Approved: January 25, 2007
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 A.M. on January 17, 2007 in Room 234-N of the Capitol.

All members were present except:
David Wysong- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Ken Wilke, Office of Revisor of Statutes
Bev Beam, Committee Secretary

Conferees appearing before the committee:
Doug Wareham, KBA
Kansas Insurance Dept.
Karla Finnell, KAMU
Dr. Marcia Nielsen, Executive Director KHPA
Dr. Andrew Allison, KHPA
Cindy D'Ercole, Kansas Action for Children
Corrie Edwards, Kansas Health Consumer Coalition

Others attending:
See attached list.

The Chair welcomed everyone to the meeting.

The first bill introduction was by Doug Wareham, Kansas Bankers' Assn. Mr. Wareham said KBA requests the introduction of legislation designed to prohibit banks from establishing or maintaining a branch in this state on the premises or property of an affiliate if the affiliate engages in commercial activities. KBA believes the longstanding prohibition on the mixing of banking and commerce should be maintained in Kansas, he said. (Attachment 1)

Senator Steineger moved introduction of the bill. Motion seconded by Senator Wilson. Motion carried.

Bob Tomlinson of the Kansas Insurance Department, introduced John Meetz of the Kansas Insurance Department, who is replacing Jared Forbes. Mr. Bob Tomlinson, Assistant Commissioner of Insurance, introduced the following bills: HIPAA, (KSA 40-2258(h) to update expiration date for Mental Health Parity Law; Renew a Resolution for Auto Insurance Verification Task Force which renews the Task Force to find solution to state uninsured motorist problem; Foreign Companies, examination reports of five years versus three years (KSA 40-209) which would require examination reports five years old as opposed to three; Sharing of market analysis, market conduct statements (KSA 40-222) which would enable the Department to share information with agencies from other countries; Continuing Education Hours (KSA 40-4903) would increase CE hours for major lines (1-6) to 24 with three being ethics; Bring Dentists and Long-term care under prompt pay law (KSA 40-2441) to include Dental and Long-term care under the requirement to pay promptly; Automobile Insurance Fraud Act to prohibit solicitation to participate in injury and disability fraud cases; Penalties for certain fraud to warrant prison time (KSA 40-2,118) to create harsher penalties (prison instead of probation) for violations involving theft of more than $25,000; and Anti-fraud become a criminal justice entity with access to KCJIS to classify Anti-fraud division as "criminal justice entity" which allows access to KCJIS criminal database. (Attachment 2)

Senator Brungardt moved collective introduction of bills by the Insurance Department. Senator Steineger seconded. Motion carried.

There being no further bill introductions, the Chair then called on Karla Finnell, Executive Director for the Kansas Association for the Medically Underserved to testify in support of the 0-5 Initiative. Ms. Finnell said KAMU is an association of primary care safety net clinics who share the mission of

increasing access to primary health care services. The funding structure and delivery model differ among clinics, but all share the principle of providing services to all persons regardless of ability to pay, by way of utilizing a sliding fee scale or donations to collect revenues from patients. She said the proposed Healthy Kansas First Five Initiative involves expanding coverage by building upon the existing HealthWave system. In the interest of increasing access to health care through making health insurance more readily available for young children, the Kansas Association for Medically Underserved supports the Healthy Kansas First Five Initiative. (Attachment 3)

The Chair called on Dr. Marcia Nielsen, Executive Director of Kansas Health Policy Authority, for her overview of KHPA. Dr. Nielsen said KHPA is an agency that coordinates health and health care for Kansas. She outlined the following initiatives since KHPA became an independent agency last year.

- Focus on budget and finance
- Increase communication
- Develop and maintain relationships with stakeholders
- Renew emphasis on health and wellness
- Strengthen Medicaid and Health Wave programs

Dr. Nielsen said the goals for KHPA are clear. The powers, duties and functions of KHPA are intended to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs.

Dr. Nielsen said KHPA looks forward to working closely with the legislature to achieve their goals and to improve the health of all Kansans. (Attachment 4)

Dr. Nielsen introduced Dr. Andy Allison, Deputy Director and Acting Medicaid Director of KHPA who testified in support of the Healthy Kansas First Five Initiative. Dr. Allison said Healthy Kansas First Five is a program that will increase access to health care for our youngest Kansans, ensuring they have a healthy start in life. He explained the proposal to increase accessibility for children under the age of five and how it would work by expanding the income eligible limits for Health Wave. Dr. Allison gave an overview on health care coverage in Kansas for low-income and needy persons and explained how Healthy Kansas First Five works. (Attachment 5)

Next to testify regarding Healthy Kansas First Five Initiative was Cindy D'Ercole, representing Kansas Action for Children. She said Children ages birth through five need access to health care in order to develop to their fullest potential and be prepared to enter school ready to learn. In Kansas, SCHIP (State Children's Health Insurance Program) and Medicaid are integrated and function as a seamless program referred to as HealthWave. HealthWave's monthly premiums are based on a sliding scale relative to the family income. HealthWave has succeeded in providing health coverage for thousands of Kansas children, but there are still 48,000 uninsured children in Kansas. The Healthy Kansas First Five initiative will build on the success of Healthwave. (Attachment 6)

Senator Brownlee asked Dr. Allison if the issue on families enrolling their children in HealthWave was that they can't afford the $20 or $30 premium, or is it that they are not aware of it? So, the money that we might spend to increase to a 300% federal poverty level, would we be better off marketing more extensively to those populations who have children who might qualify?

Dr. Allison said the effort that the Medicaid Program has put towards marketing over the years has changed quite a bit. Marketing is both the function of advertisement and ease of enrollment and ease of enrollment has changed dramatically over the years. First to become more simple and, more recently, with the citizenship verification requirements, it has become significantly more complicated. We also believe that outreach and marketing are important to reach those, especially those already eligible who are not enrolled. I think one relevant historical example would be the introduction of the SCHIP Program. In this state in 1999 they expanded eligibility for public health insurance and now I think we have around 34 or 35 thousand children enrolled in that program. But the more dramatic impact the new program had was really a bi-product to make Medicaid better known and more attractive and inviting to those who need the coverage. We saw an even greater increase in Medicaid enrollment among children than we did the increase with the new program. I would expect potentially a similar effect in this instance when we say to Kansas citizens that we are committed to making sure that individuals and children have access to affordable coverage and inviting those between 200 an 300 percent to buy into program, I would expect to see an impact on participation.

Senator Steineger commented that hard lessons have been learned about giving away without expecting anything in return. Senator Steineger said medicare expansion through whatever method appears to be

offering more and more benefits to people without asking much in return in terms of self responsibility or changing behavior. Childhood obesity is a growing trend in our country, especially in our state and my community and since this program is focused at children, what are we asking of parents whose kids will be in this program – are there disincentives, or incentives or do they get discounts if their kids are properly fed and exercised at home, or are there disincentives for parents who don't practice these good habits at home? What are we doing, if anything, in this proposed expansion to get people to modify their behavior and be better citizens and practice self responsibility?

Dr. Allison said the Health Policy Authority Board is looking forward to and is engaged in healthy discussion about ways that this state should invest in prevention and the types of incentives some state medicaid programs have engaged in to reward this or that behavior. I think what the Board is suggesting that the first move is, we have a number of children without access to care and whose families don't know how to get them to the doctor and to pay for that first service and how to invest in prevention oriented care for these children. This is the first step that the Board is recommending. We understand the implications for private markets and we will be addressing those implications with specific measures and policies within our First Five proposal but I think what you see in this proposal is a reflection of the Board's priority and ordering of those issues.

Dr. Neilson added that they also have a policy proposal that would allow kids who receive services thorough medicaid to have medical visits reimbursed to their provider specifically to the issue of obesity.

The final conferee was Corrie Edwards, Executive Director and a registered lobbyist for the Kansas Health Consumer Coalition. This Coalition works to advocate for affordable, accessible and quality health care in Kansas. She said this initiative offers Kansas the opportunity to strengthen and build on the success of health coverage programs for children. She said a lack of health insurance results in inadequate health care. This initiative offers a chance to expand children's health coverage and improve the health care they receive. (Attachment 7)

The meeting adjourned at 10:30 a.m.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 1-16-07

NAME	REPRESENTING
Alex Kotoyantz	P.I.A
Bill Sneed	Polsinelli
Corrie Edwards	KS Health Consumer Coalition
Cara M. Cramer Greve	KAMU
Mike Huttles	KAMU
Lee WRIGHT	Farmers INS.
Rick Wilborn	Farmers Alliance
Derek Hein	Hein Law Firm
John Meetz	KID
Jerel Wright	Ks Credit Union Assn
Marci Nielsen	KHPA
Andy Allison	KHPA
Mike Shields	KHI News
Callie Rockefeller	Sen Teichman Intern
Kathy Damron	Unicare
Luke Thompson	KHPA
Kerri Spielman	KAIA
Doug Wareham	KBA
Kathy Olsen	KBA
Sandra Braden	Gaches, Braden, Barbee & Assoc.
Erik Hane	Federico Consulting

Date: January 17, 2007

To: Senate Financial Institutions & Insurance Committee

From: Doug Wareham, Senior Vice President-Government Relations DW

Re: Prohibition Against Branches with Commercial Affiliates

Madam Chairman and members of the Committee, I am Doug Wareham appearing on behalf of the Kansas Bankers Association (KBA). KBA's membership includes 352 Kansas banks, which operate more than 1,300 banking facilities in 440 towns and cities across the state.

KBA would like to request the introduction of legislation designed to prohibit banks from establishing or maintaining a branch in this state on the premises or property of an affiliate if the affiliate engages in commercial activities. Simply put, we believe the longstanding prohibition on the mixing of banking and commerce should be maintained in Kansas.

Thank you for the opportunity to make this request.

FI&I
1-17-07
Attachment 1

610 S.W. Corporate View 66615 | P.O. Box 4407, Topeka, KS 66604-0407 | 785-232-3444 | Fax 785-232-3484
kbaoffice@ksbankers.com | www.ksbankers.com

Kansas Bankers Association
Prohibition Against Branches with Commercial Affiliates

New Section. (1) For the purposes of this section:
(a) "Affiliate" means any company that controls, is controlled by, or is under common control with another company.
(b) "Bank" has the meaning stated in the federal deposit insurance act, 12 U.S.C. 1813(a)(1).
(c) "Branch" means any office other than the place of business specified in the bank's certificate of authority, at which deposits are received, checks paid, money lent or trust authority exercised, if approval has been granted by the appropriate federal or state suprervisory agency.
(d) "Commercial activities" means activities in which a bank holding company, a financial holding company, a national bank, or a national bank financial subsidiary may not engage under federal or state law.
(e) "Control" means the power directly or indirectly to direct the management or policies of a bank or to vote 25% or more of any class of voting shares of a bank.
(2) A bank may not establish or maintain a branch in this state on the premises or property of an affiliate if the affiliate engages in commercial activities.

Kansas Insurance Department

Sandy Praeger COMMISSIONER OF INSURANCE

Bill Introductions for Senate FI&I Committee 1/17/07

HIPAA [KSA 40-2258(h)]	Update expiration date for Mental Health Parity Law
Renew Resolution for Auto Insurance Verification Task Force	Renews mandate for Task Force to find solution to state uninsured motorist problem
Foreign Companies, examination reports of 5 years vs. 3 years [KSA 40-209]	Requires examination reports 5 years old as opposed to 3.
Sharing of market analysis, market conduct statements [KSA 40-222]	Enables the Department to share information with agencies from other countries
CE Hours [KSA 40-4903]	Increase CE hours for major lines (1-6) to 24 with 3 being ethics
Bring Dentists and Long-term care under prompt pay law [KSA 40-2441]	Including Dental and Long-term care under the requirement to pay promptly
Automobile Insurance Fraud Act	Prohibits solicitation to participate in injury and disability fraud cases
Penalties for certain fraud to warrant prison time [KSA 40-2,118]	Creates harsher penalties (prison instead of probation) for violations involving theft of more than $25,000
Anti-fraud become criminal justice entity with access to KCJIS	Classifies Anti-fraud division as "criminal justice entity" which allows access to KCJIS criminal database

FI & I
1-17-07
Attachment 2

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Kansas Association
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Medically Underserved
The State Primary Care Association

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Good morning Madam Chairperson Teichman and Distinguished Members of the Committee. My name is Karla Finnell. I am the Executive Director for the Kansas Association for the Medically Underserved (KAMU) and am a registered lobbyist. KAMU is an association of primary care safety net clinics who share the mission of increasing access to primary health care services. The funding structure and delivery model differs among clinics but all share the guiding principle of providing services to all persons regardless of ability to pay, by way of utilizing a sliding fee scale or donations to collect revenues from patients.

Access to primary health care services is a dilemma for uninsured and underinsured Kansans, including young Kansas children. At least 5 - 6% , or just over 3600, safety net primary care clinic patients seen each year are uninsured children five years old or younger, the overwhelming majority of whom are living at or near poverty. These uninsured children are income eligible for the Kansas HealthWave program but are not currently enrolled. Efforts to enroll uninsured children in state sponsored health insurance programs through initiatives such as Healthy Kansas First Five will help reduce safety net clinics' burden of delivering uncompensated primary care services, while fostering access to a full range of health benefits for young Kansas children.

Undoubtedly, we are all aware of rising costs of health insurance. From 2000 to 2006, wages increased 16% whereas health insurance premiums increased 78%, or five times more than the increase in wages (Families USA). These statistics translate to increased numbers of uninsured Kansans. In terms of the effect on children of increasing costs of health insurance, their access to care is directly burdened. That is, even if a parent is offered coverage through their employer, coverage for dependents is frequently not available or is unaffordable. It is simply becoming more and more difficult to afford health care insurance that ensures access to care.

The role of health insurance in improving access to care is well documented. Increased access to primary health care has been directly linked to improved health outcomes. Furthermore, regardless of age, race, ethnicity, income or health status, uninsured children were much less likely to have received a well-child checkup within the past year; 50% of insured children versus 26% of uninsured children received the checkup (National Coalition on Health Care). Given this foundation, uninsured children with markedly less access to care relative to those with state sponsored or private health insurance is an issue worthy of focus.

Between 2004 and 2005, twenty states took steps to increase access to health insurance coverage for children and parents by way of coverage expansions, reduced premiums, and procedural simplifications (Kaiser). The proposed Healthy Kansas First Five Initiative involves expanding coverage by building upon the existing HealthWave system. In the interest of increasing access to health care through making health insurance more readily available for young children, the Kansas Association for the Medically Underserved supports the Healthy Kansas First Five Initiative.

Thank you for your time.

FI & I
1-17-07
Attachment 3

MARCIA J. NIELSEN, PhD, MPH
Executive Director

ANDREW ALLISON, PhD
Deputy Director

SCOTT BRUNNER
Chief Financial Officer

Testimony on:
Kansas Health Policy Authority Overview

presented to:
Senate Committee on Financial Institutions and Insurance

by:
Dr. Marcia Nielsen
Executive Director

January 17, 2007

For additional information contact:
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FI & I
1-17-07
Attachment 4

Kansas Health Policy Authority Overview

Good morning, Madame Chair and members of the Committee. I am Marcia Nielsen, Executive Director of the Kansas Health Policy Authority. I appreciate the opportunity to update the Senate Committee on Financial Institutions and Insurance regarding the Kansas Health Policy Authority's activities since last legislative session. I want to give you a brief overview of the work this agency has done and continues to do in the mission of improving health care for Kansans.

We believe we are an agency that coordinates health and health care for a thriving Kansas. In fact, that is our vision statement, and I believe it correlates well with the mission the Legislature gave us. In addition to launching our vision statement for our employees this past Monday, the Authority has taken on a number of initiatives since we became a new independent agency in July of last year:

- ***Focused on budget and finance.*** Since I became Executive Director in July, the Kansas Health Policy Authority has placed a focus on the budget and finance areas of the agency.
  - KHPA developed and received Board approval for its first budget as a state agency.
  - KHPA is now engaged in monthly public reporting of budget performance and financial status, including key administrative and programmatic details.
  - KHPA is reorganized to reflect the increased focus on financial and budgetary responsibilities, including the hiring of the agency's first Chief Financial Officer, Scott Brunner, former Director of the Kansas Medicaid and HealthWave programs.

- ***Increased communication.*** Transparency is an important part of the process of advancing health policy in the state, and effective communication is a significant means to increase our transparency. The Kansas Health Policy Authority has worked to increase its communication efforts with all stakeholders.
  - KHPA developed a new website, which is updated daily, to better inform consumers, providers, and purchasers about our programs and policies.
  - The agency instituted new ways to communicate with its staff, including the creation of a staff e-newsletter, which is distributed weekly to staff members, and established quarterly all-staff town hall meetings.
  - KHPA conducted five town hall meetings for stakeholders. These community meetings were held in Hays, Kansas City, Wichita, Pittsburg, and Garden City, allowing area residents an opportunity to voice opinions regarding the future of the Kansas health system.
  - KHPA created an Interagency Deputy Secretaries Planning Group to better coordinate the health issues and policies facing the State and Kansans. The group meets monthly to discuss new initiatives, share ideas, and facilitate effective programmatic coordination.

- ***Developed and maintained relationships with stakeholders.*** Partnership is vital to successful programs and operations of the Kansas Health Policy Authority, and the agency has continued to develop its relationships with various stakeholders throughout Kansas.
  - KHPA collaborated with stakeholders to ensure the continued success of the Provider Assessment program.

- The first two of an ongoing series of Disproportionate Share Hospital (DSH) policy planning meetings for hospitals were conducted to provide input that ensures funding is equitable and the program advances state health policy.
- KHPA worked with other state agencies to develop and oversee implementation of a CMS audit, deferral, and disallowance work plan to resolve outstanding issues, led by Dr. Barb Langner, Associate Professor at The University of Kansas School of Nursing.
- KHPA has continued to support broadly collaborative efforts focused on health information technology and health information exchange initiatives aimed at improving quality and efficiency in health and health care.

- ***Renewed emphasis on health and wellness.*** With data showing the importance of a healthy lifestyle, the Kansas Health Policy Authority has worked to emphasize the importance of health and wellness.
  - L.J. Frederickson was hired as the State Employee Health Benefits and Plan Purchasing Director and is working to increase the promotion of health and wellness in the State Employees Health Benefits Plan (SEHBP), including signing a new pharmacy benefits manager contract with Caremark which will save the State $3.6 million annually.
  - KHPA's quality and innovation team has analyzed State Employee Health Benefits Plan data, and planning has begun to enhance wellness efforts for state employees.
  - KHPA has explored additional health and wellness initiatives for Medicaid beneficiaries as outlined by the submitted FY 2008 budget, including reimbursement to physicians for weight management counseling, integrating Medicaid immunization records with KDHE, and a request for funding to study and implement health promotion programs for Medicaid beneficiaries.

- ***Strengthened Medicaid and HealthWave programs.*** As the single state agency for Medicaid, the Kansas Health Policy Authority has strengthened its Medicaid and HealthWave programs to provide affordable and quality care to enrolled Kansans.
  - On July 1, 2006, KHPA became the single state Medicaid agency, bringing efficiency to the program and maximizing the state's purchasing power. KHPA is applying this leadership role in the multi-agency Medicaid program to increase transparency, improve cooperation, and streamline operations.
  - KHPA signed two contracts for Medicaid managed care services with two contractors, saving the state between $10 to $15 million annually and introducing choice and competition into this important and growing market.
  - KHPA submitted six Medicaid transformation grant proposals which will work to increase quality and efficiency of care.
  - KHPA conducted a systematic review of its Medicaid Information Technology Architecture (MITA) to identify opportunities for structural improvement in data management and operational structures. Future MITA reviews will focus on organization structure to more effectively coordinate health care purchasing.

In terms of a vision and broad goals for the Authority -- which is the purview of the Health Policy Authority Board -- the legislation is clear. The Kansas Health Policy Authority shall develop and maintain a coordinated health policy agenda that combines the effective purchasing and administration of health care with health promotion oriented public health strategies. The powers, duties, and functions of the Authority are intended to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency, and effectiveness of health services and public health programs.

At the Board Retreat held in February 2006, there were a number of strategies and long-term goals developed to assist the Board in meeting its broad mission and charge. Using these strategies as a guideline, the Board, during recent meetings and after many spirited discussions, identified overall priorities and goals for the Authority. This fall, the Board refined and approved the draft Vision Principles to include the six areas as described below.

- Access to Health Care
- Quality and Efficiency in Health Care
- Affordable and Sustainable Health Care
- Promoting Health and Wellness
- Stewardship
- Education and Engagement of the Public

Access to Health Care. The intent of the first vision principle, Access to Health Care, is that Kansans should have access to patient-centered health care and public health services which ensure the right care, at the right time, and at the right place. The Authority will analyze and seek to eliminate the many barriers Kansans face in attaining preventive health services. This includes making available non-emergent care options for uninsured populations seeking primary care services.

Quality and Efficiency. The second principle, Quality and Efficiency, addresses how the health delivery system in Kansas should focus on quality, safety, and efficiency, and be based on best practices and evidence-based medicine. It also means that health promotion and disease prevention should be integrated into the delivery of health services. Addressing quality and safety are very important in ensuring that Kansans receive the appropriate care to prevent further health complications. Ensuring that Kansans receive appropriate care, while containing costs, is a challenge for all health care providers. A great deal of work is currently being done in the field of health information technology and exchange. Several initiatives currently underway include the Governor's Health Care Cost Containment Commission (staffed by the Authority), Advanced Technology ID cards, and the Community Health Record of which e-prescribing is a critical part. Evidence-based medicine is the conscientious, explicit and judicious use of the current best evidence in making decisions about the care of individual patients. Employing these concepts yields efficiency in health finance, and that leads to the next principle.

Affordable and Sustainable Health Care. The third principle, Affordable and Sustainable Health Care, speaks to the financing of health care in Kansas and how it should be equitable, seamless, and sustainable for consumers, purchasers, and government. Regardless of geography or insurance status, access to affordable health care must meet the varying needs of Kansans across the State. Kansans should be able to depend upon a stable health system for their families without undermining the economic growth of our State.

Health and Wellness. The next principle, Promoting Health and Wellness, emphasizes that Kansans should pursue healthy lifestyles with a focus on wellness – to include physical activity, nutrition, and refraining from tobacco use – as well as through the informed use of health services over their life course. Whenever possible, the Authority intends to implement programs that seek to encourage Kansans to improve their own health. These programs will include evaluation, education, and even incentives. Combined with incentives, providing affordable health care for Kansans may result in more individuals taking advantage of preventive services. Additionally, we will encourage partnerships among health care providers and patients, and incentives for providers and beneficiaries to promote prevention and healthy behaviors will need to be explored.

Responsible Stewardship. The next principle, Stewardship, means that the Authority will operate with the highest level of integrity, responsibility, and transparency for the resources entrusted to us by the citizens and the State of Kansas. First and foremost, the members of the Authority Board will make every effort to ensure that the policy options we put forth balance the best interests of all involved parties, including taxpayers and those that need and provide health services. At the same time, the State has created this as an independent agency to encourage decision making and idea fostering with regard to health care to not be affected by other political forces that commonly affect State agencies. The Authority plans to take advantage of this objective decision making environment that holds such a noble goal in the forefront.

Education and Engagement of the Public. Last but not least, Education and Engagement of the Public calls for Kansans to be educated about both health and health care delivery to encourage public engagement in developing an improved health system for all Kansans. One of the greatest challenges of the health system is communicating its issues outside of the health community. The system is complicated and as a result, it is easy for the public to become disengaged. And yet, every Kansas family is directly affected by their and others' health care costs. This is the reason that the Authority seeks to engage the public in the discussion about improving our health system and also our personal responsibility for our own health.

These vision principles will be used to help guide the Authority in the direction of formulating a comprehensive health agenda to achieve the goals laid out by the legislature.

As required by statute, in 2006, the Kansas Health Policy Authority Board developed and approved an initial set of health indicators that correlate with each vision principle. These indicators will include baseline and trend data on health care, health outcomes, healthy behaviors, KHPA operational integrity, and health costs.

In 2007, these health indicators will be prioritized, reviewed, and approved by the KHPA Board. The next step will be to identify the best way to quantify and measure these indicators to observe changes over time and track the impact of state health policy initiatives. The process for identifying the specific measures to be used will soon be finalized and options will be discussed by the Board in the near future.

On January 22-23, the Board will be holding its annual retreat at the Eldridge Hotel in Lawrence. We will be discussing a number of items as well as hearing from Chairman Barnett, Governor Kathleen Sebelius, and House and Senate leaders regarding their health care goals for the Legislative session. We will also be discussing our goals for the future of health care in Kansas.

As we participate in this legislative process and look to the future, we look forward to working closely with you to advance these ambitious goals to improve the health of all Kansans. I thank you for your time and welcome any of your questions.

Kansas Health Policy Authority

Coordinating health & health care for a thriving Kansas

MARCIA J. NIELSEN, PhD
Executive Director

ANDREW ALLISON, PhD
Deputy Director

SCOTT BRUNNER
Chief Financial Officer

Testimony on:

Healthy Kansas First Five Initiative

presented to:

Senate Committee on Financial Institutions and Insurance

by:

Dr. Andrew Allison
Deputy Director and
Acting Medicaid Director

January 17, 2007

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FI&I
1-17-07
Attachment 5

Healthy Kansas First Five Initiative

Good morning, Madame Chair and members of the Committee. I am Andy Allison, Deputy Director of the Kansas Health Policy Authority (KHPA) and Acting Medicaid Director. I want to thank you for today's opportunity to provide information on the Healthy Kansas First Five proposal. This morning you will also hear from several community groups who also believe this initiative is critical to the health of our state and Kansas children.

As you have seen and heard about, Healthy Kansas First Five is a program that will increase access to health care for our youngest Kansans, ensuring they have a healthy start in life. I want to explain our proposal of increasing accessibility for children under the age of five and how it would work by expanding the income eligible limits for HealthWave. First, I want to give you a brief background on health care coverage in Kansas for low-income and needy persons.

Health Insurance for Low-Income Kansans

Background. Health insurance plays an important role in the U.S. health care system, spreading costs to ensure access to care and prevent catastrophic financial loss. However, affordable private health insurance is not available to all Americans, especially the poor and those with predictable health costs, such as the elderly and disabled, for whom private insurance markets are both expensive and unstable. To address these chronic gaps in private insurance markets, states and the Federal government have invested in at least three major health insurance programs since the 1960s: Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Medicare provides traditional health insurance services for the nation's elderly and disabled. Medicaid supplements Medicare for low-income seniors and insures low-income women and children. SCHIP provides health insurance to an additional group of low-income children. Today Medicare covers about 13% of the Kansas population, while Medicaid and SCHIP cover about 10%. About 65% of Kansas' population is privately insured, and 11% remain uninsured. Most of the uninsured in Kansas live in households with at least one worker. As the cost of health insurance continues to rise, an increasing number of working Kansas families cannot afford health insurance. Those working in small businesses are less apt to be offered insurance, and those with low and modest incomes often have difficulty affording health insurance.

Federal Funding. Medicaid and the State Children's Health Insurance Program (SCHIP) are Federal programs that provide matching funds for state-run insurance programs. Both Medicaid and SCHIP are contained in the Social Security Act of 1965 (SSA): Medicaid was authorized as a part of the original SSA legislation and can be found in Title XIX of the Act; SCHIP was added as Title XXI of the SSA in 1997. The Federal match rate for SCHIP is slightly higher than Medicaid (72% v. 60% in Kansas), but unlike Medicaid, SCHIP matching funds are subject to a state-specific cap, or allotment. In Kansas, SCHIP is available state-wide to children who are Kansas residents from birth to age 19 who are not eligible for Medicaid and who live in families with incomes up to 200 percent of FPL ($33,200 annually for a family of three). Medicaid covers children at lower levels of income.

State Programs. Medicaid and SCHIP are funding sources tied to specific Federally-determined populations. The state uses those funding sources to purchase health care through both managed care and fee-for-service

pro‸ s. The managed care program is called "HealthWave," KHPA's best-known and most widely advertised product line. Both Medicaid- and SCHIP-eligible children and families have been enrolled in HealthWave since FY 2002. By state law, all 34,791 SCHIP children must be enrolled in managed care, which means all are enrolled in HealthWave. As of January 2007, about 145,000 Medicaid beneficiaries – mothers and children – are also eligible to be enrolled in HealthWave. To distinguish the Medicaid and SCHIP populations within HealthWave, KHPA often refers to the HealthWave-XIX and HealthWave-XXI populations, a direct indication of the SSA funding rules and eligibility criteria that apply to the HealthWave program.

Healthy Kansas First Five Proposal

Despite the availability of these programs and years of outreach effort, there are still today at least 40,000 Kansas children under the age of 18 without health insurance. Of those children, 15,000 are under the age of five, the most formative years when access to prevention-oriented health care is most critical. These estimates pre-date the implementation of the citizenship verification requirements and do not reflect the decline in HealthWave enrollment, and likely the increase in the number of uninsured children, associated with those requirements. KHPA is addressing the impact of the citizenship verification requirements in its budget proposal.

As the leading agency on health and health care services, the Kansas Health Policy Authority is committed to providing access to care, especially care that is cost effective for the state in the long term. To help give our children the critical healthy start in life, KHPA proposes expanding access to care for children through the creation of the Healthy Kansas First Five Program. This program would expand health care coverage to children age five and under from low and moderate income families who lack health care insurance by expanding affordable options through the HealthWave program.

This program was introduced last year by Governor Sebelius, but not funded by the Legislature. The KHPA Board considers access to care for Kansans a critical component of a coordinated health agenda for Kansas, and this program in particular a high priority this upcoming legislative session.

Healthy Kansas First Five is designed to significantly reduce the number of uninsured children below the age of five. It is estimated that 2,000 children would be served in the first year of operation (2008), with additional enrollment expected thereafter.

How Healthy Kansas First Five Works

To better explain how Healthy Kansas First Five would work, I want to give you background information on our current stairstep income thresholds for Medicaid and SCHIP eligibility. Then, I will provide you with a description as to how we would expand eligibility to include the 15,000 children under the age of five who are not insured currently.

Background on Stairstep Income Thresholds Distinguish Medicaid and SCHIP Eligibility. Eligibility for public health insurance in Kansas can be based on family income, disability, or other specific health care needs, e.g., long-term care or community-based support. Most Medicaid - and all SCHIP - enrollees are eligible solely because of their family's low income. These populations also comprise the vast majority of our HealthWave program. Income-based eligibility in Medicaid and SCHIP is tied to Federal Poverty Levels (FPL). Medicaid covers the poorest Kansas children, while SCHIP covers children with incomes that exceed Medicaid limits but

are ..s than 200% of the FPL. Because Medicaid income thresholds decline with age, the dividing line between Medicaid and SCHIP poverty-related eligibility is commonly referred to as a "stairstep."

- The highest Medicaid income threshold is 150% of the FPL and applies to infants less than one and their pre- and post-partum mothers.
- The next highest Medicaid income threshold is 133% of the FPL applies to children ages 1 through five.
- The lowest eligibility ceiling for children is 100% of FPL and applies to children ages 6 through 18.
- SCHIP funding is used to provide health coverage for children in each age group above the Medicaid eligibility levels up to 200% of FPL.

Healthy Kansas First Five Plan to Expand Thresholds. To provide coverage options for Kansas children under the age of five, KHPA proposes to expand the stairstep income eligibility thresholds in these age ranges.

The upper income limit for the HealthWave program would increase from the current level of 200% of the poverty level (yearly income of approximately $33,200 for a family of three) to 235% of the poverty level, and to create a state-only funded HealthWave buy-in option for young children in families up to 300% of the poverty level. Both components require families to pay a premium related to their level of income. Above 300% of poverty, families would be allowed to enroll their children at the full actuarial cost of the HealthWave benefit. To remain within Federal spending limits for the HealthWave program, this proposal may require some families with incomes between 133% and 200% of poverty be transferred from HealthWave Title XXI to HealthWave Title XIX coverage. Medicaid eligibility for pregnant women would also be increased to approximately 185% of poverty, increasing expectant mothers' access to prenatal care.

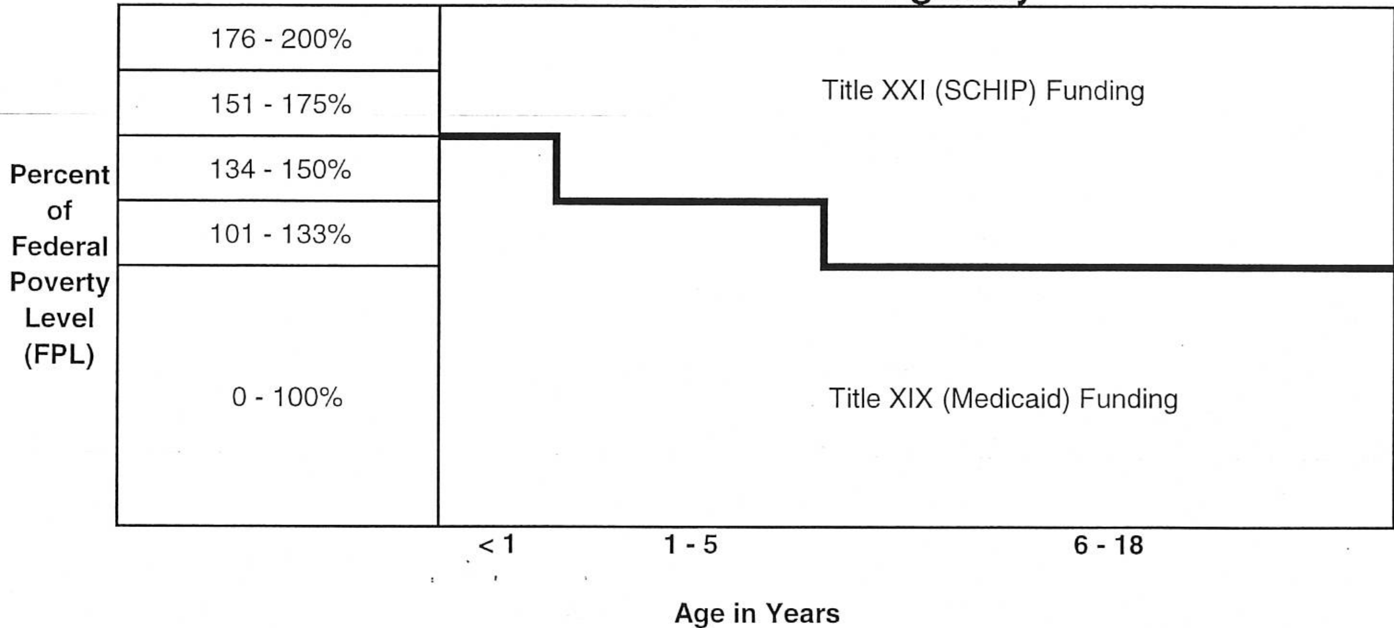
<u>**Summary**</u>

The KHPA Board voted in its November 2006 meeting to designate Healthy Kansas First Five as its top program priority for the 2007 legislative session. In addition, presenters at the various Board's Town Hall meetings offered support to this program. It is estimated to cost between $4 million and $6 million, annual cost SGF. Governor Sebelius has included $4 million SGF and $6 million All Funds for the State Fiscal Year 2008 Kansas Budget.

The Kansas Health Policy Authority's vision is to coordinate health and health care for a thriving Kansas. We hope you will join us in this effort to increase access to health care for Kansas children under the age of five.

Thank you for your time and I would be happy to answer questions.

HealthWave Income Eligibility



Federal Poverty Level (FPL) for a Household of Three (3)

Percent of Federal Poverty Level (FPL)	Income Thresholds
200%	$33,200
175%	$29,050
150%	$24,900
133%	$22,078
100%	$16,600

January 17, 2007

To: Financial Institutions and Insurance Committee
From: Cindy D'Ercole
Re: Healthy Kansas First Five Initiative

KANSAS ACTION FOR CHILDREN

Making a difference for Kansas children.

Kansas Action for Children Inc.
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Celebrating 25 years of child advocacy

Good morning Madam Chair and members of the committee. My name is Cindy D'Ercole, representing Kansas Action for Children. It is my pleasure today to appear before you today to support the Healthy Kansas First Five Initiative.

The Healthy Kansas First Five initiative will build on the success of HealthWave. Currently in Kansas there are 48,000 children without health insurance, including 15,000 children ages birth to five. Although Kansas still has many uninsured children, the HealthWave program in Kansas has successfully reduced this number over the past ten years. The percent of uninsured children in Kansas has decreased from 11% in 1997 to 7% currently. Building on the success of HealthWave, we can continue to decrease the number of uninsured children in our state. .

Access to healthcare prepares children for success in school and life. The Initiative will increase access to healthcare for Kansas' youngest citizens, and will provide them with care during their most formative years. Access to healthcare is essential for children's well-being, especially during the early years. Establishing a strong health foundation is particularly important for young children because their health has a direct impact on cognitive, linguistic, and social development, all influencing factors for future success.

Access to regular healthcare is cost effective and improves the quality of young children's lives. Not only is access to care essential to a child's success in school, it also ensures that children have access to a medical home. When children are able to visit a doctor or dentist regularly, they are more likely to receive timely and preventative care, such as on-time immunizations. Children with a medical home are less likely to rely on the emergency room and other costly forms of care. Routinely seeing the same care provider also aids in the identification of medical or emotional issues that may prove costly without early intervention.

Healthy Kansas First Five is good policy. Making sure that every young Kansas child has access to healthcare before they get sick ensures better outcomes for children and makes financial sense. Public insurance is a particularly cost-effective way to insure children.

This Initiative will serve to level the playing field, giving every young Kansas child the opportunity for a successful start and giving every Kansas family the opportunity to provide health insurance for their child.

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A Member of Voices for America's Children

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Attachment 6

KANSAS ACTION FOR CHILDREN

2007 LEGISLATIVE AGENDA

Birth through Five Health Insurance

In Kansas, there are 48,000 children without health insurance, of which approximately 15,000 are age five or younger.

Background:

Establishing a strong health foundation is especially important for young children because their health has a direct impact on cognitive, linguistic, and social development, all influencing factors for future success. Children ages birth through five need access to health care in order to develop to their fullest potential and be prepared to enter school ready to learn.

In Kansas, SCHIP (State Children's Health Insurance Program) and Medicaid are integrated and function as a seamless program referred to as HealthWave. Currently, children are eligible for health insurance through HealthWave if their family makes less than 200% of the federal poverty level. Monthly premiums are based on a sliding scale relative to the family income. HealthWave has succeeded in providing health coverage for thousands of Kansas children, but there are still 48,000 uninsured children in our state.

Benefits of Health Insurance:

- Health insurance during the first five years of life builds a foundation for school readiness, life development, and continuing healthcare.
- Children with health insurance are more likely to have a medical home. Having a regular source of health care allows for timely care, such as on-time immunizations.
- Stabilizes the health care system. When more people in the system are insured the expenses are widely distributed, resulting in cost-savings per person.

Action Steps for Kansas

Kansas can increase access to care for children ages birth through five by increasing access to the program already proven to be effective in providing health care to thousands of children. Increasing access to the HealthWave program will improve the health of our children by drastically reducing the number of uninsured children in our state.

2006 Federal Poverty Level Guidelines

Number of people in household	*200% FPL*
1	$19,600
2	$26,400
3	$33,200
4	$40,000
5	$46,800
6	$53,600
7	$60,400
8	$67,200

**For each additional person add $3,400.*

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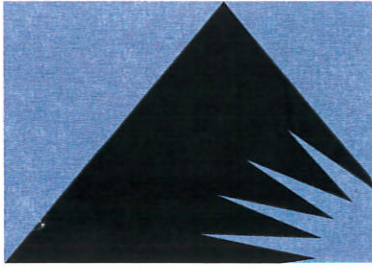

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Testimony on "Healthy Kansas First Five"

Presented to the Senate Financial Institutions and Insurance Committee

January 17, 2007

Madam Chairperson and Members of the Committee:

I would like to thank you for giving me the opportunity to address you today. My name is Corrie Edwards. I am the Executive Director of and a registered lobbyist for the Kansas Health Consumer Coalition (KHCC) based in Topeka. This Coalition works to advocate for affordable, accessible and quality health care in Kansas. I am here today to support the 0-5 Initiative, Healthy Kansas First Five.

Our coalition supports this initiative for the following reasons:
- it is a cost-effective way of providing health insurance to a relatively healthy population in need of it;
- using public programs, most of the cost of expanded health insurance for children would be paid for using federal dollars;
- having children without health insurance creates a severe financial and emotional burden on working families in Kansas.

As we understand this initiative, of the nearly 11 percent of Kansans who are uninsured, approximately 15,000 are children ages 5 and younger. This initiative addresses the health insurance needs of low income, working families by expanding the upper limit of eligibility for the state's health insurance program covering children who are Kansas residents, birth to five, in low-to-modest-income households. As it stands now, eligible families can make up to 200 percent of the federal poverty level, which amounts to about $32,000 a year for a family of three. In this initiative, the poverty level would increase to 235 percent. Families with children above 235 percent poverty, who do not have access to employer based insurance, and who have been without insurance for six months would be allowed to buy into the HealthWave package through a premium based household income. Families above 300 percent of poverty would pay the full actuarial cost to enroll their children in HealthWave.

All too often, working Kansas families cannot afford health insurance. Parents work for small businesses where either no job-based health insurance is offered or if it is offered, they cannot afford to purchase it. The number of employers offering insurance has declined and health insurance premiums have increased leading families to reject job-based insurance even when they have access to it. For many families, the purchase of health coverage would guarantee the inability to afford other basic life necessities such as groceries and utilities payments. More commonly, families who are uninsured defer medical attention due to the cost of services. This often leads to more costly care down the line. Families also are less likely to seek preventive care and then are more likely to develop serious illnesses, end up in emergency rooms or receive inpatient hospital care

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Attachment 7

utilizing very expensive services. Families struggle to pay for services and therefore access to care and treatment are compromised based on insurance status. In the end, difficulty in paying for care can cause families to not seek care at all. Ultimately, an uninsured medical expense from an illness or injury can put even the most financially responsible family on a path to greater hardship.

The implementation of this initiative offers Kansas the opportunity to strengthen and build on the success of health coverage programs for children. A lack of health insurance results in inadequate health care. This initiative offers a chance to expand children's health coverage and improve the health care they receive. I urge this committee to support Healthy Kansas First Five.

Thank you for considering this testimony. I will now stand for questions.

Respectfully submitted,

Corrie L. Edwards, MPA
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