

MINUTES OF THE HOUSE APPROPRIATIONS COMMITTEE

The meeting was called to order by Chairman Melvin Neufeld at 9:00 A.M. on February 8, 2006 in Room 514-S of the Capitol.

All members were present.

Committee staff present:

Alan Conroy, Legislative Research Department
J. G. Scott, Legislative Research Department
Becky Krahl, Legislative Research Department
Matt Spurgin, Legislative Research Department
Julian Efird, Legislative Research Department
Mike Corrigan, Revisor of Statutes
Nikki Feuerborn, Administrative Assistant
Shirley Jepson, Committee Secretary

Conferees appearing before the committee:

George Pearson, Trustee, Flint Hills Center for Public Policy
Dr. Michael Bond, Senior Fellow in Health Care Policy at the Buckeye Institute,
Cleveland State University

Others attending:

See attached list.

- Attachment 1 Information on Flint Hills Center
- Attachment 2 Bio on Dr. Michael Bond
- Attachment 3 Policy Paper by Dr. Michael Bond
- Attachment 4 Budget Committee Reports on Kansas Lottery and Kansas Racing and Gaming Commission

SB 296 was referred to the Revenue, Judicial, Transportation and Retirement Budget Committee.

Chairman Neufeld recognized George Pearson, Trustee for the Flint Hills Center for Public Policy. The Flint Hills Center is an independent non-profit public policy organization in Kansas, who generate information through their studies, to provide resources to the Legislature, public and media concerning health care, education and tax issues (Attachment 1). The organization has compiled a Medicaid resource handbook which contains studies regarding the Medicaid problem in Kansas, information on other states with similar challenges and possible solutions as to what Kansas can do. The information is available on their website or upon request from the Flint Hills Center.

Mr. Pearson introduced Dr. Michael Bond, Senior Fellow in Health Care Policy at the Buckeye Institute, Professor of Finance at Cleveland State University and adjunct lecturer at the Weatherhead School of Management at Case Western Reserve University (Attachment 2), who presented testimony on Reforming Medicaid in Kansas: A Market-Based Approach (Attachment 3).

Dr. Bond stated that Medicaid, Social Security and the Medicare system are in serious trouble, posing challenges for the nation and the State of Kansas. The problems are complex. Dr. Bond felt that some solutions to the Medicaid problem are to slow the growth of Medicaid, produce better health care, create competition in the marketplace for Medicaid beneficiaries giving a choice of plans, and provide for prepaid health plans. He noted that Florida is the first state to make major changes in the Medicaid program and currently is in the process of creating changes in the program. Responding to a question from the Committee with regard to start-up costs associated with the new program in the State of Florida, Dr. Bond noted that there will be no additional funds contributed by the federal government above the current reimbursement and any start-up costs will need to be absorbed by the State of Florida.

The Chair thanked Dr. Bond for his presentation.

CONTINUATION SHEET

MINUTES OF THE House Appropriations Committee at 9:00 A.M. on February 8, 2006 in Room 514-S of the Capitol.

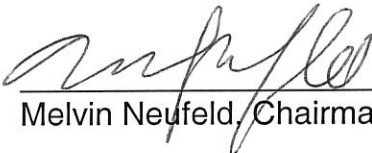
Representative Pottorff, Chair of the General Government and Commerce Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Kansas Lottery for FY 2006 and FY 2007 and moved for the adoption of the Budget Committee recommendation for FY 2006 and FY 2007 (Attachment 4). The motion was seconded by Representative Yoder. Motion carried.

Ed Van Petten, Executive Director of the Kansas Lottery, responded to questions from the Committee, stating that there is no set program in dealing with state distributors who are part of a lottery game. Mr. Van Petten noted that the state demands a discounted rate, does not promote a product from one retailer to another and there is no competition between vendors with any Kansas products. With regard to the earlier problem with the duplicate numbers from the "Pick 3" tickets, Mr. Van Petten stated that this problem was caused when the primary system that picks the numbers had a malfunction; however, indicated that the Lottery has taken steps to resolve the problem with ticket holders and the computer system. With regard to marketing costs, Mr. Van Petten stated that advertising is important to the Lottery and has been shown to increase participation. With regard to "off budget" receipts, Mr. Van Petten noted that retailers only remit to the State the amount of their sales less the amount paid out to winners. This procedure of accounting was recommended by the Division of Budget to eliminate excess paperwork and not inflate the State's 7.5% ending balance.

Representative Lane, member of the General Government and Commerce Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Kansas Racing and Gaming Commission for FY 2006 and FY 2007 and moved for the adoption of the Budget Committee recommendation for FY 2006 and FY 2007 (Attachment 4). The motion was seconded by Representative Yoder. Motion carried.

With reference to the Budget Committee's recommendation of an additional \$250,000 to the FY 2006 budget, the Budget Committee stated that these funds are recommended in case an emergency arises if a race track is forced to close and there is a need to provide care for the animals involved in the operation.


The meeting was adjourned at 10:55 a.m. The next Committee meeting will be held at 9:00 a.m. on February 9, 2006.



Melvin Neufeld, Chairman

FLINT HILLS CENTER

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Flint Hills Center Studies Addressing Medicaid Fiscal Issues:

- *Staying the Course* by Matthew Hisrich – Hisrich discusses many of the cost savings recommended in the 2003 Senate President’s Task Force Report on Medicaid Reform that have yet to be adopted.
- *Controlling Medicaid Long Term Care Costs* by Stephen Moses – Moses recommends tightening eligibility so that a program for the poor does not evolve into a universal welfare program.
- *First Things First* by Matthew Hisrich – Hisrich presents the financial challenges of financing home-based care.
- *Backgrounder on Kansas Medicaid* by Matthew Hisrich – Hisrich looks at ways to improve the quality of care and at the same time reduce the cost imposed on Medicaid.
- *Kansas Estate Recovery Primer* by Roger Van Etten and Brian Vazquez – This report addresses the challenge of capturing the millions of dollars of reimbursements that Medicaid is entitled to.

All studies are available online at www.flinthills.org. Hard copies are available upon request by contacting the Flint Hills Center at inquiries@flinthills.org or (316) 634-0218.

HOUSE APPROPRIATIONS

DATE 2-08-2006
ATTACHMENT 1

Michael Bond, Ph.D.

Senior Fellow in Health Care Policy

Michael Bond, Ph.D., is the Senior Fellow in Health Care Policy at The Buckeye Institute, Professor of Finance at Cleveland State University and adjunct lecturer at the Weatherhead School of Management at Case Western Reserve University. He has taught health care finance along with numerous other courses. He is an active consultant and has worked with over 150 law firms and companies on numerous issues. His work on Medical Savings Accounts (MSAs) and health-care policy reform has received national attention and appeared in a wide range of professional and popular publications, including Health Care Financial Management, Public Personnel Management, Compensation and Benefits Review, Benefits Quarterly, and Business Horizons. Along with over 70 articles and presentations, he is the author of the nation's first practical guide to establishing MSAs (published by The Buckeye Institute in 1997). He also co-authored a guide to reforming Medicaid using a market based plan (published by the Buckeye Institute in 2003). This resulted in the establishment of a Medicaid Commission in Ohio that adopted many of the proposals in their final report. The State of Florida recently proposed Medicaid reforms based on his "Insurance & Provider Exchange Model." Mike earned his Ph.D., M.A. and B.A. in economics from Case Western Reserve University and serves as an advisor on Medicaid to South Carolina Governor Mark Sanford.

HOUSE APPROPRIATIONS

DATE 2-08-2006
ATTACHMENT 2

POLICY PAPER

Volume 3, Issue 3

February 2, 2006

REFORMING MEDICAID IN KANSAS: A MARKET-BASED APPROACH

BY DR. MICHAEL BOND

Medicaid faces serious challenges in Kansas and across the U.S. The joint Federal/State program suffers from unsustainable budget growth that threatens the fiscal solvency of both the states and the Federal Government.¹ In addition, the level of satisfaction among Medicaid's beneficiaries is troublingly low.² A plan that is unable to deliver a satisfactory level of service and is actively driving the nation into bankruptcy is a plan that needs to be reformed.

Policymakers in Kansas should take the following steps to improve the Medicaid program:

- Create a health mart (an Insurance and Provider Exchange) where providers offer prepaid services to beneficiaries.
- Establish actuarially adjusted credits for beneficiaries to purchase care they need from competing providers.
- Offer "reverse health savings accounts" for beneficiaries to pay them for engaging in behavior that leads to better health outcomes.
- Eliminate counter-productive and anti-market schemes such as Certificate of Need Laws and formularies.

Undertaking reform of such a complicated issue is, of course, a major effort on the part of Kansas. State policymakers can be comforted that such reforms are being implemented right now elsewhere.³

I. WHAT'S WRONG WITH MEDICAID?

As mentioned in an earlier publication by The Flint Hills Center, the fundamental problem facing Medicaid is the lack of a real marketplace.⁴ In a traditional market, buyers acting in their own interest purchase goods and services with transparent prices. Sellers/providers seek to maximize their profit/incomes by offering goods and services that consumers want to buy. They also add to their bottom line by delivering those goods and services more efficiently over time and by improving the quality of their existing product. This market approach, while by no means perfect, works better than the command-control approach that has evolved.

Medicaid (and much of health care) lacks such a marketplace. There is little or no transparency in the cost of medical services. Consumers do not pay any significant portion of the cost of their care and therefore have little incentive to economize. Since they bear little or none of the cost of care they are less likely to lead healthy lifestyles that can significantly reduce medical needs.

Bureaucratic decree, rather than natural supply and demand, determines prices. Providers often have no incentive to control unnecessary utilization and/or treat health problems in a cost-effective manner. In fact, tort litigation and other pressures create an



incentive for providers to allow and/or encourage over utilization. There is little incentive to innovate in the delivery of health care. Finally, since beneficiaries are not really consumers in the traditional sense they lack the empowerment to receive quality care.

Looking to additional price controls and government regulations in Medicaid will simply make the problem worse. To fix the problem, policymakers must create a real marketplace. This requires making enrollees the buyer of the medical services they need and allowing competing providers to sell them those services. Beneficiaries need to have incentives to follow a regimen of health behavior and providers need profit/income incentives to continually innovate in the delivery of services.

II. REFORM STEP 1: CREATE AN INSURANCE AND PROVIDER EXCHANGE

Kansas Medicaid (KM) should establish an Insurance & Provider Exchange (IPE). The IPE is nothing more than a state-run mart where Medicaid beneficiaries will purchase their health care.

Providers will offer packages of services to the enrollees at the IPE. The role of the state will change from being the buyer of the health care to facilitating a real marketplace in Medicaid. KM will provide beneficiaries with funds to buy their own health care. They will mandate minimum required benefits and services from providers.

KM will require complete transparency on the part of providers with regard to the services that they offer to enrollees. KM will assist beneficiaries in selecting health products that best meet their needs but the actual choice will be made by the enrollees. KM will give beneficiaries a Medicaid Health Credit (MHC) to buy the coverage they want at the IPE from competing providers.

III. REFORM STEP 2: ALL PLANS WILL BE PREPAID

One of the major problems facing Medicaid is the large scale use of fee-for-service (FFS) delivery

systems. Essentially, the beneficiaries find a doctor or emergency room or are admitted to a hospital for services. KM then pays the provider a fee.

This system has three major flaws. First, efforts to limit usage with arbitrary bureaucratic edicts yield highly unsatisfactory results. Health care is very complicated and no bureaucracy can effectively design a rationing system to control usage in a manner that contains costs while preventing negative health outcomes. On the demand side, the beneficiary pays little or nothing out of pocket and therefore has little incentive to economize on using unneeded care. On the supply side, providers are left with an incentive to deliver services that are not appropriate given that payments follow services rather than outcomes.

Second, these payments paid to providers are not only far removed from outcomes, but they are also equally far removed from true prices based on the interaction of supply and demand. Instead, "prices" are set bureaucratically through government schemes. They are, in effect, price controls. If the rates are set too high there will be too much health care delivered (a surplus). If they are set too low there will be too little care provided (a shortage). In services like health care where quality is important these shortages can take the form of lower actual quality (5 minute office visits), long waiting periods and actual inability to get services at all. Further, rates set below market cause fewer providers to deliver services and promote the competition needed to lead to innovative medical practices.

Finally, FFS often produces episodic health care where problems are (maybe) treated instead of being prevented. Prepaid plans benefit financially from patients having better health and have an incentive to provide preventative care that reduces major health problems in the future. Further, they have an incentive to cost effectively manage existing conditions because their profits/incomes will be higher. It makes much more sense to get a pregnant beneficiary proper prenatal care than it does to spend a fortune on treating a low birth-weight baby. Since the plans can generate a higher income/profit by reducing costs, they have a strong incentive to



innovate. Competition between the plans then forces prices down to their marginal cost. The result will be a slowdown in the rate of medical inflation that Medicaid faces. This innovation will put the plan(s) on a more sustainable fiscal basis.

IV. REFORM STEP 3: THE MEDICAID HEALTH CREDIT WILL BE ACTUARIALLY RISK-ADJUSTED

Insurance companies are in the business of managing risk. Better drivers pay lower insurance premiums. Teenagers as a group are not better drivers and pay higher premiums. Younger people live longer and pay lower life insurance costs. Women live longer than men and pay lower life insurance rates. And in a properly-designed health insurance market sicker beneficiaries would pay more than healthier beneficiaries.

Due to quirks in history there effectively has not been a real market for health insurance. First, many traditional carriers practiced community rating where equalized rates encouraged sicker people to enroll and healthier people to drop out of the insurance pool. Second, tax laws encouraged the purchase of health care through employers. Employer-based insurance is, therefore, just a reallocation of employee compensation to health insurance instead of wages to minimize income taxes.

The above proposed Medicaid reform involves beneficiaries buying prepaid plans from competing providers. Existing Medicaid "managed care" plans are generally set up through selective contracting. Theoretically there may be choices for beneficiaries, but as a practical matter they tend to wind up in one plan over time.

The payment to the plan from Medicaid is an administered price (price control) and is not risk adjusted for each enrollee. While the enrollment in the plans is guaranteed, the failure to risk-adjust payments encourages "cherry picking" by prepaid plans. With the advent of easy to use software it is a relatively simple task to risk-adjust the MHC. While risk adjustment is not perfect, it significantly reduces the incentive to enroll only healthy beneficiaries.⁵

In addition to risk-adjusted Medical Health Credits (MHCs) there should also be a requirement of an actuarial payment from one provider to another if a chronically-ill enrollee switches plans. First, this will further minimize a plans desire to avoid signing up ill beneficiaries. Second, it will encourage the provider that the beneficiary is currently enrolled with to offer quality care focused on disease management. The combination of risk adjustment and a transfer actuarial payment will give plans a strong incentive to compete vigorously for all beneficiary business.

V. REFORM STEP 4: MEDICAID WILL REINSURE SMALLER PLANS

A central tenet in reforming Medicaid is creating a competitive marketplace where beneficiaries can obtain their health care. Monopolies and oligopolies are bad for consumers in any industry – health care is certainly no exception.

In order to make reform work in Kansas it is imperative that choices exist for enrollees. It is also necessary for these providers to be prepaid to control utilization and give incentives for cost reducing, quality promoting innovations. But the benefits of prepaid plans also raise a potential problem in terms of smaller providers who may wish to enter the marketplace.

For a provider to have a reasonable idea of what health costs will be in a current year requires a significantly large pool of coverages (say 5,000 lives). Larger prepaid plans will have an incentive to offer coverage to Medicaid beneficiaries if the enrollees' buying power is risk-adjusted and there is flexibility on the benefits package.

While many of these organizations are indeed effective and innovative, history shows that start-up entrepreneurs often develop revolutionary new methods and products. The problem is that a prepaid practice of, say, ten innovative doctors that enroll 1,000 beneficiaries could be wiped out if they are unlucky enough to sign up a few very high-cost patients. Thus, good ideas that could reduce Medicaid costs and improve its quality may never



make it to the marketplace. This problem, of course, is particularly acute in rural areas like Kansas.

The solution to this problem involves KM "reinsuring" smaller practices if they run into high costs. Actuarially, the risk to a prepaid plan becomes greater given a smaller number of enrollees. KM could use a sliding scale framework with very small plans having a much smaller effective stop-loss limit than medium-size providers. Large prepaid groups would not receive reinsurance. To maintain the incentive for providers to control unneeded utilization there would need to be some financial risk once the reinsurance begins. As with the reinsurance itself, this should be set up on a sliding scale with smaller groups being required to cover a smaller proportion of expenses in the reinsurance range.

As with the private sector, providers need to have flexibility in designing their product. The current Medicaid system has a federally required benefits package with states having the ability to expand the minimum required services providers must cover. Generally, states have operated with a "one-size-fits-all" mentality on the mandated benefits package. This makes no sense given the diverse population that Medicaid covers. Providers must be able to market to specific groups as in the private sector. This specialization and division of labor will increase efficiency and lower medical inflation.

Just as important, it will improve the quality of care for beneficiaries. Since payments for beneficiaries will be risk-adjusted, plans will have an incentive to enroll both healthier and sicker beneficiaries. Practices specializing in the treatment of those afflicted with AIDS could develop alongside those who provide OB/GYN services. As in the private sector, plans may implement an overall benefit limitation.

VI. REFORM STEP 5: ALL BENEFICIARIES WILL RECEIVE "REVERSE" HEALTH SAVINGS ACCOUNTS

Incentives matter. The failure to recognize this is one of the major problems of Medicaid and, indeed, all of health care. The proposed reform plan will get the

incentives right and produce cost-effective, higher-quality care for the poor.

Some have suggested that a better alternative to the supply-side control of prepaid plans is demand-side control of health care usage through significant cost-sharing. Indeed, the widely heralded Rand Health Insurance study showed significantly less usage of health care when those enrolled had higher levels of cost-sharing. Anyone familiar with the basic laws of economics could predict the result. The law of demand had its impact.

Health Savings Accounts (HSAs) are another tool touted as a solution to the problem of using health care demand and inflation. How do they work?

Suppose families have a health plan with 100 percent coverage with an average premium cost of \$10,000 per year. Under an HSA plan they or their employer increase the deductible on the plan from zero (in this example) to say, \$4,000. Since the firm or insurance carrier has less cost risk the premium on the plan will drop. How much is an actuarial issue. Health expenditures tend to be highly skewed in any given year. One rule of thumb is the 80/20 assumption where 20 percent of individuals incur 80 percent of all costs in a year. In other words, a small number of sick people run up most of the expenses annually.

The effect of these skewed expenditures on increasing the deductible to \$4,000 is that "premium" would not decline by an equal amount. The actual reduction depends on several factors but assume it is \$2,800 so that the new premium is \$7,200. Proponents argue that the high deductible will cause enrollees to use health care more carefully, and even most critics agree this will happen below the deductible.

Given the \$4,000 deductible the plan allows for a deposit of \$2,800 to each HSA. Families with expenditures of less than \$2,800 have unused funds and obviously benefit from the HSA. Those with expenses above \$2,800 now have to pay out-of-pocket up to the deductible of \$4,000. They are financially worse off.



Proponents argue this is not a major issue in the private sector for two reasons. First, the out of pocket risk is not particularly large in most cases. Second, it is not the same individuals who are sick every year. The National Bureau of Economic Research examined a large set of medical expenditures and found, as expected, that 10 percent of those covered generated 80 percent of spending in a year. But over a 35-year work life, 55 percent of employees ran up 80 percent of the medical expenses. In other words, there is declining persistency in spending over time. This has the effect of leaving the vast majority of those using HSAs with unused balances if they are enrolled in the plans over a long period of time.⁶

But these can be significant issues in Medicaid. First, from above, there is likely to be an increase in out-of-pocket risk to beneficiaries. This is obviously a much greater burden for the poor than for wealthier enrollees. Further, the Rand Study showed some unfavorable health outcomes for low-income groups when they were subjected to cost-sharing. Second, people move on and off of Medicaid over time. This does not allow for the declining persistency that occurs in the private sector and makes it less likely that a high percentage of beneficiaries will have unused HSA balances. As such, a private sector type HSA may not be advisable.⁷

A better way to generate the incentives that HSAs can produce is by “reversing” the accounts. KM should give every Medicaid beneficiary a reverse HSA (RHSA). The accounts will have a zero balance initially. KM would then add dollars to the account when beneficiaries use health care in an effective and responsible manner.

Medicaid in many states, for example, suffers from a significant problem of enrollees using hospital ER’s for non-life threatening illnesses. KM could pay beneficiaries a portion of the savings from getting coverages to use a physician for their primary care. Large savings could result by paying pregnant women to obtain proper prenatal care and avoiding low birth-weight babies. The same is true of obtaining a full panel of immunizations for children

and for diabetes spots and blood pressure checks for adults.

Funds in the account could be used to purchase additional medical care or rolled over for future purchases. They could also be used to pay for medical care when the beneficiary leaves Medicaid. The RHSA would be a money saver for KM with credits to account being a fraction of the expected actuarial savings from discouraging “bad” behavior and encouraging “good” behavior.

This type of HSA does not expose beneficiaries to out-of-pocket costs and is not dependent on a long enrollment period for effectiveness. In addition, since funds may be rolled over and taken out of the accounts at a later time they will produce a “reverse” working capital effect for Medicaid. The State of Florida’s reform plan has this account as part of its design.

VII: REFORM STEP 6: THE DISABLED AND ELDERLY WILL ENROLL IN PREPAID PLANS

As with the acute care population, Medicaid beneficiaries who are disabled and/or elderly will enroll in prepaid plans. They, too, will receive risk adjusted MHCs. The purpose of the prepaid plan, as above, is to limit unnecessary usage and create incentives for innovations in the delivery of care. This population is a minority in state Medicaid plans but accounts for majority of expenditures. As such, it is crucial that providers to these populations deliver quality care in a cost-effective manner. In addition, this group of enrollees will also receive RHSAs to encourage appropriate medical behavior that results in cost savings.

A central tenet of the proposed reform in this area involves changing the bottom line of providers. Many institutions that deliver services to Medicaid receive payment using a cost-based methodology. This, of course, is just another administered pricing scheme. And, like other price control schemes, it encourages inefficiency and low quality. The development of the MHC will make beneficiaries a sought-after “customer” and competition between providers will lower medical inflation.



Nursing homes and other institutions that provide services to Medicaid should become prepaid in nature. There are two ways this can happen. One is for the provider to list their services at the IPE. The other is for managed care companies to negotiate with these institutions the same way they negotiate with physicians and hospitals. The marketplace will determine which mechanism is most effective. Prepaid plans would have an incentive to develop innovative methods to deliver needed care in a cost-effective manner.

The RHSA can encourage behavior that lowers costs. For example, the mentally disabled sometimes stop taking medications that allow them to function in a reasonably normal manner and avoid very expensive institutionalizations. Documented care visits and usage of effective prescriptions could be rewarded by deposits to the RHSA. As well, offering RHSA funds to loved ones could allow parents and other family members to care for the mentally and physically disabled in a non-institutional setting.

Here the RHSA would essentially function as a “cash and counseling” program. These limited experiments around the country have proven very popular with the disabled. Beneficiaries who are eligible for Medicaid coverage of nursing home care could instead receive RHSA funds if they are able to obtain services in a less-costly environment. This would allow some to stay at home as opposed to assisted living facilities. Here, too, the ability of family members to receive payment from the RHSA could significantly reduce Medicaid’s nursing home costs.

It is, of course, possible that allowing payments to family members could create an “out of the woodwork” effect. That is, individuals currently not enrolled in Medicaid may sign up for the plan to access these dollars. It is crucial that estate recovery efforts be highly effective to minimize this occurrence. There are estimates that as many as 90 percent of those enrolled in Medicaid coverage for nursing homes have done some type of asset planning to qualify for their coverage. Further look-back periods and recovery programs for those seeking Medicaid nursing home coverage would produce larger potential losses in estates to family

members and reduce the incentive to game the RHSA.⁸

VIII: REFORM STEP 7: ALLOW MEDICAID BENEFICIARIES TO BUY INTO PRIVATE PLANS

Medicaid enrollees would be free to use their MHCs to join existing employer-provided plans. Given that a significant number of new Medicaid enrollees in the last 15 years dropped family coverage, this could be a low-cost way of offering coverage to these groups. Since many of them are above the poverty level, KM could offer grants to them on a sliding scale, with high amounts for near-poverty and lower amounts for incomes near the arbitrary established poverty level.

Related to this, another possible reform is to allow individuals and small businesses to purchase private health plans from the IPE. This would generate four potential benefits.

First, it could reduce Medicaid enrollments by moving some beneficiaries back into private-sector coverage. Second, it will induce more firms to offer health insurance by lowering the insurance overhead cost that exists in this market. Third, it will also reduce insurance costs by creating a larger pool of buyers with more purchasing power and reduced annual claims uncertainty. Finally, private providers seeking to sell to private firms/individuals could be required to sell in the Medicaid market as well. This will increase the number of firms competing for Medicaid beneficiary dollars.

IX: REFORM VIII: ALL MARKET-DISTORTING PRACTICES AND POLICIES ARE DISCONTINUED

Consistent with basic principles of economics, all market-distorting activities and schemes should be eliminated. These include formularies, Certificate of Need (CON) laws, and state-mandated health benefits above the Medicaid requirements. Providers of medical services would directly negotiate with drug companies for discounts. Elimination of CON laws would allow for easy entrance into the long-term care market in response to market price signals and would reduce costs by promoting more competition among providers.



X: WHAT HAPPENS IN REAL MARKETS FOR HEALTH CARE?

Would the creation of a real marketplace really help Medicaid's beneficiaries and improve Medicaid's fiscal situation? Or is the purchase of health care simply too sophisticated for most people to deal with, especially the poor? Fortunately, we have some evidence on this issue. The Rand Research Corporation conducted a huge study of the impact of financial incentives on the use of medical services between 1974 and 1982. The study included a large group of families and individuals nationwide and included a wide range of family incomes, from as high as \$100,000 (in today's dollars) down to the poverty level.

While we are simplifying the actual study here, the basic component consisted of some participants receiving "free" health care while others had to pay a deductible of up to \$1,000 (around \$4,000 in today's dollars). The conclusion of Rand Researchers:

- "The more families had to pay 'out of pocket,' the fewer medical services they used."
- "The percentage reduction in expenditure caused by cost sharing did not differ strikingly by income group...."

As economic theory predicts, the more something costs, the less of it people will use. Note that the study's low-income participants changed their behavior along with the middle- and upper-income participants.

It is important to note that there were some adverse health outcomes among the low-income participants when they were required to pay some of the cost rather than receiving the services free of charge. For instance, when blood pressure screenings were provided at no cost to the patient, mortality rates declined by about 10 percent. In addition, participants who entered the study with serious symptoms were less likely to leave them untreated when treatment cost was not a factor.

Recall, however, that most of the medical delivery system in this period (1974-82) was a standard fee-

for-service plan. Now, the adverse health outcomes cited above could easily be dealt with by HMOs and provider networks which recognize the health and financial value of certain types of preventive care. Indeed, competition among providers for beneficiary dollars would likely raise the quality of care to the poor.

Broad market-based reforms are virtually non-existent in Medicaid. In the past, those in Washington would have looked unfavorably on significant reforms. While attempts have been made to utilize HMOs, these continue to suffer from administered pricing schemes where reimbursements to providers are set too low, causing providers to drop out of the system. Now, however, a new, more receptive attitude in Washington opens up the possibility of dramatically changing the system. Nonetheless, thus far no broad-based reforms have been undertaken at the federal level.

There are, however, several small market-based programs that have shown great success.⁹ One of these is the "Cash and Counseling" approach tried in a few states. Florida, for example, operates a program where beneficiaries who are eligible for home- and community-based services receive a monthly budget instead. They may use this to hire caregivers or purchase services. Surveys of participants indicate that 96 percent were "very satisfied" with the service they received, and 97 percent would recommend the program. These are astonishing satisfaction levels!

A similar program in Arkansas called Independent Choices showed a similarly high degree of customer satisfaction, with 93 percent of the participants recommending the program to others. New Jersey has a related program called Personal Preferences. An amazing 99 percent of beneficiaries reported "satisfying" relationships with their caregivers, and 97 percent would recommend the program to others. Does anyone believe that Medicaid's more traditional programs produce these types of outcomes? While such programs are relatively new and limited in scope, we believe the success of "Cash and Counseling" shows that the idea of allowing



beneficiaries to buy their care in the market can work.

While the private sector suffers from many of the same problems as the public sector, we can see how a real market in medical care would operate. Most people did not have prescription drug coverage until the 1980s and 90s. They paid out-of-pocket. The result was a 34 percent increase in drug costs between 1960 and 1980 vs. a 236 percent increase in the general cost of medical care. After drug coverage became much more commonplace, prescription drug costs rose 336 percent vs. 281 percent for general health care from 1980 through 2002.

In cash medical markets such as for cosmetic care, the results are startlingly different. Along with continuing advances in quality, innovations, and comfort, the discipline of the market controls costs. Medical inflation between 1992 and 2001 was three times as high as that of cosmetic care, and these types of services rose in cost at a lower rate than general inflation.

Eye care costs and services where there is not nearly as much third party payment rose at 33 percent between 1990 and 2002, while general medical costs increased at 75 percent. This is in a period when there were dramatic advances in technology and services such as LASIK. In addition, the cost of other types of medical services such as podiatry and chiropractic care (which are often not insured) rose at 43 percent between 1990 and 2002.¹⁰

XI: SUMMARY AND CONCLUSION

Kansas Medicaid is in serious trouble. It produces a quality of health care that is increasingly

unsatisfactory and its long-run fiscal situation is unsustainable. Its problems exist because of the lack of a real marketplace for medical services for beneficiaries. Price controls are inherently inefficient. Any plan for reform needs to address this fundamental flaw. If changes are not made the fiscal state of the plan will only worsen. The State of Kansas faces the unappealing situation of huge cuts in other government spending and tax increases that would wreak havoc on its economy. No reform would inevitably mean even worse health care for enrollees down the road.

Kansas should move now to reform its troubled plan. It needs to create a real marketplace where buyers act in their own interest and providers have an incentive to deliver quality care in a cost-effective manner. This involves creating a mart (an Insurance and Provider Exchange) where beneficiaries buy services from competing prepaid providers with risk-adjusted credits (Medicaid Health Credits) provided by Medicaid. Providers would be allowed to tailor plans for Medicaid's diverse population and Medicaid would reinsure smaller plans to promote competition in both urban and rural areas. All beneficiaries would also receive accounts (Reverse Health Savings Accounts) where they would essentially be paid for engaging in healthy and/or low cost behavior. The resulting outcome will be lower cost inflation in the future combined with better care for beneficiaries.

ABOUT THE AUTHOR

Michael Bond, Ph.D., is an adjunct scholar with The Flint Hills Center for Public Policy, a fellow at the National Center for Policy Analysis and a professor in the Department of Finance at Cleveland State University.



NOTES

¹ For more information on the budget crisis facing Medicaid, see the "Medicaid Handbook" section of The Flint Hills Center's website. This report builds on two other reports recently completed by Dr. Bond on the subject of Medicaid reform for The Flint Hills Center. For these and to access the Medicaid Handbook, please visit: <http://www.flinthills.org/>.

² "Satisfaction with Own Health Insurance Remarkably Stable," press release (Rochester, NY: Harris Interactive, 29 March 2004). According to the Harris poll, "There are now only modest differences in the levels of dissatisfaction with employer-provided, privately purchased insurance and Medicare programs. However, Medicaid beneficiaries are more likely to be dissatisfied, with 36% of them rating Medicaid D, E or F, 27% not recommending Medicaid to healthy friends and family and 33% not recommending it to those who have serious or chronic illnesses." Available at: <http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=781>.

³ Dr. Bond recently completed a review of other state actions. See Michael Bond, "Reforming Medicaid in Kansas: What are Other States Doing?," The Flint Hills Center, 16 January 2006.

⁴ Michael Bond, "What's Wrong With Medicaid in Kansas?," The Flint Hills Center, 26 December 2006.

⁵ See eBenX (<http://www.ebenx.com/>) and DxCG (<http://www.dxcg.com/>) for two firms that have developed software for risk-adjustment.

⁶ See Matthew J. Eichner, Mark B. McClellan and David A. Wise, "Insurance or Self-Insurance?: Variation, Persistence, and Individual Health Accounts," NBER Working Paper 5640 (Cambridge, MA: The National Bureau of Economic Research, June 1996). Available at: <http://www.nber.org/papers/W5640>.

⁷ For an alternative view on this point, see Devon Herrick, "The Future Of Health Care For Kansans," The Flint Hills Center, 14 February 2005.

⁸ For more information on the Estate Recovery program in Kansas, see Roger A. Van Etten and Brian M. Vazquez, "Kansas Estate Recovery Primer," The Flint Hills Center, 22 September 2005.

⁹ For more detailed information on this subject, see Bond, "Reforming Medicaid in Kansas: What are Other States Doing?," The Flint Hills Center.

¹⁰ See Michael Bond, "Reforming Florida's Medicaid Program with Consumer Choice and Competition," The James Madison Institute Backgrounder, number 43 (Tallahassee, FL: The James Madison Institute, February 2005). Available at: <http://www.jamesmadison.org/article.php/331.html?PHPSESSID=68d249d5c06d5e56fdd4009259ec8580>.

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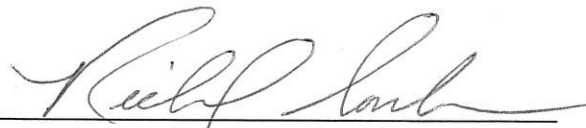
HOUSE BUDGET COMMITTEE REPORT

Kansas Lottery
Kansas Racing and Gaming Commission

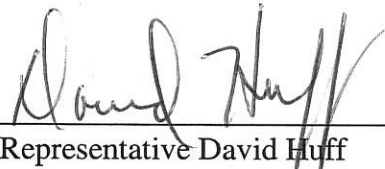
February 6, 2006



Representative JoAnn Pottorff, Chairperson



Representative Richard Carlson



Representative David Huff



Representative Annie Kuether



Representative Harold Lane



Representative Clark Shultz



Representative Kevin Yoder

HOUSE APPROPRIATIONS

DATE 2-08-2006
ATTACHMENT 4

House Budget Committee Report

Agency: Kansas Lottery

Bill No.

Bill Sec.

Analyst: Efird

Analysis Pg. No. Vol. I – 685

Budget Page No. 311

Expenditure	Agency Est. FY 06	Governor Rec. FY 06	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	\$ 0	\$ 0	\$ 0
Other Funds	55,391,215	55,391,215	(5,451,828)
TOTAL	<u>\$ 55,391,215</u>	<u>\$ 55,391,215</u>	<u>\$ (5,451,828)</u>
 FTE Positions	 87.0	 87.0	 0.0

Agency Estimate

Sales of lottery games totaling \$223.0 million are estimated by the agency, an increase of \$16.0 million from the actual FY 2005 amount. Administrative costs are requested at \$22.4 million, an increase of \$2.2 million from the actual FY 2005 amount. State paid prizes are estimated at \$33.0 million in FY 2006, an increase of \$2.4 million from \$30.6 million in FY 2005. Staffing is maintained at 87.0 FTE positions. State Gaming Revenues Fund (SGRF) transfers are estimated at \$66.712 million, an increase of \$712,000 from the approved FY 2006 amount.

Governor's Recommendation

The Governor concurs with sales of \$223.0 million, with the agency's request for FY 2006 expenditures, and with staffing of 87.0 FTE positions. The Governor recommends increasing the approved SGRF transfers by \$1.0 million in FY 2006, with total transfers of \$67.0 million recommended.

House Budget Committee Recommendation

The Budget Committee concurs with the Governor's FY 2006 recommendation and makes the following adjustment:

1. **Nonreportable Expenditure Adjustment.** The Budget Committee recommends a decrease of \$5,451,828 in the estimate for reportable state-paid prizes, which was the amount of taxes deducted from prize payments and treated as a nonreportable expenditure in FY 2005. The same estimated tax amount of \$5,451,828 may be treated as nonreportable in FY 2006 in order to more accurately reflect the agency's reportable expenditures. This is a technical change to the Governor's recommendation.

House Budget Committee Report

Agency: Kansas Lottery

Bill No.

Bill Sec.

Analyst: Efird

Analysis Pg. No. Vol. I – 685

Budget Page No. 311

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	\$ 0	\$ 0	\$ 0
Other Funds	55,518,409	55,585,554	(5,573,428)
TOTAL	<u>\$ 55,518,409</u>	<u>\$ 55,585,554</u>	<u>\$ (5,573,428)</u>

FTE Positions	87.0	87.0	0.0
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Agency Request

Sales of lottery games totaling \$224.5 million are estimated by the agency, an increase of \$1.5 million from the current fiscal year estimate. Administrative costs are requested at \$22.3 million, a decrease of \$0.1 million from the current fiscal year. Absent \$331,267 in expenditures for the Kansas Savings Incentive Program in FY 2006, there would be an increase of \$0.2 million in FY 2007. State paid prizes are estimated at \$33.3 million in FY 2007, an increase of almost \$0.3 million from FY 2006. Staffing is maintained at 87.0 FTE positions. The agency estimates SGRF transfers totaling \$66,712,000 in FY 2007.

Governor's Recommendation

The Governor concurs with estimated sales of \$224.5 million in FY 2007. The Governor concurs with the agency's request for FY 2007 expenditures, including enhancements of \$152,800, and adds funding for a 2.5 percent salary plan adjustment. The Governor recommends SGRF transfers of \$67.0 million in FY 2007.

House Budget Committee Recommendation

The Budget Committee concurs with the Governor's FY 2007 recommendation and makes the following adjustments and observations:

- FY 2007 Baseline Budget.** To establish a baseline FY 2007 budget, the FY 2006 budget, as approved by the 2005 Legislature, was adjusted to reflect salary adjustments (removal of the 27th payroll period funding included in FY 2006, annualization of the FY 2006 phased in 2.5 percent base salary adjustment and statutorily required adjustments for Kansas Public Employees Retirement System (KPERs) rates, KPERs death and disability insurance, and longevity). In addition, adjustments were made for required debt service payments, revenue transfers, and consensus items including school finance funding and caseload estimates for the Department of Social and Rehabilitation Services, the Department of Administration, the Department on Aging, and the Board of

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Indigents' Defense Services. Finally, adjustments were made for one-time items which impact specific agency budgets.

For this agency, the FY 2006 approved budget totaled \$61,157,996, all from special revenue funds. The approved budget was decreased by a net total of \$303,279, all from special revenue funds to establish a baseline budget for FY 2007. The reductions included \$71,979 in salary adjustments and \$213,300 in one-time adjustments.

2. **Comparison of FY 2007 Baseline Budget to Governor's Recommendation.**

The table below reflects the difference between the Governor's recommendation and the baseline budget.

	SGF	All Funds
Governor's Recommendation	\$ 0	\$ 55,585,554
Baseline Budget	0	60,854,717
Dollar Difference	<u>\$ 0</u>	<u>\$ (5,269,163)</u>
<i>Percent Difference</i>	<i>0.0%</i>	<i>(9.5)%</i>

The following table reflects items included in the Governor's recommendation which differ from the baseline budget.

	SGF	All Funds
Base Salary Adjustment	\$ 0	\$ 98,345
State Paid Prizes*	0	(5,436,754)
New Vehicle Purchases	0	121,600
Other Net Adjustments	0	(52,354)
TOTAL	<u>\$ 0</u>	<u>\$ (5,269,163)</u>

*Agency's revised and Governor's recommended FY 2006 budget shifts the prize payment estimate from state paid to local paid which are off-budget.

3. **Vehicles Reduction.** The Budget Committee recommends removing \$121,600 from the Lottery Operating Fund for the purchase of replacement vehicles in FY 2007 and for the issue to be considered during Omnibus.
4. **Change in Ticket Distribution.** The Budget Committee commends the Lottery for switching from agency distribution to commercial delivery distribution for instant lottery tickets. The new method allows the Lottery to maintain better point of sales supplies and contributes to the increased sales of instant tickets. The conversion also resulted in cost savings which the Lottery will calculate after the new method of distribution operates for a full year. The most notable change is the down-sizing of the agency's delivery vehicles to smaller vans which are less expensive and more fuel efficient.
5. **Nonreportable Expenditure Adjustment.** The Budget Committee recommends a decrease of \$5,451,828 in the estimate for reportable state-paid prizes, which was the amount of taxes deducted from prize payments and treated as a nonreportable expenditure in FY 2005. The same estimated tax amount of \$5,451,828 may be treated as nonreportable in FY 2007 in order to more accurately reflect the agency's reportable expenditures. This is a technical

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change to the Governor's recommendation.

6. **Rents.** The Budget Committee notes that the Lottery does not occupy state-owned space in either Topeka or Great Bend where it has offices. The agency's FY 2006 rents of \$446,238 increase to \$474,620 in FY 2007 due to an inflationary clause in the multiyear lease.
7. **No Limit Authority.** The Budget Committee recommends continuing in FY 2007 the no limit expenditures line item for agency operations. The 2005 Legislature added and the Governor approved the no limit authority in FY 2006 for the first time. With the Lottery operated more like a business than most other state agencies, this no limit flexibility allows expenditures to increase as sales increase, without having to wait for the Legislature or State Finance Council to increase expenditure authority. The most recent Legislative Post Audit Financial and Compliance Audit Report for FY 2005 had no negative findings for the Lottery.
8. **Oklahoma Lottery.** The Lottery's Executive Director indicates the new lottery in Oklahoma has not resulted in significant Kansas sales reductions and that the prize structure in Oklahoma for instant tickets, as mandated by their state legislature, is not generous as the Kansas prize payouts. Kansas offers a higher percentage of prize payouts than Oklahoma. Some reduction in Kansas sales occurred with the implementation of the online PowerBall game that completes head-to-head for customers since both states participate in that multistate lottery.
9. **Special Company Promotions.** The Budget Committee commends the Lottery's Executive Director for continuing to form partnerships with Kansas-based business, including the Kansas Speedway, Midwest Ford, Dodge City Steak Company, the Kansas State Fair, General Motors Corporation, Cobalt Boats, the Wichita River Festival, and Harley-Davidson. The Lottery plans to continue partnering with various Kansas based businesses in offering special games and second change drawings to create retailer and player sales promotions and incentives.

House Budget Committee Report

Agency: Kansas Racing and Gaming Commission **Bill No.** **Bill Sec.**
Analyst: Efird **Analysis Pg. No.** Vol. I – 696 **Budget Page No.** 323

Expenditure	Agency Est. FY 06	Governor Rec. FY 06	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	\$ 200,000	\$ 0	\$ 250,000
Other Funds	6,003,334	6,203,334	0
TOTAL	<u>\$ 6,203,334</u>	<u>\$ 6,203,334</u>	<u>\$ 250,000</u>

FTE Positions	67.0	67.0	0.0
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Agency Estimate

The agency estimates revised FY 2006 expenditures totaling \$6,203,334 all funds, including \$200,000 from the State General Fund. The agency requests a supplemental appropriation of \$200,000 from the State General Fund to maintain a cash balance in the State Racing Fund, to finance Racing Operations expenses during this fiscal year, and to provide a cash balance at the beginning of next fiscal year. In addition, the agency requests an expenditure increase of \$31,461 all other funds from the Tribal Gaming Fund for the State Gaming Agency this fiscal year.

Governor's Recommendation

The Governor concurs with the revised FY 2006 expenditures of \$6,203,334 all funds and with an increase in expenditures of \$31,461 from the Tribal Gaming Fund. The Governor does not recommend a supplemental State General Fund appropriation in FY 2006. Instead, the Governor recommends increasing expenditures from the State Racing Fund by almost \$200,000.

House Budget Committee Recommendation

The Budget Committee concurs with the Governor's FY 2006 recommendation and also recommends the following:

1. Appropriate \$250,000 from the State General Fund, subject to release by the State Finance Council, for emergencies that may disrupt the flow of revenue to the State Racing Fund.
2. Introduce an emergency supplemental appropriations bill and include this single item in the legislation that should be passed as quickly as possible.

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The Budget Committee is concerned about the decrease in the cash balance of the State Racing Fund. The Governor's recommendation would spend all available cash in FY 2006 and in FY 2007, with no projected ending balance for either fiscal year. The Budget Committee also is concerned that the cash operating balance in the State Racing Fund is inadequate if revenues are disrupted and expenditures must be made without sufficient reserve resources. According to the agency's report, the lack of an adequate cash balance in the State Racing Fund during each fiscal year may cause serious problems, especially if a race track permanently closes or if a race track temporarily closes for a period of time due to a disease such as kennel cough that requires a quarantine of the animals.

Historically, the State Racing Fund was allowed to carry a \$300,000 cash operating balance. During FY 2005, that amount was reduced to \$200,000. In FY 2006, the 2005 Legislature approved a transfer of \$200,000 from the State General Fund to maintain a cash balance in the State Racing Fund. The Governor's FY 2006 budget recommendation expends this \$200,000 from the State Racing Fund and leaves no ending balance at the conclusion of this fiscal year. The Governor does not recommend supplemental financing of an additional \$200,000 from the State General Fund that was requested by the agency in its revised budget to maintain a cash operating balance in the State Racing Fund.

Without a cash reserve, the agency might not be able to perform its legal duties should there be an unexpected closing of a race track. The disposition of the animals is of critical concern if a closing takes place, and at least a three-month to four-month period of funding for agency operations is required to insure continued day-to-day activities are not disrupted by inadequate cash reserves.

Fee Fund Analysis

The agency includes in net receipts a transfer of \$200,000 from the State General Fund in FY 2006 that was appropriated by the 2005 Legislature and deposited in the State Racing Fund. The agency's revised estimate reflects a reduction in parimutuel related revenues of approximately 10.3 percent in FY 2006 but no further reduction is applied in FY 2007 according to its budget narrative. The Governor concurs with the agency's revenue estimates in FY 2006 and FY 2007. The Governor recommends increasing expenditures financed from the State Racing Fund in FY 2006 to \$2,948,156 which would appear to exceed by \$2.00 the amount of financing available in the current fiscal year. The Governor concurs with the agency's estimate of FY 2007 expenditures which would be equal to the revenues for the next fiscal year.

State Racing Fund Resource Estimate	Actual FY 2005	Agency Estimate FY 2006	Gov. Rec. FY 2006	Agency Request FY 2007	Gov. Rec. FY 2007
Beginning Balance	\$ 408,296	\$ 338,415	\$ 338,415	\$ 199,998	\$ (2)
Net Receipts	2,652,917	2,646,877	2,646,877	2,446,877	2,446,877
Total Funds Available	\$ 3,061,213	\$ 2,985,292	\$ 2,985,292	\$ 2,646,875	\$ 2,446,875
Less: Expenditures	2,711,826	2,748,156	2,948,156	2,446,877	2,446,877
Less: Transfers	10,972	37,138	37,138	0	0
Ending Balance	\$ 338,415	\$ 199,998	\$ (2)	\$ 199,998	\$ (2)
Ending Balance as Percent of Expenditures	12.5%	7.3%	0.0%	8.2%	0.0%

House Budget Committee Report

Agency: Kansas Racing and Gaming Commission **Bill No.** **Bill Sec.**
Analyst: Efird **Analysis Pg. No.** Vol. I – 696 **Budget Page No.** 323

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	\$ 510,584	\$ 0	\$ 250,000
Other Funds	5,626,053	5,855,441	(40,000)
TOTAL	<u>\$ 6,136,637</u>	<u>\$ 5,855,441</u>	<u>\$ 210,000</u>
 FTE Positions	 67.0	 67.0	 0.0

Agency Request

For next fiscal year, the agency requests expenditures totaling \$6,136,637, including \$510,584 from the State General Fund. The agency's request for an appropriation of \$510,584 from the State General Fund is intended to maintain a \$200,000 cash balance in the State Racing Fund and to provide financing for expenses of Racing Operations in FY 2007.

Governor's Recommendation

The Governor recommends expenditures totaling \$5,888,441 in FY 2007, including funds for a 2.5 percent pay plan adjustment. The Governor does not recommend any State General Fund financing in FY 2007. Instead, the Governor recommends \$200,000 from the Economic Development Initiatives Fund for FY 2007 financing of Racing Operations. The Governor recommends a reduction in total agency expenditures in order to address the financing issues of Racing Operations in particular. The Governor's FY 2007 recommended financing for salaries and wages is \$220,746 less than the amount recommended in FY 2006 for the same number of FTE positions. The Governor's recommendation for contractual services is \$79,647 less than the amount recommended in FY 2006. The remaining \$47,500 net reduction is in other areas, primarily other assistance.

House Budget Committee Recommendation

The Budget Committee concurs with the Governor's FY 2007 recommendations and makes the following adjustments and recommendations:

- FY 2007 Baseline Budget.** To establish a baseline FY 2007 budget, the FY 2006 budget, as approved by the 2005 Legislature, was adjusted to reflect salary adjustments (removal of the 27th payroll period funding included in FY 2006, annualization of the FY 2006 phased in 2.5 percent base salary adjustment and statutorily required adjustments for Kansas Public Employees Retirement System

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(KPERs) rates, KPERs death and disability insurance, and longevity). In addition, adjustments were made for required debt service payments, revenue transfers, and consensus items including school finance funding and caseload estimates for the Department of Social and Rehabilitation Services, the Department of Administration, the Department on Aging, and the Board of Indigents' Defense Services. Finally, adjustments were made for one-time items which impact specific agency budgets.

For this agency, the FY 2006 approved budget totaled \$6,099,744, all from special revenue funds. The approved budget was decreased by a net total of \$120,990, all from special revenue funds to establish a baseline budget for FY 2007. The reductions included \$60,990 in salary adjustments and \$60,000 in one-time adjustments.

2. Comparison of FY 2007 Baseline Budget to Governor's Recommendation.

The table below reflects the difference between the Governor's recommendation and the baseline budget.

	<u>SGF</u>	<u>All Funds</u>
Governor's Recommendation	\$ 0	\$ 5,855,441
Baseline Budget	<u>0</u>	<u>5,978,754</u>
Dollar Difference	<u>\$ 0</u>	<u>\$ (123,313)</u>
<i>Percent Difference</i>	<i>0.0%</i>	<i>(2.1)%</i>

The following table reflects items included in the Governor's recommendation which differ from the baseline budget.

	<u>SGF</u>	<u>All Funds</u>
Base Salary Adjustment	\$ 0	\$ 69,217
New Vehicle Purchases	0	40,000
Other Net Adjustments*	<u>0</u>	<u>(232,530)</u>
TOTAL	<u>\$ 0</u>	<u>\$ (123,313)</u>

* primarily salaries and wages plus contractual services.

3. **Vehicles Reduction.** The Budget Committee recommends removing \$40,000 from the Tribal Gaming Fund for the purchase of replacement vehicles in FY 2007 and for the issue to be considered during Omnibus.
4. **Emergency Funding.** The Budget Committee recommends continuing the \$250,000 appropriation from the State General Fund, subject to release by the State Finance Council, if an emergency disrupts the flow of revenue to the State Racing Fund.
5. **Omnibus Review of Funding.** The Budget Committee recommends that a more comprehensive review of Racing Operations financing be undertaken during Omnibus. The Racing and Gaming Commission should consider raising fees for licenses and increasing the parimutuel tax as alternatives for FY 2007, with a

report back to the Budget Committee. In addition, the Budget Committee recommends review of the statutory distribution of the parimutuel taxes from simulcast racing, and for the Racing and Gaming Commission and other interested parties to respond as to whether more funding should be allocated for Racing Operations and operational costs and less for subsidies to county fairs and parimutuel racing at those locations.

The agency awarded grants from the Horse Fair Racing Benefit Fund of \$700,000 in FY 2004 and \$650,000 in FY 2005, with \$168,000 and \$162,500 paid to the Anthony county fair and \$532,000 and \$487,500 paid to the Eureka county fair in each respective fiscal year. The Governor recommends \$600,000 in FY 2006 and \$550,000 in FY 2007 for county fair grant awards. The Racing and Gaming Commission will determine the amounts awarded to applicants, based on requests and available funds. The funding for these grants is derived from the statutory distribution of one-third of the parimutuel tax from simulcast racing.

6. **State Gaming Agency.** The Budget Committee notes that cash flow is NOT a problem for Gaming Operations and the Tribal Gaming Fund. There are no current disputes with any of the four tribes and no pending arbitration this year. The four tribes are paying their assessments on time this fiscal year.
7. **Rents.** The Budget Committee notes that FY 2006 and FY 2007 rental expenditures for office space appear constant after increasing from FY 2005 when the agency relocated to the Eisenhower State Office Building. Previously, each entity was located in separate, non-state owned space. Racing Operations includes expenditures of \$158,000 both fiscal years and Gaming Operations includes expenditures of \$132,000 both fiscal years.