Approved: March 23, 2004
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairperson Patricia Barbieri-Lightner at 3:30 p.m. on March 9, 2004 in Room 527-S of the Capitol.

All members were present except:
Representative Eber Phelps- excused

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

Conferees appearing before the committee:
Senator Stan Clark, Presidents Task Force on Medicaid Reform
Jarrod Forbes, Kansas Insurance Department
Bill Sneed, Health Insurance Association of America
Beverly Gossage, Olympic Financial Marketing

Others attending:
Twenty One including but not limited to the attached list.

Presentation on:
President's Task Force on Medicaid Reform

Senator Stan Clark, Presidents Task Force on Medicaid Reform, (Attachment #1), spoke on many health care issues that are currently problems tasked to the Presidents Task Force on Medicaid Reform. If the current rate of increase of medicaid expenses continues and the current 5% per year increase in revenue received continues, by the year 2020 medicaid will consume the budget of Kansas and of all state budgets across the nation. Several options that were discussed at the Task Force forum were relayed back to the committee.

Questions were posed by: Representatives Jan Scoggins-Waite, Nancy Kirk, and Mario Goico.

Hearing on:
SB 348: Insurance: Conformance with federal law regarding health savings accounts.

Jarrod Forbes, Kansas Insurance Department, (Attachment #2), highlighted **SB348.** This bill needs to be passed out for health savings plans to be offered in Kansas. These plans need to have a high deductible in order to receive their federally qualified designation.

Questions were posed by: Representatives Stephanie Sharp, Nancy Kirk, Jan Scoggins-Waite, and Mario Goico.

Bill Sneed, Health Insurance Association of America, (Attachment #3), rose in support of **SB 348** but requested that the effective date be changed to date of publication, and provide that the provisions would attach regardless of the policy affective date. So that if a policy was eligible for conversion, for example January 15, that it would allow the individuals to go back to its January 15 conversion date as its affective date as it relates to the conversion from the medical savings to the health plan. This might not affect more than a couple of hundred Kansans, but it would be of benefit to them to allow them to take full advantage of the federal law.

Questions were posed by: Representatives Nancy Kirk, Mary Kauffman, Jan Scoggins-Waite, and Scott Schwab.

Some of the questions received response from staff member Bill Wolff, research.

MINUTES OF THE HOUSE INSURANCE COMMITTEE at 3:30 p.m. on March 9, 2004 in Room 527-S of the Capitol.

Beverly Gossage, Olympic Financial Marketing, (Attachment #4), spoke on her personal experience with writing health benefit savings plans and the savings that are allowed for small businesses and personal individuals carrying their own health insurance.

Questions were posed by: Representatives David Huff, and Jan Scoggins-Waite.

Chuck Stones, Senior Vice President, The Kansas Bankers Association, (Attachment #5), presented written testimony.

Hearing Closed.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: ~~February 5~~ MARCH 9, 2004

NAME	REPRESENTING
Bill Sneed	AAHP-HIAA
~~Diana Vaughn~~	SRS
~~Laurel Lobb~~	KID
Larrie Ann Lower	~~KAHP~~
Natalie Haag	Security Benefit

40TH DISTRICT

KANSAS SENATE

Stan Clark

COMMITTEE ASSIGNMENTS
CHAIR: UTILITIES
MEMBER: ASSESSMENT & TAXATION
ELECTIONS & LOCAL GOVERNMENT
ORGANIZATIONS, CALENDAR, & RULES
RULES & REGULATIONS

Testimony before the House Insurance Committee
President's Task Force on Medicaid Reform
SB 348
March 9, 2004

Madam Chairman and members of the committee:

(***attachment 1***) Take two snapshots, one represents FY2000 state General Fund expenditures and the second represents FY 2004 SGF expenditures. The chart before you represents the changing priorities of the Legislature between those two snapshots. Postsecondary education received 5.7% more funding; K-12 education received 4.9% more; corrections and prisons received 6.0% more; social services received 30.0% more and every other agency or program received an average 22% state general fund budget cut.

(***attachment 2***) How have the State General Fund receipts changed over the same period of time? Working with the bottom row of numbers you can see total tax receipts increased from $4.1 billion to $4,366 billion for an increase of $268 million or 6.5% increase. Where did those increases come from? The numbers above that row identify their source. The frightening number is the top row, individual income tax receipts have not changed; sales tax receipts are 13.5% higher which reflects the change in the sales tax rate which changed from 4.9% to 5.3%; cigarette tax receipts are higher which represents the change from taxes of 20 cents per pack to 70 cents per pack.

(***attachment 3***) On the first attachment we noted that social services expenditures increased 30%. Where was this money spent? The chart on attachment 3 itemizes the major categories with medical services accounting for probably 85% of the increase. You will notice the increases in foster care/adoption and HCBS waivers and a slight decrease partially attributed to the closure of many offices in rural Kansas. 16 of the 18 offices in my legislative district are scheduled to be closed by the end of this year.

205 U.S. 83
OAKLEY, KANSAS 67748
785-672-4280
FAX 801-457-9064
E-Mail sclark@ink.org

House Insurance
Date: 3/9/04
Attachment # 1

STATE CAPITOL
OFFICE-449 NORTH
TOPEKA, KANSAS 66612-1504
785-296-7399
1-800-432-3924

(***attachment 4***) The chart on attachment 4 further illustrates my point. About a third of the way down that page I have placed an "x". Medical Assistance- Consumers. Note that in 1998 240,000 Kansans received medical assistance at a cost of about $936 million.

(***attachment 5***) On the chart on attachment 5, about 1/4th of the way down the page, I have placed a corresponding "x". In 2003, 311,814 Kansans received medical assistance at a cost of $1.561 billion; this is an increase of $620 million over 6 years. Yes, the federal government pays 60% of this cost but those increases are totally unsustainable. The lines below the information that I highlighted identify the specific categories of services provided. Pharmacy costs are one example. On attachment four 161,041 Kansans received pharmaceutical assistance at a cost of $116 million in 1998; last year 1500 more Kansans received assistance at a cost of $225 million, the cost almost doubled with less than a one percent increase in the number of consumers.

Medicaid is the largest health care program in America serving 51 million people at an annual cost of $280 billion which increases from 8 to 13% annually.

- It provides health care coverage to 1 in 4 children; pays for 37% of all deliveries; and over 50% of all mental health care.
- Forty-four percent of all federal grants to states are through the Medicaid program.
- Seventeen percent of the dollars spent for health care in America is paid by Medicaid.
- Medicaid today serves 11 million more people that Medicare.
- Within 5 years at current growth rates, Medicaid will be larger than the retirement benefits paid by Social Security.
- If State budgets would increase tax receipts by 5% annually and Medicaid costs continue to increase at their current rate, by 2020 Medicaid will consume the entire budgets of every state in the union.

Doing nothing is not an option. The charts on attachments 4 and 5 are statewide totals that are published every year by county. Some costs currently are not identified with specific recipients; the chart on ***attachment 6*** recognizes that the total Medicaid costs in FY2003 were

$1,691,308,193 which is $150 million more than was recognized on attachment 5.

What can be done?

Last November Congress passed legislation that created Health Savings Accounts (HSA's). Health Savings Accounts are similar to Individual Retirement Accounts (IRA's) except that the money is used for medical expenses rather than retirement.

- An individual can put $2,600 tax free every year and a family $5,150 into these accounts. The contributions can come either from the employee, proprietor or employer.
- All unused amounts can be carried forward year-to-year-to-year. At retirement age any amount due the employee from unused vacation or sick leave can be placed in this account tax free and used to pay Medicare premiums.
- Money in this account will be used to pay medical expenses and can be used to pay long-term care insurance premiums.
- The goal is to make individuals more responsible for their medical expenses and to make health care insurance more affordable.
- Everyone that opens a HSA has to also have a health plan with an annual deductible of at least $1000 for individual coverage and at least $2000 for family coverage.
- My wife and son have a $7500 deductible health insurance policy whose premium is $2050 per year. We see Health Savings Accounts working hand in hand with major medical insurance as part of the solution to provide health care for working Kansans. Dollars in your personal HSA create the incentive to closely monitor the cost of our individual health care.
- Personally I would like to see the State of Kansas, and a number of schools across our state utilize this combination.

Currently in Kansas health insurance policies are required to provide first dollar coverage for certain medical conditions. SB 348 grants an exclusion from this requirement when the policy is purchased in connection with a HSA. With your support of SB 348, insurance companies will

develop and market their policies to Kansans and the premiums should be noticeably lower than policies currently available.

President Bush has also introduced legislation which allows a refundable tax credit to encourage the purchase of health insurance. His proposal provides for up to a $1000 deduction for an individual and up to a $3000 deduction for a family. If adopted, if an individual owes Uncle Sam $5000 on his 1040 income tax return, you would subtract the $1000 and cut a check for $4000; for a family under the same scenario, you would subtract $3000 and cut a check for $2000 to Uncle Sam.

The individual person has to have a personal stake in the costs of their health care. The responsibility is just as great for the wise use of health care dollars for the family with a BC-BS health insurance plan as it is for a Medicaid recipient. We have to inject a strong dose of responsibility and there has to be tangible consequences to those choices which encourage long-term changes in our individual health and relieve the demands placed on our safety net, the Medicaid system.

Attachment 7 is the Task Force's Report on Medicaid Reform and ***attachment 8*** is a 5 page letter to the Legislative Coordinating Council with the Task Force's implementation recommendations.

Long-term Care (pages 3-7)

1. Long-term Care Insurance- Incentives have to be created to encourage individuals to purchase long-term care insurance. Senate Bill 370 provides that incentive. Beginning in 2005, long-term care insurance premiums can be deductible from Kansas income taxes. The maximum allowable deduction is $500 in 2005 and the deduction increases $100 per year until the deduction is $1000 in 2010. Just think, you can pay for your long-term care insurance policy with tax-free dollars from your Health Savings Accounts and receive a tax deduction from your Kansas Income Tax. Legislative Research indicates that our State should save $7.8 million annually because the long-term care costs will be paid by insurance rather than Medicaid. Additionally, you will have more options in determining the level of care you might want instead of the level of care the State will pay for. Prior to 1992 Congress allowed individuals to shield and pass on to their heirs an amount that matched the value of their long-term care

insurance policy, the Bush administration is proposing to reinstate this provision. This allows individuals to become eligible for Medicaid without having to divest of all of their assets.

2. This coming Thursday, in the House Appropriations Committee, a bill will be worked that establishes the policy – if you have the means to pay for your long-term care, you will pay it. Personal responsibility trumps any heir's right to an inheritance or any attempt by an elder law attorney to make an individual artificially poor. The legislation:

- Makes jointly owned property a countable asset in determining eligibility for a Medicaid Applicant;
- limits discretionary trusts which are created to be supplemental to any public assistance received;
- limits contracts that bear no relationship to the value of services provided or are prepaid. An example given was an agreement to pay your granddaughter $50,000 to visit you once a week for the rest of your life;
- limits contracts on prepaid professional services;
- allows a lien to be placed on real property after the recipient has been in a nursing home for six months. Currently, Kansas law provides that SRS is to collect from an individual's estate the costs of the Medicaid services provided. But with no lien, many times the surviving spouse sells the asset and thereby outmaneuvers the state's recovery efforts; and
- expands the list of assets that a claim may be filed against, the primary target being jointly owned property, annuities and trusts.

3. The report recommends increasing the look-back period to 60 months from the current 36 months for people that have created trusts or transferred assets to make themselves artificially poor to qualify for Medicaid.
4. The report recommends expanding our waiver program to "Cash and Counsel" or "Project Independence" similar to Arkansas and Florida. The importance of the individual or guardian planning and purchasing their long-term self-directed care services is the key. Individuals can hire and fire workers; and schedule services when they want them instead of when the care giver gets around to it. If you want a bath at 8:00 in the morning- that is what you schedule. Contrasting this with one example where on Monday the worker arrived as scheduled at 8:00am; on Wednesday she arrived at 4:00pm and Friday failed to

show up. Why sit around waiting for the services! Plan, purchase, and schedule when you want the services. This allows movement towards implementing two of the core findings in Dr. William Dietz's presentation earlier this session before a joint committee of the House and Senate Health Committees:

- Moving from a disease management agenda to a health care agenda;
- Engaging the patient in management of their health care which moves us towards improved self-behavior.

Prescription Drugs (pages 7—11)

1. Academic Detailing- the average physician prescribes 25 different medications. Generics, over-the-counter and herbal supplements offer complimentary and alternative remedies with potential dollar savings without compromising patient care.
2. Review all patients' prescriptions upon discharge from the hospital. Assess all prescriptions- those being taken before admittance to the hospital and those prescribed in the hospital- to make sure the combination of prescriptions truly contribute to the well-being of the patient.
3. Pay pharmacists $15 for every generic prescription filled and $10 for name brand prescriptions. Adopt a system similar to Alcohol Beverage Control to track the cost of drugs at the manufacturer, wholesaler and retail level. We encourage multi-state and multinational buying cartels.

Care Management (pages 11-14)

1. Different than *managed care* because *care management* is a descriptive phrase to where a trained person gives assistance to an individual who wants guidance in planning and purchasing their own medical care. It is the interaction of the individual with medical professionals and attendant care providers. The greatest potential individual care savings is in this area, many have multiple physical and mental health ailments. In 2002 the top 2500 recipients health care costs averaged $56,529; the top 200 recipients health care costs averaged $191,848 each. Via Christi and Associates in Health LLC, both in Wichita are good examples of providing care management.

Direction for the Future (pages 18-20)

1. The report recommends expansion of Medical Savings Accounts, Health Reimbursement Arrangements. With the recent Congressional passage of Health Savings Accounts to assist family with health insurance coverage we have a more effective tool. Only when we address health insurance costs and assist families in its purchase do we start to take the pressure off the Medicaid system. Medicaid has to exist as a safety net. Our State has to be an aggressive advocate for some of these health coverage options.
2. The report makes specific recommendations for advocating healthier lifestyles and moving from disease management and acute care towards well-being and health care. It asks the question: Do more health care services mean better health? A Dartmouth study found that 20 to 30% of all health care spending pays for services that do absolutely nothing to improve the quality or increase the length of our lives. Recent studies show that patients with special medical facilities nearby, large numbers of doctors and specialized medical services available do not buy the citizens better health; in fact they are no more likely to receive preventive care such as flu shots or careful monitoring of their diabetes and they do not live longer. In fact their lives are slightly shorter. The most likely explanation of the increased mortality is they spend more time in the hospital.

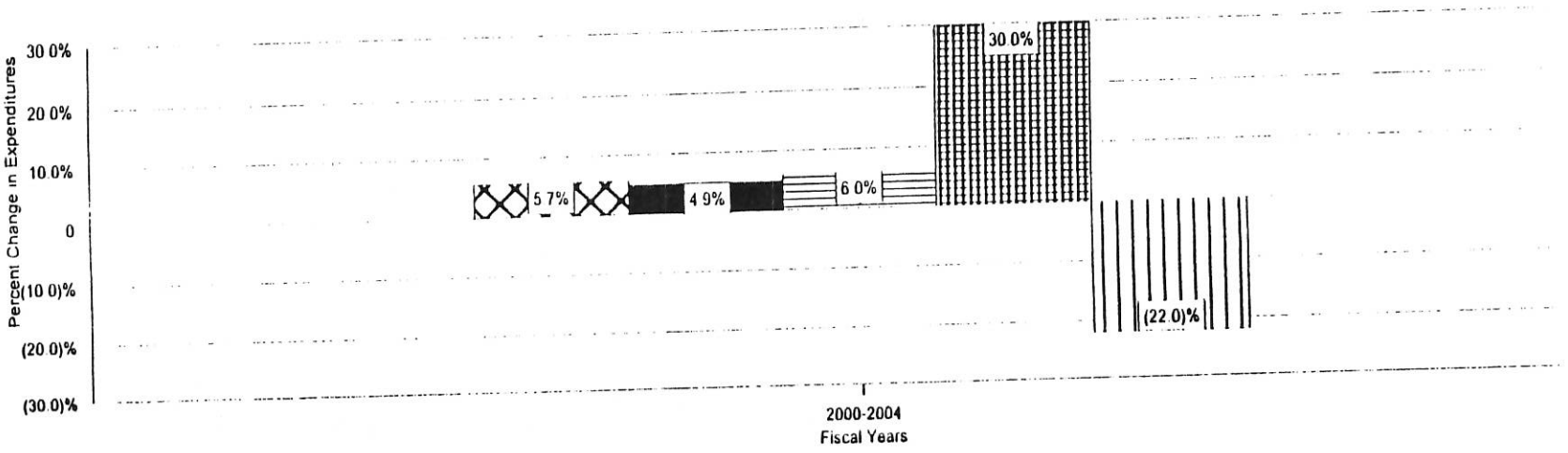
There are many other recommendations in this report but I have highlighted specific examples that I believe Kansas needs to champion.

The final two attachments (***attachments 9 and 10***) correspond to attachments 4 and 5 except you can look at the county or counties in your House district and better understand the number of individuals that utilize Medicaid services, their cost and any changes over the past six years.

Madame Chairman, I will gladly stand for questions.

8-1

State of Kansas
Percentage Change in State General Fund Expenditures
FY 2000-FY 2004



Attachment 1

Agency/Program	Percent of Approved FY 2004 State General Fund Budget
Postsecondary Education	14.5%
Elementary/Secondary Education	51.4
Department of Corrections and Facilities	4.7
Department of Social and Rehabilitation Services (state welfare and social services agency)	16.4
All Other	12.7
TOTAL	**100.0%**

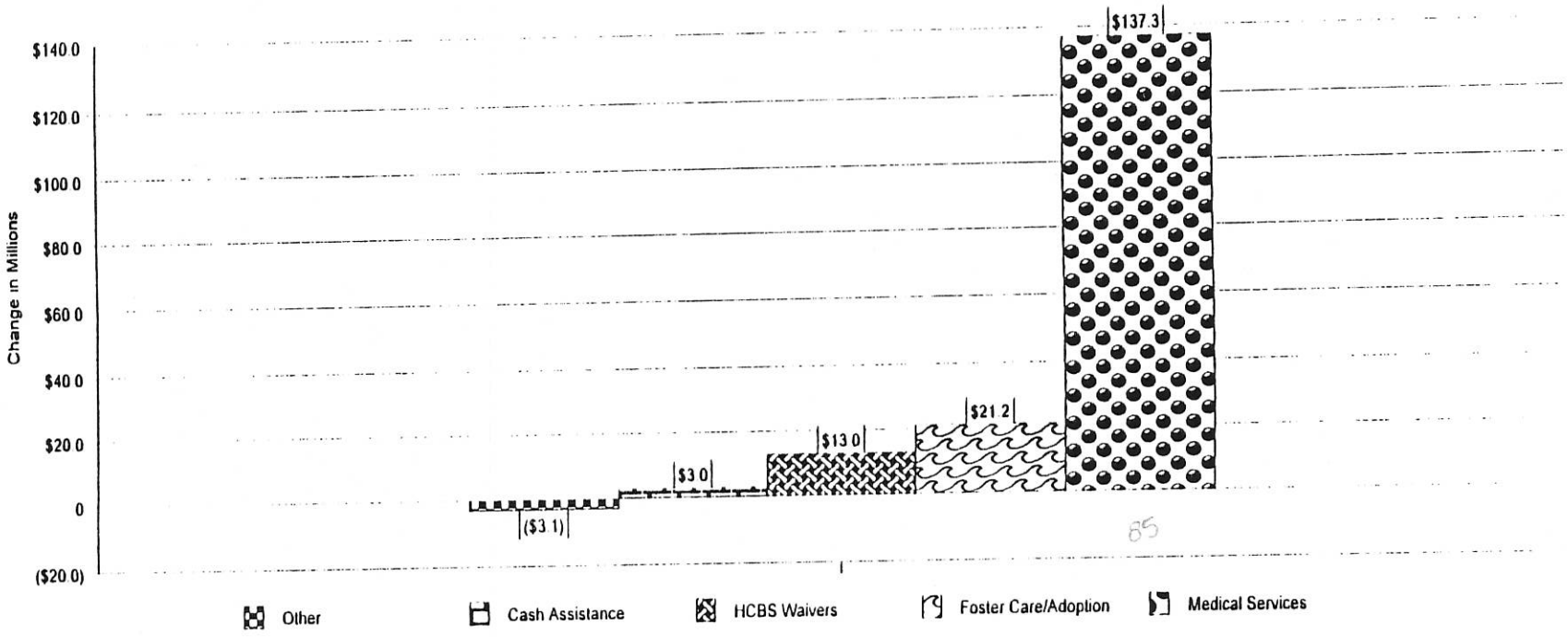
State of Kansas
State General Fund Tax Receipts
FY 2000-FY 2004
(In Thousands)

	FY 2000	FY 2004*	Four-Year Change Dollar	Four-Year Change Percent
Individual Income	$ 1,854,726	$ 1,855,000	$ 274	0.0 %
Corporation Income	250,123	120,000	(130,123)	(52.0)
Retail Sales	1,440,303	1,635,000	194,697	13.5
Compensating Use	209,966	220,000	10,034	4.8
Cigarette	49,125	130,000	80,875	164.6
All Other Tax Receipts	293,306	405,800	112,494	38.4
TOTAL TAX RECEIPTS	**$ 4,097,549**	**$ 4,365,800**	**$ 268,251**	**6.5 %**

*FY 2004 amounts reflect the estimates of the Consensus Revenue Estimating Group as of November 3, 2003.

Attachment 3

Department of Social and Rehabilitation Services
Change in State General Fund Expenditures
FY 2000-FY 2004
(In millions)



Notes: Foster Care/Adoption State General Fund increase reflects the reduced availability of Temporary Assistance for Needy Families (TANF) funds for Foster Care since FY 2000 as TAF caseloads increased.

Other includes programs such as Child Care, Family Preservation, Vocational Rehabilitation, and Nursing Facilities and Grants for Mental Health and Developmental Disabilities.

Medical Services pays for services such as doctor visits, inpatient hospital, outpatient hospital, prescription drugs, and home health care for income eligible pregnant women, children and people who are elderly or disabled.

SOCIAL AND REHABILITATION SERVICES

STATE OF KANSAS

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	39,751	32,764	$55,453,842	45,389,148
Number of Children in Program	28,056	23,389		
General Assistance	2,368	2,308	4,390,098	4,249,672
Refugee Assistance	77	25	103,072	41,789
MEDICAL ASSISTANCE				
(Fiscal Year Unduplicated)				
Beneficiaries (See Note 3)	253,352	250,264		
Consumers (See Note 3)	240,352	244,303	936,081,069	1,090,900,206
Major Categories of Service (See Note 1)				
Adult Care Home	19,065	19,141	284,343,252	287,335,470
Home and Community Based Services	13,714	17,184	177,321,782	241,280,472
Inpatient Hospital	38,386	39,844	137,983,072	142,009,582
Outpatient Hospital	92,609	103,836	13,134,568	14,464,305
Pharmacy	161,041	154,888	116,165,505	141,492,065
Physician	171,063	180,998	47,612,127	48,536,588
OTHER ASSISTANCE (See Note 2)				
(Fiscal Year Average Per Month)				
Food Stamps	120,465	110,767	87,345,135	79,702,839
Child Care	12,617	13,231	32,851,350	37,610,070
Employment Preparation Services	6,312	6,468	3,719,368	7,097,516
(Fiscal Year Unduplicated)				
LIEAP Heating	54,352	55,316	7,233,108	6,995,307
Rehabilitation Services	10,997	12,329	10,101,926	13,535,937
Burial	837	829	$459,088	451,277

Statewide information includes adjustments and recoupments and may not be a summary of the county level information .

1996 STATEWIDE DEMOGRAPHICS	
Population	2,572,150
Under 20	763,298
20-64	1,457,017
65 Plus	351,835
Male	1,266,212
Female	1,305,938

ABBREVIATIONS
HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 2: This is not an exhaustive listing of all programs available within SRS.
Note 3: Medical beneficiaries and consumers are unduplicated at the state level.

attachment 4

State of Kansas

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	34,461	37,762	$48,201,402	$52,958,638
Number of Children in Program	24,259	26,190	N/A	N/A
General Assistance	3,160	3,663	$5,929,205	$6,854,554
Refugee Assistance	10	8	$16,622	$7,505
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	301,377	311,814	$1,500,654,119	$1,561,529,097
HealthWave Beneficiaries	40,602	45,941	$43,165,349	$47,202,055
Major Categories of Service (See Note 2)				
Adult Care Home	18,498	17,182	$334,868,704	$337,897,726
Home and Community Based Services				
Head Injury	171	236	$3,974,400	$4,544,733
Technology Assisted Children	42	52	$149,637	$160,231
Mental Retardation/Developmental Disability	6,386	6,534	$190,003,000	$194,386,809
Severe Emotional Disturbance	1,675	2,207	$8,545,010	$10,060,481
Physically Disabled	4,971	5,193	$60,467,730	$60,138,890
Inpatient Hospital	35,787	35,583	$161,104,317	$166,673,106
Outpatient Hospital	92,608	95,800	$21,425,242	$21,730,858
Pharmacy	156,838	162,511	$213,054,599	$225,723,165
Physician	161,723	172,966	$60,582,279	$68,859,119
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	131,726	155,908	$107,186,250	$134,388,301
Child Care	16,158	16,728	$50,827,245	$54,437,020
Employment Preparation Services	11,346	14,185	$7,781,360	$9,097,221
(Fiscal Year Unduplicated)				
LIEAP Heating	72,239	91,887	$8,786,702	$12,568,402
Rehabilitation Services	12,451	12,766	$13,507,337	$13,175,145
Burial	846	824	$458,390	$447,897
Family Preservation	16,096	14,640	N/A	N/A
Children in SRS Custody	9,825	9,413	N/A	N/A
Child Support Enforcement	308,239	299,809	$107,457,005	$109,757,343
Number of Children in Program	173,500	170,566	N/A	N/A

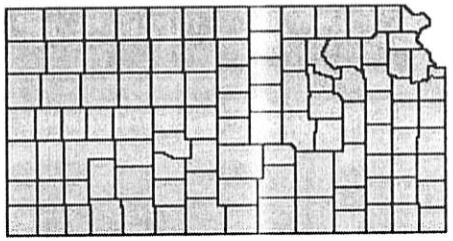
Statewide information includes adjustments and recoupments and may not be a summary of the county level information.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.



KANSAS DEPARTMENT OF SOCIAL and REHABILITATION SERVICES

Central Office:

Office of the Secretary
915 SW Harrison, Room 603 N
Topeka, Kansas 66612
(785) 296-3271

2000 STATEWIDE DEMOGRAPHICS

Population	2,688,418
Under 20	798,418
20-64	1,533,681
65 Plus	356,229
Male	1,328,474
Female	1,359,944

Note: 2000 demographics are not certified as the official population.

AREA OFFICES

Chanute
Emporia
Garden City
Hays
Hutchinson
Kansas City
Lawrence
Manhattan
Overland Park
Topeka
Wichita

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

MEDICAL ASSISTANCE
EXPENDITURES BY CATEGORY OF SERVICE

Fiscal Year 2003

CATEGORY OF SERVICE	July	August	September	October	November	December	January	February	March	April	May	June	Fiscal Year to Date Total	Fiscal Year to Date Monthly Average
(Providers)														
Inpatient Hospital	$8,746,177	$13,926,909	$11,882,971	$13,523,082	$17,334,212	$16,191,796	$20,816,281	$13,406,805	$10,937,578	$18,008,588	$14,999,996	$6,915,676	$166,690,071	$13,890,839
Outpatient Hospital	$1,085,984	$1,500,456	$1,375,489	$1,828,479	$1,516,298	$1,774,525	$2,747,952	$2,487,437	$1,865,561	$2,684,257	$1,991,841	$863,987	21,722,266	$1,810,189
Physician Services	$3,169,481	$5,467,273	$3,437,474	$4,850,831	$5,272,650	$5,810,534	$7,886,118	$6,611,619	$6,481,880	$7,987,902	$6,193,783	$5,687,685	68,857,230	$5,738,103
Pharmacy	$17,179,946	$21,390,156	$17,477,508	$21,939,378	$18,450,431	$17,850,321	$23,251,432	$18,702,188	$19,008,999	$22,622,759	$18,828,319	$9,028,013	225,729,450	$18,810,788
Dental Services	$469,330	$1,037,954	$1,118,934	$1,954,452	$1,126,901	$2,135,848	$1,970,811	$1,531,536	$1,288,250	$1,948,593	$1,596,747	$1,326,216	17,505,572	$1,458,798
Chiropractor	$0	$3	$0	$0	$0	$0	$2	$232	$104	$44	$24	$41	450	$38
Vision	$103,784	$221,923	$149,807	$242,965	$258,774	$299,174	$315,395	$219,581	$214,439	$274,713	$188,136	$146,741	2,635,432	$219,619
Podiatrist	$319	$552	$244	$1,074	$667	$523	$1,792	$2,396	$2,091	$2,566	$1,041	$982	14,247	$1,187
Psychology Services	$56,871	$94,530	$45,593	$80,635	$86,428	$88,175	$131,405	$121,977	$120,582	$136,282	$94,602	$89,044	1,146,124	$95,510
ARNP	$152,633	$168,942	$182,845	$209,443	$237,652	$231,026	$306,491	$264,803	$259,391	$258,696	$227,800	$220,507	2,720,229	$226,686
ARNP/ARNP Group	*31,909*	*56,733*	*43,893*	*44,663*	*53,593*	*74,133*	*99,287*	*73,565*	*74,744*	*79,850*	*61,562*	*69,164*	*763,096*	$63,591
Nurse Midwife	*581*	*8,163*	*803*	*5,992*	*4,001*	*10,768*	*15,150*	*9,501*	*13,690*	*6,368*	*9,096*	*5,253*	*89,366*	$7,447
Nurse Practitioner	*120,164*	*105,799*	*138,161*	*158,930*	*180,793*	*146,554*	*192,791*	*182,458*	*171,277*	*173,657*	*157,859*	*148,234*	*1,876,677*	$156,390
Health Centers	380,772	541,823	400,580	710,412	700,300	758,563	1,068,291	867,336	948,517	1,175,531	807,792	688,401	9,048,318	$754,027
Rural Health Clinic	*390,095*	*973,366*	*924,846*	*1,054,624*	*1,266,146*	*659,490*	*930,465*	*768,042*	*860,326*	*1,497,045*	*924,310*	*612,070*	*10,860,825*	$905,069
FQHC	*92,470*	*71,413*	*45,734*	*106,017*	*101,085*	*158,765*	*150,881*	*107,466*	*126,533*	*293,628*	*205,942*	*120,840*	*1,580,774*	$131,731
Indian Health	*3,611*	*2,355*	*3,297*	*1,727*	*2,789*	*1,970*	*1,781*	*8*	*8*	*2,408*	*3,848*	*488*	*24,290*	$2,024
Ambulatory Surgery Center	29,686	86,890	26,740	44,295	60,607	82,970	128,287	88,644	137,778	125,695	128,626	101,228	1,041,446	$86,787
Local Health Department	55,097	89,064	102,175	71,013	91,083	91,202	123,884	139,029	116,639	157,615	97,734	89,613	1,224,148	$102,012
Lab/Radiology	178,130	286,956	187,914	244,898	301,141	270,447	362,232	313,226	323,243	415,944	318,057	281,604	3,483,792	$290,316
Home Health Services	3,071,146	3,920,650	3,619,083	3,906,924	2,442,465	2,924,278	3,962,058	3,085,580	2,944,219	4,095,687	3,298,815	3,517,275	40,788,180	$3,399,015
Hearing Services	17,933	30,030	20,653	26,878	28,833	29,802	53,378	26,533	16,059	18,665	7,284	3,536	279,584	$23,299
Non-CMHC Partial Hosp.	0	0	0	0	0	0	0	0	0	0	0	0	0	$0
CMHC	4,692,550	6,133,912	4,295,133	5,870,298	5,334,400	5,193,285	6,384,580	5,048,573	5,476,858	7,732,054	6,655,985	5,485,007	68,302,635	$5,691,886
Rehabilitative Services	3,179,268	3,869,243	4,540,321	5,337,303	4,970,937	4,661,235	5,634,136	4,610,444	6,438,194	6,067,967	4,804,544	4,704,186	58,817,778	$4,901,482
HIRF	*213,615*	*152,805*	*105,431*	*162,779*	*217,146*	*118,332*	*396,651*	*130,205*	*109,777*	*447,461*	*161,755*	*36,689*	*2,252,646*	$187,721
ADAS Rehab.	*501,805*	*653,744*	*629,789*	*580,010*	*717,481*	*556,616*	*731,970*	*750,696*	*717,540*	*897,127*	*732,318*	*678,219*	*8,147,315*	$678,943
CMRC	*757,754*	*796,847*	*2,130,594*	*2,304,112*	*1,800,126*	*1,731,656*	*1,976,133*	*1,751,797*	*1,805,129*	*2,001,957*	*1,772,686*	*1,805,160*	*20,633,951*	$1,719,496
Behavior Management	*1,694,444*	*2,198,914*	*1,644,849*	*2,223,568*	*2,246,281*	*2,137,295*	*2,477,297*	*1,929,149*	*3,744,040*	*2,673,713*	*1,997,600*	*2,133,332*	*27,120,482*	$2,260,040
Dietician	*0*	*40*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*180*	*6*	*226*	$19
Physical Therapist	*14,597*	*20,788*	*12,924*	*5,860*	*23,876*	*12,446*	*25,135*	*12,168*	*18,116*	*32,398*	*22,417*	*20,282*	*221,007*	$18,417
Early Intervention	958,509	464,012	1,119,759	2,484,476	2,320,487	3,457,733	3,194,037	3,381,367	3,589,485	3,502,157	2,590,782	3,960,232	31,023,036	$2,585,253
Local Education Agency	*891,188*	*344,857*	*1,019,299*	*2,335,172*	*2,229,607*	*3,396,793*	*3,040,773*	*3,289,800*	*3,467,868*	*3,370,107*	*2,549,870*	*3,841,081*	*29,776,415*	$2,481,368
Head Start	*235*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*235*	$20
Supplies	456,797	748,787	501,110	484,836	852,166	929,687	1,530,878	1,171,580	1,154,152	1,492,599	1,133,427	1,061,349	11,517,368	$959,781
Transportation	533,149	736,237	535,577	847,827	833,759	808,850	874,452	531,775	449,183	639,554	502,981	496,487	7,789,831	$649,153
Medicare Buy-In	2,777,897	2,477,160	2,727,676	2,574,470	2,762,057	2,995,301	3,177,439	2,787,493	3,163,367	2,961,684	3,005,474	3,006,052	34,416,070	$2,868,006
QMB Services	12,328	12,928	9,915	5,513	11,194	6,687	20,289	24,048	20,812	38,336	17,530	18,795	198,375	$16,531
HIPPS	27,122	41,134	34,482	45,817	49,622	54,500	49,311	38,344	39,355	68,110	51,873	44,446	544,116	$45,343
Managed Care	137,974	140,226	28,403,147	9,186,759	9,225,569	9,387,079	10,361,778	9,360,934	9,057,021	9,305,137	9,731,142	9,288,503	113,585,269	$9,465,439
HMO	*0*	*0*	*28,265,687*	*9,041,174*	*9,069,884*	*9,225,591*	*10,204,589*	*9,202,281*	*8,900,246*	*9,147,954*	*9,572,346*	*9,128,089*	*111,757,841*	$9,313,153
PCCM Case Management	*137,974*	*140,226*	*137,460*	*146,966*	*157,798*	*163,458*	*159,018*	*160,726*	*158,742*	*159,486*	*161,266*	*163,107*	*1,846,227*	$153,852
Other MARS COS	45,511	-32,979	37,094	40,127	54,319	-8,993	34,504	84,316	41,517	53,917	49,767	18,170	417,270	$34,773
FE Targeted Case Management	*322,571*	*392,354*	*313,308*	*352,138*	*349,326*	*242,780*	*394,855*	*327,568*	*313,820*	*358,112*	*232,105*	*278,060*	*3,876,997*	$323,083
Subtotal Regular Medical	47,518,394	63,354,771	82,232,224	76,512,185	74,322,952	76,024,548	94,387,213	74,907,796	74,095,274	91,775,052	77,324,102	57,043,776	*889,498,287*	$74,124,857
Adult Care Home	24,719,968	30,371,500	27,681,409	32,376,256	27,726,445	24,537,134	32,865,311	27,306,506	25,523,579	31,155,304	26,607,199	27,027,116	337,897,727	$28,158,144
NF/Mental Health - SGF	*746,836*	*978,357*	*755,746*	*957,747*	*774,606*	*684,996*	*936,576*	*729,476*	*755,363*	*904,998*	*756,667*	*731,307*	*9,712,675*	$809,390
NF/Mental Health - Medicaid	*328,914*	*389,376*	*331,299*	*344,069*	*331,181*	*311,326*	*375,458*	*290,867*	*295,742*	*328,611*	*311,141*	*274,764*	*3,912,748*	$326,062
Nursing Facility	*22,292,594*	*27,334,910*	*25,083,503*	*29,143,261*	*25,184,586*	*22,199,397*	*29,711,939*	*24,906,317*	*23,221,585*	*28,122,168*	*24,303,917*	*24,617,596*	*306,121,773*	$25,510,148
ICF/MR Extra Care	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1,200*	*0*	*0*	*1,200*	$100
ICF/MR	*1,551,445*	*1,848,811*	*1,537,211*	*1,994,020*	*1,549,564*	*1,377,701*	*1,908,364*	*1,470,910*	*1,363,475*	*1,931,750*	*1,511,502*	*1,524,403*	*19,569,156*	$1,630,763
Home & Community Based Svc.	24,314,128	31,712,427	26,321,545	31,773,743	29,550,715	25,282,039	31,627,316	27,922,405	23,990,393	29,826,319	24,433,792	20,402,889	327,157,711	$27,263,143
Men. Ret./Dev. Dis. Waiv.	*15,098,410*	*18,095,315*	*16,175,159*	*18,114,307*	*16,642,347*	*14,944,490*	*18,683,398*	*16,645,049*	*15,088,456*	*17,559,304*	*15,273,003*	*11,892,984*	*194,212,222*	$16,184,352
Traumatic Brain Inj. Waiv.	*169,290*	*536,869*	*249,016*	*545,352*	*369,895*	*256,942*	*413,590*	*517,253*	*384,022*	*483,023*	*295,548*	*323,934*	*4,544,734*	$378,728
Technology Assisted Waiv.	*11,510*	*13,700*	*14,010*	*12,675*	*11,791*	*13,872*	*13,676*	*15,517*	*11,535*	*13,834*	*14,711*	*13,400*	*160,231*	$13,353
Physically Disabled Waiv.	*3,847,118*	*5,991,436*	*4,720,054*	*6,705,585*	*6,234,785*	*4,184,922*	*5,882,237*	*5,552,352*	*4,055,241*	*5,523,661*	*3,901,899*	*3,539,600*	*60,138,890*	$5,011,574
Frail Elderly Waiver	*3,991,793*	*5,582,588*	*4,243,128*	*5,211,592*	*5,074,620*	*4,935,324*	*5,168,842*	*4,137,050*	*3,296,844*	*4,640,730*	*3,588,427*	*3,603,204*	*53,474,142*	$4,456,179
Serv. Emot. Dis. Waiv.	*835,451*	*888,556*	*551,752*	*792,570*	*714,610*	*660,255*	*974,841*	*736,178*	*885,576*	*1,219,902*	*1,106,467*	*706,832*	*10,072,990*	$839,416
Subtotal Long Term Care	49,034,096	62,083,927	54,002,954	64,149,999	57,277,160	49,819,173	64,492,627	55,228,911	49,513,972	60,981,623	51,040,991	47,430,005	*665,055,438*	$55,421,287
MMIS Expenditure Total	**$96,552,490**	**$125,438,698**	**$136,235,178**	**$140,662,184**	**$131,600,112**	**$125,843,721**	**$158,879,840**	**$130,136,707**	**$123,609,246**	**$152,756,675**	**$128,365,093**	**$104,473,781**	**$1,554,553,725**	$129,546,144
Non Client Specific Dollars	**$30,174,632**	**-$7,277,808**	**$24,047,632**	**$8,128,578**	**$43,937,706**	**$6,701,026**	**-$2,980,046**	**$7,530,297**	**-$1,488,182**	**$624,268**	**$26,696,525**	**$579,848**	**$136,754,468**	$11,396,206
Grand Total	**$126,727,122**	**$118,160,890**	**$160,282,810**	**$148,790,762**	**$175,537,818**	**$132,544,747**	**$155,899,794**	**$137,667,004**	**$122,201,064**	**$153,380,935**	**$155,061,618**	**$105,053,629**	**$1,691,308,193**	$140,942,349

Note: MMIS Expenditure Total Dollars are for Client Specific Expenditures only.
Providers(indicated in italics) will not add up to Categories of Service because the reports are run at different times of the month.
N/A: Data not available at time of printing.

PRESIDENT'S TASK FORCE ON MEDICAID REFORM

Final Report to the 2003 Kansas Legislature

TASK FORCE MEMBERS

Senator Stan Clark, Chair
Senator James Barnett
Senator Pete Brungardt
Senator Paul Feleciano, Jr.
Senator Tim Huelskamp
Senator Janis Lee

Representative Bob Bethell*
Representative Don Hill*

*** Participated in Task Force meetings.**

March 21, 2003

Attachment 7

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EXECUTIVE SUMMARY

The Task Force recommends the following items for immediate action:

Legislative Action Items

- Allow the state to establish a lien on the real property of Medicaid recipients.
- Change the definition of estate to include jointly-owned property.
- Prohibit property owners applying for Medicaid from specifying a percentage ownership of jointly-owned property.
- Require that discretionary trusts be considered a countable resource for public assistance.
- Limit the scope of life contracts established between Medicaid recipients and family members.
- Institute a refundable tax credit for long-term care insurance premiums.

Regulatory Action Items

- Extend the look-back period for transfers of non-trust property to five years and apply any resulting penalty period to begin with month of application.
- Adopt current federal minimum limits on the exempted value of non-business property and the value of vehicles.
- Replace the blanket exemption of all personal effects and furnishings with a $15,000 limit.
- Request a Cash and Counseling Section 1115 Waiver from the federal government.
- Install requested edits on the new Medicaid Management Information System:
  - Undertake a study of care management for multiple diagnosis and dual eligible recipients; and
  - Additional actions on completion of the edits should be pursued.
- Undertake a study of prescription drug use in Kansas nursing homes.

MEDICAID IN KANSAS: 35 YEARS AND BEYOND

INTRODUCTION

Kansas incorporated the Medicaid program into its state structure during the summer of 1967. The program began on a comprehensive basis, both from the standpoint of covering all eligible groups (both mandatory and optional) and included most of the mandatory and optional medical services.

Kansas government has kept a steady eye on the expenditures involved in the Medical Assistance Program also referred to as MAP, Title 19, and Medicaid. The executive branch, through the Division of the Budget, and the legislative branch, primarily through the standing Senate Ways and Means and House Appropriations committees, the Division of Legislative Post Audit, and more recently, through joint select committees have reviewed various aspects of the Medicaid program. These reviews have generally focused on one or two major topics. There was not always the opportunity for a comprehensive look at developments in the program.

In retrospect, the Kansas Medicaid program was probably at its best in the early days, because it was comprehensive in covering needy populations and providing medical services. Early on, controls were set in place, but even with the controls, the increasing costs of providing medical coverage continued to expand. Institutional services were controlled by various audit mechanisms. Reimbursements to hospitals were based on Medicare audits, and nursing home costs were set through audits of cost statements as submitted by the nursing homes. Especially in the instance of nursing homes, strict controls were applied by Social and Rehabilitation Services. The individual provider fees were set internally by the state agency. For example, there was a time when physicians' fees were set by a relationship to the Medicare fee schedule. That practice has been all but abandoned except in areas where a fee adjustment is mandated by the federal government. Because of the ever-increasing cost of providing health care, there have been a number of legislative studies looking at financing issues related to Medicaid. These studies were often at the same time that Social and Rehabilitation Services was looking for ways to contain costs.

By the mid-1970s, the pressure was on the Department of Social and Rehabilitation Services to, at least, rein in the spiraling costs of providing services. The state, up to that time, had not only a medical assistance program for those families just above the cash assistance level of income; it had a General Assistance and Medical Only program which provided medical assistance to the working poor. The funding for persons eligible for General Assistance and General Assistance and Medical Only was from State General Fund money. The state tried to manage the level of services within the General Assistance and Medical Only programs for about 10,000 persons. When eligible populations increased beyond this number, programs and available services tended to be scaled back, and many contend that these reductions and cutbacks have been continuous since that time.

During the 1980s, Congress mandated that certain special populations be covered through Medicaid. With the adding of new populations, there was the obvious increase in

costs. Medicaid has always been a joint effort with the federal government. The federal match for Kansas has generally been in the range of 50-60 percent, and currently the federal government pays 60 percent of the cost of Medicaid services. Even with that favorable match, when the state's medical budget is over 1.5 billion dollars, it means that the state is putting significant state dollars into funding Medical Assistance. The federal government has set the general guidelines for carrying out the Medical Assistance Program; consequently the state has not had the flexibility it would like to have in carrying out the program. Beginning in the 1980s, the federal government made it possible for the states to make significant changes in Medical Assistance through the use of waivers. Waivers have made it possible for the states to adjust the program to more nearly match what the needs are in a particular state.

One of the most significant waiver programs has been Home and Community Based Services. This program has made it possible to present a community alternative to those persons headed towards nursing home or institutional placements. The major Kansas waivers have been geared to serve the physically disabled, the developmentally disabled, and the frail elderly.* This significant change in state policy has meant the nursing home population for the disabled exceeded 14,000 persons at one time. Now that population is between 1,000 and 1,100 persons. Such a change in program philosophy has meant that hundreds of people are living independently and in the community. These services are also less expensive which is a win-win proposition for all parties concerned.

Over the last three years, the Division of Legislative Post Audit has done significant work in defining some of the critical issues related to cost containment. Through these audits there has been the opportunity to re-examine such issues as caps on the various programs, eligibility, recouping of funds, recovery of funds as it relates to long-term care, and the increased use of generic drugs. All of these audits and the audit staff have aided the Task Force in developing a better understanding of the financial issues which need our attention.

It is important to note that Medicaid is the payer of last resort. Other resources that always pay first include Medicare, private health insurance, employee group health insurance, and any other "third party" payments.

As the state looks at the Medicaid program, it may seem as if it is disjointed and expensive. In a real sense that is true because that is the way the whole medical delivery system looks at this time. The President's Task Force has had the opportunity to go beyond the casual look. It appears to the members that over the 35-year period the consumers, the consumer advocates, the providers, and the Departments of Social and Rehabilitation Services and Aging have done a good job of putting the scattered pieces together. All parties seem to be committed to working together to make the system work for those individuals eligible and needing service.

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* Kansas has six home and community based services' waivers that serve the frail elderly (HCBS-FE), the developmentally disabled (HCBS-DD), the physically disabled (HCBS-PD), the head injured (HCBS-HI), the technology dependent (HCBS-TD), and the severe emotionally disturbed (HCBS-SED) waiver.

Kansas Senate President Dave Kerr appointed the members of the President's Task Force on Medicaid Reform on February 3, 2003, with a deadline of reporting to the President by March 17, 2003. The members are Senators Jim Barnett, Pete Brungardt, Stan Clark, Paul Feleciano, Jr., Tim Huelskamp, and Janis Lee. Members of the House of Representatives, though not officially part of the Task Force but extremely helpful, were Representatives Bob Bethell and Don Hill.

Social and Rehabilitation Services signed a contract with Don Muse which provided the Task Force with an overview of the Medicaid program. The report provided a very informative analysis and breakdown of Medicaid eligibles by maintenance assistance; age groups; and types of service (all actual Kansas numbers are included in Appendix A).

The Task Force held 17 meetings, with over 50 conferees covering the whole range of topics related to Medicaid. Nationwide, Medicaid currently covers more people and has a larger budget than the Medicare program. Within five years at current growth rates, Medicaid will be larger than the total retirement benefits paid by the Social Security Administration. By 2020, assuming current growth rates for Medicaid and 5 percent growth rates for each state budget in the United States, Medicaid will consume the entire budget of all 50 states.

There is the tug on each of our hearts to expand coverage, but hold down costs at the same time. It is evident that people have no stomach for health care reform that contains even a whiff of rationing. Though largely unspoken, there was the thought throughout the hearings: "Does more health care mean better health"? What if this assumption is wrong? Should the focus be more on quality rather than quantity? Throughout the testimony, articles, studies, and reports there is an unmistakable thread and growing body of evidence that recipients of both Medicare and Medicaid health care want more decision making responsibility. They want the system to be more patient-centered and consumer-directed so they can make their own personal health choices.

LONG-TERM CARE

Statement of the Issue

Kansas residents between the ages of 38 and 66 will, on average, face expenses that exceed income by at least $10,000 annually during their retirement years, and the projected income deficit will be more than $20,000 annually for single women. By 2031, the aggregate annual deficit for retired Kansans could be in the $700 million range. With an aging population and the need to ensure opportunity for disabled persons to remain in their own homes and in the community; the Task Force agreed this was an area which needed major attention. The elderly and disabled accounted for 94 percent of the increased long-term care costs and 70 percent of the increased medical costs from 1998 to 2000. The expenditures in the nursing home program (approximately $335 million) and the expenditures in the home and community based waiver programs (HCBS) (approximately $318 million) represent the two largest categories The Task Force is interested in continuing to support the blend of

services now being given. However, there were issues the Task Force thought should be explored.

Strategies for Action

Long-Term Care Insurance

1.1 • The Task Force recommends the Office of the Governor and the Office of the Insurance Commissioner launch a statewide public education campaign to educate the public as to the importance of buying long-term care insurance. Geared to persons in their 50s or early 60s, the campaign should encourage citizens to plan for their own long-term care.

1.2 • Long-term care insurance premiums should be deductible from Kansas Income Tax as part of Kansas Schedule S, Part A (Kansas Modifications to Federal Adjusted Gross Income).

1.3 • The state should allow a refundable tax credit of 25 percent of the long-term care insurance premium to be claimed on line 22 of K-40 Individual Income Tax.

1.4 • The state should protect an individual's estate by excluding from Medicaid spend-down, assets of value equal to the amount of the policy maximum benefit. Additionally, we should suggest a similar policy be adopted in the U.S. Congress.

Regulatory Changes Regarding Asset Requirements

1.5 • Social and Rehabilitation Services and the Department on Aging should jointly review financial and disability requirements to ensure a tight system, yet one that accounts for the particular needs of each person. Kansas Medicaid financial eligibility standards currently are more lenient than other states. They allow Kansans to shelter a large portion of their assets and become eligible sooner than they would in other states.

1.6 • Social and Rehabilitation Services should become more aggressive in identifying people who have transferred assets or created trusts by increasing the look-back period to 60 months from the current 36 months for non-trust property and apply any resulting penalty period to begin with the month of application for assistance rather than the month the property was transferred.

1.7 • The Task Force supports the Social and Rehabilitation Services-proposed regulatory change to adopt the current federal minimum limit on non-business property ($6,000 limit with 6 percent return requirement). Additionally, the agency should adopt the federal minimum limit on the

value of vehicles ($4,500) and replace the blanket exemption of all personal effects and furnishings with a limit of $15,000. In so doing, the Department may focus any recovery assets on extravagant purchases done for sheltering purposes.

Legislative Proposals Regarding Asset Requirements

1.8

- We support legislation similar to SB 497 presented in the 2002 Session which permitted the agency to establish a lien on the real property of a Medicaid recipient who has been in a long-term care facility for a year or more. The lien would be enforced at the time of sale or upon the death of the individual for repayment of Medicaid expenditures.

6 months

1.8

- We support legislation changing the definition of an estate, for estate recovery purposes, to include jointly owned property. Such property currently passes to a survivor upon the death of the other joint owner and is not available for estate recovery purposes. Each year, the Social and Rehabilitation Services Estate Recovery Unit closes out approximately 1,000 cases due to property which cannot be collected because of joint tenancy ownership. The property passes to other survivors and does not go to probate. If such property were subject to estate recovery, it is estimated that recoveries could increase by at least $1 million.

1.8

- The state should prohibit property owners applying for or receiving Medicaid from specifying a certain percentage of ownership of jointly owned property. Where such ownership already exists, the full value of the property would still be considered for Medicaid purposes and be subject to estate recovery. A recent Kansas Court of Appeals decision allowed a Medicaid recipient to add an additional owner to exempt property without penalty and avoid estate recovery. The new owner received only 1 percent ownership while the recipient retained 99 percent. This did not result in a penalizable transfer, but did remove the property from the recipient's estate and prohibit the agency from establishing a claim at the time of death.

1.8

- We support legislation that requires discretionary trusts funded by people other than the consumer (or spouse) to be considered a countable resource for public assistance purposes based on the total value of assets contained in such trusts. Refusal to pay for necessary medical care from the trust would be considered a breach of fiduciary duty and contrary to public policy. This would overrule a longstanding District Court case that allowed such trusts to be exempted for Medicaid purposes.

1.8

- We support legislation to limit the scope of contracts, written prior to Medicaid eligibility being established, between a Medicaid recipient and his or her family members to provide basic services in exchange for a large prepayment. These contracts established solely for socialization services such as visitation and transportation for appointments and

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errands would be considered as a transfer of assets solely to obtain Medicaid coverage and result in a penalty. The agency has seen an increase in such contracts whereby, for example, the recipient gives his or her family $50,000 or more to perform such duties instead of using the money for medical needs.

Public Education

1.9

- As the above changes are adopted, Social and Rehabilitation Services and Aging should gather a multi-disciplined team of all interested parties, including consumers and consumer advocates to review the results.

1.9

- Social and Rehabilitation Services and Aging should educate the public on eligibility requirements and enforcement actions as it applies to recipients, parties that jointly own property with recipients, and potential heirs. The legal department of Social and Rehabilitation Services shall closely monitor Elder Law Seminars and report the latest impoverishment schemes to become eligible for Medicaid.

Program Request

1.10

- The Task Force heard testimony on waivers referred to as "Cash and Counsel" or referred to as "Project Independence" by the Centers for Medicare and Medicaid Services, that recognize the importance of an individual or family member planning and purchasing his or her community-based long-term care services. This type of waiver is designed to delay more restrictive institutional or other high cost care by supporting the elderly or disabled individual in his or her own home. In the three states that have experience with such waivers, each individual in the waiver receives a cash allowance based on a calculation of service needs developed by each state. Individuals may, at any time, drop out of the project and return to more traditional waiver services. In one program, while enrolled, the participants are assigned a counselor who offers advice and recommendations about issues involved with self-directing care and assistance with management functions, particularly payroll and bookkeeping. Funds can be used for virtually any facet of the waiver, services or items; they are not exclusively for salary. The potential for fraud and abuse critics of these waivers feared has not materialized and consumer satisfaction has been nearly universal. The Task Force believes the objective of this type of waiver is for the individual to get the right amount of care, and recommends a Project Independence waiver be requested by Social and Rehabilitation Services or Department on Aging. The Task Force believes this approach could be beneficial in other parts of the Medicaid system.

Legislative Follow-Up

1.11

The Task Force understands that nationwide, states will be very active adopting and implementing many of these initiatives. We recommend and encourage the Legislative Post Audit Committee periodically to direct Legislative Post Audit to review Kansas compliance with changes related to the sheltering of assets and other relevant aspects of long-term care. The findings from those audits should be presented to the appropriate legislative committees.

PRESCRIPTION DRUGS

Statement of the Issue

Prescription drugs are an essential component of any Medicaid solution. Last year there were 7,500 less people receiving pharmacy assistance, but the prescriptions of those that did receive assistance cost $25 million more. During the first six months of FY 2003, the cost of prescription drugs was approximately $114 million, while the combined cost of inpatient and outpatient hospital services and physicians' fees was approximately $118 million. The Task Force recognizes prescription drugs have had a significant and beneficial effect on the lives of many Kansans. Many disabled and elderly Kansans are able to have productive lives through the stabilizing effect of medications.

However, the Task Force views with alarm the extreme growth in prescription drug costs. Without proper cost competition at the manufacturing level, further hardship will fall to the Kansas pharmacists whose dispensing fees have been reduced from $7.05 in the 1960s to $3.40 currently. However, any system changes require a close partnership with pharmacists, but little trust exists for efforts to reform this system.

According to figures provided by IMS Health (2001), 22.4 percent of an average prescription cost stays with the retailer. 3.4 percent for the wholesaler, and 74.2 percent makes its way back to the manufacturer. Further breakdown of the manufacturer's 74.2 percent portion indicates that only 29.3 percent goes to material cost: the rest is distributed 28.7 percent for advertising, 20.8 percent for research and development, 6.1 percent for taxes, and 15.1 percent for net profit. While nationally 92.5 percent of all prescription dollars are for brand names, in the Kansas Medicaid program, Social and Rehabilitation Services has reduced the brand name proportion to 85 percent.

Jim Cleland, pharmacist from WaKeeney, provided revealing information as to how complicated the pricing structure is for prescription drugs. As he went through a number of containers he had with him, it was hard to avoid the sense that the pharmacist who was the best bargainer was going to be the pharmacist who got the best price. There did not seem to be a lot of logic to the pricing. The Task Force was struck by the fact that, when Mr. Cleland suggested the state should get rid of the Average Wholesale Price (AWP), one of the drug company lobbyists indicated agreement with such a change.

Interestingly, the Task Force reviewed information indicating that both the privately insured population and Medicaid beneficiaries have little incentive to manage their prescription costs. Prescription benefits, in both cases, are constructed with relatively low, fixed-dollar co-payments. In Medicaid, the maximum co-payment is $3.00 and is a voluntary payment.

Some medications can be obtained either in a higher dosage form with a doctor's prescription or a lower-dosage form across the counter. An example is Pepcid AC, a popular stomach acid controller, which can be obtained as a 20 mg. pill with a doctor's prescription or as a 10 mg. pill over the counter. A study of the average price from eight Kansas City area pharmacies found the 30 pill quantity 20 mg. Pepcid AC to be $67.94 and the price of a 60 pill quantity 10 mg. over the counter to be $21.33. Why the difference? The doctor prescribed form is covered by insurance and Medicaid; the over the counter dosage is not.

In the current system(s), the physician, the patient, or the pharmacist has no financial incentive to save money. Requiring beneficiaries to pay a percentage of the costs of brand name medicines at 20 percent, 30 percent, or even higher will create consumer discretion.

A positive side the Task Force saw was in the work of Steve Smith, pharmacist from Hiawatha. He knows his community and its facilities and has developed, in cooperation with medical staff in his community, a means to integrate the medical-pharmaceutical needs of persons receiving institutional care so the prescription drugs are geared to the needs of the patients, including a means for cross-checking to ensure there are not competing medications. Members of the Task Force have had the opportunity to talk about this system and are optimistic that a similar system would work in the Medicaid program.

We commend Social and Rehabilitation Services and the pharmacists of the state for all of the good work that has been done in a genuine effort to contain costs related to prescription drugs. A complete listing of these steps and possible savings has been incorporated into the Medicaid budget document, so we will not repeat that information. We do suggest a review of those steps to get a sense of the work that has been done.

Because of the potential for continued escalating costs in this area, it is imperative that new and innovative thinking go into new strategies in this area.

Strategies for Action

Purchasing and Negotiation

2.1

- Social and Rehabilitation Services legal and program staff, the Office of the Attorney General, the Office of the Governor, the President's Task Force and pharmacists should explore ways for the agency to make maximum use of its purchasing power to drive down the costs of drugs. The exploration should look at the possibility of Social and Rehabilitation Services securing a purchase price for the individual pharmacist which is as low as any place the drug can be purchased in the United States. This negotiation with wholesalers and drug manufacturers should be on behalf of all citizens and not just the Medicaid recipients. This would require a

change in federal law. The Task Force suggests the development of a multi-state purchasing cooperative. (Note: In FY 2002, the state spent $27.5 million for the top five drugs by expenditure and $41.6 million on the top ten. Any purchasing cooperative could focus on these drugs for bulk purchase.)

2.2

- On Friday, March 14, 2003, the Task Force was notified by the Governor's Office of a pending agreement to join the State of Michigan in a multi-state pharmaceutical program. Michigan took the lead in establishing an expansive preferred drug list and supplemental rebates with pharmaceutical manufacturers negotiated through First Health Services. While we appreciate the Governor's efforts and the direct rebate payments to the state, we believe it still allows manufacturers to raise their selling prices to all citizens to cover such rebates.

2.3

- An important factor in maximizing purchasing power is the ability to determine actual costs. Social and Rehabilitation Services should consider reviewing the systematic approach used to track the cost of liquor at the manufacturer, wholesaler, and retailer level to see if it is transferrable to the pharmacy system. Both systems have the same three tier industry structure and require permits or licenses at each tier. The pharmacy compensation fee will be implemented simultaneously with this strategy.

Cooperation With Pharmacists

2.4a

- Participating pharmacists should receive adequate compensation for their services; we would recommend a pharmacy compensation fee of $10 for brand name prescriptions and $15 for generics. When tablets are prescribed, many times money can be saved if higher strength tablets are halved by the pharmacist. We recommend paying the pharmacist 50 cents for each dosage halved. Legislative Post Audit estimates $700,000 can be saved annually by halving tablets on one drug alone.

2.4b

- Social and Rehabilitation Services and the Kansas Pharmacists Association. should work together to develop several pilot projects that duplicate the whole care integration of Mr. Smith in Hiawatha.

2.4c

- The Task Force recommends the Kansas Board of Pharmacy beef up its inspectors. We would recommend hiring pharmacists that have many years of experience behind the counter and want a new challenge. We would like to raise the level of professionalism within the ranks and recommend inspections include spot checks comparing amounts of specific medicines ordered with medicines dispensed as well as Medicaid compliance checks.

2.4d

- Clinical pharmacists should be utilized to provide academic detailing to providers. The Task Force received an example of how a pharmacist worked with the physician and patient, without compromising the patient's

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welfare, to reduce the number of prescriptions from 12 to 9 and the cost from $1,315.11 per month to $96.96 per month. Many drugs are tried and true. Generics, over-the-counter, and herbal supplements are available. Thousands of drugs have been approved for dispensing, but the average physician prescribes less than 25 different drugs. Knowledgeable academic detailing offers potential savings without compromising patient care.

Scrutiny of Medicaid Claims

2.5a

- The prescription drug program lends itself to management by exception. Recipients taking more than nine unique medications per day should have their medications reviewed by their doctor and pharmacist. Edits in the new Medicaid claims system (MMIS) can identify these recipients on the basis of high usage, expensive medications, or multiple prescriptions from different pharmacies.

2.5b

- Social and Rehabilitation Services should identify and counsel doctors who might be over-prescribing certain medications as indicated in the MMIS edits.

2.5c

- Medicaid currently allows and pays pharmacy claims without requiring the pharmacist submitting the claim to include information identifying the prescribing physician. Without that information on the claim, it is impossible to conduct a review of claims information to identify potential fraud or efficiently pursue alleged fraud. We recommend the new Medicaid Management Information System require this information before payment authorization.

2.5d

- Social and Rehabilitation Services should consider audits of pharmacy providers that include comparing claims to actual prescription documents.

2.5e

- An initial check of all Medicaid eligible patients should include a review of eligibility for Veterans Administration assistance.

Program Request

2.5f

- As noted previously, Independence Plus and Cash and Counseling are waiver programs currently operating in other states. These waiver programs allow the consumer to buy his or her own personal home and community based services and the consumer satisfaction rates are near 100 percent. One reason this is so successful is consumers move from a defined benefit program to a system where the money they save in one area can be utilized in others. Examples given include saving money to purchase a new wheelchair for the consumer. We recommend Social and Rehabilitation Services ask for a demonstration waiver or develop a pilot program to establish a voucher system that encourages consumers to

utilize over-the-counter or generic drugs instead of brand name prescriptions and allow the money they save to be utilized like a medical savings account in other areas.

Legislative Follow-Up

2.6 The items suggested above could have a significant impact on the way in which the state does business in the name of Social and Rehabilitation Services. For that reason, we are suggesting regular reports be made to the Office of the Governor and the Legislature.

CARE MANAGEMENT AND THE VARIOUS POPULATIONS

Statement of the Issue

One of the most important topics covered by the Task Force is care management which arose from a recommendation of the consultant, Don Muse, who pointed out certain high cost Medicaid clients whose care, if managed by a team of health professionals, could result in better quality care at lower cost. The Task Force also discussed capitated managed care with conferees as well as traditional case management.

In the 1980s and 90s, managed care became a buzz word denoting a number of ideas. For persons with long involvement in the health services area, it was taken as an idea for genuinely managing the care of individuals. Medicaid is widely thought of as protection for poor women and children. Indeed, they are 75 percent of the recipients, and Kansas covers uninsured kids and pays for over half the births through Medicaid, largely through capitated managed care providers. The costs represent about 32 percent of the money in the program.

For the aged, mentally ill, and disabled consumers, though much smaller in terms of numbers of recipients, capitated managed care has been more challenging. It was thought that managed care was a way to assure adequate and appropriate care. It did not take long to discover that managed care had too often become another mechanism for controlling cost by turning medical practice over to clerks. It became a different way of rationing care and met very few expectations of persons who were getting the service or purchasing the service.

Over time, the medical system, the consumers, and the advocates insisted there be some mechanism for making good decisions on behalf of one's medical care. In this context, care management began to emerge as a more descriptive term. It was a term that could be filled with new meaning and was not burdened with the same, faulty ideas encompassed in managed care. It began to emerge as a descriptive word to explain that there was going to be a trained person giving an assist to those who were needing additional guidance as to their own medical care. Medical care management moves away from the concept of capitated managed care guided by clerks to an understanding that a trained person, where

necessary will interact with the medical professionals to arrange the proper and appropriate care.

The problem already being faced by Social and Rehabilitation Services is the question of who is to provide the care management. If the agency and the state are to be assured of the best possible use of budget dollars, then there has to be an evaluation as to whether the service is best provided by a professionally trained medical person or by an attendant. It would seem that if the care management system is to work in the best interest of the consumer, then the initial medical evaluation needs to be done by a medically trained professional. The implementing of the medically prescribed program, hopefully, could be done by an attendant. By the blending of these two functions, the hope is that there can be a medically sound program which is guided day-to-day by an attendant but under the watchful eye of the health professional.

As we begin to think about care management, it is important to note we have two large population groups that Social and Rehabilitation Services is working to serve. The first grouping would be that of persons qualified for some type of institutional care and care provided through the home and community based waiver programs. The second grouping would be those individuals who are a part of Temporary Assistance for Needy Families (TANF), Pregnant Women and Children, and other childrens' groupings. These two populations are similar in that they are dependent upon Medicaid for their medical services, but they are different in that the latter group would not necessarily be involved with a medical professional or making use of attendant care. For that reason, different strategies will need to come into play.

The issue of long-term care and home and community based services is probably the most important topic covered by the Task Force. Both the manner in which the programs are operated and the recommendations the Task Force can make will make a difference in the lives of many. The significant challenge faced by the Legislature and Governor is to structure and fund the programs in ways to ensure individuals continue to have a high degree of independence and living in the community.

Strategies for Action

- Social and Rehabilitation Services should continue its good work with the consumers and consumer advocates to build even stronger community-based programs. In view of the substantial cuts made in home health skilled services last year, the Task Force is calling upon the agency to re-examine the extent of those cuts. The Task Force agrees with the turn to care management, but it should not be viewed as a new way to cut back on the quality of care for these vulnerable populations.

3.1

- The Task Force feels that to provide an opportunity for long-term control of health care costs, Social and Rehabilitation Services should complete an analysis of the major causes of illness and disability found in Medicaid recipients. Following that analysis, recommendations should be considered for development of appropriate public policy dealing with prevention and health promotion.

3.2

- If it is not already available, the Task Force recommends that a health and well-being protocol be developed and agreed to by all parties to assure the citizens of Kansas that appropriate medical services and attendant care are being provided by our health care personnel. These vulnerable populations should not feel as if they are second-class citizens simply because they are making use of these state sponsored programs.

3.3

- We recommend that a program be devised that would assure the Medicaid consumer there is someone who cares about his or her health and well-being and that such professional is really working to keep the consumer healthy. This could be the beginning of an extensive program of preventative care and wellness maintenance, instead of over-utilization of emergency rooms and hospitalization. Wichita or Sedgwick County could be the site for a pilot program in light of past activities in the area.

3.4

- In reviewing these recommendations, the Task Force recognizes there are likely existing multi-discipline committees already functioning. If so, such committees could do some of this review. The Task Force asks only that the committees be multi-discipline and they include consumers and consumer advocates.

3.5

- Target care management, identify the amount of financial resources we can commit, strategically analyze and select a specific area for care management, make the investment, learn from mistakes and expand the program. We suggest that we start with patients with congestive heart failure just as they are discharged from a hospital and those that have any major chronic disease such as diabetes or asthma combined with mental illness, *i.e.*, a dual diagnosis.

3.6

- There have to be financial incentives for the individuals involved in care management, not flat fees, but rewards for doing great work. It cannot be on the "low-hanging fruit" legislative budget list. Care management is a long-term commitment, and the Legislature has to be a trustworthy partner.

3.7

- The State of Kansas should make a commitment to increasing the Medicaid physician fee schedule so it is equivalent to the Medicare fee schedule. This should be phased in over a three or four year period.

3.8

- The state should pursue all options available under federal rules to maximize how hospitals are compensated for their services. The state should re-examine the methodologies and rational it uses for establishing payment rates and work collaboratively with providers to ensure that state resources are being spent appropriately.

3.9

- In urban areas specifically, and other areas where practical, the Task Force recommends the expansion of the Program of All-Inclusive Care for the Elderly (PACE). This is a unique capitated frail elderly management care idea that utilizes a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service based on the participants' needs.

3.10

- Quietly whispered, though not substantiated, is the insinuation that psychotropic drugs are being used as a restraint in nursing homes and in schools. Drugs developed for schizophrenic disorders and other mental illnesses are being prescribed in disturbing amounts to people who do not have these clinical diagnoses. Therefore, the Task Force recommends a study involving six nursing homes that have received no citizen complaints or any citations by the Department of Health and Environment for violations of rules and regulations within the last two years to be compared with six nursing homes that have been cited with substantial complaints and violations. The study should analyze the prescribing practices between the two groups; render an opinion on the appropriateness of the prescribed drugs; compare the interaction of multiple drugs of each resident of the nursing home; and compare each nursing home's emphasis on resident participation in social activities and wellness activities. With these study results, the state will have the tools to assess the effective level of psychotropic drug use in Kansas, and provide the appropriate education to the nursing home provider.

3.11

- The Task Force is aware of a pilot program in Wichita that integrates primary care and mental health services through the utilization of advanced registered nurse practitioners. Research has shown that such nurse practitioner providers are particularly well suited to manage the primary care patient, including the medically complex patient with demanding chronic health issues. By integrating family practice and psychiatric health care specialities under the "same roof" and using advanced registered nurse practitioner providers, this model meets the three critical standards for today's health care delivery systems of effectiveness, efficacy, and efficiency, and patient satisfaction. The Task Force recommends this pilot project be expanded beyond Wichita and be used as a model of treatment for those with a combined diagnosis of mental illness and chronic health issues.

3.12

Legislative Follow-Up

As noted, the Task Force thinks the provision of long-term care and home and community-based care, as well as covering the balance of populations in the Medicaid program, is very essential and sets the tone for how we respond to vulnerable populations. As a result, the Task Force requests an assessment by Social and Rehabilitation and others as to the feasibility of the action items above and a report to the Task Force during the Veto Session.

3.13

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INTERNAL MANAGEMENT

Statement of the Issue

The members of the Task Force are firmly convinced the management of the Medical Assistance Program within Social and Rehabilitation Services is a monumental task. We have been pleased with our interactions with the appropriate agency staff in their information and insights. We recognize the dispensing of money for services rendered has the potential to generate ill will. However, it appears that hard work by both Social and Rehabilitation Services and the various service providers has resulted in a reasonably good working relationship. Nevertheless, with that said, there are some areas that need critical attention.

Strategies for Action

- In administration of the Medicaid program, the level of reimbursement for service providers has not changed in many years. With that in mind, the Task Force suggests a determined effort to reduce the hassle factor for providers. In light of the flexibility offered by the federal Department of Health and Human Services, we suggest Social and Rehabilitation Services and the Kansas Medical Society develop a plan to incorporate best management practices (BMP) into a payment plan. As a result, any provider operating within these BMPs would be cleared for payment. To assure program integrity, a sample audit of claims would remain.

4.1

- It would appear the state and the Department of Social and Rehabilitation Services will continue to operate with scarce funds. At the same time, the agency has moved to do even more purchasing of services from individual providers or small operations. This means they have limited cash flow capability. For that reason, Social and Rehabilitation Services must further refine its reporting systems in order to make timely reimbursement adjustments so local providers may avoid cash flow problems.

4.2

- Over time the Medicaid Program has loosened up in such a way that it is possible for a variety of non-SRS programs to make use of favorable funding available through Medicaid. The Task Force requests a report on these arrangements; a location of such funding, how the non-federal match is handled, and other similar programs that might qualify under Medicaid.

4.3

- In certain circumstances, waiver services for individuals are costing more than if the individual were in a long-term care facility. As such, the Task Force recommends placing appropriate caps on waivers so others on the waiting list can utilize waivered services. We fully recognize the restraints imposed by the Olmstead case and recommend sensible parameters for determinations.

4.4

- Persons qualifying for the frail elderly or physically disabled waivers that currently are served in a long-term care facility should have the appropriate dollars follow them into independent living. A mechanism needs to be adopted where there is a transfer of budgeted dollars from Social and Rehabilitation Services to the Department on Aging. As an example, a person who falls and breaks a hip, following successful rehabilitation in a nursing home, may need to utilize some waivered services in order to return home. The transition plan approved by a care management team should provide that financial resources will follow the person until the waivered services become more expensive in the community than in a long-term care facility.

4.5

- The Task Force recommends that Social and Rehabilitation Services and the Department on Aging, along with their contractors, provide for the payment of durable medical equipment when an individual is transferred between programs instead of equipment being retained by the agency. We also recommend that the equipment be recouped at the time the equipment is no longer needed or at the death of the client. We suggest any equipment that needs to be refurbished be sent to the Ellsworth Correctional Facility for refurbishing by inmates who now refurbish bicycles.

4.6

Legislative Follow-Up

Testimony from Social and Rehabilitation Services indicated there were a certain number of provider claims exceeding the expected number of claims in process. Hence, the Task Force would like to have a current report on the claims processing during the Veto Session.

4.7

Additionally, the Task Force requests a progress report on each of the above recommendations. After receiving these reports, the Task Force will determine when and where there might be additional reporting to the Legislature.

ISSUES BEYOND THE STATE

Statement of the Issue

The Task Force recognizes we are a small state, and for that reason we think attention should be given to see if there are ways to enhance the power of our state. Large numbers and expenditures are persuasive. The current federal administration has given every indication of wanting to reach out to the states. Any case that Kansas wanted to make would be enhanced if other states joined with it. Through the various associations in which Kansas has membership as well as Health and Human Services, every effort should be made to secure greater flexibility in funding and programs.

Strategies for Action

5.1

- The Task Force underlines again the exploration of the possibility of establishing a purchasing cooperative with other states to drive down the costs related to medical supplies, durable medical equipment, and assistive technology.

5.2

- The Task Force should work with the leadership of the Legislature and their counterparts in other states to make the case for the federal government to assume full responsibility for those individuals who are dually eligible for both Medicare and Medicaid. This could be a win-win situation all of the way around. It would financially benefit the state, and it would simplify the administration of both programs. If federal funding is unsuccessful, we would then advocate that any realized cost savings to Medicare as a result of successful care management be reimbursed to Kansas at the current Medicaid reimbursement rate.

5.3

- The Medicaid program should be subject to the same provisions of the Veterans Administration Federal Supply Schedule prices for purchasing prescriptions. According to the annual report of the U.S. Attorney General, Medicare paid more than double the Veterans Administration price for name brand prescriptions. We assume Medicaid and Medicare prescription costs are similar. Working with the National Conference of State Legislatures, the American Legislative Exchange Council, the Council of State Governments, and the National Governers Association, we advocate seeking immediate administrative and legislative remedies.

5.4

- State and federal policy makers know the current growth of the costs of providing Medicaid services is unsustainable. A primary Task Force goal is care management, not managed money. In order to work, Medicaid must be structured to place more decision making authority in consumers. "Independence Plus" and "Cash and Counsel" waivers are steps in the right direction, but voucher programs have to be authorized for consumers, and risk-based contracting that rewards providers must be adopted. This Task Force is committed to an investigation of the reform of Medicaid and the opportunity to work with President Bush and Governor Sebelius.

PUBLIC HEALTH ISSUES

Statement of the Issue

When the work of the Task Force began, we did not anticipate significant discussion of public health issues. However, a representative of Social and Rehabilitation Services articulated that before the state makes any significant improvement in the health conditions of many Medicaid recipients, it will have to give attention to the environment in which we all

live. While we imagine the scope and needs in the area of public health, the Task Force did not spend enough time on this topic to make an extended statement. Just the suggestion of the topic with some amplification suggested that we should not let it drop. It is on that basis we make some observations.

6.2 We would like to see special attention given to encouraging more healthy living options for Medicaid recipients and the general public. There is a considerable body of literature that outlines some broad social health risks: We don't eat in a healthy way. We don't take good care of our bodies. We don't exercise properly. The list is extensive. An 6.1 extensive public education campaign on healthy living may be necessary to address these societal problems.

The Task Force recognizes everyone is functioning on an overload basis. Yet we wanted to recognize that work in the area of changing the health environment, living 6.3 healthier lifestyles, and making greater use of existing research has the potential for changing the well-being of many. We suggest inter-agency discussion and joint development of a coordinated public education campaigns on this subject.

DIRECTION FOR THE FUTURE

Statement of the Issue

Does more health care mean better health? What is this assumption is wrong? According to the Center for Evaluative Clinical Sciences at Dartmouth Medical School, 20 to 30 percent of health care spending pays for procedures, office visits, drugs, hospitalization, and treatments that do absolutely nothing to improve the quality or increase the length of our lives. At the same time, the type of treatment that offers clear benefits is not reaching many Americans, even those who are insured.

It is a sobering thought, but perhaps legislators, insurers, and the health-care industry might be able to save money by concentrating on improving the quality of medicine rather than controlling costs. Statistical patterns of Medicare spending nationwide are enlightening. A 65-year old in Miami will typically spend $50,000 more in Medicare expenses over the rest of his life than a 65-year old in Minneapolis. During the last six months of life, a Miamian spends twice as many days in the hospital and is twice as likely to see the inside of an intensive care unit.

This regional variation would make perfect sense if the regions where citizens were the sickest were the ones that used the most medical services. If this were true, the region around Provo, Utah , one of the healthiest in the country, would get fourteen percent fewer Medicare dollars than the national average. Instead it receives seven percent more. In contrast, the elderly around Richmond, Virginia tend to be sicker than the average American and should be receiving eleven percent more–than 21 percent less–than the national average. And these regional differences are not as a result of the cost of health care.

Rather, much of the variation among regions–about 41 percent–is driven by hospital resources and the number of doctors. In other words, it is the supply of medical services, rather than the demand for them, that determines the amount of care delivered. The national average for expensive MRI technology is said to be 7.6 machines per one million patients. By this standard, Kansas should have 19. We have 47! Nearly the same as Michigan (48) which has four times the population. Medicare beneficiaries in Miami see, on average, 25 specialists in the last year of their life versus two in Mason City, Iowa, largely because Miami is home to a lot more specialists.

Recent studies show that excess spending in high cost regions does not buy the citizens better health. Patients in high-cost areas are no more likely to receive preventive care such as flu shots or careful monitoring of their diabetes, and they do not live longer. In fact their lives may be slightly shorter. The most likely explanation for the increased mortality in high-cost regions is they spend more time in the hospital. (Shannon Brownlee, "The Overtreated American," *Atlantic Monthly*, January-February 2003).

In the private sector, Blue Cross-Blue Shield of Kansas reported there were 201,000 more physician office visits in 2001 than in 2000. This is an increase of 14 percent, even though their membership grew only 5 percent. Hospital charges were 20.6 percent higher, diagnostic imaging 25.3 percent higher, clinical lab work was 29.2 percent higher, and speech, occupational, and physical therapy charges were 26.9 percent higher. If you are paying $1,000 or more a month for your family health insurance policy, you expect to get your money's worth. However, the incentive is in the wrong place and thus utilization rates continue to increase!

As noted previously, the runaway health costs of recent years have led many Medicaid programs and private insurance companies to impose Managed Care. And all too often, managed care consisted of an impersonal bureaucracy with a focus on managing dollars, instead of providing needed care. As an alternative, employers (and a few states with specific Medicaid waivers) across the country are empowering employees instead—by giving them the opportunity to manage some of their own health care dollars and experience the costs and benefits of prudent consumer behavior in the medical marketplace.

Additionally, a new ruling from the Internal Revenue Service allows the creation of a new kind of policy, called a Health Reimbursement Arrangement (HRA), which resembles a Medical Savings Account (MSA). HRAs, used with high deductible health insurance, can be funded by the employer and offer the employer an excellent vehicle to provide health insurance benefits. Individuals utilize the money in their HRA to pay out of pocket medical expenses. Money from the accounts can be rolled over year to year and the money travels with the employee in the event that the employee leaves the job. These accounts, instead of being drivers of medical inflation, now become inhibitors of inflation.

Strategies for Action

- Kansas Medicaid needs to follow the example of the private-sector HRAs. Accordingly, Social and Rehabilitation Services should explore the possibility of developing a Medicaid Benefit Account (MBA) to include patient cost-sharing and a health care savings account.

7.1

- Since these MBA's would be funded with taxpayer dollars, they should be restricted to the payment of medical bills and insurance premiums. This means that beneficiaries who consume health care wisely and see their account balances grow through time would not be able to withdraw these balances for non-health care spending. Instead, they would be able to use the funds for medical services not covered by their health plan. And in the future, they would be able to use unspent balances to pay insurance premiums and buy medical care directly after they have left the Medicaid rolls.

7.2

- We commend Social and Rehabilitation Services for the development of the Working Healthy program and encourage its continuation and expansion to allow individuals to retain health care coverage as they transition from welfare to the workforce.

7.3

- Challenges to the Medicaid system will persist until solutions are found for health insurance. Medicaid has to exist as a safety net. Market initiatives have to be adopted in both areas with individuals making and paying for the medical services that they choose to access.

7.4

AN ONGOING MEDICAID REVIEW STRUCTURE

Statement of the Issue

When President Kerr established his Task Force on Medicaid Reform, we had no idea of the level of interest which has been shown by interested parties. For Task Force members, it has been an eye-opening experience as we developed a deeper understanding of the work of Medicaid.

We have been pleased to learn of the many instances of positive activities taking place among consumers, consumer advocates, providers, Social and Rehabilitation Services and Aging. We commend all of them for their hard work. With a program as massive as the Medicaid program and involving so many people, it is not by accident that good things are happening. Good things are happening because of cross-discipline activity and the desire to serve the consumers. While there have been some instances where communication may have broken down, our general sense is that there has been good discussion. We have been pleased that the work of this Task Force has provided further opportunities for interaction between all parties. There are serious minded people working to make a system out of an unsystem.

In that context we recognize the merit of ongoing meetings of a multi-discipline group representing all aspects of the Medicaid program. While the Task Force is not interested in pointless busy work, an ongoing committee with the task of looking at the big picture would have merit. Such a committee of this type, including agencies, consumers, and providers, would have the task of visualizing the grand design of a Medicaid Program in Kansas. Instead of simply looking at the mechanics of the program, this committee should

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focus on how to make the system professionally sound, fiscally sound, user friendly, and responsive to the Governor and the Legislature.

The Task Force believes the work started here allows us an opportunity to begin adopting and implementing many of the initiatives discussed during the last seventeen meetings. To that end the Task Force highly recommends that an ongoing review continue to take place and recommends that a proposal be put together to solicit a health grant from Kansas foundations. We would recommend the following possibilities:

- Kansas Health Foundation
- Sunflower Foundation
- United Methodist Health Ministry Fund
- Wyandotte Health Foundation (see also Appendix B)

Additionally, Social and Rehabilitation Services has just received a three-year grant of $1,385,000 funded from the Centers for Medicare and Medicaid Services. This grant, the Real Choice Systems Change Grant for Long-Term Care in Kansas, will be used to help make community based services as accessible as institutional services. As Task Force members we are interested in further pursuing this issue. To that end, if asked, we will pursue the outline of a plan before the end of the Veto Session. See also Appendix C.

40TH DISTRICT

KANSAS SENATE

Stan Clark

COMMITTEE ASSIGNMENTS
CHAIR: UTILITIES
MEMBER: ASSESSMENT & TAXATION
ELECTIONS & LOCAL GOVERNMENT
ORGANIZATIONS, CALENDAR, & RULES
RULES & REGULATIONS

May 3, 2003

Sen. Dave Kerr,
Chairman Legislative Coordinating Council
State Capitol, Room 359-E
Topeka, KS 66612

Dear Sen. Kerr,

The work of the President's Task Force on Medicaid Reform appears to be right in line with many studies being conducted by government associated organizations covering the same topic. The most recent announcement was on April 10, 2003 when the National Governor's Association formed a task force to study many of the same topics covered by our Task Force. This news helps validate the ideas expressed in the report and reinforce our resolve to move the Task Force's Report off the shelf and into action.

On May 1, 2003, I had the opportunity to confer with the members of the Task Force and we are eager to move forward. The continuing responsibility for implementation of the President's Task Force on Medicaid Reform Report is now vested in the Legislative Coordinating Council. The eight areas specifically identified in the Report are:

(1) Long Term Care Insurance
(2) Prescription Drugs
(3) Care Management and the Various Populations
(4) Internal Management
(5) Issues Beyond the State
(6) Public Health Issues
(7) Directions for the Future
(8) An Ongoing Medicaid Review Structure

Working from pages 4 through 21 of the final report, the following are our recommendations for implementing the proposed "strategies for action".

(1) Long Term Care Insurance (pages 4-7)

1. Statewide public education campaign - Governor Sebelius/Ins.Comm. Praeger
We recommend that we delay implementing this strategy until after the legislature adopts one of the following two items. At that time we believe the results of this education campaign will be more effective and rewarding.

205 U.S. 83
OAKLEY, KANSAS 67748
785-672-4280
FAX 801-457-9064
E-Mail sclark@ink.org

STATE CAPITOL
OFFICE-449 NORTH
TOPEKA, KANSAS 66612-1504
785-296-7399
1-800-432-3924

Attachment 8

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2. Deductible long term care insurance premiums- We recommend this initiative be included as a topic for the Interim Tax Committee.

3. Refundable tax credit of 25 per cent of long term care insurance premium -We recommend this initiative be included as a topic for the Interim Tax Committee.

4. Spend-down – We recommend that Norm Furse, Revisor of Statutes and Dennis Priest from SRS lead this initiative and that they work with NCSL, National Governor's Association and others to plan the appropriate venue to encourage Congress to change Federal Code.

5. Financial and disability requirements – We recommend Joann Corpstein, Chief Counsel, Dept.of Aging and Dennis Priest from SRS jointly review these requirements.

6. Identification of people who have transferred assets and increase the look-back period- Joann Corpstein, Dept.of Aging and Dennis Priest from SRS jointly implement these changes.

7. SRS proposed regulatory change - Dennis Priest from SRS has presented this change to the Legislative Administrative Rules and Regulations Committee and is waiting adoption following the public hearing.

8. Legislative Proposals regarding assets requirements – There are 5 proposals on page 5 of the Report. All are part of **SB 272** which passed the Senate 40-0 on April 4, 2003 and hopefully will receive House approval before session's end.

9. Public education and monitoring Elder Law Seminars – Janet Schlansky, SRS

10. Program Request - waivers -
    Janet Schlansky, SRS
    Gina McDonald, Kansas Assn. For Centers of Independent Living
    Shannon Jones, Statewide Independent Living Council of Kansas

11. Legislative Follow up - Legislative Post Audit

(2) Prescription Drugs (pages 8-11)

1. Purchasing and Negotiation – We would recommend that you invite the Attorney General and Governor to meet with you to coordinate leadership on this issue. The key is finding the best negotiator.

2. Multi-state pharmaceutical program – The Governor is the leader on this initiative.

3. Develop tracking system for prescription drugs similar to Alcohol Beverage Control. The Task Force recommend that we delay action on this initiative for a year and concentrate on other ideas.

4. Cooperation with Pharmacists
    a. Compensation for services - Bob Day, SRS
    b. Pilot projects - whole care integration - Bob Day, SRS
    c. Pharmacy inspectors - Ks. Board of Pharmacy
    d. Academic detailing - Bob Day, SRS

5. Medicaid Claims
    a. Review of exceptions – Bob Day and Laura Howard of SRS should work with Jerry Slaughter of the Kansas Medical Society.

b. Over-prescribing - Bob Day and Laura Howard of SRS should work with Jerry Slaughter of the Kansas Medical Society.

c. Review of claims information - Bob Day and Laura Howard of SRS should work with Jerry Slaughter of the Kansas Medical Society.

d. Audits of pharmacy providers- Bob Day of SRS should work with the Attorney General's Fraud Unit.

e. Eligibility for VA assistance - Dennis Priest, Candace Shively and Janet Schlansky of SRS

f. Waiver programs -
Janet Schlansky, SRS
Gina McDonald, Kansas Assn. For Centers of Independent Living
Shannon Jones, Statewide Independent Living Council of Kansas

6. Legislative follow up - LCC

(3) Care Management and the Various Populations (pages 12-14)

1. Community-based programs -
Janet Schlansky, SRS
Gina McDonald, Kansas Assn. For Centers of Independent Living
Shannon Jones, Statewide Independent Living Council of Kansas
2. Long Term control of Health care costs -
Janet Schlansky, SRS
Gina McDonald, Kansas Assn. For Centers of Independent Living
Shannon Jones, Statewide Independent Living Council of Kansas
Roderick Bremby, Secy. KDHE
3. Health and well-being protocol - Roderick Bremby, Secy. KDHE and Richard Morrissey, Director of the Office of Local and Rural Health with KDHE as part of Healthy Kansas 2010.
4. Program of preventative care - Mark Bailey, Via Christi HOPE; cc: Richard Morrissey, Healthy Kansas 2010
5. Multi-discipline review – Roderick Bremby, Secy. KDHE; and Richard Morrissey, Director of the Office of Local and Rural Health with KDHE as part of Healthy Kansas 2010.
6. Targeted care management - Janet Schlansky and Bob Day of SRS
7. Financial incentives - Janet Schlansky and Bob Day of SRS
8. Medicaid Physician Fee schedule - Sen. Morris, Rep. Neufeld; cc: Duane Goossen, Director of the Budget and Jerry Slaughter
9. Hospital compensation - Kansas Hospital Assn., Don Wilson
10. PACE (Program of All Inclusive Care of the Elderly) - Pam Betts, Dept. of Aging
11. Use of Psychotropic drugs - Request a Post Audit
12. Primary care and MH services - Bob Day of SRS; Martha Kuhlmann and Barry Reynolds of Assn. of Health; LCC
13. Legislative follow up - LCC

(4) Internal Management (pages 15-16)

1. Reimbursement for service providers -Bob Day, Laura Howard and Janet Schlansky of SRS.

2. More timely reimbursement - Bob Day, Laura Howard and Janet Schlansky of SRS.

3. Other programs using Medicaid funding - Bob Day, Laura Howard and Janet Schlansky of SRS.

4. Waiver caps -

Janet Schlansky and Bob Day of SRS
Gina McDonald, Kansas Assn. For Centers of Independent Living
Shannon Jones, Statewide Independent Living Council of Kansas

5. Have $$ follow LTC to Independent living - in Governor's budget amendment, tracking by Secretary of Aging Betts

6. Durable medical equipment - retain and refurbish - Schlansky, Day and Howard of SRS; Betts from Aging; cc - Roger Werholtz, Dept. Of Corrections

7. Legislative follow up - LCC

(5) Issues Beyond the State (pages 16-17)

1. Purchasing cooperative with other states - Attorney General and Governor – We recommend a representative from legislative leadership attend National Legislative Assn. On Prescription Drug Prices meeting on June 27, 2003 in Concord, N.H.

2. Federal govt. assume responsibility for dually eligible - LCC letter to Congressional Delegation and Tommy Thompson, HHS Secretary; also work with NCSL and National Governor's Assn.

3. Same drug purchasing provisions as VA - Attorney General, Governor

4. Voucher programs -

Janet Schlansky, SRS; Bob Day, SRS
Gina McDonald, Kansas Assn. For Centers of Independent Living
Shannon Jones, Statewide Independent Living Council of Kansas

(6) Public Health Issues (Pages 17-18)

1. Public health environment - Roderick Bremby, Secy. KDHE and Richard Morrissey, Director of the Office of Local and Rural Health with KDHE as part of Healthy Kansas 2010.

2. Healthy living options - Roderick Bremby, Secy. KDHE and Richard Morrissey, Director of the Office of Local and Rural Health with KDHE as part of Healthy Kansas 2010.

3. Living healthier live styles - Roderick Bremby, Secy. KDHE and Richard Morrissey, Director of the Office of Local and Rural Health with KDHE as part of Healthy Kansas 2010.

(7) Directions for the Future (Pages 19-20)

1. Develop Medicaid Benefit Accounts - LCC Interim Tax and Insurance Committee Topic Recommendation.

2. Restrict MBAs to health care - LCC Interim Tax and Insurance Committee Topic Recommendation.

3. Working Healthy program - Gina McDonald and Shannon Jones

4. Solutions for health insurance - LCC Interim Tax and Insurance Committee Topic Recommendation.

(8) An Ongoing Medicaid Review Structure (Pages 20-21)

Dr. Robert St. Peter, Kansas Health Institute

The Task Force would ask that you assign these responsibilities and that you ask for periodic progress reports. Our suggestion in most cases would be that you would receive a progress report every 90 days but would note that there will be exceptions. In all cases we would recommend that a report be required by December 1, 2003 so that the appropriate Legislative committees would have the information available for the 2004 legislative session.

Additionally, it is our understanding that Donald Muse is under contract for one more day in Kansas. We would suggest that his expertise be utilized as a consultant on how best to solve issues between Kansas and the Federal Government and to assist in implementing the data which will become available when the Medicaid Management Information System comes online in October.

Sincerely,

Stan Clark

Attachment: President's Task Force on Medicaid Reform – Final Report to the 2003 Kansas Legislature

Cc: Doug Mays, Speaker of the Kansas House of Representatives
John Ballou, Speaker Pro Tem of the Kansas House of Representatives
Clay Aurand, Majority Leader of the Kansas House of Representatives
Dennis McKinney, Minority Leader of the Kansas House of Representatives
Lana Oleen, Majority Leader of the Kansas Senate
Anthony Hensley, Minority Leader of the Kansas Senate
Members of the President's Task Force on Medicaid Reform

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ALLEN

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	218	218	$279,087	$282,380
Number of Children in Program	150	150		
General Assistance	12	10	20,605	20,513
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	2,261	2,278		
Consumers	2,062	2,022	6,734,105	8,224,749
Major Categories of Service (See Note 2)				
Adult Care Home	163	132	1,684,739	1,464,010
Home and Community Based Services	170	249	1,498,328	2,524,106
Inpatient Hospital	352	298	991,516	805,788
Outpatient Hospital	869	973	117,920	126,550
Pharmacy	1,546	1,532	1,098,465	1,375,591
Physician	1,770	1,831	413,359	400,561
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	971	936	636,735	620,853
Child Care	175	137	327,408	262,572
Employment Preparation Services	49	51	34,801	114,379
(Fiscal Year Unduplicated)				
LIEAP Heating	534	673	75,473	84,547
Rehabilitation Services	117	95	142,588	139,235
Burial	21	11	$11,115	$6,050

1996 COUNTY DEMOGRAPHICS	
Population	14,645
Under 20	4,439
20-64	7,410
65 Plus	2,796
Male	7,081
Female	7,564

ABBREVIATIONS
HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
Note 4: 1996 demographics are not certified as the official population

attachment 9-1

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ANDERSON

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	75	89	$95,175	$120,195
Number of Children in Program	56	64		
General Assistance	5	9	10,623	14,295
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	858	869		
Consumers	769	771	2,947,760	3,383,926
Major Categories of Service (See Note 2)				
Adult Care Home	81	53	727,669	660,266
Home and Community Based Services	98	119	748,451	1,070,908
Inpatient Hospital	122	114	414,701	320,014
Outpatient Hospital	328	366	49,108	38,808
Pharmacy	580	570	510,145	642,496
Physician	548	588	128,403	110,092
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	361	379	228,516	243,873
Child Care	36	47	82,136	121,324
Employment Preparation Services	14	18	19,361	57,711
(Fiscal Year Unduplicated)				
LIEAP Heating	226	217	32,147	28,175
Rehabilitation Services	21	30	20,661	30,852
Burial	0	5	$0	$2,750

1996 COUNTY DEMOGRAPHICS	
Population	8,054
Under 20	2,296
20-64	3,976
65 Plus	1,782
Male	3,917
Female	4,137

ABBREVIATIONS
HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

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Note 4: 1996 demographics are not certified as the official population

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

BOURBON

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	420	334	$535,438	$435,244
Number of Children in Program	296	243		
General Assistance	14	20	23,713	36,616
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	2,467	2,529		
Consumers	2,248	2,248	7,789,964	9,362,022
Major Categories of Service (See Note 2)				
Adult Care Home	203	174	2,158,389	2,009,962
Home and Community Based Services	193	238	1,726,786	2,535,246
Inpatient Hospital	380	425	1,277,545	1,448,709
Outpatient Hospital	948	1,294	143,795	231,539
Pharmacy	1,808	1,806	1,088,417	1,377,466
Physician	1,994	2,122	499,238	530,522
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	1,388	1,263	928,496	844,541
Child Care	128	142	240,140	302,405
Employment Preparation Services	86	73	43,379	58,055
(Fiscal Year Unduplicated)				
LIEAP Heating	1,074	958	143,832	123,909
Rehabilitation Services	59	45	59,819	48,313
Burial	17	11	$9,300	$6,050

1996 COUNTY DEMOGRAPHICS	
Population	15,159
Under 20	4,430
20-64	7,632
65 Plus	3,097
Male	7,199
Female	7,960

ABBREVIATIONS

HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

CHEROKEE

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	630	584	$856,566	$791,465
Number of Children in Program	434	396		
General Assistance	40	39	68,424	64,507
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	4,194	4,166		
Consumers	3,839	3,769	11,068,189	13,411,626
Major Categories of Service (See Note 2)				
Adult Care Home	232	224	2,519,065	2,568,179
Home and Community Based Services	348	433	2,064,194	2,950,534
Inpatient Hospital	593	664	1,706,537	2,118,721
Outpatient Hospital	1,821	2,231	277,394	296,491
Pharmacy	3,053	3,070	2,081,088	2,653,977
Physician	2,759	3,054	775,540	783,905
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	2,316	2,186	1,630,744	1,535,408
Child Care	157	138	266,005	262,242
Employment Preparation Services	98	107	58,973	102,018
(Fiscal Year Unduplicated)				
LIEAP Heating	1,615	1,727	238,199	229,578
Rehabilitation Services	94	129	128,196	179,593
Burial	12	6	$6,445	$3,300

1996 COUNTY DEMOGRAPHICS	
Population	22,505
Under 20	6,552
20-64	12,000
65 Plus	3,953
Male	10,762
Female	11,743

ABBREVIATIONS
HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
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Note 4: 1996 demographics are not certified as the official population

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

COFFEY

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	108	73	$138,708	$94,331
Number of Children in Program	76	49		
General Assistance	7	8	13,751	15,700
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	975	909		
Consumers	868	809	3,964,782	5,005,021
Major Categories of Service (See Note 2)				
Adult Care Home	85	99	1,044,843	1,116,824
Home and Community Based Services	107	136	1,286,297	1,929,565
Inpatient Hospital	137	136	434,717	542,426
Outpatient Hospital	429	482	82,699	57,569
Pharmacy	667	623	563,747	675,690
Physician	736	731	144,609	153,104
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	403	349	270,584	213,803
Child Care	24	20	54,063	44,442
Employment Preparation Services	20	19	1,481	55,942
(Fiscal Year Unduplicated)				
LIEAP Heating	251	192	38,884	32,204
Rehabilitation Services	31	41	23,396	33,536
Burial	1	5	$550	$2,750

1996 COUNTY DEMOGRAPHICS	
Population	8,743
Under 20	2,561
20-64	4,448
65 Plus	1,734
Male	4,346
Female	4,397

ABBREVIATIONS
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HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

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Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
Note 4: 1996 demographics are not certified as the official population

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

CRAWFORD

	Customers		Annual Expenditures	
PROGRAM SERVICES	**FY 1998**	**FY 1999**	**FY 1998**	**FY 1999**
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	717	635	$936,554	$820,987
Number of Children in Program	475	424		
General Assistance	48	53	83,299	99,016
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	5,762	5,678		
Consumers	5,350	5,233	19,769,273	25,175,325
Major Categories of Service (See Note 2)				
Adult Care Home	547	545	8,514,703	8,897,860
Home and Community Based Services	310	417	2,150,289	4,479,429
Inpatient Hospital	1,012	1,061	2,671,456	3,379,288
Outpatient Hospital	2,871	3,225	421,547	517,212
Pharmacy	3,969	3,951	2,516,343	3,302,826
Physician	4,219	4,475	921,515	994,090
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	2,889	2,679	2,002,186	1,840,269
Child Care	301	308	597,680	641,690
Employment Preparation Services	169	144	97,805	179,050
(Fiscal Year Unduplicated)				
LIEAP Heating	2,151	2,179	307,872	298,567
Rehabilitation Services	204	243	226,133	250,733
Burial	22	24	$12,100	$12,650

1996 COUNTY DEMOGRAPHICS	
Population	36,337
Under 20	9,782
20-64	19,403
65 Plus	7,152
Male	17,558
Female	18,779

ABBREVIATIONS
HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DOUGLAS

	Customers		Annual Expenditures	
PROGRAM SERVICES	**FY 1998**	**FY 1999**	**FY 1998**	**FY 1999**
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	1,103	853	$1,637,879	$1,226,757
Number of Children in Program	752	600		
General Assistance	77	74	164,277	155,314
Refugee Assistance	5	0	534	212
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	6,917	6,917		
Consumers	6,249	6,199	27,638,001	31,931,822
Major Categories of Service (See Note 2)				
Adult Care Home	391	394	8,323,867	8,215,895
Home and Community Based Services	388	477	7,874,415	10,026,898
Inpatient Hospital	945	820	3,313,515	3,124,606
Outpatient Hospital	2,756	2,452	363,413	320,808
Pharmacy	4,345	3,833	3,116,700	3,683,516
Physician	4,692	4,953	1,215,115	1,071,183
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	3,231	3,052	2,462,823	2,259,201
Child Care	479	540	1,517,472	1,833,066
Employment Preparation Services	200	174	154,254	242,507
(Fiscal Year Unduplicated)				
LIEAP Heating	1,207	1,317	147,353	161,578
Rehabilitation Services	419	540	366,540	736,932
Burial	13	20	$7,111	$11,000

1996 COUNTY DEMOGRAPHICS		ABBREVIATIONS
Population	89,899	HIPPS: Health Insurance Premium Pay. Sys.
Under 20	25,362	HCBS: Home & Community Based Svcs.
20-64	57,045	LIEAP: Low Income Energy Assistance Pgm.
65 Plus	7,492	
Male	44,789	
Female	45,110	

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ELLIS

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	133	137	$198,462	$189,354
Number of Children in Program	91	95		
General Assistance	15	21	28,650	37,929
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	2,245	2,211		
Consumers	2,064	1,978	11,470,651	13,415,407
Major Categories of Service (See Note 2)				
Adult Care Home	237	253	3,397,755	3,621,308
Home and Community Based Services	167	213	3,282,823	4,780,876
Inpatient Hospital	357	380	1,243,124	1,119,353
Outpatient Hospital	762	905	138,084	137,690
Pharmacy	1,483	1,447	1,195,658	1,476,800
Physician	1,293	1,332	332,249	355,819
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	1,053	963	704,581	616,150
Child Care	146	89	368,955	387,668
Employment Preparation Services	35	24	5,537	7,180
(Fiscal Year Unduplicated)				
LIEAP Heating	434	478	59,193	72,578
Rehabilitation Services	126	143	57,295	118,432
Burial	9	9	$4,950	$4,950

1996 COUNTY DEMOGRAPHICS	
Population	26,186
Under 20	8,012
20-64	14,646
65 Plus	3,528
Male	12,892
Female	13,294

ABBREVIATIONS

HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
Note 4: 1996 demographics are not certified as the official population

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

FORD

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	390	498	$504,044	$647,739
Number of Children in Program	288	345		
General Assistance	15	21	28,630	35,402
Refugee Assistance	5	0	2,375	507
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	3,734	3,965		
Consumers	3,152	3,372	10,317,736	11,474,467
Major Categories of Service (See Note 2)				
Adult Care Home	145	145	2,048,122	1,951,409
Home and Community Based Services	172	198	3,206,637	3,415,495
Inpatient Hospital	745	707	1,591,917	1,870,056
Outpatient Hospital	910	1,082	112,909	120,998
Pharmacy	2,017	2,078	1,044,111	1,251,164
Physician	2,749	3,064	739,259	849,433
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	1,277	1,312	894,446	993,864
Child Care	183	206	403,312	479,079
Employment Preparation Services	77	108	26,654	66,810
(Fiscal Year Unduplicated)				
LIEAP Heating	386	385	36,895	43,904
Rehabilitation Services	110	122	101,380	81,111
Burial	10	10	$5,500	$5,375

1996 COUNTY DEMOGRAPHICS	
Population	29,309
Under 20	9,690
20-64	16,005
65 Plus	3,614
Male	14,920
Female	14,389

ABBREVIATIONS
HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

FRANKLIN

	Customers		Annual Expenditures	
PROGRAM SERVICES	**FY 1998**	**FY 1999**	**FY 1998**	**FY 1999**
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	413	343	$586,147	$454,002
Number of Children in Program	277	232		
General Assistance	25	25	44,276	40,589
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	3,025	3,070		
Consumers	2,712	2,744	10,069,655	11,064,700
Major Categories of Service (See Note 2)				
Adult Care Home	194	178	2,095,917	2,154,996
Home and Community Based Services	230	288	2,098,152	2,797,489
Inpatient Hospital	502	354	1,801,647	1,378,987
Outpatient Hospital	1,229	1,233	220,330	204,594
Pharmacy	1,961	1,822	1,381,875	1,702,504
Physician	1,947	2,018	491,442	435,161
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	1,325	1,236	946,349	857,525
Child Care	224	210	583,255	602,759
Employment Preparation Services	86	96	77,144	153,501
(Fiscal Year Unduplicated)				
LIEAP Heating	468	562	73,448	77,343
Rehabilitation Services	96	131	95,408	106,447
Burial	12	6	$6,600	$3,300

1996 COUNTY DEMOGRAPHICS	
Population	23,565
Under 20	7,197
20-64	12,633
65 Plus	3,735
Male	11,469
Female	12,096

ABBREVIATIONS
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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

JOHNSON

	Customers		Annual Expenditures	
PROGRAM SERVICES	**FY 1998**	**FY 1999**	**FY 1998**	**FY 1999**
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	1,167	989	$1,932,226	$1,569,718
Number of Children in Program	842	729		
General Assistance	100	111	195,513	216,223
Refugee Assistance	6	3	10,632	5,523
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	12,666	12,631		
Consumers	11,155	10,816	66,871,265	81,327,713
Major Categories of Service (See Note 2)				
Adult Care Home	1,579	1,821	26,388,651	32,344,581
Home and Community Based Services	958	1,204	15,293,432	18,721,676
Inpatient Hospital	1,810	1,692	7,471,127	8,532,904
Outpatient Hospital	3,962	4,301	617,201	678,426
Pharmacy	7,322	7,402	7,524,243	9,310,890
Physician	8,154	8,611	2,217,714	1,947,122
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	3,697	3,411	2,668,499	2,423,256
Child Care	685	743	2,274,300	2,702,619
Employment Preparation Services	247	233	66,097	190,896
(Fiscal Year Unduplicated)				
LIEAP Heating	1,737	1,745	203,675	191,448
Rehabilitation Services	1,188	1,221	1,249,520	1,915,797
Burial	28	24	$15,850	$12,971

1996 COUNTY DEMOGRAPHICS	
Population	408,341
Under 20	118,378
20-64	252,051
65 Plus	37,912
Male	198,317
Female	210,024

ABBREVIATIONS
HIPPS: Health Insurance Premium Pay. Sys.
HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
Note 4: 1996 demographics are not certified as the official population

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

OSAGE

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	213	193	$294,629	$280,283
Number of Children in Program	151	139		
General Assistance	12	14	25,044	30,072
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	1,650	1,677		
Consumers	1,494	1,521	6,401,402	7,796,964
Major Categories of Service (See Note 2)				
Adult Care Home	182	193	2,409,413	2,542,184
Home and Community Based Services	146	184	1,184,457	1,883,607
Inpatient Hospital	207	241	1,034,790	904,356
Outpatient Hospital	528	629	68,222	71,356
Pharmacy	1,104	1,157	762,967	1,010,980
Physician	1,074	1,201	273,556	367,195
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	794	737	564,209	537,266
Child Care	76	98	152,885	215,376
Employment Preparation Services	39	37	20,320	110,386
(Fiscal Year Unduplicated)				
LIEAP Heating	385	373	57,255	50,579
Rehabilitation Services	45	44	85,470	54,804
Burial	4	4	$2,200	$2,750

1996 COUNTY DEMOGRAPHICS	
Population	16,726
Under 20	4,888
20-64	8,910
65 Plus	2,928
Male	8,206
Female	8,520

ABBREVIATIONS
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Note 4: 1996 demographics are not certified as the official population

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

RENO

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	1,002	684	$1,377,012	$1,008,304
Number of Children in Program	702	484		
General Assistance	67	64	141,150	127,378
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	7,439	7,275		
Consumers	6,826	6,604	25,908,815	30,304,632
Major Categories of Service (See Note 2)				
Adult Care Home	594	576	9,932,388	9,250,705
Home and Community Based Services	398	516	4,111,189	5,666,849
Inpatient Hospital	1,241	1,261	3,246,192	4,415,907
Outpatient Hospital	2,851	3,400	363,570	482,828
Pharmacy	5,289	5,324	3,402,834	4,213,129
Physician	4,916	5,346	1,544,417	1,839,221
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	3,746	3,505	2,714,968	2,611,466
Child Care	410	444	916,841	1,111,062
Employment Preparation Services	136	124	56,149	60,075
(Fiscal Year Unduplicated)				
LIEAP Heating	1,697	1,711	237,058	223,720
Rehabilitation Services	283	348	116,074	211,286
Burial	28	36	$15,117	$19,450

1996 COUNTY DEMOGRAPHICS	
Population	62,901
Under 20	17,938
20-64	34,820
65 Plus	10,143
Male	31,121
Female	31,780

ABBREVIATIONS
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LIEAP: Low Income Energy Assistance Pgm.

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

SEDGWICK

	Customers		Annual Expenditures	
PROGRAM SERVICES	**FY 1998**	**FY 1999**	**FY 1998**	**FY 1999**
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	10,855	7,785	$15,227,150	$10,896,856
Number of Children in Program	7,653	5,669		
General Assistance	704	613	1,341,831	1,152,166
Refugee Assistance	47	11	60,231	16,732
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	51,130	48,969		
Consumers	46,703	43,756	144,093,712	163,630,136
Major Categories of Service (See Note 2)				
Adult Care Home	1,975	2,012	29,616,278	30,556,291
Home and Community Based Services	1,752	2,248	24,400,933	31,383,557
Inpatient Hospital	7,971	9,066	30,725,443	30,057,886
Outpatient Hospital	17,472	20,087	2,556,906	2,826,745
Pharmacy	33,665	31,617	20,146,755	23,214,384
Physician	38,508	40,341	11,801,761	12,679,318
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	27,554	24,750	21,946,491	19,696,647
Child Care	2,083	2,460	6,623,876	8,070,977
Employment Preparation Services	1,438	1,486	1,164,162	1,179,152
(Fiscal Year Unduplicated)				
LIEAP Heating	9,343	9,617	1,130,143	1,112,723
Rehabilitation Services	1,372	1,536	1,113,344	1,291,979
Burial	203	176	$112,502	$97,513

1996 COUNTY DEMOGRAPHICS	
Population	422,437
Under 20	128,485
20-64	246,040
65 Plus	47,912
Male	207,280
Female	215,157

ABBREVIATIONS
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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

SHAWNEE

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	3,652	3,052	$5,196,826	$4,403,714
Number of Children in Program	2,615	2,203		
General Assistance	202	242	395,501	484,283
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	19,255	18,969		
Consumers	17,648	17,095	65,046,728	81,231,259
Major Categories of Service (See Note 2)				
Adult Care Home	1,310	1,353	17,187,533	17,577,875
Home and Community Based Services	1,063	1,377	16,314,584	22,500,990
Inpatient Hospital	2,330	2,732	8,527,194	10,808,241
Outpatient Hospital	7,914	9,408	791,992	1,010,944
Pharmacy	12,394	12,256	9,369,673	11,754,794
Physician	12,759	13,896	3,302,057	3,414,091
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	9,580	8,786	7,118,067	6,714,950
Child Care	1,302	1,421	3,685,708	4,373,318
Employment Preparation Services	521	563	708,249	1,006,042
(Fiscal Year Unduplicated)				
LIEAP Heating	4,627	4,738	558,594	536,713
Rehabilitation Services	1,319	1,494	1,314,660	1,312,665
Burial	60	84	$32,890	$44,281

1996 COUNTY DEMOGRAPHICS	
Population	164,938
Under 20	46,975
20-64	96,431
65 Plus	21,532
Male	79,907
Female	85,031

ABBREVIATIONS

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WABAUNSEE

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	15	23	$28,280	$28,113
Number of Children in Program	11	17		
General Assistance	1	2	1,181	4,348
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	350	375		
Consumers	313	344	2,342,381	2,362,290
Major Categories of Service (See Note 2)				
Adult Care Home	97	108	1,348,223	1,389,690
Home and Community Based Services	21	26	185,844	113,397
Inpatient Hospital	36	45	150,638	166,855
Outpatient Hospital	135	172	23,732	20,536
Pharmacy	266	284	376,147	450,361
Physician	300	282	92,726	56,683
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	104	111	61,223	72,024
Child Care	6	8	14,329	16,042
Employment Preparation Services	0	2	0	292
(Fiscal Year Unduplicated)				
LIEAP Heating	94	113	12,992	13,598
Rehabilitation Services	20	24	13,523	36,260
Burial	0	2	$0	$1,100

1996 COUNTY DEMOGRAPHICS	
Population	6,664
Under 20	1,952
20-64	3,532
65 Plus	1,180
Male	3,314
Female	3,350

ABBREVIATIONS
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LIEAP: Low Income Energy Assistance Pgm.

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WOODSON

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	25	23	$38,967	$36,232
Number of Children in Program	17	16		
General Assistance	4	4	5,507	5,511
Refugee Assistance	0	0	0	0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	403	416		
Consumers	378	380	1,849,729	2,167,874
Major Categories of Service (See Note 2)				
Adult Care Home	38	43	380,625	488,362
Home and Community Based Services	37	51	557,339	652,910
Inpatient Hospital	85	78	182,194	146,615
Outpatient Hospital	147	182	19,049	24,165
Pharmacy	344	351	337,461	417,849
Physician	378	402	82,090	80,368
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	238	217	146,208	125,392
Child Care	12	8	29,065	20,350
Employment Preparation Services	3	1	70	56
(Fiscal Year Unduplicated)				
LIEAP Heating	192	217	34,245	36,763
Rehabilitation Services	16	28	18,834	41,563
Burial	1	2	$550	$1,100

1996 COUNTY DEMOGRAPHICS	
Population	3,980
Under 20	1,020
20-64	1,902
65 Plus	1,058
Male	1,954
Female	2,026

ABBREVIATIONS
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HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
Note 4: 1996 demographics are not certified as the official population

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WYANDOTTE

PROGRAM SERVICES	Customers FY 1998	Customers FY 1999	Annual Expenditures FY 1998	Annual Expenditures FY 1999
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	6,842	5,669	$9,625,104	$7,900,121
Number of Children in Program	4,986	4,173		
General Assistance	261	263	481,280	490,791
Refugee Assistance	12	7	12,863	12,374
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Beneficiaries	28,092	26,859		
Consumers	25,294	23,724	78,749,139	83,660,124
Major Categories of Service (See Note 2)				
Adult Care Home	1,002	950	15,010,460	11,927,658
Home and Community Based Services	795	1,098	10,625,838	14,681,550
Inpatient Hospital	4,444	3,955	25,036,782	24,888,190
Outpatient Hospital	9,864	9,991	1,628,785	1,404,323
Pharmacy	15,353	13,260	8,180,709	9,504,623
Physician	18,552	19,100	5,561,140	4,462,842
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	14,037	12,333	10,689,717	9,363,606
Child Care	1,050	1,204	3,202,065	3,782,766
Employment Preparation Services	370	861	216,971	496,245
(Fiscal Year Unduplicated)				
LIEAP Heating	4,312	4,137	489,680	445,537
Rehabilitation Services	770	835	593,758	892,818
Burial	55	56	$29,061	$29,704

1996 COUNTY DEMOGRAPHICS	
Population	153,427
Under 20	47,755
20-64	85,875
65 Plus	19,797
Male	73,409
Female	80,018

ABBREVIATIONS
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HCBS: Home & Community Based Svcs.
LIEAP: Low Income Energy Assistance Pgm.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
Note 4: 1996 demographics are not certified as the official population

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ALLEN

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	268	291	$360,062	$379,203
Number of Children in Program	181	192	N/A	N/A
General Assistance	14	15	$26,639	$27,610
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	2,581	2,739	$12,013,209	$12,051,358
HealthWave Beneficiaries	290	268	$298,947	$242,452
Major Categories of Service (See Note 2)				
Adult Care Home	136	130	$2,023,928	$2,100,584
Home and Community Based Services				
Head Injury	0	0	$0	$0
Technology Assisted Children	0	0	$0	$0
Mental Retardation/Developmental Disability	52	51	$1,560,408	$1,505,095
Severe Emotional Disturbance	7	8	$28,535	$28,385
Physically Disabled	69	72	$736,344	$733,234
Inpatient Hospital	289	241	$1,098,874	$732,864
Outpatient Hospital	869	753	$250,154	$193,729
Pharmacy	1,439	1,383	$2,036,651	$2,086,610
Physician	1,449	1,399	$444,292	$407,738
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	1,266	1,418	$931,277	$1,095,073
Child Care	130	132	$270,620	$293,342
Employment Preparation Services	136	169	$126,929	$97,669
(Fiscal Year Unduplicated)				
LIEAP Heating	1,019	1,102	$116,194	$152,778
Rehabilitation Services	86	80	$228,312	$138,879
Burial	10	7	$5,500	$3,850
Family Preservation	33	38	N/A	N/A
Children in SRS Custody	107	107	N/A	N/A

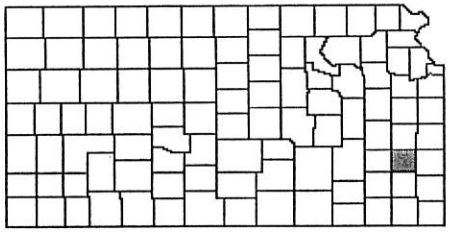
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	14,385
Under 20	4,194
20-64	7,598
65 Plus	2,593
Male	7,029
Female	7,356

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

Attachment 10-1

7-61

10-61

ANDERSON

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	103	135	$133,499	$182,122
Number of Children in Program	70	90	N/A	N/A
General Assistance	10	9	$18,343	$15,502
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	1,067	1,132	$4,972,351	$4,416,576
HealthWave Beneficiaries	174	169	$178,130	$185,736
Major Categories of Service (See Note 2)				
Adult Care Home	67	49	$1,031,519	$959,799
Home and Community Based Services				
Head Injury	0	0	$0	$0
Technology Assisted Children	0	0	$0	$0
Mental Retardation/Developmental Disability	20	20	$419,982	$428,712
Severe Emotional Disturbance	14	16	$63,266	$61,799
Physically Disabled	32	33	$274,484	$285,253
Inpatient Hospital	109	104	$938,419	$460,042
Outpatient Hospital	355	366	$132,435	$82,958
Pharmacy	524	522	$708,242	$752,751
Physician	538	498	$193,843	$138,196
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	433	530	$323,567	$422,513
Child Care	42	45	$99,639	$118,627
Employment Preparation Services	48	69	$68,308	$63,907
(Fiscal Year Unduplicated)				
LIEAP Heating	313	383	$36,171	$49,937
Rehabilitation Services	22	19	$54,862	$41,962
Burial	3	0	$1,650	$0
Family Preservation	53	34	N/A	N/A
Children in SRS Custody	26	25	N/A	N/A

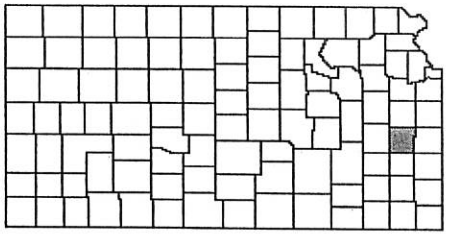
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	8,110
Under 20	2,345
20-64	4,139
65 Plus	1,626
Male	3,987
Female	4,123

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

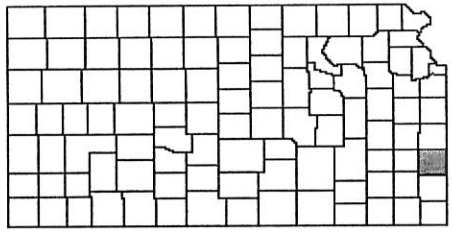
LIEAP: Low Income Energy Assistance Program

BOURBON

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	248	311	$340,116	$407,191
Number of Children in Program	183	218	N/A	N/A
General Assistance	25	32	$42,913	$58,252
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	2,716	2,888	$13,255,109	$13,097,676
HealthWave Beneficiaries	353	387	$341,495	$354,563
Major Categories of Service (See Note 2)				
Adult Care Home	136	105	$2,449,271	$2,164,555
Home and Community Based Services				
Head Injury	0	0	$0	$0
Technology Assisted Children	1	1	$2,300	$2,150
Mental Retardation/Developmental Disability	51	45	$1,554,275	$1,446,711
Severe Emotional Disturbance	8	9	$23,818	$24,067
Physically Disabled	76	77	$1,003,199	$1,178,503
Inpatient Hospital	446	469	$1,940,322	$2,225,715
Outpatient Hospital	1,192	1,305	$301,195	$309,791
Pharmacy	1,794	1,954	$2,244,538	$2,130,288
Physician	1,896	2,129	$672,076	$762,526
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	1,315	1,572	$954,561	$1,251,389
Child Care	175	154	$450,844	$411,139
Employment Preparation Services	107	175	$54,649	$131,030
(Fiscal Year Unduplicated)				
LIEAP Heating	1,019	1,282	$128,015	$185,626
Rehabilitation Services	36	32	$39,518	$31,188
Burial	6	7	$2,800	$3,850
Family Preservation	156	143	N/A	N/A
Children in SRS Custody	59	79	N/A	N/A

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	15,379
Under 20	4,529
20-64	8,046
65 Plus	2,804
Male	7,412
Female	7,967

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System
HCBS: Home and Community Based Services
LIEAP: Low Income Energy Assistance Program

CHEROKEE

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	630	642	$845,379	$864,699
Number of Children in Program	404	406	N/A	N/A
General Assistance	81	71	$137,109	$125,306
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	4,563	4,894	$19,305,036	$21,153,135
HealthWave Beneficiaries	426	484	$367,190	$439,608
Major Categories of Service (See Note 2)				
Adult Care Home	177	188	$3,048,541	$2,956,684
Home and Community Based Services				
Head Injury	6	6	$203,000	$144,175
Technology Assisted Children	0	0	$0	$0
Mental Retardation/Developmental Disability	59	58	$777,565	$844,770
Severe Emotional Disturbance	25	30	$118,481	$124,214
Physically Disabled	225	238	$1,886,947	$2,365,200
Inpatient Hospital	681	627	$2,303,605	$2,687,952
Outpatient Hospital	2,131	2,371	$525,556	$575,177
Pharmacy	3,199	3,384	$4,257,560	$4,528,208
Physician	3,060	3,321	$1,140,349	$1,175,478
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	2,337	2,541	$1,850,918	$2,139,294
Child Care	146	155	$313,604	$354,493
Employment Preparation Services	220	261	$169,798	$189,282
(Fiscal Year Unduplicated)				
LIEAP Heating	2,012	2,131	$242,424	$313,086
Rehabilitation Services	150	116	$199,579	$88,192
Burial	4	8	$2,200	$4,400
Family Preservation	173	139	N/A	N/A
Children in SRS Custody	124	126	N/A	N/A

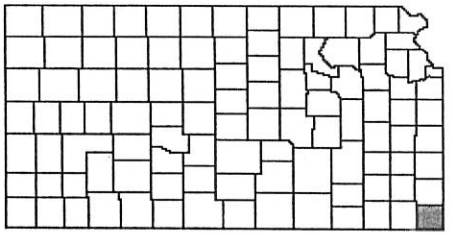
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	22,605
Under 20	6,626
20-64	12,554
65 Plus	3,425
Male	10,963
Female	11,642

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

COFFEY

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	89	80	$122,969	$113,732
Number of Children in Program	57	52	N/A	N/A
General Assistance	12	18	$21,568	$30,800
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	1,101	1,277	$6,271,968	$7,129,149
HealthWave Beneficiaries	195	197	$203,227	$182,853
Major Categories of Service (See Note 2)				
Adult Care Home	74	77	$1,355,143	$1,455,292
Home and Community Based Services				
Head Injury	3	8	$196,244	$240,566
Technology Assisted Children	0	0	$0	$0
Mental Retardation/Developmental Disability	62	62	$1,772,081	$1,893,039
Severe Emotional Disturbance	2	3	$8,873	$13,926
Physically Disabled	28	32	$224,322	$231,394
Inpatient Hospital	84	107	$357,624	$431,154
Outpatient Hospital	385	419	$83,756	$119,939
Pharmacy	553	617	$997,739	$1,090,009
Physician	587	652	$160,554	$186,306
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	467	577	$350,770	$461,907
Child Care	34	24	$71,327	$56,049
Employment Preparation Services	34	39	$31,672	$19,565
(Fiscal Year Unduplicated)				
LIEAP Heating	276	413	$41,625	$63,804
Rehabilitation Services	57	45	$31,789	$40,554
Burial	4	5	$2,200	$2,750
Family Preservation	41	21	N/A	N/A
Children in SRS Custody	21	24	N/A	N/A

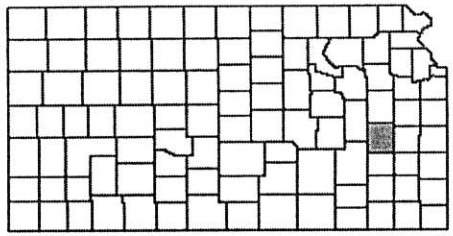
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	8,865
Under 20	2,585
20-64	4,841
65 Plus	1,439
Male	4,347
Female	4,518

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

CRAWFORD

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	892	960	$1,175,699	$1,292,983
Number of Children in Program	556	608	N/A	N/A
General Assistance	80	102	$147,294	$183,443
Refugee Assistance	0	1	$0	$166
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	6,751	7,227	$36,181,429	$38,339,188
HealthWave Beneficiaries	613	684	$603,265	$626,913
Major Categories of Service (See Note 2)				
Adult Care Home	514	481	$9,591,503	$8,958,249
Home and Community Based Services				
Head Injury	3	5	$62,164	$30,619
Technology Assisted Children	0	0	$0	$0
Mental Retardation/Developmental Disability	183	186	$4,860,766	$5,959,371
Severe Emotional Disturbance	33	29	$225,302	$215,875
Physically Disabled	180	204	$1,730,783	$2,216,168
Inpatient Hospital	802	865	$3,020,655	$3,254,055
Outpatient Hospital	2,373	2,551	$660,961	$715,378
Pharmacy	3,721	3,903	$5,191,718	$5,660,660
Physician	3,729	4,012	$1,152,711	$1,317,166
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	3,158	3,800	$2,559,756	$3,304,484
Child Care	312	337	$667,495	$817,421
Employment Preparation Services	423	509	$396,861	$1,556
(Fiscal Year Unduplicated)				
LIEAP Heating	2,708	3,158	$350,875	$466,430
Rehabilitation Services	250	211	$474,066	$202,529
Burial	29	22	$15,539	$12,100
Family Preservation	243	248	N/A	N/A
Children in SRS Custody	263	254	N/A	N/A

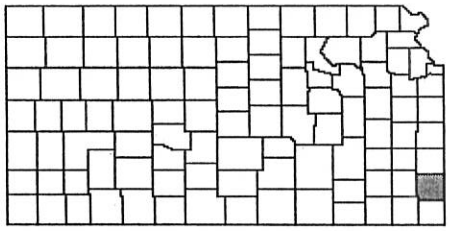
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	38,242
Under 20	10,579
20-64	21,753
65 Plus	5,910
Male	18,634
Female	19,608

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

DOUGLAS

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	737	750	$1,130,845	$1,146,545
Number of Children in Program	510	512	N/A	N/A
General Assistance	76	96	$160,326	$205,481
Refugee Assistance	1	0	$868	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	7,737	8,319	$41,448,679	$43,755,944
HealthWave Beneficiaries	980	1,112	$1,015,950	$1,126,001
Major Categories of Service (See Note 2)				
Adult Care Home	326	328	$8,475,091	$8,746,333
Home and Community Based Services				
Head Injury	6	17	$55,480	$58,063
Technology Assisted Children	2	3	$5,190	$7,930
Mental Retardation/Developmental Disability	305	312	$9,786,782	$9,840,645
Severe Emotional Disturbance	36	57	$291,252	$391,403
Physically Disabled	142	160	$2,129,636	$2,409,438
Inpatient Hospital	564	597	$2,975,774	$3,861,977
Outpatient Hospital	2,039	2,824	$539,070	$515,877
Pharmacy	3,246	3,359	$5,172,511	$5,494,405
Physician	3,413	3,646	$1,062,781	$1,266,337
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	3,134	3,700	$2,634,644	$3,268,484
Child Care	513	549	$2,005,309	$2,502,808
Employment Preparation Services	317	455	$241,211	$16,083
(Fiscal Year Unduplicated)				
LIEAP Heating	1,489	2,098	$169,322	$272,847
Rehabilitation Services	559	578	$709,073	$709,441
Burial	25	22	$13,750	$12,100
Family Preservation	362	298	N/A	N/A
Children in SRS Custody	187	172	N/A	N/A

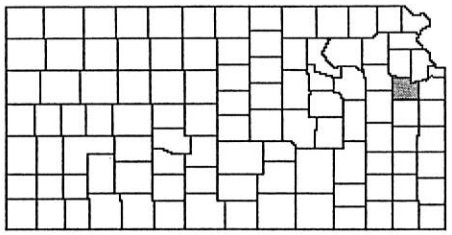
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	99,962
Under 20	27,535
20-64	64,490
65 Plus	7,937
Male	49,651
Female	50,311

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

ELLIS

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	115	144	$156,270	$205,085
Number of Children in Program	79	95	N/A	N/A
General Assistance	18	17	$33,103	$30,385
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	2,620	2,825	$17,106,992	$17,364,565
HealthWave Beneficiaries	379	434	$447,962	$471,706
Major Categories of Service (See Note 2)				
Adult Care Home	219	196	$3,687,409	$3,721,251
Home and Community Based Services				
Head Injury	4	6	$105,169	$89,783
Technology Assisted Children	1	1	$3,030	$3,015
Mental Retardation/Developmental Disability	139	141	$4,618,726	$4,500,477
Severe Emotional Disturbance	26	32	$102,073	$73,179
Physically Disabled	42	45	$616,267	$701,060
Inpatient Hospital	213	206	$1,011,500	$777,335
Outpatient Hospital	710	725	$215,154	$162,624
Pharmacy	1,229	1,309	$2,232,617	$2,501,514
Physician	1,012	1,103	$315,284	$336,064
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	995	1,129	$708,300	$872,980
Child Care	70	122	$201,818	$258,997
Employment Preparation Services	69	88	$45,418	$122,903
(Fiscal Year Unduplicated)				
LIEAP Heating	584	790	$81,555	$118,820
Rehabilitation Services	146	153	$105,664	$112,484
Burial	8	10	$4,400	$5,279
Family Preservation	61	66	N/A	N/A
Children in SRS Custody	85	72	N/A	N/A

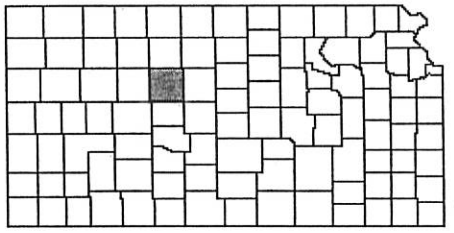
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	27,507
Under 20	7,616
20-64	15,952
65 Plus	3,939
Male	13,461
Female	14,046

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

FORD

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	511	567	$665,690	$728,538
Number of Children in Program	359	396	N/A	N/A
General Assistance	20	22	$40,053	$42,913
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	4,888	5,043	$16,131,223	$16,873,154
HealthWave Beneficiaries	721	801	$786,867	$849,041
Major Categories of Service (See Note 2)				
Adult Care Home	159	161	$2,856,704	$2,997,880
Home and Community Based Services				
Head Injury	0	1	$0	$663
Technology Assisted Children	0	0	$0	$0
Mental Retardation/Developmental Disability	103	99	$3,146,211	$3,207,528
Severe Emotional Disturbance	26	45	$171,168	$165,392
Physically Disabled	40	48	$926,373	$1,011,390
Inpatient Hospital	669	606	$2,050,642	$1,757,144
Outpatient Hospital	1,006	983	$185,716	$180,677
Pharmacy	2,051	2,025	$1,921,296	$2,017,239
Physician	2,514	2,488	$979,082	$933,715
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	1,569	1,846	$1,242,295	$1,538,561
Child Care	266	266	$628,948	$649,557
Employment Preparation Services	192	220	$180,692	$18,413
(Fiscal Year Unduplicated)				
LIEAP Heating	526	654	$55,578	$80,786
Rehabilitation Services	74	78	$74,028	$62,177
Burial	16	14	$8,800	$7,700
Family Preservation	89	155	N/A	N/A
Children in SRS Custody	173	141	N/A	N/A

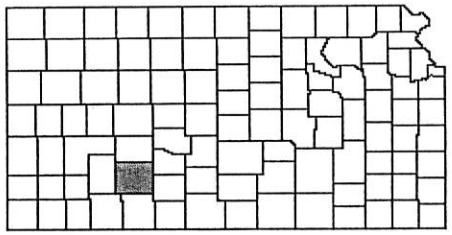
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	32,458
Under 20	11,184
20-64	17,708
65 Plus	3,566
Male	16,791
Female	15,667

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

FRANKLIN

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	306	306	$417,944	$419,043
Number of Children in Program	208	203	N/A	N/A
General Assistance	31	25	$55,853	$48,054
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	3,568	3,754	$17,024,786	$17,059,084
HealthWave Beneficiaries	473	501	$489,675	$480,904
Major Categories of Service (See Note 2)				
Adult Care Home	195	152	$2,568,682	$2,428,215
Home and Community Based Services				
Head Injury	0	1	$0	$10,813
Technology Assisted Children	3	2	$9,885	$5,690
Mental Retardation/Developmental Disability	88	89	$2,215,204	$2,114,895
Severe Emotional Disturbance	30	33	$130,895	$146,647
Physically Disabled	101	113	$1,057,645	$1,097,922
Inpatient Hospital	379	376	$1,757,007	$1,573,190
Outpatient Hospital	1,237	1,366	$359,414	$375,190
Pharmacy	1,822	1,966	$2,813,854	$2,940,610
Physician	1,705	1,819	$585,211	$617,143
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	1,440	1,759	$1,130,340	$1,462,037
Child Care	196	212	$611,287	$622,856
Employment Preparation Services	180	256	$105,970	$11,946
(Fiscal Year Unduplicated)				
LIEAP Heating	698	931	$91,288	$130,333
Rehabilitation Services	73	70	$52,560	$65,468
Burial	7	7	$3,759	$3,850
Family Preservation	68	57	N/A	N/A
Children in SRS Custody	108	96	N/A	N/A

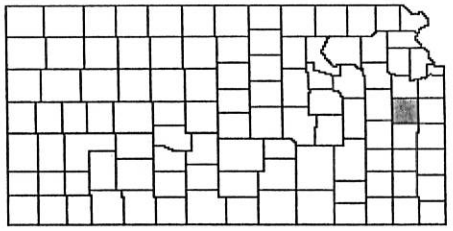
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	24,784
Under 20	7,528
20-64	13,780
65 Plus	3,476
Male	12,284
Female	12,500

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

JOHNSON

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	1,106	1,264	$1,721,096	$1,936,975
Number of Children in Program	801	909	N/A	N/A
General Assistance	129	150	$259,118	$288,816
Refugee Assistance	2	3	$3,602	$5,090
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	18,525	21,869	$118,752,241	$131,447,590
HealthWave Beneficiaries	2,879	3,416	$3,574,397	$4,209,269
Major Categories of Service (See Note 2)				
Adult Care Home	1,833	1,786	$39,092,495	$41,412,931
Home and Community Based Services				
Head Injury	34	47	$1,033,954	$1,287,685
Technology Assisted Children	8	12	$28,475	$33,914
Mental Retardation/Developmental Disability	678	693	$16,438,693	$17,653,764
Severe Emotional Disturbance	218	241	$782,158	$829,694
Physically Disabled	304	324	$4,146,532	$3,657,848
Inpatient Hospital	2,172	2,699	$11,735,340	$15,227,989
Outpatient Hospital	4,434	5,661	$959,700	$1,340,486
Pharmacy	8,436	10,469	$14,929,640	$17,367,557
Physician	8,777	11,397	$3,002,388	$4,362,796
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	4,883	6,278	$3,836,809	$5,244,863
Child Care	952	1,071	$3,834,224	$4,794,490
Employment Preparation Services	344	476	$247,583	$62,006
(Fiscal Year Unduplicated)				
LIEAP Heating	2,662	3,579	$263,571	$412,882
Rehabilitation Services	1,382	1,632	$1,906,608	$2,219,907
Burial	32	32	$17,361	$17,495
Family Preservation	842	721	N/A	N/A
Children in SRS Custody	522	578	N/A	N/A

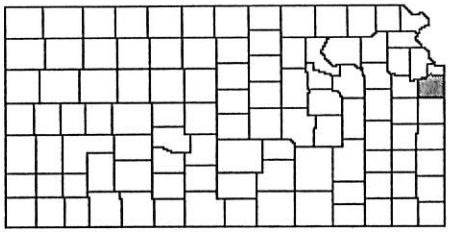
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	451,086
Under 20	132,194
20-64	273,823
65 Plus	45,069
Male	220,329
Female	230,757

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

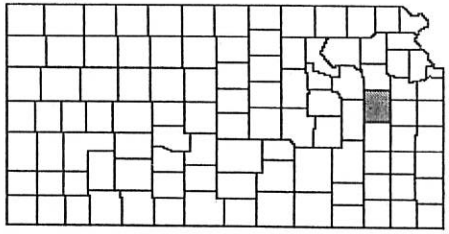
LIEAP: Low Income Energy Assistance Program

OSAGE

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	204	198	$279,889	$278,766
Number of Children in Program	142	140	N/A	N/A
General Assistance	16	22	$26,435	$39,585
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	2,211	2,223	$9,503,010	$9,500,736
HealthWave Beneficiaries	319	361	$322,520	$344,298
Major Categories of Service (See Note 2)				
Adult Care Home	145	124	$2,338,305	$2,056,979
Home and Community Based Services				
Head Injury	0	1	$0	$72,431
Technology Assisted Children	0	0	$0	$0
Mental Retardation/Developmental Disability	45	46	$1,282,351	$1,272,317
Severe Emotional Disturbance	4	7	$19,901	$35,719
Physically Disabled	48	48	$739,553	$551,482
Inpatient Hospital	175	199	$637,871	$595,027
Outpatient Hospital	513	485	$122,672	$119,863
Pharmacy	1,104	1,037	$1,640,611	$1,671,503
Physician	1,078	1,099	$322,926	$387,931
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	803	927	$625,170	$767,764
Child Care	102	84	$264,931	$218,026
Employment Preparation Services	81	80	$63,909	$185,788
(Fiscal Year Unduplicated)				
LIEAP Heating	562	681	$68,640	$90,473
Rehabilitation Services	45	50	$70,024	$59,508
Burial	2	5	$1,100	$2,750
Family Preservation	101	119	N/A	N/A
Children in SRS Custody	54	43	N/A	N/A

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	16,712
Under 20	4,893
20-64	9,171
65 Plus	2,648
Male	8,184
Female	8,528

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System
HCBS: Home and Community Based Services
LIEAP: Low Income Energy Assistance Program

RENO

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	807	1,091	$1,176,236	$1,553,810
Number of Children in Program	553	739	N/A	N/A
General Assistance	95	118	$179,330	$218,428
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	8,917	9,405	$39,927,243	$41,267,534
HealthWave Beneficiaries	1,009	1,145	$955,755	$1,057,086
Major Categories of Service (See Note 2)				
Adult Care Home	497	488	$9,862,751	$9,638,884
Home and Community Based Services				
Head Injury	0	1	$0	$3,578
Technology Assisted Children	2	3	$7,715	$8,575
Mental Retardation/Developmental Disability	187	181	$4,514,288	$4,620,511
Severe Emotional Disturbance	40	44	$227,480	$244,058
Physically Disabled	105	131	$1,154,996	$1,171,721
Inpatient Hospital	1,191	1,136	$4,239,816	$4,336,181
Outpatient Hospital	2,637	2,726	$504,253	$592,412
Pharmacy	5,743	6,182	$6,512,022	$6,726,675
Physician	5,549	5,769	$2,980,319	$3,325,818
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	4,088	4,915	$3,505,098	$4,454,716
Child Care	535	560	$1,411,614	$1,477,514
Employment Preparation Services	268	461	$195,901	$103,032
(Fiscal Year Unduplicated)				
LIEAP Heating	2,352	3,038	$306,020	$442,726
Rehabilitation Services	493	596	$519,370	$419,970
Burial	24	21	$12,514	$11,550
Family Preservation	514	573	N/A	N/A
Children in SRS Custody	539	490	N/A	N/A

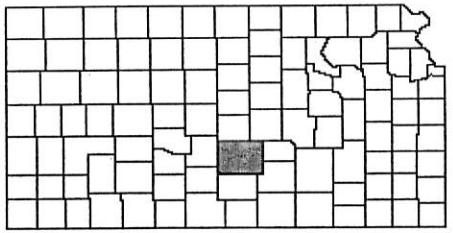
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	64,790
Under 20	17,835
20-64	36,337
65 Plus	10,618
Male	32,534
Female	32,256

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

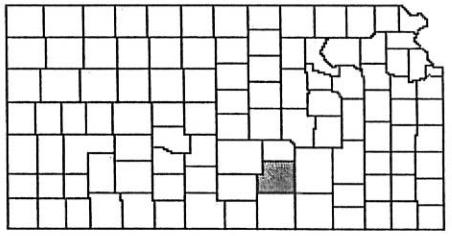
LIEAP: Low Income Energy Assistance Program

SEDGWICK

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	9,621	11,586	$13,649,235	$16,470,257
Number of Children in Program	6,831	7,993	N/A	N/A
General Assistance	903	1,068	$1,731,554	$2,052,923
Refugee Assistance	1	1	$2,552	$964
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	63,229	69,873	$254,833,580	$264,064,585
HealthWave Beneficiaries	6,969	8,269	$6,634,084	$7,598,351
Major Categories of Service (See Note 2)				
Adult Care Home	1,842	1,758	$35,789,243	$34,795,752
Home and Community Based Services				
Head Injury	26	42	$398,969	$613,073
Technology Assisted Children	7	7	$29,525	$30,660
Mental Retardation/Developmental Disability	950	1,033	$23,349,583	$26,175,576
Severe Emotional Disturbance	278	431	$1,514,824	$1,919,275
Physically Disabled	724	767	$9,491,821	$8,855,951
Inpatient Hospital	7,384	7,057	$36,431,610	$34,824,109
Outpatient Hospital	17,867	16,679	$3,460,189	$3,242,638
Pharmacy	30,627	30,670	$35,529,834	$37,793,696
Physician	34,373	35,553	$14,680,701	$16,271,946
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	32,493	40,248	$29,281,450	$38,424,737
Child Care	3,665	3,783	$13,193,810	$13,923,396
Employment Preparation Services	2,695	3,490	$1,507,774	$24,266
(Fiscal Year Unduplicated)				
LIEAP Heating	12,414	17,649	$1,447,934	$2,253,818
Rehabilitation Services	1,493	1,511	$1,625,181	$1,651,534
Burial	197	227	$106,185	$123,107
Family Preservation	3,660	3,416	N/A	N/A
Children in SRS Custody	2,355	2,214	N/A	N/A

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	452,869
Under 20	139,837
20-64	261,458
65 Plus	51,574
Male	223,870
Female	228,999

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System
HCBS: Home and Community Based Services
LIEAP: Low Income Energy Assistance Program

SHAWNEE

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	2,652	2,591	$3,864,517	$3,769,558
Number of Children in Program	1,922	1,878	N/A	N/A
General Assistance	274	319	$562,396	$638,793
Refugee Assistance	0	1	$0	$705
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	23,055	24,389	$132,685,733	$134,730,806
HealthWave Beneficiaries	2,845	3,089	$3,019,684	$3,202,749
Major Categories of Service (See Note 2)				
Adult Care Home	1,373	1,236	$22,615,951	$23,263,563
Home and Community Based Services				
Head Injury	5	8	$18,630	$41,449
Technology Assisted Children	0	3	$0	$1,955
Mental Retardation/Developmental Disability	486	497	$16,245,666	$16,262,524
Severe Emotional Disturbance	89	109	$482,630	$513,173
Physically Disabled	412	417	$4,673,061	$3,975,328
Inpatient Hospital	2,324	2,310	$10,736,431	$9,814,543
Outpatient Hospital	7,371	6,927	$1,328,986	$1,323,331
Pharmacy	11,254	10,829	$17,683,463	$18,413,023
Physician	12,355	12,383	$4,116,951	$4,035,743
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	9,425	10,604	$7,740,527	$9,171,540
Child Care	1,654	1,576	$5,581,134	$5,505,532
Employment Preparation Services	857	957	$405,194	$3,712
(Fiscal Year Unduplicated)				
LIEAP Heating	6,361	7,744	$716,776	$1,016,098
Rehabilitation Services	1,514	1,575	$1,314,786	$1,399,354
Burial	63	61	$34,240	$32,963
Family Preservation	1,400	1,400	N/A	N/A
Children in SRS Custody	853	771	N/A	N/A

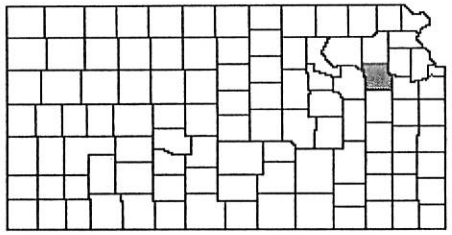
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	169,871
Under 20	47,536
20-64	98,994
65 Plus	23,341
Male	82,239
Female	87,632

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

WABAUNSEE

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	19	30	$27,228	$36,066
Number of Children in Program	15	21	N/A	N/A
General Assistance	4	2	$7,715	$3,826
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	562	579	$3,001,558	$2,990,633
HealthWave Beneficiaries	85	107	$78,381	$112,488
Major Categories of Service (See Note 2)				
Adult Care Home	72	72	$1,418,405	$1,540,103
Home and Community Based Services				
Head Injury	0	0	$0	$0
Technology Assisted Children	1	1	$4,050	$2,295
Mental Retardation/Developmental Disability	1	2	$5,046	$2,324
Severe Emotional Disturbance	2	1	$4,077	$275
Physically Disabled	7	9	$45,482	$51,753
Inpatient Hospital	38	54	$213,900	$127,614
Outpatient Hospital	126	129	$23,135	$28,003
Pharmacy	249	232	$556,133	$581,625
Physician	253	277	$71,770	$76,366
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	174	187	$112,789	$148,575
Child Care	8	14	$21,663	$34,226
Employment Preparation Services	5	10	$1,453	$9,660
(Fiscal Year Unduplicated)				
LIEAP Heating	134	162	$14,235	$24,228
Rehabilitation Services	42	39	$45,127	$21,230
Burial	2	2	$1,100	$1,100
Family Preservation	61	35	N/A	N/A
Children in SRS Custody	6	8	N/A	N/A

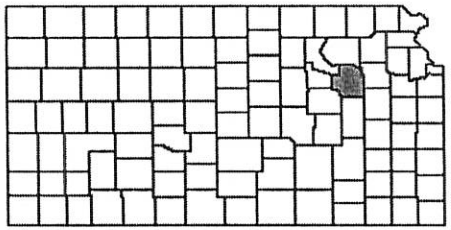
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	6,885
Under 20	2,003
20-64	3,809
65 Plus	1,073
Male	3,485
Female	3,400

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

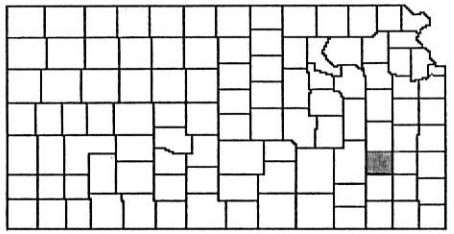
LIEAP: Low Income Energy Assistance Program

WOODSON

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	46	41	$61,926	$57,209
Number of Children in Program	35	30	N/A	N/A
General Assistance	4	7	$7,182	$12,536
Refugee Assistance	0	0	$0	$0
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	546	578	$3,051,305	$3,315,457
HealthWave Beneficiaries	49	51	$48,747	$42,368
Major Categories of Service (See Note 2)				
Adult Care Home	52	37	$593,125	$620,015
Home and Community Based Services				
Head Injury	0	0	$0	$0
Technology Assisted Children	0	1	$0	$1,045
Mental Retardation/Developmental Disability	14	14	$448,981	$392,307
Severe Emotional Disturbance	5	5	$28,861	$38,919
Physically Disabled	17	18	$261,753	$325,624
Inpatient Hospital	49	50	$229,005	$258,967
Outpatient Hospital	133	139	$29,599	$45,055
Pharmacy	280	305	$595,151	$660,014
Physician	280	332	$78,908	$120,913
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	245	287	$184,027	$219,082
Child Care	12	15	$26,022	$25,732
Employment Preparation Services	9	12	$4,478	$986,110
(Fiscal Year Unduplicated)				
LIEAP Heating	209	285	$33,064	$45,033
Rehabilitation Services	14	6	$33,231	$12,293
Burial	4	3	$2,200	$1,650
Family Preservation	15	9	N/A	N/A
Children in SRS Custody	9	11	N/A	N/A

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	3,788
Under 20	920
20-64	1,929
65 Plus	939
Male	1,863
Female	1,925

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System
HCBS: Home and Community Based Services
LIEAP: Low Income Energy Assistance Program

WYANDOTTE

PROGRAM SERVICES	Customers FY 2002	Customers FY 2003	Annual Expenditures FY 2002	Annual Expenditures FY 2003
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	4,655	4,905	$6,539,351	$6,891,964
Number of Children in Program	3,458	3,598	N/A	N/A
General Assistance	340	416	$639,660	$783,296
Refugee Assistance	3	1	$6,148	$351
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	31,586	33,483	$116,826,380	$122,352,375
HealthWave Beneficiaries	4,007	4,543	$5,018,155	$5,493,433
Major Categories of Service (See Note 2)				
Adult Care Home	926	808	$15,380,179	$15,803,917
Home and Community Based Services				
Head Injury	9	11	$174,087	$258,369
Technology Assisted Children	0	0	$0	$0
Mental Retardation/Developmental Disability	230	235	$5,901,197	$5,708,795
Severe Emotional Disturbance	88	157	$320,708	$585,027
Physically Disabled	472	461	$6,460,685	$6,138,427
Inpatient Hospital	3,704	3,593	$24,907,604	$27,156,346
Outpatient Hospital	7,527	8,300	$2,128,937	$2,134,350
Pharmacy	11,858	11,828	$13,738,480	$14,604,425
Physician	14,379	15,312	$5,978,839	$6,791,551
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	12,625	14,276	$10,432,076	$12,515,707
Child Care	1,631	1,626	$5,487,427	$5,936,035
Employment Preparation Services	1,089	1,370	$933,410	$1,589,673
(Fiscal Year Unduplicated)				
LIEAP Heating	5,784	7,216	$643,326	$906,269
Rehabilitation Services	682	646	$529,071	$489,789
Burial	44	32	$24,150	$17,597
Family Preservation	1,919	1,542	N/A	N/A
Children in SRS Custody	983	954	N/A	N/A

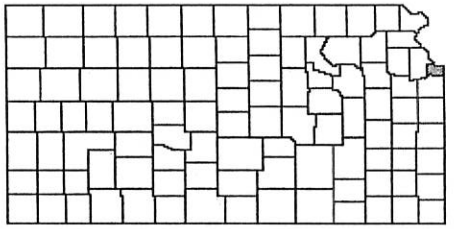
Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.

Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.

Note 3: This is not an exhaustive listing of all programs available within SRS.

N/A: Not applicable.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES



2000 COUNTY DEMOGRAPHICS

Population	157,882
Under 20	49,808
20-64	89,554
65 Plus	18,520
Male	77,071
Female	80,811

Note: 2000 demographics are not certified as the official population.

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System

HCBS: Home and Community Based Services

LIEAP: Low Income Energy Assistance Program

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

COMMENTS
ON
SB 348—HEALTH SAVINGS ACCOUNTS
HOUSE INSURANCE COMMITTEE
March 9, 2004

Madam Chair and Members of the Committee:

Thank you for the opportunity to visit with you on behalf of the Kansas Insurance Department. Senate Bill 348 would amend current law allowing Medical Savings Accounts (MSA) to also allow *Health* Savings Accounts (HSA).

This bill comes out of federal legislation passed and signed by the President allowing such accounts. We have received confirmation from the federal government that this bill must pass before these accounts can be offered to Kansans. Health Savings Accounts work by individuals saving pre-tax monies to put toward their health insurance. In addition these plans must have a high deductible in order to receive their federally qualified designation.

In the days of a tight insurance market the Department believes HSA's should be available to Kansans. Clearly, this is not a product that will benefit everyone, but we do believe it should be available to those it can benefit.

With that madam chair, I would be happy to stand for questions.

Jarrod Forbes
Legislative Liaison

House Insurance
Date: 3/9/04
Attachment # 2

420 SW 9TH STREET
TOPEKA, KANSAS 66612-1678

PHONE 785.296.3071
FAX 785.296.2283

CONSUMER HOTLINE
1.800.432.2484

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Memorandum

TO: THE HONORABLE PATRICIA BARBIERI-LIGHTNER, CHAIR
HOUSE INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
AAHP-HIAA

RE: S.B. 348

DATE: MARCH 9, 2004

Madame Chair, Members of the Committee: My name is Bill Sneed and I represent AAHP-HIAA. AAHP-HIAA is the national trade association representing nearly 1300 member companies providing health insurance coverage to more than two hundred million Americans. We appreciate the opportunity to testify in favor of S.B. 348. As I am sure has been noted by the authors of the bill, this is a technical amendment needed in our current law so that it complies with the new federal laws that came into effective January 1, 2004. As stated earlier, we are in favor of this technical amendment. However, since the passage of this bill by the Senate, we have become aware that in order to facilitate coverage on all Kansans, we would respectfully request an additional technical amendment.

Attached to my testimony is a proposed balloon amendment, which in effect changes the effective date of S.B. 348 to its publication in the *Kansas Register*. Also, instead of the word "act," we use the term "federal law," which would be consistent throughout the bill, as well as making the provisions apply to those policies issued regardless of its effective date. Thus, those consumers who have procured policies prior to the effective date of this act, but after the effective date of the federal act, would be covered by this change.

Again, we believe that these changes are technical in nature, but they are sure to afford all consumers who are utilizing this program the utmost coverage allowed by federal law.

House Insurance
Date: 3/9/04
Attachment # 3

One AmVestors Place
555 Kansas Avenue, Suite 301
Topeka, KS 66603
Telephone: (785) 233-1446
Fax: (785) 233-1939

Again, we appreciate the opportunity to present this, and if you have any questions, I will be happy to answer them.

Respectfully submitted,

William W. Sneed

WWS:kjb

30825 / 66955
WWSNE 1078849

342

association but shall not include conditions:

(1) Not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, 1994); and

(2) defined as a mental illness in K.S.A. 2003 Supp. 40-2,105a and amendments thereto.

(c) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated.

(d) There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto or for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

(e) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

(f) The provisions of this section shall be applicable to the Kansas state employees health care benefits program developed and provided by the Kansas state employees health care commission.

(g) The outpatient coverage provisions of this section shall not apply to a high deductible health plan as defined in ~~Section 301 of P.L. 104-191 and any amendments thereto~~ *federal law* if such plan is purchased in connection with a medical *or health* savings account pursuant to ~~that act~~. After the amount of eligible deductible expenses have been paid by the insured, the outpatient costs of treatment of the insured for alcoholism, drug abuse and nervous or mental conditions shall be paid on the same level they are provided for a medical condition, subject to the yearly and lifetime maximums provided in subsection (a).

federal law, regardless of the policy effective date.

Sec. 2. K.S.A. 2003 Supp. 40-2,105 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the ~~statute book~~.

Kansas Register.

3-2

WHAT THE EXPERTS ARE SAYING ABOUT HSA'S

Reuters: Linda Stern January 10, 2004

"The legislation established new tax-deductible medical savings accounts that could be the best savings vehicle yet. These are going to be a huge deal. They're like a flex spending account on steroids; they're better than an IRA.
It's a back door, tax-free way to save for retirement. Feed it to the max every year, get a tax deduction regardless of your income level, and then build up a kitty to spend down when you're paying doctor bills in dribs and drabs after you retire. No taxes, ever.
There's really no downside to this deal."

Wall Street Journal: Martin Feldstein January 19, 2004

"The Health Savings Accounts that President Bush recently signed into law may well be the most important piece of legislation of 2003.
These new tax and Medical insurance rules have the potential to transform health-care finances, bringing costs under control and making health care reflect what patients and their doctors really want. When spending comes from the individuals' own Health Savings Accounts, individuals and their doctors have a strong favorable impact on health."

NCPA: John C. Goodman January 15, 2004 *Health Savings Accounts Will Revolutionize American Health Care*

"Account balances can earn interest or be invested in stocks or mutual funds, and they will grow tax-free. Thus a young person could accumulate hundreds of thousands of dollars by the time he or she retires. It's an empowerment idea."

Washington Post: Albert B. Crenshaw November 27, 2003

"A provision of the Medicare bill Congress passed would allow workers to turn a health insurance feature they normally dislike--a high deductible--into tax-free savings that could grow to large sums over a lifetime."

Edwin Park, a senior health policy analyst with the Liberal Center for Budget & Policy Priorities, as quoted in the Washington Post, November 27, 2003

"...the first universally available savings accounts that are tax-free at both ends; funded with pre-tax dollars and tax-free when withdrawn to pay for health care."

Michael Berry, American Health Value in Boise, Idaho

"Such plans allow workers and their employers to pay sharply lower premiums and plow the savings into an HSA rather than give that money to the insurance company month after month."

Greg Scandlen, a health care expert at the Galen Institute

"They have the potential to become the dominant kind of health care financing in the next five to ten years."

For additional information on Health Savings Accounts, contact:

BEVERLY GOSSAGE
(913) 207-6141

Olympic Financial Marketing

House Insurance
Date: 3/9/04
Attachment # 4

Q&A

Health Savings Plans Should Have Major Impact, Expert Says

INVESTOR'S BUSINESS DAILY
IBD
MONDAY SPECIAL

For Employees And Employers

New accounts designed to let workers save money used for minor expenses

BY AMY REEVES
INVESTOR'S BUSINESS DAILY

The new year brought the arrival of a new type of health coverage: health savings accounts.

These accounts were legalized as part of Congress' Medicare overhaul. They give employees the option to save money earmarked for minor medical expenditures so those expenditures don't count against regular health-insurance plans.

Minor medical costs, such as doctor visits and drugs, can be left up to the worker, since he'll pay for them directly through the HSAs. That means he can save regular insurance coverage for major expenses.

HSAs can grow free of taxes, are portable between employers and can roll over from one year to the next. This makes them more lucrative for the consumer than current options such as health reimbursement accounts and flexible spending accounts.

Devon Herrick

- National Center for Policy Analysis
- Senior fellow
- Ph.D., political economy, master's in public affairs, University of Texas

A question is how much HSAs actually will help employees.

There's little doubt they'll have an impact on employers, according to Devon Herrick, a health economist and senior fellow at the Center for Policy Analysis.

He recently discussed the plans with IBD.

IBD: *What kind of financial effect do you see HSAs having on employers?*

Herrick: I think it will have a major effect on employers. For example, you've probably heard about a lot of midsize employers, and even large employers, looking for ways to rein in the cost of health insurance. The annual increases have been double digits the last couple of years.

In the '90s the idea was managed care. But employees and voters created a backlash against the idea. So employers begin to look at other avenues — including ones that give consumers incentive to be wiser medical consumers.

The HSAs do precisely that by taking the same money they would have spent on health insurance, and instead buying catastrophic plans and putting the balance funds into a health savings account.

The first $1,000 or more would be discretionary. The employee thinks, "Do I really want to see the doctor if I have to pay full price? Do I want to use the cheaper prescription drug vs. the high-priced prescription drug?"

I think you'll see more employers look at this option as the price of insurance does rise more slowly under these programs.

IBD: *Do you have an idea how long it would take before companies would realize savings?*

Herrick: We've already seen the (health reimbursement accounts) becoming increasingly popular, and they have only one or two years' worth of history.

Currently these types of plans only comprise about 1% of the employer-sponsored market. (But) according to a 2002 study in Health Affairs, (health care experts) see the consumer-driven plans accounting for 20% of the market by 2005, and 50% by 2007.

Keep in mind this prediction was made when the only real vehicles for these types of plans were health reimbursing arrangements and medical savings accounts.

But I see HSAs increasing this rate of acceptance because they're far more versatile. It does grant the worker a much greater degree of control.

IBD: *What effect will this have on health insurers?*

Herrick: We're hoping it will become far more competitive. Quite often health care is free at the point of service, but you have a lot of layers of bureaucracy whose function it is to conserve the dollars, to assure that the care that is paid for is necessary.

You'll see some of those functions go away as individuals become the gatekeeper. Health insurance will only have to worry about those with catastrophic needs.

Health insurers will have to cut back on some of those functions, but at the same time they will probably benefit by offering a greater range of products.

Really, this stands a chance of changing the face of health insurance. The way it's worked in the past is that the patient has paid a third party to buy health insurance. This will connect the patient with more of those decisions and, by default, take some away from the insurer.

IBD: *Do you have figures on how much money this would save?*

Herrick: There have been studies of medical savings accounts in the past — the Rand health insurance experiment was a classic example of that.

Also, we did some research on some medical savings accounts in South Africa. That saved 47% on discretionary purposes — things that maybe you don't have to have, but you might benefit from them.

But most of the figures I've seen show (such plans) saving about 30%. That was what the Rand experiment showed.

We could find no real evidence of people foregoing needed care. You may not get the doctor visits for conditions that weren't serious, but you still took your blood-pressure medication and things like that.

IBD: *Will this put pressure on drug prices?*

Herrick: Oh, absolutely. For example, we had a medical savings account a couple years ago at our employer. The first $1,200 of our care was out of pocket.

So I went to my doctor and he gave me a free sample of (Schering-Plough Corp.'s anti-allergy drug) Claritin, a month's supply. And when the month was up, I looked at the price and saw Claritin was about $1,000 a year.

I decided that I would just keep that money and use Actifed, which is over the counter and a fraction of the cost. If I'd been insured with a traditional plan, I would have been highly annoyed if my insurer made me take Actifed instead of Claritin. But when it's my money, I think, it's $1,000 difference.

When people make these decisions, the drug companies will be under pressure.

IBD: *Are there any other business effects you see HSAs having?*

Herrick: I think a lot more small employers who have not offered health insurance in the past will begin offering these plans to the employees. The IRS' data shows 73% of medical savings accounts today are owned by people who were previously uninsured.

Wall Street Journal 1-19-2004

Health and Taxes By MARTIN FELDSTEIN

The Health Savings Accounts that President Bush recently signed into law may well be the most important piece of legislation of 2003. These new tax and medical insurance rules have the potential to transform health-care finances, bringing costs under control and making health care reflect what patients and their doctors really want. It is remarkable that this legislation has received so little public attention.

Today's high cost of health care reflects the way that the tax law has subsidized the use of insurance to pay for health care. Private insurance now pays 70% of all non-government healthcare costs and more than 90% of non-government hospital costs. Because out-of-pocket payments at the time of care are only a small fraction of the total cost of producing that care, individuals naturally want "the best care" that medical science can provide. And the demand for that high-tech care drives medical innovation toward new and more expensive modes of treatment.

The demand for the typical health-insurance policy reflects the tax provision that allows employees to exclude payments for health insurance from their taxable income. Since the annual premium for a family may be as much as $10,000, the resulting tax saving is a very large subsidy for the purchase of the kind of comprehensive, low-deductible insurance policy that drives up health-care costs and that has led to the imposition of controls on patient choice. In the aggregate, this exclusion reduces Federal income-tax collections by $120 billion a year, essentially a $120 billion subsidy for purchasing the wrong kind of insurance.

Although HMOs and other forms of managed care that aim at controlling health costs have become increasingly common in recent years, health costs continue to take a growing share of GDP. And neither patients nor doctors are happy when HMOs restrict the health care that can be given, or limit the time that doctors can spend with each patient, or appear to deny patients information about the care that might benefit them.

The new HSA law (a part of the recent Medicare reform bill) eliminates the preferential subsidy for comprehensive insurance by giving the same tax treatment to individuals who set aside income to pay cash for a larger share of their own health care. Anyone under the age of 65 can establish a Health Savings Account if they have a "qualified" health-insurance plan. A "qualified" plan is an insurance policy that has a minimum deductible of $2,000 for a family and a $10,000 limit on the family's annual out-of-pocket expenses. The deductible is designed to make individuals more cost-conscious in their consumption of health care, and the annual limit on out-of-pocket expenses is there to prevent financial hardship or a lack of care because of an inability to pay. Individuals or their employers can make annual pretax contributions to Health Savings Accounts of up to 100% of the health-plan deductible, with a maximum of $5,150 in 2004.

An individual can withdraw funds from his HSA without paying tax if the money is used for any kind of health bills, including prescription drugs, dental care and long-term care. Any funds not used in one year are automatically carried forward to the future. Individuals can also withdraw funds from these Health Savings Accounts for non-medical expenses by paying tax as they would for any IRA withdrawal. And the individual pays no tax on the interest, dividends or capital gains earned on the HSA investment.

[illegible]s an example of how such a "qualified plan" and an HSA can substantially reduce costs for a family without increasing its financial risk. California Blue Cross now offers a traditional low-deductible plan (a deductible of $500 per family member, up to a maximum of two) with an annual premium of $8,460. It also offers a high-deductible plan that is similar except that the deductible is $2,500 per family member, also up to a maximum of two. The annual premium for the high-deductible plan is only $3,936, a premium saving of $4,524. The premium saving is so large that it actually exceeds the maximum additional out-of-pocket cost that the family would face if it reached the maximum deductible for both individuals!

The traditional tax rules are the only reason why someone in the past would have chosen the low deductible policy. A family that earns $50,000 faces a marginal tax rate of about 45% (a 27% federal income tax rate, 15% payroll tax rate and a state income tax rate of about 5%). If the $4,524 premium saving was turned into taxable salary, the individual's net income would rise by only 55% of $4,524, or $2,488. But when the saving of $4,524 is put into a Health Savings Account, there is no tax to pay and the funds can accumulate tax-free.

High-deductible policies give individuals and their doctors an incentive to avoid wasteful health spending. When spending comes from the individuals' own Health Savings Accounts, individuals and their doctors have a strong favorable impact on health. The same incentive can influence the choice among hospitals and among different prescription drugs. And because these cost incentives reduce the need for HMO rules that limit the availability of care, individuals can have greater scope for choosing the care that they want.

In short, the new HSA tax and insurance rules can be the beginning of successfully controlling medical spending and bringing it in line with what patients and their doctors really think is best.

Mr. Feldstein, chairman of the Council of Economic Advisers under President Reagan, is an economics professor at Harvard and a member of the Journal's Board of Contributors.

Alameda Times-Star

Saving for a sick day

By Eve Mitchell
BUSINESS WRITER

Sunday, January 18, 2004 - OAKLAND business owner DeeDee Towery is fed up with double-digit premium hikes for the health insurance plans she offers her workers, a frustration shared by many employers hit by spiraling health care costs.

"I can tell you over the last three years our health costs have gone up every single year. It's averaging 15 percent," said Towery, owner of ProActive Business Solutions, a 70-employee firm.

Across town, Jim Gray, a 32-year-old self-employed general contractor, figures the flip side of being healthy is that he just isn't getting his money's worth from his health plan, and would like to save more for his retirement health costs. But in the meantime, Gray wants to be covered by a health plan in case he gets hit by that proverbial truck and ends up in the hospital.

Now, relief is in store for both business owners like Towery, who want to save on health care premiums, and workers looking to have health care now while saving for future medical expenses and retirement.

The relief comes from tax-advantaged Health Savings Accounts, which could be offered starting Jan. 1 under a provision of the Medicare Reform Act signed by President Bush in December.

The idea behind HSAs, supporters say, is to provide people with a way to fund a 401(k)-like investment account to cover ongoing medical expenses and future post-retirement medical expenses not covered by Medicare.

For businesses, HSAs can help rein in rising health insurance premiums since they require participants to select a high-deductible plan geared to providing catastrophic care as opposed to traditional, low-deductible comprehensive plans.

Industry experts point out that HSAs could lead to insurance plans with lower premiums and help small companies that haven't offered health insurance be able to do so.

Generally, the higher the deductible, the lower the premium and vice-versa, according to industry experts. Besides the higher deductible, a key difference between an HSA-linked insurance plan compared to a traditional one is that it does not include co-pays from insurers for prescription drugs and doctor visits.

"The more exposure (the employee has with a high deductible plan), the less exposure the insurance company has and the lower the premiums are going to be," said Bill Lavis, a partner at Oakland-based Sitzmann, Morris & Lavis, an independent insurance advisory firm.

Supporters of HSAs say they are a tool that will help consumers save for future health care costs and retirement expenses while helping companies keep insurance costs in check. Opponents argue HSAs will end up becoming a tax shelter for the wealthy and healthy and lead to higher premiums for those with traditional, low-deductible plans.

HSAs work like this:

Participants enroll in a high-deductible health insurance plan, either through an employer-sponsored plan or a plan purchased by self-employed people. For individuals, the yearly minimum deductible is $1,000, while for families it's $2,000. Employees and their employers can contribute up to 100 percent of their deductible through a pre-tax payroll deduction, though there is a $2,600 annually cap for individuals.

They then open a tax-deductible HSA to cover qualified out-of-pocket medical expenses that would have to be paid before the plan's deductible is met or for other expenses not covered by insurance. While an HSA cannot be used to cover health care premiums while working, funds can be used to pay for COBRA or insurance premiums while unemployed.

Funds taken out of an HSA to pay for qualified medical expenses are tax-free, and they are not taxed when initially put into the account.

Whatever money is not spent on health care in a given year rolls over from year to year. The HSA can be held in a mutual fund or other investment account, and any earnings are tax free.

For example, if a single person had a $1,000 HSA but only spent $200 on out-of-pocket expenses, the remaining $800 in the account would be rolled over.

With an HSA, out-of-pocket expenses would be paid for with pre-tax dollars, which is not the case when it comes to out-of-pocket expenses paid for under traditional health plans unless you have an employer-offered Flexible Spending Account.

HSAs are meant to replace the Medical Savings Account, a pilot program that was restricted to only small employers and the self-employed, and required even higher deductibles than HSAs.

HSAs also differ from Flexible Spending Accounts, which can also be used to pay for medical expenses but include a "use-it-lose-it provision," which means workers forfeit funds not spent by year's end or if they leave their job.

That's not the case with HSAs, the latest offering in what is known as consumer-driven health care.

Opponents say HSAs could weaken traditional health plans that feature comprehensive coverage, low deductibles and co-payments by drawing away their healthy customers.

"If you think about who would get the most benefit, it's people in higher tax brackets who can afford the risk of possibly having to pay for health care out of pocket. If you're healthy the risk is low," said Len Burman, a tax expert with the Tax Policy Center, a joint effort of the Urban Institute and Brookings Institution.

"If employers offer a choice between more comprehensive insurance and catastrophic high-deductible, people that take the high-deductible tend to be healthier than average," he said. "So the premiums for the (comprehensive) goes up because people buying that insurance tend to be less healthy."

And while the HSA is meant to encourage consumers to become more aware of health care spending, Burman points out that the vast majority of health care spending stems from a small minority. He cited a 1996 study published in Health Affairs Journal that found 30 percent of the population -- insured and uninsured -- account for 90 percent of health-care spending nationwide.

Berman said that the tax break high-income earners will get from HSAs will result in a bigger shift of the tax burden to people with lower incomes.

"I view (HSAs) as inequitable. It works most for people who have very high incomes," he said.

Over the next decade, the U.S. Treasury Department expects that the tax treatment of HSAs will reduce Treasury revenues by $6.4 billion.

The Center on Budget and Policy Priorities also opposes HSAs, saying they will "be extremely attractive to healthier, more affluent workers. ... Workers in the higher tax brackets would secure large deductions for deposits into HSAs. ... As a result, these would be quite lucrative as tax shelters."

Devon Herrick, a health economist with the Dallas-based National Center for Policy Analysis, says HSAs will provide all consumers with a tax-free way to save for their future medical needs, as opposed to paying into a pool to take care of other people's medical bills.

"HSAs will empower consumers to be wiser medical consumers," said Herrick, "You can pool your health care costs over your lifetime with an HSA. What you do now, when you pay into a health plan, most of your money goes to pay someone else's (medical bills)."

Herrick disputes critics' arguments that an HSA is a tax-shelter for the rich. He points to IRS statistics for the 2001 tax year that show 73 percent of the 78,913 taxpayers who opened Medical Savings Account, the precursor of HSAs, previously did not have health insurance.

Since consumers would be paying for health care expenses from their own account -- instead of the insurance company's pocket -- they would become better informed about health-care costs, proponents say. The idea is that they would think twice before using medical services that aren't necessary.

"The best-case scenario would be if employees rethink how they use health care," said Lavis. "There is no incentive for you to shop (with conventional health care plans). If you set up a HSA, you'd ask, 'What's the cost going to be?'"

Towery and Gray are interested in setting up HSAs.

"It definitely looks as if it could lower (premiums) cost per person," said Towery. "Health care costs are increasing. If you can lower the fees, you can pass on the savings to clients and to the employees. It promises the individuals who take good care of themselves to be able to manage their health care costs."

Gray says an HSA would be the right move for him, in part because he's in good health.

"Granted, I can take a gamble on a high deductible. Would I rather pay the deductible with pre-tax dollars? Absolutely," he said. "But if I don't use (the health plan) I'm still benefiting. The plan can roll over year after year ... just like a 401(k)."

Gray likes the idea of HSAs not only to help pay for current and future medical expenses but also to help save for retirement. He's not sure Social Security will be around when he retires. "You don't know for sure. But if I was a betting man, I would definitely think less, compared to more, is going to be there."

Health Savings Accounts Will Revolutionize American Health Care

Brief Analysis

No. 464

Thursday, January 15, 2004

by John C. Goodman president of the National Center for Policy Analysis.

The idea behind Health Savings Accounts (HSAs) is quite simple. Individuals should be able to manage some of their own health care dollars through accounts they own and control. They should be able to use these funds to pay expenses not paid by third-party insurance, including the cost of out-of-network doctors and diagnostic tests. They should be able to profit from being wise consumers of medical care by having account balances grow tax free and eventually be available for nonmedical purchases.

As of January 1, 2004, 250 million nonelderly Americans now have access to HSAs, provided they are combined with catastrophic insurance.

Creating a Level Playing Field for Individual Self Insurance. Health Savings Accounts are designed to help correct a major flaw in tax law that distorts our entire health care system.

Every dollar an employer pays for employee health insurance premiums avoids income and payroll taxes. For a middle-income employee, this generous tax subsidy means that government is effectively paying for almost half the cost of the health insurance. [See Figure I.] On the other hand, the government taxes away almost half of every dollar employers put into savings accounts for employees to pay their medical expenses directly. The result is a tax law that lavishly subsidizes third-party insurance and severely penalizes individual self-insurance. This encourages people to use third-party bureaucracies to pay every medical bill, even though it often makes more sense for patients to manage discretionary expenses themselves.

The new law, part of the recently enacted Medicare prescription drug bill, gives deposits to HSAs the same tax advantages formerly granted only to health insurance premiums. Employer and employee deposits to HSAs will avoid all federal income and payroll taxes. When combined with individually owned insurance, HSA deposits will be a deductible expense, even for income tax filers who do not itemize.

Making Choices. Advances in medical science have reached a point where we can probably spend the entire gross domestic product on health care — in useful ways! The Cooper Clinic in Dallas now offers a super-duper checkup (with a full body scan) for about $2,500 or more. If everyone in America took advantage of this opportunity, we would increase our nation's annual health care bill by one-half. There are more than 900 diagnostic tests that can be done on blood alone, and one doesn't need too much imagination to justify, say, $5,000 worth of tests each year. But if everyone did that we would double the nation's health care spending. So how do we decide which procedures are worthwhile and which are not?

There are basically only three ways. In other developed countries, these decisions are made either directly or indirectly by government. But government-imposed rationing is arbitrary, inefficient, unfair and probably unacceptable to most Americans. The second method is to restrain spending using managed care techniques. But during the 1990s voters expressed discomfort with having employers and large insurers ration their health care. The third option is to allow individuals to make their own choices between health care and other uses of money, through a vehicle such as HSAs.

Restoring the Doctor-Patient Relationship. Patients will make better choices if they can rely on doctors who put their interests first. In a managed care world, doctors too often look to employers and insurers for guidance in deciding how to practice medicine. In a very real sense, providers view insurers rather than patients as their customers. With HSAs, however, physicians will be free to act as the agents of their patients.

Expanding Options. Since 1996, a pilot program has made Medical Savings Accounts available to small businesses and the self-employed. But because of the many restrictions, only about 70,000 people have these accounts. A U.S. Treasury Department ruling in 2002 allowed large companies to establish Health Reimbursement Arrangements, and at last count, 1.5 million employees had enrolled. But these accounts are also unreasonably restricted. Flexible Spending Accounts offer consumers the chance to withhold funds tax free for medical care. But these have a use-it-or-lose-it feature which requires employees to forfeit unused funds to employers at the end of the year. This forfeiture provision encourages employees to waste money on unnecessary care and makes most people apprehensive about depositing money except when they can precisely predict their future medical needs.

How HSAs Work. HSAs will be the most flexible, consumer-friendly accounts yet devised. They will allow individuals and employers to make deposits each year equal to their health insurance deductible. The health insurance policy that accompanies an HSA must have an overall deductible of at least $1,000 for an individual or $2,000 for a family policy. A typical plan will work like this: When individuals enter the medical marketplace, they will spend first from their HSA. [See Figure II.] If they exhaust their HSA funds before reaching the deductible, they will then pay out-of-pocket. Once they reach their deductible, insurance pays all remaining costs.

Annual HSA deposits cannot exceed the amount of the health insurance deductible, and typically cannot exceed $2,600 for individuals and $5,150 for families. However, the account balances can earn interest or be invested in stocks or mutual funds, and they will grow tax free. Thus a young person could accumulate hundreds of thousands of dollars by the time he or she retires.

HSA balances belong to the individual account holders and remain theirs if they switch jobs, become unemployed or retire. The funds can be used to pay expenses not covered by insurance, insurance premiums while unemployed and health expenses during retirement. In the event of death, HSAs may be bequeathed to a spouse, or (like an IRA) the funds may flow to other heirs.

Conclusion. The concept of HSAs is not conservative or liberal. It's an empowerment idea. It should appeal to liberals who want an alternative to HMO rationing. It should appeal to conservatives who want an alternative to government rationing. It should appeal to everyone who suspects that impersonal bureaucracies care less about us than we care about ourselves.

Health savings can be tax shelter

By Thomas A. Fogarty, USA TODAY

A potentially lucrative tax shelter becomes available to the masses next month, courtesy of the Medicare act Congress just passed.

In IRA-like fashion, investors soon can build tax-sheltered nest eggs to cover out-of-pocket medical costs. Called a Health Savings Account, the new investment vehicle permits a taxpayer, starting in 2004, to shelter up to $4,500 annually.

But there's a catch. The new accounts are linked to high-deductible health insurance plans. The accounts are designed in part to help consumers pay for health expenses until insurance benefits kick in.

Just how popular the new accounts will become remains unclear. But their cost-saving features and likely promotion by big employers could make them huge. (**Related chart:** Health costs and the income tax)

Uses for accounts

The new Health Savings Accounts provide a broad range of tax-free withdrawals including:

- Doctors, dentists and hospitals
- Artificial limbs
- Drugs
- Eyeglasses and contacts
- Chiropractic
- Laboratory expenses
- Nursing home costs
- Physical therapy
- Psychoanalysis
- X-rays
- Nursing home insurance premiums

"They have the potential to become the dominant kind of health care financing in the next five to 10 years," says Greg Scandlen, a health care expert at the Galen Institute, a Washington think tank.

But they aren't for everyone, says Scandlen, an advocate of the new accounts. Families with young children probably will benefit more from traditional managed-care options such as preferred provider organizations. And, he says, HSAs demand more planning than many people are willing to give.

But the new accounts could become the preferred route for families with few health care spending needs, as well as those who spend $4,000 or more a year, he says.

The self-employed and others who buy individual health policies can plunge in as early as next month. Workers insured through employers could see them during their next open enrollment period, when they're allowed to adjust workplace benefits.

Insurers Golden Rule of Lawrenceville, Ill., and Fortis Health of Milwaukee, plan to begin selling HSAs on the first business day of 2004. Others say they need time. "We're not poised to jump in, but we're assessing the legislation," says Mutual of Omaha spokesman Jim Nolan.

How the new accounts work:

The health care angle

High-deductible health insurance policies are now the rage. By leaving more costs for a patient to cover out-of-pocket, rapidly rising insurance premiums will moderate, the theory goes.

President Bush and Republicans in Congress favor investment accounts to help more Americans cover expenses until a high-deductible policy kicks in. As defined in the new Medicare legislation, which Bush is expected to sign, a high-deductible policy is $1,000 for individual coverage, $2,000 for a family.

The accounts have the potential to accumulate huge balances over years of contributions and investment gains. In theory, that puts consumers in a better position to pay for their own health care as they grow old, when costs typically peak. The new law imposes two requirements for opening an HSA:

•It must be done in conjunction with high-deductible health coverage.

•A taxpayermust be under 65 — the age of Medicare eligibility — when opening an account.

The tax angle

Few Americans — particularly among the young — are likely to max out annual contributions just so they can pay drug and nursing home bills in old age. But the tax incentives are powerful for those who do, or for anyone who wants to build a modest account to cover routine health expenses.

The accounts will join about a half dozen other major provisions in the federal law that provide a tax advantage for health care spending. But nothing now in the law combines the broad eligibility and generous tax benefits of HSAs. "This is far and above superior to all the other ones that are out there," says Jay Nawrocki, legislative analyst at tax publisher CCH.

Contributions, investment growth and withdrawals for health-related expenses are all free from taxation. That makes tax benefits superior even to IRAs. With IRAs, the money is taxed either before it goes into the investment account, or as it is taken out. Of course, money from an IRA, when taken after age 591/2, can be spent without restriction.

Health savings accounts carry generous annual contribution limits. The law allows an annual tax write-off equal to the deductible amount of the accompanying health care plan. But the tax write-off can't exceed $2,250 for an individual plan, $4,500 for a family plan. Limits bump higher in years ahead.

For taxpayers 55 and older, the new law permits an additional $500 contribution in 2004. And, like IRAs, contributions may be made for the previous year through April 15.

CCH's Nawrocki says health-savings accounts are likely to diminish the popularity of flexible-spending accounts.

Flex-spending accounts permit workers to make pretax contributions by payroll deduction to meet health care costs.

But they have two big drawbacks: Money in the accounts earns no interest; and unspent funds must

be forfeited at the end of each year.

Flex accounts won't be rendered obsolete, though, because they allow pretax purchase of routine health care items not now covered by HSAs.

In general, tax-free expenditures for HSAs mimic those the IRS now allows as deductions to taxpayers who have been smacked by unusually high medical bills.

An HSA holder who uses the money for a non-health expenditure pays tax on it, plus a 10% penalty. After age 65, a withdrawal used for a non-health purpose will be taxed, but not penalized.

The investment angle

The new law imposes few restrictions on how money might be invested. Health insurers will be first out of the box to offer the new accounts, but banks, brokerages and mutual fund companies are free to jump in, says Scandlen of the Galen Institute.

HSAs now have a first cousin in tax law, Archer Medical Savings Accounts. In seven years of existence, Archer MSAs haven't gotten much use, partly because of strict eligibility requirements. HSAs replace them.

Brian McManus, vice president at Golden Rule, says the company's first HSA will direct all investment money to an interest-bearing savings account. Fortis Health Vice President Scott Krienke says his company will offer HSA investors a choice of a savings account or an array of mutual funds.

As with IRAs, Scandlen says, HSA investors are allowed to hold multiple accounts, but they'll be subject to a single annual contribution limit.

Find this article at:
http://www.usatoday.com/money/perfi/taxes/2003-12-04-mym_x.htm

1. MEDICAL SAVINGS ACCOUNTS GET BETTER

Sat January 10, 2004 10:42 AM ET – By Linda Stern - WASHINGTON (Reuters) - If you like having an Individual Retirement Account, you'll love the even sweeter deal that was tucked into the Medicare prescription benefit bill that Congress passed at the end of 2003. The legislation established new tax-deductible medical savings accounts that could be the best savings vehicle yet. Healthcare Savings Accounts (HSAs) debuted on Jan. 1, so watch and wait for them to come to market. "These are going to be a huge deal. They're like a flex spending account on steroids, they're better than an IRA," enthused Richmond, Virginia, financial planner David David E. Hultstrom. "My plan will be to stuff away as much money as possible."

Anyone with a high-deductible health insurance plan and not on Medicare is eligible to open one of these accounts and contribute as much as $2,600 (single), $5,150 (family) and an additional $500 (for those over 55) this year. That contribution is fully tax deductible and if the money is withdrawn to pay for health-care costs -- including over-the-counter medicines, eyeglasses and more -- it becomes tax free forever. Furthermore, the money does not have to be spent down every year. It's a back door, tax-free way to save for retirement. Feed it to the max every year, get a tax deduction regardless of your income level, and then build up a kitty to spend down when you're paying doctor bills in dribs and drabs after you retire. No taxes, ever.

Self-employed workers who take advantage of this may get an even better break: They can set it up in their company and deduct it as a business expense, offsetting the double Social Security and Medicare taxes that self-employed workers pay, according to Hultstrom. Why wouldn't you want to do this? The catch is that you have to currently have a high-deductible medical plan to qualify. If you're one of the few whose employer still pays all costs for a low-deductible plan, that's probably a better deal. But most Americans, even those with employer-provided insurance, can opt for a high-deductible plan, save themselves some premium payments and a boatload of taxes.

If you end up pulling money out after retirement for non-health related costs, it will be subject to income tax, but that's no worse than a deductible IRA or 401(k) account. If you die with money in your account, it will pass to your beneficiaries just like an IRA. Only a smattering of insurance companies currently offer these new plans, though they are likely to come to market from banks and other financial companies by the middle of the year. All you have to do to get the tax breaks this year is open the account and feed it before Dec. 31, so you've got almost a year to get ready.

Fortis Health, a Milwaukee insurance company that was one of the first out of the block with a complete plan, has more than 1,000 applications pending in the first week of offering HSAs; and it only provides the HSAs to its health insurance clients. Most health-insurance plans, even those with high deductibles, are structured so that they might not fit the IRS's description of a qualified plan. For example, the IRS says a high-deductible plan is one that requires a deductible of $1,000 for an individual or $2,000 for a family. But a family with a $2,000 deductible, $1,000 individual deductible plan that starts paying out when any family member's covered costs exceed $1,000, would not qualify.

If that's the kind of insurance you have, it's a good time to start bugging your insurance company to see if they will modify the plan, or start looking elsewhere for insurance. In general, it's a good idea to buy high-deductible insurance if you can afford it because the monthly premiums tend to be far less than they are for low-deductible plans. You can save money by sweating the small stuff yourself. However, don't rush into the first HSA you find. Surely by the third quarter of 2004, there will be enough competition in the market so that you can carefully consider the fees, investment practices and withdrawal mechanics of the various plans out there. Then find your plan and fill it -- there's really no downside to this deal. Back to Top

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http://www.sunspot.net/business/investing/bal-kristof121703,0,4585402.column

From the Los Angeles Times

Health savings accounts can help handle expenses

The tax-favored plans, which begin next year, are open to workers with high-deductible insurance policies.

Kathy M. Kristof

December 17, 2003

LOS ANGELES -- The Medicare reform act signed last week by President Bush will give many Americans a new tool for defraying medical costs: "health savings accounts."

These tax-favored accounts, to be available after Jan. 1, will be open to any working person with a high-deductible health insurance policy.

The idea is for consumers to use tax-free savings accumulated in the accounts to pay for medical expenses that aren't covered by health plans.

And unlike some existing health-care savings plans, money left unspent in the new health savings account can be rolled over year after year, providing those who are lucky enough to stay healthy with a pot of cash to cover medical expenses when they're older.

The accounts quickly will become as ubiquitous as individual retirement accounts and so-called 529 savings plans for college, said Paul S. Devore, chief executive of Financial Management Services, an Encino financial planning firm.

Here's a look at how the accounts will work:

What are health savings accounts?

Health savings accounts are a tax-favored savings plan created by the 2003 Medicare act. The accounts work a bit like an individual retirement account: Eligible participants can deposit money in an HSA, and deduct the amount of the deposits from taxable income.

But unlike in the case of IRA assets, which are taxed when withdrawn, withdrawals from health savings accounts will be tax-free when used for qualifying medical expenses.

If money is withdrawn for nonmedical expenses, however, the withdrawal is subject to income tax and a 10% penalty. One exception: Those who are age 65 or older can withdraw money for any purpose without penalty, but they would have to pay income tax on any money withdrawn for a non-qualified purpose.

Who is eligible to contribute to an HSA?

Anyone who is working and covered by a high-deductible health insurance plan. A high-deductible plan is defined as one in which coverage starts after the consumer pays the first $1,000 on individual coverage or the first $2,000 for family coverage.

The insurance plan also must limit the person's total out-of-pocket costs to no more than $5,000 annually for an individual or $10,000 for a family. However, so-called out-of-network charges don't count toward the out-of-pocket totals.

What's the maximum annual amount that can be contributed to an HSA?

The maximum contribution is equal to the deductible on the consumer's insurance plan, but no more than $2,600 for individuals and $5,150 for families.

Workers age 55 or older can contribute an additional $500 in 2004. The catch-up contribution amount will increase by $100 each year until it reaches $1,000 in 2009, said Mark Luscombe, principal tax analyst with CCH Inc., a publisher of tax information based in Riverwoods, Ill.

What are qualifying medical expenses for HSA purposes?

They generally are defined as costs incurred to diagnose, cure, treat or prevent a disease. This would include doctor visits and medications.

The plans allow for payments for laser eye surgery but generally not cosmetic surgery. (There are some exceptions when the cosmetic procedure cures an ailment, such as when rhinoplasty is necessary to fix a breathing problem, or when reconstructive surgery is required after an accident or operation.)

Money in an HSA account also can be used for dental expenses and orthodontia.

What's more, the money can be used to pay premiums on Medicare coverage, long-term care insurance and so-called COBRA insurance coverage (which provides continuing health insurance for those who are between jobs), Luscombe said.

What's the difference between an HSA and the flexible spending account many employers offer at work?

Flexible spending accounts are similar plans. They allow workers to save their own money, on a pretax basis, to pay medical expenses that come up during the year.

4-14

The biggest difference between flexible accounts and HSAs is that any money left unspent in a flexible account at year-end is lost, whereas money in an HSA can accumulate from year to year.

That also means that consumers may have to decide how to save or invest the money — for example, in a bank account or a mutual fund.

The money saved in a health savings account can be provided by the employer, the employee or a combination of both. Whoever makes the contribution gets the tax deduction.

Can I contribute to both a health savings account and a flexible spending account?

Yes, Devore said. But you cannot double dip by using funds in both accounts to pay the same expense.

You can, however, pay expenses with the flexible savings account first and, if that money runs out, tap the health savings account.

What happens if I die with money in an HSA?

If you have a surviving spouse, the account can be transferred directly to the survivor, without distribution or immediate tax implications, Devore said.

If the money goes to other heirs it would be subject to income tax but not to the 10 percent penalty.

Will HSAs be offered through employers, or can individuals set them up themselves?

Both, Devore said. Employers can set them up for workers in concert with a health insurance plan. Or individuals with a high-deductible health plan can set up a health savings account separately.

Because the accounts are new, it may be difficult to find an institution offering them right away, he added.

But wait a few months. Aetna Inc. and UnitedHealth Group Inc. already have announced plans to create HSAs, Devore said.

He expects mutual fund companies and banks to jump into the fray, too.

Los Angeles Times Staff Writer Kathy M. Kristof, author of "Investing 101" and "Taming the Tuition Tiger," welcomes your comments and suggestions but regrets that she is

unable to respond individually. Write to Personal Finance, Business Section, Los Angeles Times, 202 W. First St., Los Angeles, CA 90012, or e-mail kathy.kristof@latimes.com.

Health Savings Account Summary

The new Health Savings Accounts (HSA) provision included in the Medicare bill just passed the Senate 54-44. The new law will go into effect January 1, 2004.

Advantages to an HSA over an MSA		
	MSA	HSA
Contribution source	Either individual or employer, not both	Individual and/or employer
Contribution Levels	65% of deductible single, 75% of deductible family	Up to 100% of the deductible with maximum limitations determined by the IRS each year.
Deductible Ranges	*For 2003:* $1,700-2,500 for single $3,350-5,050 for family	*For 2004:* Min. = $1,000 for single Min. = $2,000 for family
Max. Out-of Pocket	*For 2003:* Max. = $3,350 for single Max. = $6,150 for family	*For 2004:* Max.= $5,000 for single Max.= $10,000 for family

Insurance Plans

- Account holders must have a qualified insurance plan, but the insurance requirements have been opened up considerably.
- Allowable deductibles have been lowered to **$1,000 for an individual** and **$2,000 for a family**.
- The **maximum deductible requirement has been replaced by maximum out-of-pocket limits** of $5,000 for individuals and $10,000 for families. These limits include deductibles and coinsurance for "in-network" providers. These amounts will be adjusted annually for cost of living increases. There is no restriction on the stop-loss limits for out-of-network services.

Annual Contributions

- Annual contributions to the HSA are limited to 100% of the deductible up to a maximum a maximum limitation determined by the IRS each year. Proposed limitations for 2004: $2,600 for an individual or $5,150 for a family. Limitations could be higher pending IRS Regulations.
- Account holders aged 55 and up may make additional contributions of $500 in 2004, increasing by $100 each year until it reaches $1,000 in 2009.
- Such **contributions may be made** by any combination of **employer and individual**. Employer contributions are excludable from income and individual contributions are deductible "above the line." That is, a taxpayer does not have to itemize deductions in order to take the contribution as a deduction.
- Employers must make comparable contributions to employees (cannot discriminate)

HSA Investing / Earnings / Tax treatment

- Funds in an HSA may be invested as the account holder sees fit (CDs, money market funds, mutual funds, etc.) except they may not be invested in life insurance contracts.
- Earnings on the accounts **build-up free of taxes**. The funds will be held in a trust administered by a bank, insurance company, or other approved administrator.
- Funds may be **withdrawn tax-free** to pay for qualified medical expenses, which include all section 213(d) expenses, except health insurance premium payments.
- HSA funds may be used to pay premiums only for long-term care insurance, COBRA continuation premiums, or other health insurance premiums for people receiving unemployment benefits.
- Funds withdrawn for non-medical purposes will be included in the account holder's gross income and taxed accordingly. A **penalty of 10%** will also be applied except in cases of death, disability, or Medicare eligibility.
- In the case of death or divorce, the account may be transferred to a spouse without incurring taxes. If someone other than a spouse is the beneficiary, the funds will be treated as taxable income.
- MSA Transfer: MSAs will be able to transfer into an HSA. However, we do not know at this time if it will occur automatically or if customers will need to complete a transfer form.

MSA Bank Info

- HSA fees and rates will be the same as MSA fees and rates.
- New forms will be required to open an HSA. Forms are available at www.msabank.com click on Forms, then Application Forms.

seattletimes.com
The Seattle Times

Sunday, December 07, 2003, 12:00 A.M. Pacific

Health savings accounts could benefit workers

By Mark Schwanhausser
Knight Ridder Newspapers

SAN JOSE, Calif. — The raucous debate over the Medicare bill overshadowed a provision that could change how — and how much — some pay for health care.

The Medicare reform bill will allow employers to create tax-exempt "health savings accounts" that workers will be able to tap to pay medical expenses. That means qualifying employees will have access to tax-sheltered accounts for three of life's biggest bills: retirement, college tuition and medical care.

However, only those employees enrolled in company-sponsored health plans with high deductibles can open the accounts.

President Bush is expected to sign the legislation, which passed the Senate Nov. 25 and the House the previous week.

Loosely akin to a medical 401(k), the health savings accounts will appeal to many workers. The so-called HSAs can build from year to year as employers and employees contribute money. Workers can take the money with them if they change jobs.

The accounts may be used to pay for everything from doctor's visits and drug prescriptions to chiropractic care and premiums for long-term-care insurance. Cash-strapped workers can even tap their HSA for nonmedical expenses but they must pay a 10 percent penalty on the amount withdrawn. Experts predict such accounts could slow spiraling health-care costs by encouraging workers to conserve on medical care because they'll be paying some bills themselves.

Not all workers will be eligible, however. To qualify, workers must be enrolled in "high-deductible" insurance plans that require workers to pay at least the first $1,000 of medical expenses themselves before the insurance begins to pick up the tab.

Such plans allow workers and their employers to pay sharply lower premiums — and plow the savings into an HSA "rather than give that money to the insurance company month after month after month," said Michael Berry, who heads American Health Value in Boise, Idaho.

Under the new Medicare bill, workers or their employers could fund HSAs with the amount of the deductible, not to exceed $2,250 for an individual and $4,500 for family coverage. Starting in 2006, workers who are 55 and older would be allowed to contribute at least $500 extra.

washingtonpost.com

Tax-Free Plans Could Alter Health Coverage

By Albert B. Crenshaw
Washington Post Staff Writer
Thursday, November 27, 2003; Page E01

A provision of the Medicare bill Congress passed this week would allow workers to turn a health insurance feature they normally dislike -- a high deductible -- into tax-free savings that could grow to large sums over a lifetime.

The measure would allow people under age 65 who buy medical policies with deductibles of at least $1,000 for a single person or $2,000 for a family to establish tax-free "health savings accounts." They, or their employers, could fund them each year with an amount equal to the deductible and the money could be used to pay health care expenses. If not needed, the money could be invested. The money going in would be pre-tax dollars and withdrawals for medical care would be tax-free.

The provision, effective next year, is expected to cost the Treasury $6.4 billion in lost revenue over 10 years. The new accounts and high-deductible insurance would replace, not supplement, existing coverage.

The provision could have a profound effect on employer-base medical insurance plans, some experts said.

Conservatives argue that allowing participants to keep unspent money in their accounts gives them an incentive to restrain their use of medical services and shop for the best combination of service and price, putting downward pressure on health care charges. That is in contrast to the flexible spending accounts now offered by many employers, in which workers set aside up to $5,000 pre-tax dollars to pay medical costs not covered by insurance. Those have a use-it-or-lose it feature that critics say encourages unnecessary year-end spending to avoid forfeitures.

President Bush, speaking at a hospital in Las Vegas Tuesday, called the new plans "an important part" of Medicare reform because the accounts "trust the consumers, provide incentives for people to make wise choices, and help to maintain the doctor-patient relationship."

Liberals say the accounts would appeal to young and healthy workers, drawing them out of traditional plans and undermining them.

The new accounts are modeled on the Archer Medical Savings Account, which were first allowed on a limited basis in the 1990s but are not very popular. Although 700,000 Archer accounts were permitted, only about 80,000 people opened them, according to tax filings. Supporters contend that various restrictions discouraged people from opening the

accounts, and that the caps on total participants convinced insurers that there would be only a limited market.

Some employers have introduced "consumer-driven" health care plans, and several experts said they think the new savings account feature will make such plans much more attractive.

"I would expect this would become far more popular [than Archer accounts], and that high-deductible plans would become more common and popular," said Joseph J. Martingale of Watson Wyatt Worldwide, a big benefits consulting firm.

Martingale said he could imagine an employer offering workers the option of a health spending account, and perhaps making a contribution to it, much like an 401(k) retirement plan. The employer might find the high-deductible plan cheaper, and workers who invested successfully could accumulate a substantial nest egg to help pay medical expenses in retirement. Withdrawals from the accounts for medical expenses would be tax-free, and the accounts could be passed on tax-free to a surviving spouse.

Employers might contract with operators of their 401(k) plans to handle the new savings accounts, Martingale said.

"These changes will offer a tremendous boost to consumer-driven health care," according to an analysis by accounting firm Deloitte & Touche. "Since most existing consumer-driven health plans have high deductibles and co-payments, plan designs would have to change little, if at all. So long as the employer offered a high deductible plan, any employee enrolled in that plan could set up an health savings account without involving the employer in any way."

A "qualified" health care plan would be one in which preventive care isn't subject to the high deductible and out-of-pocket expenses are limited to $5,000 for individuals and $10,000 for families. Once covered by such a plan, an employee could contribute an amount equal to 100 percent of the deductible up to a maximum of $2,600 for an individual and $5,150 for a family -- whichever amount is less. Contributions could be made by the employee, employer or other family members. Thus, parents could fund such an account for a child. In addition, people ages 55 to 65 could make annual "catch-up" contributions. Those could start at $500 next year and increase to $1,000 by 2009.

Critics say the new accounts will appeal mainly to the healthy and the wealthy -- to the wealthy as tax shelters and to the healthy as low-cost coverage because they don't expect to have claims.

Edwin Park, a senior health policy analyst with the liberal Center for Budget and Policy Priorities, said the new accounts "could increase premiums and in turn drive more healthy and affluent workers -- who are also healthier -- out of the risk pool."

That might encourage employers "to say 'I can't afford this anymore' and switch to a [health savings account] exclusively, or say, 'I'm going to pass on more of the cost to the employees,' and then the older and sicker workers want to stay in, but can't afford it," Park said. "Employer-based coverage is eroding but this accelerates that trend."

Park also said that as the first universally available savings accounts that are tax-free at both ends -- funded with pre-tax dollars and tax-free when withdrawn to pay for health care -- the health savings accounts are a worrisome precedent for tax policy at a time when large deficits are looming.

December 8, 2003

Health savings accounts could slash costs

Kent Hoover
Washington Bureau Chief

By passing the Medicare reform bill, Congress not only created a prescription drug plan for senior citizens; it also established a new way for small businesses to obtain affordable health insurance.

The bill establishes health savings accounts -- tax-free accounts similar to IRAs that individuals with high-deductible insurance policies can use to pay medical expenses. HSAs replace medical savings accounts, a pilot program that was much more limited in scope and expires at the end of this year.

HSAs are expected to be widely used by self-employed individuals and workers at businesses that do not provide health insurance to their employees.

"The individual market will convert to HSAs in droves," says Greg Scandlen, director of the Galen Institute's Center for Consumer Driven Health Care. "It is hard to imagine very many individual purchasers who would not prefer an HSA over anything else on the market."

Small business groups say HSAs also offer an attractive option for small employers who are struggling to afford conventional health insurance. Premiums for high-deductible insurance policies offered with HSAs could be 40 percent cheaper, according to the National Small Business Association.

Employers could use the savings on premiums to contribute to their employees' HSAs and still end up paying less for health care coverage than they do now, NSBA states. Both employers and employees can contribute to HSAs, unlike medical savings accounts, which could be funded by either an employer or employee, but not both.

NSBA offers the following example: A small business with 15 employees is paying $72,000 in health insurance premiums a year now. Using HSAs, it reduces its premiums to $40,000 a year by changing to a plan with a $2,500 deductible. The business then contributes $1,000 to each employee's HSA (with employees contributing $1,500 each), bringing its total insurance cost to $55,000, compared with $72,000 now.

Until employees with HSAs reach their deductible, they will pay health care providers directly for medical services. This will provide them with an "incentive to be judicious in their use of health care dollars," says NSBA spokesman Jeremy Claeys, since they will be allowed to keep any money they do not spend.

Neither employers nor employees pay taxes on the money contributed to HSAs, and individuals do not have to pay taxes on withdrawals if the money is used to pay medical expenses. Individuals with HSAs choose how the money is invested, and they are not taxed on the accounts' earnings.

Unlike health reimbursement arrangements -- a similar form of consumer-driven health plan that businesses began offering last year -- HSAs are portable. Individuals who leave a job take their HSAs with them.

Critics: Healthy, wealthy benefit

Critics of HSAs say they mostly will benefit healthier and more affluent individuals, at the expense of workers who want to remain covered by a traditional, low-deductible insurance plan.

If large numbers of healthy workers opt out of traditional insurance plans in favor of HSAs, "the pool of people left in comprehensive plans would be older and sicker, causing premiums for comprehensive insurance to rise significantly," states the Center on Budget and Policy Priorities, a Washington, D.C. think tank.

These higher costs could result in an increase in the number of uninsured Americans "as more employers and employees alike drop out of comprehensive coverage because they could no longer afford it," the center contends.

Meanwhile, wealthy individuals with low medical bills would use HSAs as a tax shelter, the center states. This would mean less tax revenue for the federal government at a time of rising deficits, according to the center.

'Enormous push' expected by mid-2004

Insurers and financial services companies failed to promote medical savings accounts aggressively because the program was temporary and limited to 750,000 enrollees, experts say.

"Companies were reluctant to invest much development in a product that was so tentative," the Galen Institute's Scandlen says.

But the insurance industry is expected to develop "a lot of products" for HSAs, says Jessie Brairton, manager of legislative affairs for the National Federation of Independent Business.

"If agents are out there talking about the product, you will see utilization increase a lot," Brairton says.

Scandlen, a former health benefits consultant, predicts "an enormous push" by HSA vendors by the middle of next year.

"The market is ready for this," he says. "All of the discussion about consumer-directed health care in the last few years has sensitized corporate decision makers to the advantage of putting more control in the hands of employees.

"HSAs provide them with the perfect opportunity to do exactly that."

Health savings accounts offer tax-favored remedy

By Ann Meyer
Special to the Tribune
Published November 27, 2003

Health savings accounts, one provision of the new Medicare drug bill passed by Congress this week, could appear as soon as January to help companies and employees pay rapidly rising health insurance costs.

The health savings account program is designed to salve the sting of high-deductible health plans by providing a tax incentive to employers and employees who fund special savings accounts to pay those high deductibles.

And it is designed to encourage employees to help control costs: If employees don't use the money in their HSAs, it may be rolled over or ultimately kept by the employee for long-term care or retirement health expenses while earning interest, tax-free. It is also portable should the employee move to another company.

"It's going to change the way people think about health insurance and the way they pay for it. The entire landscape has really changed," said Allen Wishner, chief executive of Rosemont-based Flexible Benefit Service Corp., specializing in tax-advantaged health-care delivery systems.

"It gives employees a significant tax benefit to pay for out-of-pocket health expenses. It opens up the ability to make health insurance more affordable by allowing us to pay [deductibles] on a tax-favored basis," Wishner said.

Specifically, employees and employers can deduct money they contribute to health savings accounts. And the money employees receive from the account to pay a health expense is tax exempt, experts say.

In addition to doctor's visits and medical treatment, the money can be used for prescription drugs, retiree health insurance, long-term care insurance, Cobra continuation coverage, health insurance for the unemployed, and other qualified medical expenses--including some dental and vision coverage.If employees do take money out of their HSAs to be used for a purpose other than health expenses, those funds would be treated as taxable income and be subject to a 10 percent excise tax.

"But with the employer making some of the contributions, at the end of the day, that 10 percent excise tax won't be much of a penalty," said Kenneth Olson, divisional president at TJ Adams Group, a Lombard brokerage firm.

Health savings accounts, which would take effect Jan. 1 if President Bush signs the Medicare bill into law, closely resemble medical savings accounts, which have been available to small businesses with 50 or fewer employers and the self-employed since 1997, Wishner said.

Evanston small-business owners Christopher and Jinshil Duquet decided to offer MSAs to their employees several years ago after receiving notice that their health insurance premiums were scheduled to jump 35 percent.

For 10 years, the company had been paying the full premium for employees' health insurance, but costs were climbing 20 percent or more each year.

Then Jinshil found MSAs described on the Internet and immediately liked the concept.

"It made sense with the way my employees were using their health benefit," she said, which was primarily for doctor's visits once or twice a year. "They never met their deductibles."

Employees did not like having to pay out of their pocket the full fee for doctor's visits, and the Duquets didn't enjoy paying hundreds of dollars a month for insurance that was not used.

By going with a plan with a deductible of $2,250 for singles and $4,500 for family coverage, the business' insurance premiums have gone down 30 or 40 percent, Jinshil said. In return, she gives workers $500 to start their MSA. After that, she matches 50 percent of what they put in.

"It's cheaper for me, and as long as we're covered for catastrophic, they can keep part of the savings in the medical savings account. It's good for all of us," she said.

Employees receive a debit card to use at the doctor's office, with the funds coming straight out of the MSA, so they do not even need to be reimbursed. But because they also have insurance, they receive the insurer's negotiated rate for doctor's fees or medical tests.

The new HSAs will work the same way, Wishner said, but employees at companies of all sizes can use them. He forewarned other companies that the concept of a high-deductible plan coupled with a separate savings account can be confusing.

"A lot of people just won't understand it at first. We experienced this ourselves," he said.

Northwest Family Church in Lake Zurich also offers MSAs as a benefit to its nine employees.

Even though it contributes to the accounts up to the limit allowed by law, the church is still paying less than it would with a low-deductible insurance plan, said Melissa Keen, administrator.

Employees like the benefit now, she said, but she acknowledged that the concept took some time to sink in.

"Many companies don't use it because they don't offer a high-deductible plan because it freaks their employees out," she said.

But as deductibles of $1,000 or more have become the norm at many firms, the fear factor is smaller, Olson said. The new rules likely will entice small firms currently using MSAs to roll over those accounts to HSAs because they are more flexible in design and have fewer restrictions, Olson said.

For example, insurance plans with deductibles as small as $1,000 for singles and $2,000 for family coverage now qualify for an HSA, down from $1,700 for singles and about $3,450 for family coverage using an MSA.

And unlike MSAs, which limit the amount that can be set aside to 65 percent of a single's health insurance deductible and 75 percent of a family's deductible, HSAs allow employers and employees to fund the entire deductible--up to a limit of $2,250 for single coverage and $4,500 for family coverage.

HSAs also resemble so-called health reimbursement arrangements, which likewise involve using tax-advantaged funds in conjunction with high-deductible insurance plans.

Using HRAs, Section 105s in IRS parlance, employers set up accounts to reimburse employees for out-of-pocket health expenses. But unlike HSAs, those accounts do not have to be funded until expenses are incurred.

Perhaps the biggest difference between HSAs and HRAs is the underlying philosophy behind each, Wishner said. Both help companies save money on insurance through high-deductible plans, but the new HSAs purposely give employees more of a financial incentive to spend less on health care by allowing them to keep unused funds.

People will begin to shop for medical care the same way they shop for other consumer services, suggested Larry Boress, executive director of the Chicago Business Group on Health.

"Now that it's your money, you want to make sure you're spending it appropriately--that means with the right provider," he said.

Meanwhile, the presence of two similar arrangements--HSAs and HRAs--will not only spur interest in high-deductible health insurance plans, but also provide an arena to see whether one type of plan affects consumer behavior more than the other.

"It will create a debate and competition," Wishner said.

Health costs and the income tax

A new tax shelter, the Health Savings Account, will be available in 2004 for people with high-deductible health plans. The law defines a high deductible as at least $1,000 for an individual plan, $2,000 for a family plan. How the tax law treats health care costs:

	Health Savings Accounts	Health reimbursement	Flex accounts	Medical-dental expense tax deduction
Who qualifies?	All taxpayers under age 65 covered by a high-deductible health plan.	Workers whose employers provide it.	Workers whose employers provide it.	Taxpayers who itemize.
Purpose	Promote use of high-deductible insurance plans by sheltering income used to pay health care costs.	Employer-funded program to reimburse workers for out-of-pocket costs of a high-deductible health plan. May cover part or all of plan's deductibles.	Worker-funded accounts used to pay out-of-pocket medical and dental costs, including over-the-counter drugs.	Limits tax liability for those with high medical expenses relative to their income.
Tax benefits	Tax-free contributions and withdrawals when used for health expenses. Non-health withdrawals after age 65 are taxed but not penalized.	Plan costs are tax deductions for employer. Reimbursement to worker is not treated as income.	Contributions, which are made from payroll withholding, are exempt from income tax.	Income tax deduction for insurance premiums and out-of-pocket medical and dental costs.
Comments	Annual contribution limits: Maximum of $2,250 to meet an individual health plan's deductible; $4,500 for family plan. Replaces Archer MSAs. Effective Jan. 1.	Employer may keep the money when a worker quits or retires.	Worker forfeits unspent money at the end of each year. No interest paid on account balances.	Only qualifying expenses in excess of 7.5% of adjusted gross income may be deducted.

Sources: IRS, CCH, HealthcareShopper.com

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Eligible Medical Expenses

An eligible expense is defined as those expenses paid for care as described in Section 213 (d) of the Internal Revenue Code. Below are two lists which may help determine whether an expense is eligible.

These lists are to serve as a quick reference and are provided to you with the understanding that *MSA Bank*™ is not engaged in rendering tax advice. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses," Catalog Number 15002Q. Publications can be ordered directly from the IRS by calling 1-800-TAX FORM. If tax advice is required, you should seek the services of a competent professional.

Deductible Medical Expenses

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Birth Control Pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium Therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Non-Deductible Medical Expenses

- Advancement payment for services to be rendered next year
- Athletic Club membership
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Bottled Water
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Funeral, cremation, or burial expenses
- Health programs offered by resort hotels, health clubs, and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Maternity clothes
- Non-prescription medication
- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Scientology counseling
- Social activities
- Special foods and beverages
- Specially designed car for the handcapped other than an autoette or special equipment
- Stop-smoking programs
- Swimming pool
- Travel for general health improvement
- Tuition and travel expenses a problem child to a particular school
- Weight loss programs

Health insurance may not be purchased with MSA Funds. There are three (3) situations which are exceptions whereby MSA funds can be used to pay for:

1) A health plan during any period of continuation coverage required under any Federal law

EMPLOYEE BENEFITS

PASSING THE BUCK

How to cut health care costs? Make your employees do the cutting

AS HUMAN RESOURCES director for Fletcher-Thompson Inc., a 160-employee architecture and engineering firm in Shelton, Conn., Susan Pellerin is always looking for ways to hold the line on health care costs, which have been soaring 15% to 20% a year. Last year, she found one: health reimbursement accounts, or HRAs.

Such plans aim to reduce premiums by transferring more of the responsibility for managing health care costs to employees. In an HRA, a health insurance provider creates an account for each of your employees. You contribute a certain amount to each account—typically, about $1,500 to $2,500 a year. Your employees have access to a network of physicians and hospitals, as in any managed-care arrangement. But when they incur a medical expense, they pay for it out of their HRA. When the money is gone, subsequent payments come out of their own pockets. HRAs are typically offered in conjunction with a high-deductible medical plan, which kicks in when an employee's HRA has been tapped. For example, if you put $1,500 into an HRA, and offer a plan with a $5,000 deductible, your employees would be out $3,500 before the medical plan took effect.

Think of it this way: Most current health insurance arrangements resemble an all-you-can-eat buffet in Las Vegas. Cough up the copay and take what you want, whether an MRI or an office visit. HRAs, on the other hand, create an incentive for employees to "treat each doctor's visit or prescription with more scrutiny," says Devon Herrick, a health care economist with the National Center for Policy Analysis in Dallas. To avoid dipping into their own pockets, the theory goes, employees will opt for cheaper, generic drugs, or think twice before a frivolous trip to the doctor.

That made sense to Fletcher-Thompson's Pellerin, who switched to an HRA plan about a year ago. "It seems only natural that if you want to get a handle on costs, you need to involve the people using the product—employees," she says. Fletcher-Thompson now puts between $600 and $1,200 a year into employees' HRAs, depending on the number of people in the person's household. Employees use the funds for copayments, prescriptions, and any other expenses; after the HRA is used up, the copays come from their own pockets. Only a handful of employees have spent the entire amount, Pellerin says, and the company's total costs have dropped 10%.

Not everyone is impressed. Mila Kofman, a professor at Georgetown University's Health Policy Institute, finds it hard to believe that employees will actually cut back on their health care spending. What's more, she points out, thriftiness today could be catastrophically expensive tomorrow. The money saved by skipping, say, a cholesterol screen would be more than outweighed by the costs of treating a heart attack down the road. "There's no question that this is a lesser benefit," says Robert Natt, CEO of MBI, a Waltham, Mass., software company that administers debit cards for HRAs.

But HRAs are an alternative to cutting coverage altogether, Natt adds. Unused money rolls over from year to year, so if you don't need much care for a few years, there should be enough to cover the costs when health woes finally strike. Of course, as with many health insurance fixes, HRAs do little to help those who actually need care. "None of this goes to the core reasons why health care prices are going up," says Kofman.

Still, HRAs appear to be catching on. Many major health insurance providers—including Oxford and Aetna—began offering them last year. Some 1.5 million people are now covered under "consumer-directed health plans," according to a study in the journal *Health Affairs*. By 2005, such plans will account for 20% of the market, the survey found; by 2007, the number could hit 50%. So employees should eat up now. The days of the "copay buffet" may be numbered.

Alison Stein Wellner

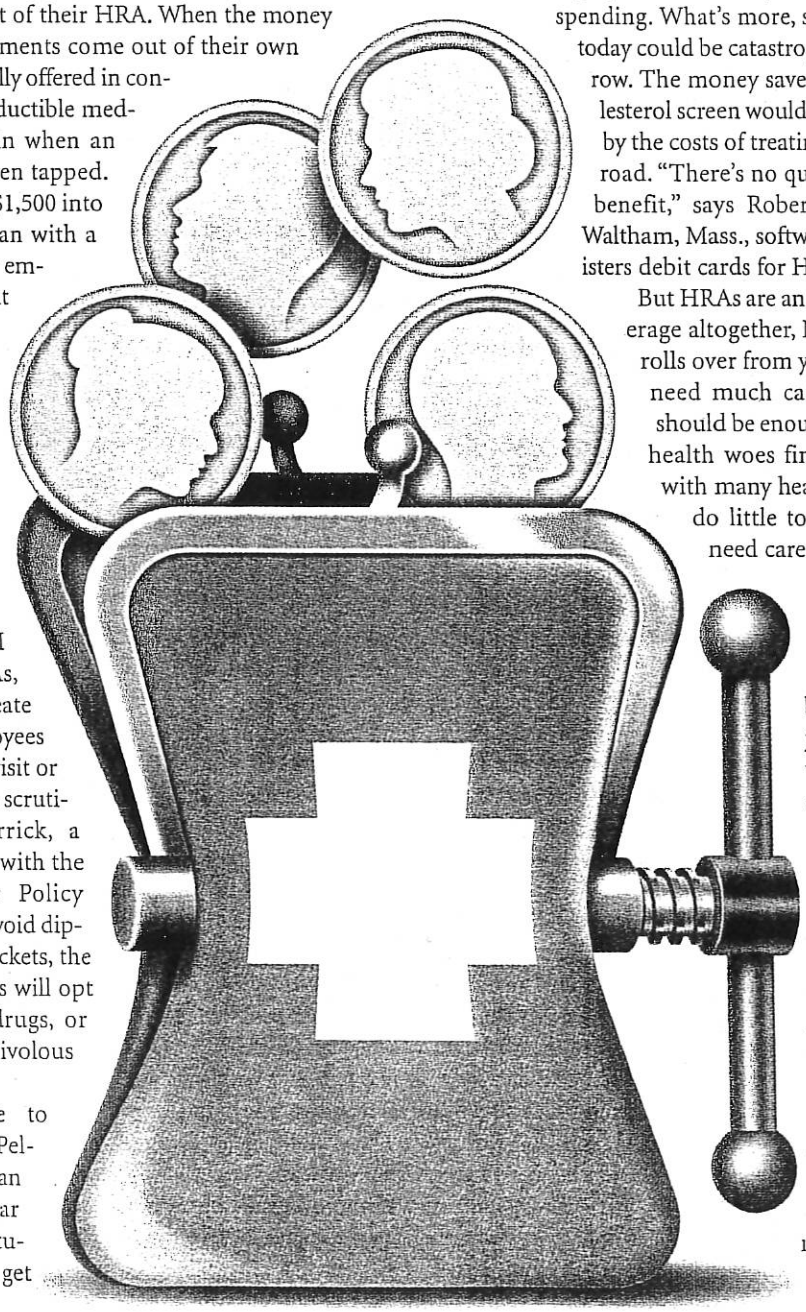

Illustration by Lloyd Miller

Teaching Your Children Wealth
By: Jonathan Clements
Wall Street Journal

Why I Decided
To Close Down
The Bank of Dad

It's easy to spend other people's money. Just ask my kids.

When we're at the supermarket, Henry happily tosses his favorite items into the shopping cart. When we're at a restaurant, Hannah invariably craves an appetizer, a main course and dessert.

This, of course, is no great surprise. Like a crooked chief executive with a compliant board of directors or a salesman with a generous expense account, my children have no incentive to be thrifty. Let's face it, they aren't footing the bill. I am.

How can you get children to show greater restraint? After years of trial and error, I think I have discovered the key: You've got to make kids feel like they're spending their own money.

Inheriting Wisdom: Ever wondered why the children of wealthy parents often grow up to be wealthy themselves? Clearly, many of these kids benefit from a more expensive education and from financial gifts from their parents.

But that doesn't explain the entire phenomenon, according to a study by economics professors Kerwin Kofi Charles and Erik Hurst that is slated to appear in the December 2003 Journal of Political Economy. Instead, it seems wealthy parents also help their kids by passing along good financial habits.

Prof. Hurst, who teaches at the University of Chicago, says these children seem to adopt not only their parents' savings habits, but also their investment style. For instance, if the parents owned their own business or invested heavily in stocks, the kids are likely to do the same.

FURTHER READING

Ages & Stages: Teaching Kids About Money

He doesn't know precisely what the mechanism is. Maybe it's the power of example. Maybe parents who are financially prudent are more likely to teach their kids how to save and invest. But whatever the case, it seems the financial lessons learned in childhood are enormously powerful.

On that score, I am leaving nothing to chance. After all, I am the personal-finance columnist for The Wall Street Journal. It would be a tad embarrassing if Henry, age 11, and Hannah, 15, grew up to be financial ne'er-do-wells.

Believe me, I have had my worries. At one point, Henry appeared to be developing a serious baseball-card addiction, while Hannah seemed to need a weekly fix at Abercrombie & Fitch. Whenever they ended up with a few extra bucks, I knew exactly where the dollars would go.

To nix these nasty spending habits and instill great appreciation for the mighty greenback, I tried a bunch of strategies, some successful, some not. For instance, I started an investment game, where we all picked a mutual fund and then I invested a small sum

POCKET MONEY

How big an allowance should your kid get? Here's what other children receive.

AGE GROUP	% RECEIVING ALLOWANCE	AVERAGE WEEKLY AMOUNT*
15-17	57%	$19.30
12-14	67	$11.30
9-11	58	$8.00
6-8	50	$6.00

Among those receiving an allowance

Source: 2003 Yankelovich Youth Monitor

for everybody each month. I figured this would give the kids a lesson in investing, while also teaching them the virtues of saving regularly.

But despite my high hopes, the game has been a bust. Henry has displayed the financial acumen of the typical performance-crazed mutual-fund investor, opting for a highflying growth-stock fund at the peak of the bull market and then swapping to a conservative balanced fund close to the bear-market low. Yet, despite these missteps, he hasn't shown the slightest remorse.

Why not? My hunch: Even though his funds lagged behind those of his father and sister, he knew his account would keep growing, thanks to his father's regular monthly contributions. Just as it's easy to spend other people's money, so it's painless to lose somebody else's cash.

Saving Themselves: I didn't have much better luck with "Dad's bank," a makeshift financial institution that consisted of a spiral notebook where I kept track of Henry and Hannah's modest savings.

Henry, in particular, was disturbed by the way his deposits ended up in his father's wallet. Sure, I credited the accounts with a generous 1% in monthly interest and, whenever either kid requested a withdrawal, I always promptly produced the necessary dollars. But Henry clearly doubted the soundness of this banking system. It just didn't seem like a real bank.

So I shuttered Dad's bank and opened real savings accounts for both kids. The new accounts didn't pay nearly as much interest. But Henry and Hannah got monthly statements in the mail and they could view their accounts online. And, best of all, the accounts came with a no-fee cash-machine card.

Now, whenever Henry and Hannah want to buy something, they don't ask me for money. Instead, they troop down to the local cash machine and withdraw $20 or $40 from their savings accounts.

The effect has been astonishing. Almost immediately, Henry lost his appetite for baseball cards, preferring instead to watch his account grow. Hannah, meanwhile, hasn't given up on Abercrombie & Fitch. But her trips to the mall have become far less frequent.

I asked Hannah what explained her newfound thrift. "Before, it seemed like it was your money," she offered. "Now, it feels like it belongs to us."

Want to see how your children's attitude changes when they are spending their own money? Try one of my favorite tricks.

Next time you go to the mall, give your kids $10 each to spend, but tell them you expect change. Trust me, you won't get much back. On a subsequent visit, give them $10 again. But this time, tell them they can keep the change. You will be amazed by how much less they spend.

How much can an employee save with a Health Savings Account?

Single Employee

	Current Provider No Tax Advantages			HSA Tax-Advantaged Plan				HSA Contribution Total max 100% of ded =$2500		
								Carry over	Employer	Employee
EXAMPLE YEAR										
Super Healthy Scenario:									$1,080	
Medical Expenses		$0			$0				running balance	
Tax Savings					($216)					
Balance in HSA account					$1,080					
Total Out-Of-Pocket		$0			($1,296)					
Emper Pd (prem.+HSA=total)*	$290.45	$3,485		$167.25	$90.00	$257.25	$3,087			
Total Cost of Insurance		$3,485					$1,791			
				ATD=Applies To Deductible						
EXAMPLE YEAR										
Healthy Scenario:									$1,080	
Medical Expenses								$1,080	running balance	
Dr. Visit (80)	1 visit	$20		1 visit ATD			$70	$1,010		
Prescription ($50)	1 generic pres	$15		ATD			$50	$960		
Glasses		$250					$250	$710		
Tax Savings		$0					($216)			
Balance in HSA account		$0					$710			
Total Out-Of-Pocket		$285					($926)			
Emper Pd (prem.+HSA=total)*	$290.45	$3,485		$167.25	$90.00	257.25	$3,087			
Total Cost of Insurance		$3,770					$2,161			
					ATD=Applies To Deductible					
EXAMPLE YEAR TWO										
Catastrophic Scenario:								$710	$1,080	
Medical Expenses								$1,790	running balance	
Dr. Visit	1 visit	$20		1 visit ATD			$70	$1,720		
Prescription ($90X6 mths)	1 presc. NF (20%)	$108		ATD			$540	$1,180		
Chiropractor ($70)	2 visits	$40		2 visits ATD			$140	$1,040		
Surgery ($40,000)				(Deductible-ATD=)				$1,040		
Deductible	500	$500		2500	$750	$1,750	$1,750	$710		
Coinsurance	1000	$1,000						$2,130		$1,420
Tax Savings							($500)			
Balance in HSA account							$2,130			
Total Out-Of-Pocket		$1,668					($1,210)			
Emper Pd (prem.+HSA=total)*	$290.45	$3,485		$167.25	$90.00	257.25	$3,087			
Total Cost of Insurance		$5,153					$1,877			
					ATD=Applies To Deductible					

This example is based upon avg. single and assumes a 20% tax bracket. Federal and state tax regulations are subject to change.
We are not engaged in rendering tax investment or legal advice. Contact a licensed professional if those services are required.
All comparisons are based upon the outline of benefits for both companies.

$2500 deductible insurance

How much can an employee save with a Health Savings Account?

FAMILY (Employee/Spouse/Children)

	Current Provider No Tax Advantages		HSA Provider Tax Advantages				HSA Contribution Total max 100% of ded =$5050 Carry over	Employer	Employee
EXAMPLE YEAR ONE									
Super Healthy Scenario:								$1,080	1,080
Medical Expenses							$2,160	running balance	
Dr. Visit ($80)	2 visits copay	$40	2 visits (discounted)			$140	$2,020		
Prescription ($50)	2 pres.	$30	2 pres			$100	$1,920		
Glasses	1 pair	$250	1 pair			$250	$1,670		
Tax Savings						($778)			
Balance in HSA account						$1,670			
Total Out-Of-Pocket		$320				**($2,448)**			
Empee. Pd (dep prem.+HSA=Total)	$603.20	$7,238	$318.52	$90.00	$408.52	$4,902			
Total Emp. Cost		$7,558				$2,455			
Emper Pd (prem.+HSA=Total)*	$290.45	$3,485	$167.25	$90.00	$257.25	$3,087			
Total Cost of Insurance	emp + deps.	$11,044	emp. + deps.			$5,542			
EXAMPLE YEAR ONE									
Healthy Scenario:								$1,080	1,080
Medical Expenses							$2,160	running balance	
Dr. Visit ($80)	4 visits	$80	4 visits (discounted)			$280	$1,880		
Prescription ($60)	4 pres.	$120	ATD 4 pres.			$240	$1,640		
Glasses		$250				$250	$1,390		
accident (500)	500 deduct.	500 deduct.	ATD			$500	$890		
		$0				$0	$890		
Tax Savings		$0				($778)			
Balance in HSA account		$0				$890			
Total Out-Of-Pocket		$450				**($1,668)**			
Empee. Pd (dep prem.+HSA=Total)	$603.20	$7,238	$318.52	$90.00	$408.52	$4,902			
Total Emp. Cost		$7,688				$3,235			
Emper Pd (prem.+HSA=Total)*	$290.45	$3,485	$167.25	$90.00	$257.25	$3,087			
Total Cost of Insurance	emp + deps.	$11,174	emp. + deps.			$6,322			
	ATCO+Applies to Coins.		ATD=Applies To Deductible						
EXAMPLE YEAR TWO									
Catastrophic Scenario:							$890	$1,080	1,080
Medical Expenses							$3,050	running balance	
Dr. Visit ($80)	4 visits	$80	ATD 4 visits (discounted)			$280	$2,770		
Prescription ($90X6 mths)	1 presc. NF	$180	ATD			$540	$2,230		
Chiropractor ($70)	2 visits	$40	2 visits ATD			$140	$2,090		
Orthodontist	6000/36mths	$2,000	6000/36mths			$2,000	$2,980	2,890	
accident (2000) Dep.	500	$500	ATD			$2,000	$980		
Coinsurance	300	$300							
Surgery ($40,000) Self			(deductible-ATD=)						
Deductible	500	$500	5050	2960	2090	$955	$25	left in MSA to keep acct open	
Coinsurance	1000	$1,000	2090	955	1135	$1,135			
Tax Savings						($1,818)			
Balance in HSA account						$25			
Total Out-Of-Pocket		$4,600				$1,047			
Empee. Pd (dep prem.+HSA=Total)	$603.20	$7,238	$318.52	$90.00	$408.52	$4,902			
Total Emp. Cost		$11,838				$5,949			
Emper Pd (prem.+HSA=Total)*	$290.45	$3,485	$167.25	$90.00	$257.25	$3,087			
Total Cost of Insurance	emp + deps.	$15,324	emp. + deps.			$9,036			
						ATD=Applies To Deductible			

This example is based upon avg. family of four and assumes a .36 tax bracket. Federal and state tax regulations are subject to change.
We are not engaged in rendering tax investment or legal advice. Contact a licensed professional if those services are required.
All comparisons are based upon the outline of benefits for both companies.

HOW MUCH DOES EVERYONE PAY ON THE BCBS PLAN?

MONTHLY

	Med. Premium Emp'er pays	Med. Premium Emp'ee. pays	Dental Emp'er. pays	Dental Emp'ee. pays
Employee Only	$270.54	$0.00	$19.91	$0.00
Employee/Spouse	$270.54	$310.28	$19.91	$22.90
Employee/Children	$270.54	$250.56	$19.91	$19.47
Employee/Sp/Children	$270.54	$560.84	$19.91	$42.36

Summary of Monthly Insurance Expenses on BCBS Plan

*Based upon data received

	Employees	Med. Premium Pd. By Emp'er	Med. Premium Pd. By Emp'ee	Med. Premium Total	Dental Pd. By Emp'er	Dental Pd. By Emp'ee	Dental Total	Premiums Total
Employee Only	9	$2,434.86	$0.00	$2,434.86	$179.19	$0.00	$179.19	$2,614.05
Employee/Spouse	3	$811.62	$930.84	$1,742.46	$59.73	$68.70	$128.43	$1,870.89
Employee/Children	1	$270.54	$250.56	$521.10	$19.91	$19.47	$39.38	$560.48
Employee/Sp/Children	4	$1,082.16	$2,243.36	$3,325.52	$79.64	$169.44	$249.08	$3,574.60
	17	$4,599.18	$3,424.76	$8,023.94	$338.47	$257.61	$596.08	$8,620.02
		X12	X12	X12	X12	X12	X12	X12
		$55,190	$41,097	$96,287	$4,062	$3,091	$7,153	$103,440

Summary of Annual Insurance Expenses

	Total Employer Insurance Premiums			Total Employee Insurance Premiums			Total Premiums
	$55,190	$4,062	$59,252	$41,097	$3,091	$44,188	$103,440
Assuming 15% Increase							
Year 2	$63,469	$4,671	$68,140	$47,262	$3,555	$50,817	$118,956
Year 3	$72,989	$5,372	$78,361	$54,351	$4,088	$58,439	$136,800
Year 4	$83,937	$6,177	$90,115	$62,504	$4,702	$67,205	$157,320
Year 5	$96,528	$7,104	$103,632	$71,879	$5,407	$77,286	$180,918
Year 6	$111,007	$8,169	$119,177	$82,661	$6,218	$88,879	$208,055

HSA

	MONTHLY			
	Premium Emp'er pays	Premium Emp'ee pays	HSA Contribution Emp'er pays	*HSA Contribution Emp'ee pays
Employee Only	$167.25	$0.00	$90.00	$0 *
Employee/Spouse	$167.25	$209.92	$90.00	$90.00
Employee/Children	$167.25	$108.60	$90.00	$90.00
Employee/Sp/Children	$167.25	$318.52	$90.00	$90.00

* suggested amount only (employee's choice up to maximum) SEE BELOW

What is the Maximum Total **ANNUAL** HSA Contribution Allowed by Law?

		*Maximum Allowed	Amount Emp'er Pays	Max Additional Allowed	If pd. Max Add. Allowed mthly
Employee Only	*100% of Deductible/12 X #mths. eligible that year	$2,500.00	$1,080.00	$1,420.00	$118.33
Employee w. Deps.	*100% of Deductible/12 X #mths. eligible that year	$5,050.00	$1,080.00	$3,970.00	$330.83

*Summary of Monthly Insurance Expenses

*Based upon data received

	Employees	Premium Pd. By Emp'er	Premium Pd. By Emp'ee	Premium Total	HSA Contrib. Pd. By Emp'er	HSA Contrib. Pd. By Emp'ee	HSA Contrib. Total
Employee Only	9	$1,505.25	$0.00	$1,505.25	$810.00	$0.00	$810.00
Employee/Spouse	3	$501.75	$629.76	$1,131.51	$270.00	$270.00	$540.00
Employee/Children	1	$167.25	$108.60	$275.85	$90.00	$90.00	$180.00
Employee/Sp/Children	4	$669.00	$1,274.08	$1,943.08	$360.00	$360.00	$720.00
	17	$2,843.25	$2,012.44	$4,855.69	$1,530.00	$720.00	$2,250.00
		X12	X12	X12	X12	X12	X12
		34,119	24,149	58,268	18,360	8,640	27,000

*Summary of Annual Insurance Expenses

	Total Emp'er Premium + HSA			Total Emp'ee Premium + HSA			Total Premium+HSA
	34,119	18,360	52,479	24,149	8,640	32,789	85,268
Assuming 15% increase							
year 2	39,237	18,360	57,597	27,772	8,640	36,412	94,009
year 3	45,122	18,360	63,482	31,937	8,640	40,577	104,060
year 4	51,891	18,360	70,251	36,728	8,640	45,368	115,619
year 5	59,674	18,360	78,034	42,237	8,640	50,877	128,912
year 6	68,625	18,360	86,985	48,573	8,640	57,213	144,198

KASTL PLUMBING, INC.

March 1, 2004

TO: Rep. Rob Boyer
FROM: Marilyn Pearse
RE: MSA/HSA Innovation

I am writing to provide you with an example of a small business who has implemented an MSA/HSA health insurance for the employees. Historically, we have paid health insurance premiums for our employees, and they have paid for their family coverage, if any. Like most small businesses, our insurance premiums were escalating to the point that we were no longer going to be able to provide health insurance to our employees. Fortunately, our new agent discovered the MSA alternative for us.

At first, our employees did not like the idea, especially the high deductible insurance coverage that the MSA participation required. However, now that we are nearly a year past implementation, our employees have really changed their attitudes. Since the government has allowed for participants to place 100% of the deductible in their HSA, most of our employees, particularly those with families, are taking full advantage of this ability. They understand that by fully funding their HSA, the money that they pay for health issues is being paid with pretax dollars. They also realize now that they no longer have to be concerned about doctor co-pays, prescription limitations, etc. and they can use the funds for dental and vision needs.

I think that it has been empowering and somewhat liberating to these guys that they not only have control of their health care, but, should they decide to leave our employee, they can take it with them. They no longer have to be tied to a dead end job (not that we have any of those here) simply because they are concerned about losing their health care.

As an accountant, I am so impressed with the success of this program. I have many tax clients that are in the same position we were last year. I have explained, to the best of my ability, all of the attributes of the MSA/HSA programs, and, thus far, have found no down side. I have also written to Sam Brownback and suggested that this is a perfect solution to the other small businesses across the state.

Now that companies are no longer limited to the "less than 50 employees restriction," any size business or even an individual can take advantage of this program. My tax clients are excited about the tax savings offered since they can profit in a healthy year, instead of the insurance company, and save in the event of an unhealthy one.

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PHONE (785) 841-2112

LAWRENCE, KANSAS 66049
FAX (785) 749-2355

Please share this information with the insurance committee and ask them to encourage the Department of Insurance to review the current restrictions on insurance companies. My agent tells us that rates could be lower as more companies develop HSA plans and bring those to Kansas. We could use more competition in our state.

Marilyn Pearse
Accountant

The Kansas Bankers Association

3-9-04

TO: House Insurance Committee
FROM: Chuck Stones, Senior Vice President

RE: SB 348

Madam Chair and Members of the Committee,

The Kansas Bankers Association appreciates this opportunity to appear before you in support to SB 348.

SB 348 allows the offering of health savings accounts in Kansas by including them, with medical savings accounts already listed, as exempt from the first-dollar coverage provisions of current law related to accident and health insurance policies.

The KBA is fully supportive of SB 348. As an automatic custodian of these proposed accounts our members are fielding a lot of questions regarding these accounts. We think these type of account will provide a valuable tool for consumers and their health care options in the future. Kansas needs to make the changes necessary to allow its citizens to take advantage of this option.

We would like to request an amendment to make the bill effective upon publication in the Kansas register rather than wait until July. This will allow more time for banks and other custodians to get the proper training and be able to gear up to make these accounts available.

Thank you for your consideration and we urge you to support SB 348.

House Insurance
Date: 3/9/04
Attachment # 5

610 SW Corporate View, Box 4407 ♦ Topeka, KS ♦ 66604-0407 ♦ 785-232-3444 fax- 785-232-3484
e-mail – cstones@ksbankers.com