables pharmacists and physicians to jointly manage a patient's drug therapy. Kansas

allows such interaction albeit as a delegation from the physician to the pharmacist. That type of drug management is routine practice in hospitals.

The Kansas State Nurses Association executive director emphasized that patient education is a major function of nursing. Nurses work with physicians and pharmacists regarding medicines and treatment plans while encouraging patient compliance with provider directives. Since chronic care patients tend to communicate more often with nurses, nurses are in an especially advantageous position to implement educational and motivational practices to promote compliance. She noted that numerous patient and consumer pamphlets are available through the Association to educate the public.

The Insurance Commissioner reported that the Insurance Department employees 23 persons who are the heart of the consumer education program of the Department. The staff of the Consumer Assistance Division works on a case-by-case basis with Kansans who have questions, concerns, or complaints regarding their insurance coverages. Further, the Department publishes several shoppers guides which offer consumers the basic information they need to choose health insurance coverage, whether in group plans or individual insurance products. Finally, the Commissioner noted that the Department shortly would be unveiling a new *Take Control* campaign for health care and health insurance costs. The campaign will be directed at everyone who uses health care services and will provide information explaining why costs are increasing and how each person can help to take control of those costs.

The Secretary of the Department of Health and Environment (KDHE) and his program staff explained what the Department was doing to educate consumers regarding its role in generating and controlling health care costs. Health promotion programs at KDHE are primarily targeted at the leading causes of chronic disease and injury. Chronic diseases account for approximately 75 percent of health care costs each year. Further, 33 percent of all deaths are attributable to three modifiable behaviors – tobacco use, lack of physical activity, and poor eating habits. However, he noted that a majority of funding goes to intervention and service and much less on prevention. Financial resources available are used to mobilize communities to promote healthy behaviors.

From that discussion, the Working Group focused more narrowly on those programs aimed at smoking cessation and obesity.

The Cost of Tobacco Use. Data presented by the Department of Health and Environment indicate that the direct medical costs of tobacco are staggering. Smoking is the largest cause of preventable death and disease in Kansas causing an estimate 3,800 deaths from disease, including cancer, stroke, and chronic obstructive pulmonary disease.

Several states have implemented comprehensive tobacco use prevention programs, including Florida, Massachusetts, and California, states that have demonstrated significant reduction in tobacco use. Department staff pointed out that Kansas, too, could quickly reduce smoking by making relatively modest investments in new statewide efforts to prevent and reduce tobacco use. As a result of such an investment, Kansas could see a reduction in smoking-caused health costs saving millions of dollars.

If the Legislature were to invest the minimum annual tobacco control expenditure recommended by the United States Center for Disease Control, $18.1 million annually for five years, the following results could be expected. About 98,700 adults would quit smoking; 35,600 young people would be prevented from addicted use; and 33,100 early smoking deaths would be prevented. Direct health care lifetime savings would be $1.241 billion and total future Medicaid savings would be $141.5 million. Less than the minimum expenditure

would generate results less than projected as outcomes are not directly proportional to the expenditures.

Obesity. In the last decade, there has been a steady increase in the prevalence of obesity up from 13 percent in 1992 to 23 percent in 2002. More than 40 percent of adults in the age group 45-64 years, and in the age group 65 plus, are overweight.

The issue is not isolated to Kansas; rather obesity and overweight are chronic health conditions nationwide. In that regard, the costs of obesity also are staggering. In 2000, the total cost of obesity in the United States was estimated at $117 billion. Included in that estimate was $14 billion in Medicaid expenditures and $23.5 billion in Medicare expenditures.

In addition to information from the Department of Health and Environment on this issue, the Committee received significant testimony from the Kansas Public Health Association, the American Cancer Society, and the Kansas Sunflower Foundation. Representatives of the Foundation described its strategic approach to obesity prevention through collaboration with other stakeholders. Most importantly, they identified several grants that have been made to entities interested in addressing the health implications associated with obesity. One grant was of particular interest as it funds a project at a school district that is working to restructure the school day to increase the level of physical activity.

In addition to making grants, the Foundation is serving as a convener of interested parties to develop a state plan for obesity prevention to address the growing burden of health disease related to obesity and being overweight. The planning process will draw on the expertise of a broad range of stakeholders with the resulting plan being offered to policy makers at all levels. The effort is envisioned to take 12 to 18 months.

Health Care Data. From the outset of the Working Group's hearings and deliberations, it became clear that very little data pertinent to Kansas is available. Absent that data, policymakers, including the Legislature, have interpreted data and based decisions on information gathered by other states and the federal government.

The Kansas Data Governing Board collects and manages health care data currently being collected. Representatives of the Department noted that the Board was formed at a time much different from now and when decision-making also was different. They believed it was time that the Board review its role in order to be more current and more proactive and able to assist policymakers to make better decisions. Since the Board is a creature of state statute, the Legislature also may need to ensure that the law is broad enough to collect and analyze the data received. The Director of the newly created Governor's Office of Health Planning and Finance concurred in the need for data that can be transformed into useful information; however, the Department probably lacks sufficient resources to obtain the appropriate technology for effective data collection.

Asked what he would least like to do in the 2004 Legislative Session, ask for funding for prevention programs, *i.e.*, smoking and obesity, or for data collection, the Secretary of Health and Environment replied that his concern is that the Department not have to grovel for resources because the Legislature would be aware of all of those needs.

Value-Based Purchasing/ Leveraging Market Forces in Purchasing Health Care

The issues of value-based purchasing and leveraging market forces in purchasing health care were the last topics considered by the Working Group. While the discussion time was short, the Group became aware early in the interim of the major issue implicit in the topics—quality care. The issue of the quality of care being purchased ran through nearly all of the topics

considered by the Group in that poor quality costs a lot of money, whether that care is paid for by private insurance, out of pocket resources, or state and federal programs. Clearly, the cost of care and the quality of the care purchased are linked and any policy initiative focused on cost also must look at quality. From the perspective of the state, the question of quality has great relevance as the state purchases about $2 billion in health care every year.

Indicators of poor quality include medical errors, inconsistent treatment practices or low utilization of recommended guidelines, and under use of medications. Since quality outcomes are not consistently emphasized in health care purchasing, purchasers of health care will need to change how they do business, *i.e.*, not just look at cost, but at performance as well. Insurers and federal health care programs are beginning to look at ways to reimburse providers based on the quality of care they provide under a "Pay for Performance" model.

In part, success in this area will depend on good data as discussed earlier. Consumers must have good information about the products and services they purchase in order to make informed decisions. The Working Group was told that the Governor's Office of Planning and Finance has a goal to work with providers and stakeholders in developing quality measures that can be used in guiding the state's purchase of health care for its employees and for Medicaid clients.

Conclusions and Recommendations

The Working Group was pleased to be informed of the current activities in the insurance marketplace.

- Regarding HRAs, since no statutory changes are required for the marketing and sale of the product, the Working Group has no recommendation for legislative action. However, the Group recommends that the Department of Administration, the State Employee Health Care Commission, and the Kansas Public Employees Retirement System explore further the many features of HRAs, both for health insurance purposes as well as for retirement benefits for state employees.

- Concerning the purchase of insurance by small employers, the Working Group encourages the Business Health Partnership to continue exploring ways to structure policies and benefits in order to make health care coverage available to their employees.

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- Community health care centers can make health care both available and affordable for many Kansans. The Working Group recommends that the Department of Health and Environment, the Kansas Association for the Medically Underserved, the Sunflower Foundation, the United Methodist Ministries, and the Kansas Health Institute continue to explore ways of assisting local communities in becoming eligible for consideration for federal funding for additional centers. The Working Group encourages the stakeholders to participate in the informational and training meetings that are planned for early in 2004 and work toward a plan that can be brought to the Legislature for consideration in the 2004 Session.

- Long-term care insurance has some potential for reducing the state's Medicaid expenditures for nursing home care, albeit over an extended period of time. To remove any impediments to the purchase of such insurance, and to remove confusion that might exist in the marketplace, the Working Group recommends that the Insurance Commissioner modify existing rules and regulations to require that potential purchasers of the insurance be provided a Kansas specific shoppers guide.

Further, the Group recommends that the Department of Social and Rehabilitation Services and the Legislature review existing Medicaid program laws to assure that the law serves to encourage Kansans to purchase long-term care insurance rather than serving to encourage reliance upon the state for the future payment of long-term care. Additionally, the Group recommends that the tax committees of the Legislature explore tax incentives that would include a deduction for premium payments made for long-term care insurance, as well as other tax incentives that might be offered to encourage the purchase of long-term care insurance.

- Educating consumers about health care costs and their role in generating those costs need to be continued. Health insurers, health plans and governmental agencies are encouraged to continue their efforts with their subscribers and clients and with the public at large in informing consumers of the cost of health care and of the most appropriate usage of that care.

- The Health Insurance Issues Working Group recognizes the critical role health data play in making public policy, and realizes that Kansas policymakers are at a significant disadvantage because of the lack of usable data and personnel to process existing data into useful information. The Group recommends that the Kansas Data Governing Board review its role in order to be more current and more proactive in assisting policymakers in the health care arena. That review should include an assessment of the current laws that create the Board, establish the method of data collection, and provide the funding for the Board's collection activities. The goal of the review should be to identify the types of data to be collected and the barriers to the collection of that data and its conversion to useful information. The Department should report the results of its review along with its recommendations for change, including a fiscal note identifying the cost of the proposed changes.

- The Working Group requests that the Director of the Governor's Office of Health Planning and Financing keep the Legislature informed of that office's activities through reports to the appropriate standing committees during the 2004 Session. Included in that report should be an update on the implementation of the Maine program.

- In the course of its studies, the Working Group was reminded of legislation enacted some time ago that would assist in providing health care coverage for children of state employees who met all the qualifications for coverage under the

HealthWave program, but were excluded solely because of state employment. The Working Group reviewed the report on that legislation required by the law and recommends that it be shared with the appropriate standing committees during the 2004 Session.

- The Working Group was informed that Kansas' ranking among the states for immunization of children has slipped considerably. One reason for that slippage, perhaps, is the manner in which many Kansas children receive those immunization. Since many immunizations are provided through local health departments, there is a greater likelihood that they are not reported. The Working Group recommends that the Department of Health and Environment and local health departments review where immunizations are provided and how those can be included in the count of Kansas children who have received age appropriate immunizations. The review should include changes in federal law that appear to make could include revisiting the idea of a mandatory state register. Upon the completion of the agency review, a report should be made to the appropriate standing committees of the Legislature during the 2004 Session.

Finally, the Working Group learned at its last meeting that the federal government has enhanced enforcement of the immunization programs it funds. As a consequence, there may fewer federal dollars available for immunizations that are generally provided through local health departments. The Group anticipates that the Department of Health and Environment will keep the appropriate committees of the Legislature apprised of the consequences of the federal action.