Approved: January 28, 2008
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairperson Brenda Landwehr at 1:30 P.M. on January 23, 2008 in Room 526-S of the Capitol.

All members were present except:
Representative Kiegerl

Committee staff present:
Cindy Lash, Legislative Research
Melissa Calderwood, Legislative Research
Dianne Rosell, Revisor of Statutes
Chris Haug, Committee Assistant

Conferees appearing before the committee:
Rachel Smit, MPA Kansas Health Institute
Gina Maree, Director of Health Care Finance and Organization, Kansas Health Institute

Others Attending:
See attached list

The minutes of the last meeting were reviewed. Vice Chairperson Mast made a motion to approve the minutes, Representative Neighbor seconded. The motion carried.

Tom Bruno introduced a bill on the Athletic Trainer Licensing Act. Vice Chairperson Mast made a motion to accept. Ranking Minority Member Flaharty seconded. The motion carried.

Chairperson Landwehr introduced a bill on Hospital Liens. Vice Chairperson Mast made the motion to accept. Ranking Minority Member Flaharty seconded the motion. The motion carried.

Rachel Smit, MPA of Kansas Health Institute made a presentation on Health Insurance. See (Attachment 1). Ranking Minority Member Flaharty asked why there was a decline in insurance coverage for children in the employment based insured. Ms. Smit indicated the enrollment in Medicaid and SCHIP increased during this same time period, but she would try to find out the reason for the decline in employment based insured.

Representative Neighbor asked if it was the cost of insurance premiums that caused the decline. Ms. Smit stated she would try to get the background of the results.

Chairperson Landwehr asked if a breakdown, of the employed and unemployed, could be given for slide 22, which is the "Uninsured Kansans within poverty categories". Ms. Smit said she could provide this. Chairperson Landwehr also asked if she could get the number of uninsured eligible for SCHIP or Medicaid that did not apply. Ms. Smit stated they don't ask why they don't have a particular type of insurance.

Representative Holland wondered if you would expect to see the same trend in uninsured rates during the next 10 or 20 years. Rachel said she has not looked into this, but she would. Rep. Holland asked if there was a changing dynamic, or is this the way it's always been. He was surprised the employers with over 500 employees had such high uninsured rates. Ms. Smit stated these were national numbers and most of the employers were probably retail. She wasn't sure about the Kansas rates.

Vice Chairperson Mast asked a question in relation to Kansas families. She asked what the average size of a family would be. Ms. Smit explained that she would have to research this.

Representative Garcia asked if there were any factors as to why they were not insured. Ms. Smit stated they don't ask why on the survey but there are ways to match up with the other surveys taken in the past year. This is a Federal Survey. The sample in Kansas was only 3000 individuals.

Representative Patton had a question about slide number 5: Sources of health insurance: All Kansans. He wondered if you did a pie without the uninsured how the results would come out. Rachel said she could provide this. She didn't feel it would look dramatically different.

MINUTES OF THE House Health and Human Services Committee at 1:30 P.M. on January 23, 2008 in Room 526-S of the Capitol.

Representative Colyer remarked there had been expanded enrollments in Medicaid and SCHIP. He wondered why the number of children with private health insurance had declined in employment based insurance. Rachel stated the decline occurred nationally from 2005 to 2006 in the private employment based insurance her guess was this was due to higher premiums. Representative Colyer stated that those on Medicaid for years who started to earn more money were now off. He asked about those on Medicaid, "can they find private insurance out on the market?" Ms. Smit said she would have to look into that.

Representative Storm asked what adults are eligible for Medicaid or what are the requirements to qualify for Medicaid? Ms. Smit said you have to be under 37% of the poverty level and have children or be disabled or pregnant. Adults without children must be between 37% and 100% of the poverty level. Rep. Storm wondered what was being done to take care of their health needs and what kind of options they had.

Gina Maree, Director of Health Care Finance and Organization with the Kansas Health Institute made a presentation on the Missouri House Bill 818 and Senate Bill 577. See (Attachment 2). The report was based on the 2007 legislative session in Missouri.

Representative Rhoades asked about the tax credit. He wondered if it was just adopted and what the cost of it was to the Missouri tax payers. Ms. Maree did not know, but said she would try to find out.

Candace Ayars, Ph.D. Interim Director of Public Health Studies with the Kansas Health Institute made a presentation on Obesity Prevalence and Risk Factors among Kansas Minorities. See (Attachment 3).

Representative Garcia wondered if produce was causing the most problems with unsafe foods. Dr. Ayars did not have any figures on this. Rep. Garcia also wondered if Dr. Ayars had any figures for the number of programs existing for community gardens. The only community garden that Dr. Ayars was aware of was in Kansas City.

Representative Colyer asked that in looking at national data for HP2010, is there any evidence that any states have changed their trend lines and if so, what did they do? Dr. Ayars said Colorado is the only state where the trends are getting better. Arkansas enacted a school program to educate students on weight control, but now Arkansas is leading the nation in eating disorders. They are currently trying to determine if there is some correlation to the two.

Chairperson Landwehr said we would allow Gina Maree to reschedule next week, due to her health concerns today.

Chairperson Landwehr adjourned the meeting at 2:35 p.m. The next meeting will be January 28, 2008.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE GUEST LIST

DATE: January 23, 2008

NAME	REPRESENTING
Candace Ayers	KHI
Dennis Kriesel	KAC
Nate Michel	Hein Law Firm
Isaac Ferguson	Kansas Chamber of Commerce
Bill Sneed	ATIP
Tom BRUNO	FDS
Gina Maree	KHI
Scott Heidner	Gaches Braden
Rachel Smith	KHI
Sarah Cardcliff Fizell	KHI
LARRY MAGILL	KAIA
KERRI SPIELMAN	
Amy Campbell	KMHC

Health Insurance and the Uninsured in Kansas

Health & Human Services Committee
January 23, 2008

Rachel Smit, MPA
Kansas Health Institute

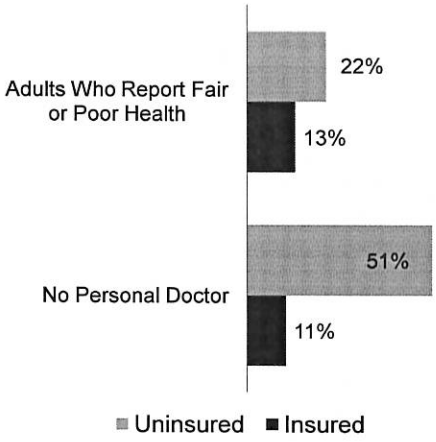
Why is Health Insurance Important?

- Health insurance provides protection from the financial burden of costly illness or injury
- Kansans with health insurance have better access to services and are healthier than uninsured Kansans

Health + Human Services Comm.
1-23-08
Attachment 1

Why is Health Insurance Important?

Health insurance is an important determinant of health status and use of physician services.

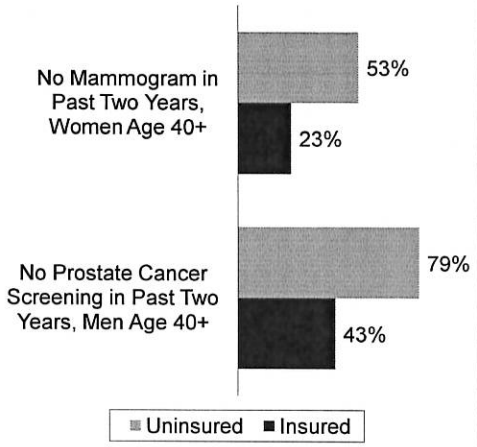


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2006

3

Why is Health Insurance Important?

Health insurance is an important determinant of use of preventive services.

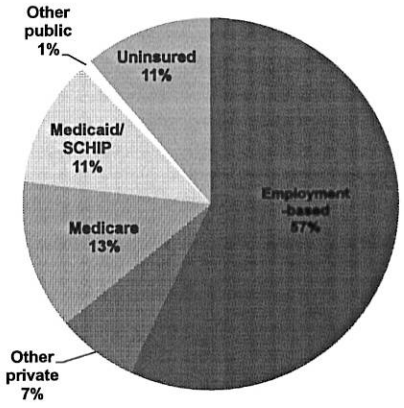


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2006

4

Sources of health insurance: All Kansans

Most Kansans (57 percent) rely on health insurance through an employer, but more than 40 percent do not.

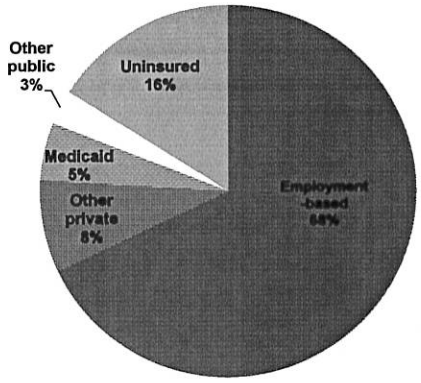


Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

5

Sources of health insurance: Adults (age 19-64)

Only a small proportion of adults are covered by Medicaid.

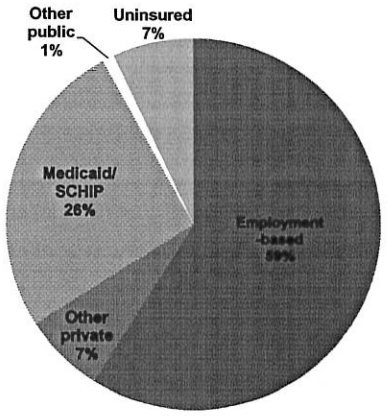


Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

6

Sources of health insurance: Children (under age 19)

Medicaid & SCHIP are important sources of health insurance for Kansas children.

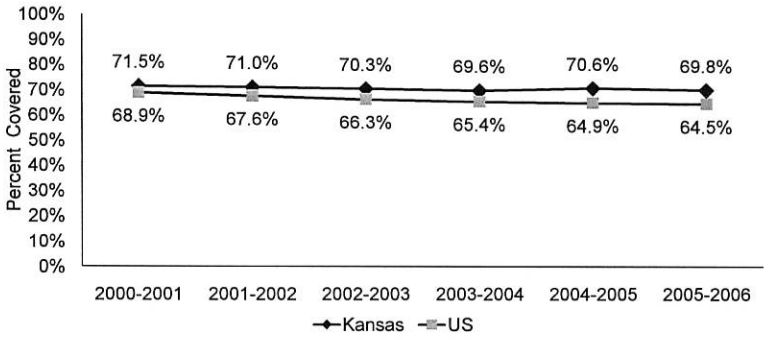


Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

7

Employment-based insurance: Adults

Employment-based insurance coverage for adult Kansans remained relatively stable over the past six years.

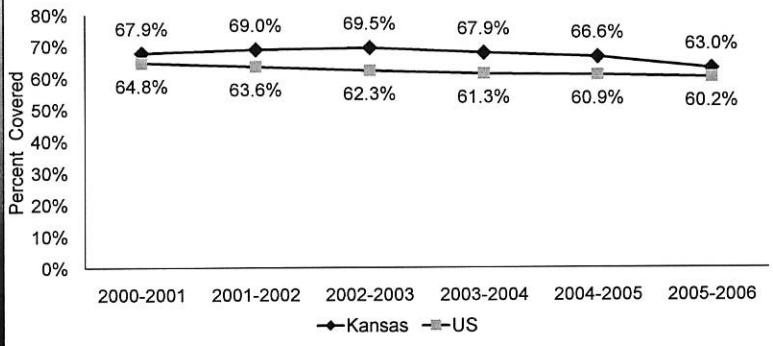


Source: KHI estimates are two-year averages based on the March Current Population Survey, 2001 to 2007.

8

Employment-based Insurance: Children

*Health insurance coverage through a parent's or guardian's employer has declined for Kansas children.**

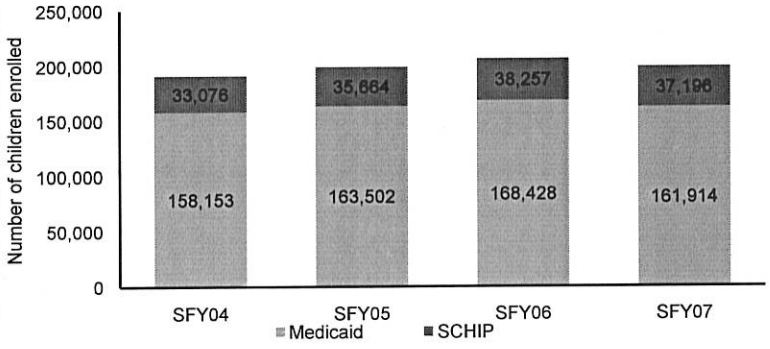


Source: KHI estimates are two-year averages based on the March Current Population Survey, 2001 to 2007.
*The decline from 66.6 percent in 2004-2005 to 63 .0 percent in 2005-2006 is statistically significant. Part of the recent decline might be explained by changes in reporting on the CPS as opposed to actual changes in coverage.

9

Medicaid & SCHIP Enrollment: Children

Children's enrollment in Medicaid & SCHIP increased through SFY06 and then declined in SFY07.

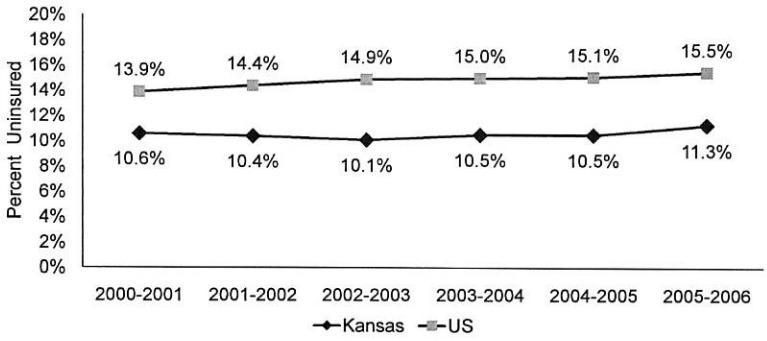


Source: Average monthly enrollment in Medicaid & SCHIP, KHPA administrative data

10

Uninsured Kansans

The percentage of all Kansans who are uninsured crept upward to 11.3 percent in 2005-2006.

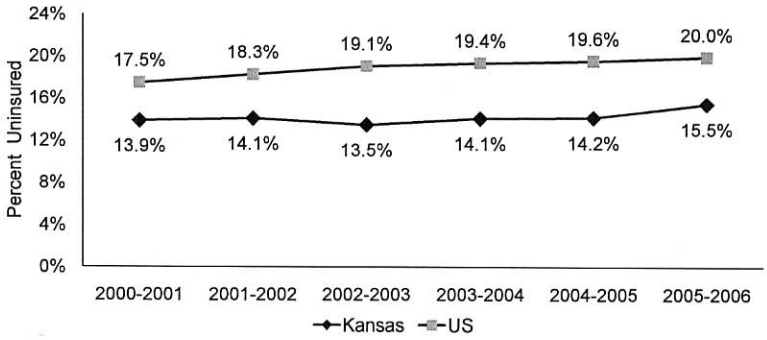


Source: KHI estimates are two-year averages based on the March Current Population Survey, 2001 to 2007.

11

Uninsured Adults

The percentage of adult Kansans who are uninsured has increased.

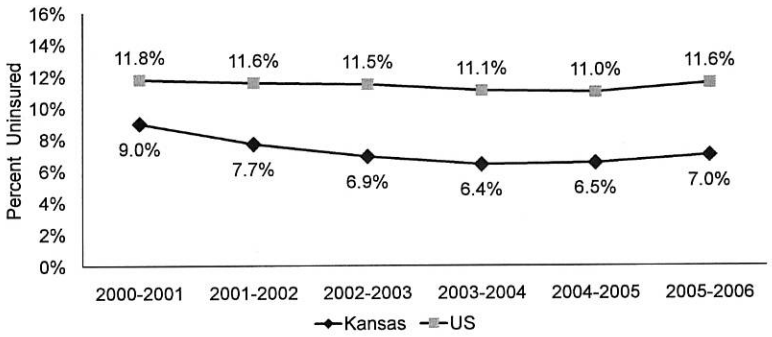


Source: KHI estimates are two-year averages based on the March Current Population Survey, 2001 to 2007.
*The KS increase from 13.5 percent in 2002-2003 to 15.5 percent in 2005-2006 is statistically significant.

12

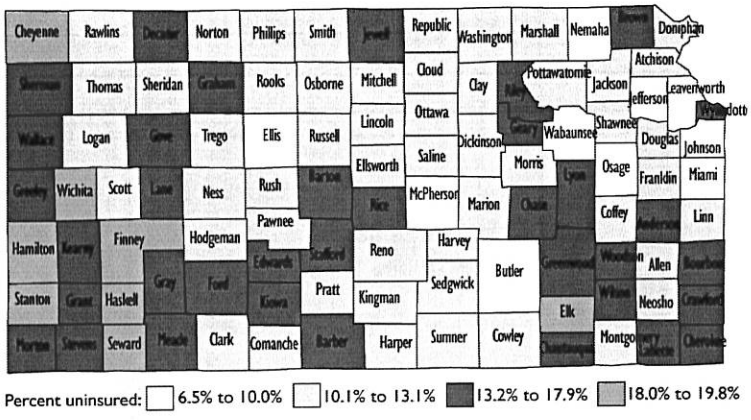
Uninsured Children

The downward trend in the percentage of Kansas children who are uninsured appears to have halted.



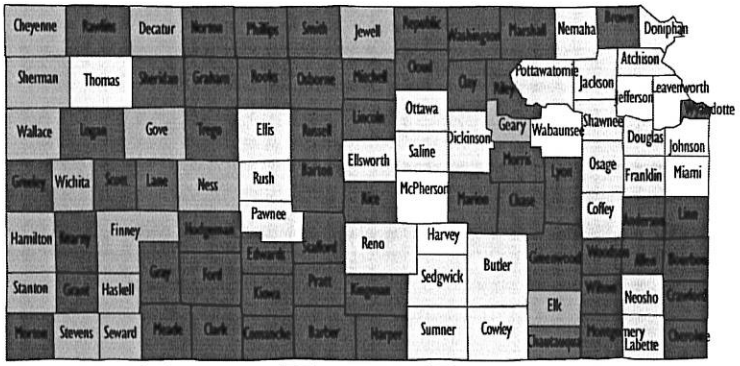
Source: KHI estimates are two-year averages based on the March Current Population Survey, 2001 to 2007.

Uninsured rates by county



Source: U.S. Census Bureau , Small Area Health Insurance Estimates (SAHIE) for 2000

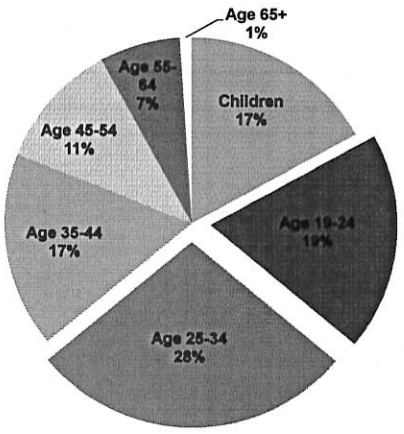
Uninsured rates by county: Children (under age 18)



Source: U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE) for 2000

Uninsured Kansans by age

Almost half of the uninsured are young adults age 19-34.



Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

Uninsured Kansans within age groups

Young adults age 19-24 and age 25-34 are more likely to be uninsured than other age groups.

	All Kansans	Children	Age 19-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+
# Uninsured	306,626	51,044	58,222	84,980	52,270	33,593*	22,197*	4,321*
Total #	2,708,719	729,297	251,684	377,651	333,311	375,377	281,690	359,709
% Uninsured	11%	7%	23%	23%	16%	9%	8%	1%

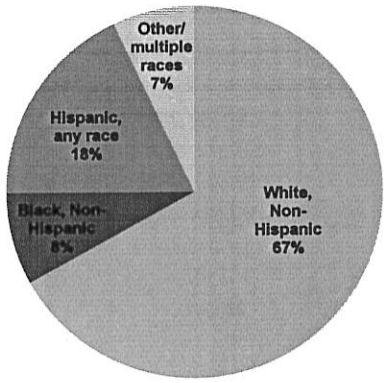
Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

*This estimate is unreliable due to the small sample size.

17

Uninsured Kansans by race/ethnicity

Most uninsured Kansans are non-Hispanic Whites.



Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

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Uninsured Kansans within racial/ethnic groups

Minorities, especially Hispanics, are more likely to be uninsured than non-Hispanic Whites.

	All Kansans	White, Non-Hispanic	Black, Non-Hispanic	Hispanic, Any Race	Other/ Multiple Races
# Uninsured	306,626	205,822	22,996*	54,819	22,988*
Total #	2,708,719	2,232,190	147,205	193,202	136,121
% Uninsured	11%	9%	16%	28%	17%

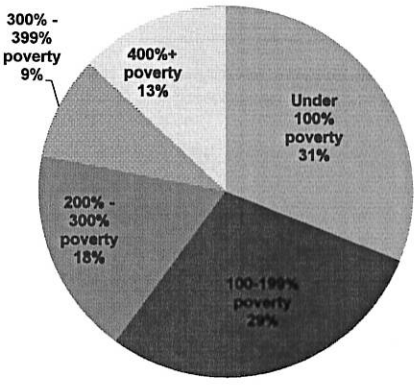
Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

*This estimate is unreliable due to the small sample size.

19

Uninsured Kansans by poverty status

Most uninsured Kansans are low-income, but a sizable share of the uninsured are middle-income or above.



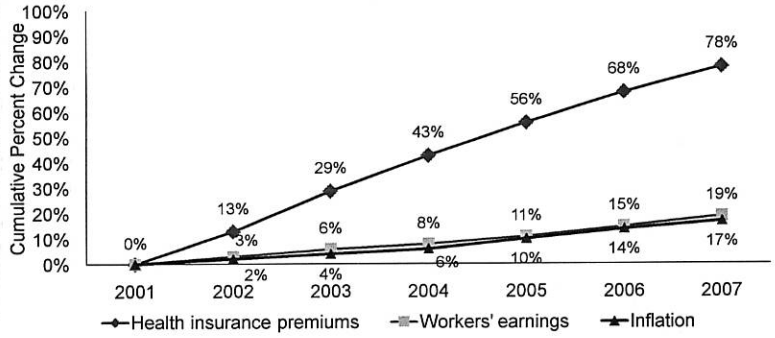
Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

20

1-10

Health insurance premiums have increased

Increases in health insurance premiums have outpaced inflation and workers' earnings.



Sources: Kaiser Family Foundation/HRET "Survey of Employer-Sponsored Health Benefits, 2007" & Bureau of Labor Statistics

Uninsured Kansans within poverty categories

Poor Kansans are more likely to be uninsured.

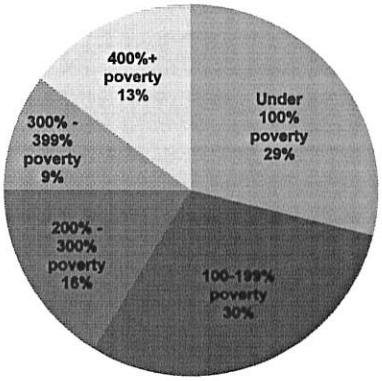
	All Kansans	Under 100% Poverty	100-199% Poverty	200-299% Poverty	300-399% Poverty	400%+ Poverty
# Uninsured	306,626	95,140	87,652	54,289	28,175*	41,370*
Total #	2,708,719	345,161	458,498	483,550	414,171	1,007,339
% Uninsured	**11%**	**28%**	**19%**	**11%**	**7%**	**4%**

Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

*This estimate is unreliable due to the small sample size.

Uninsured adults by poverty status

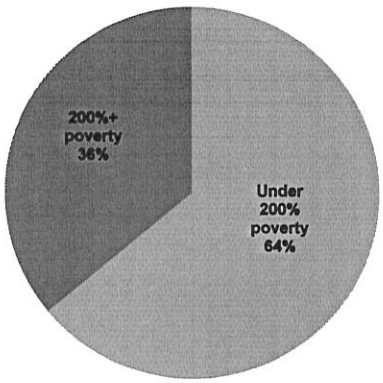
About 30 percent of uninsured adults have family incomes under 100% of poverty.



Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

Uninsured children by poverty status

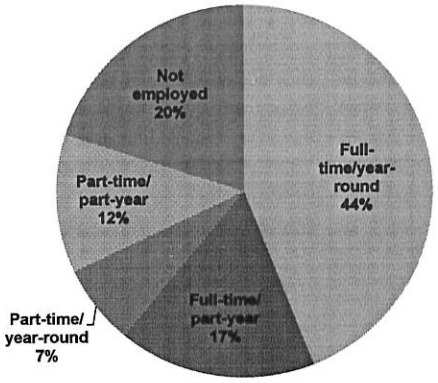
*About two-thirds of uninsured Kansas children are income-eligible for Medicaid or SCHIP.**



Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.
*This estimate is based on a small sample size and the true value could be as low as 53 percent or as high as 76 percent.

Uninsured adults by work status

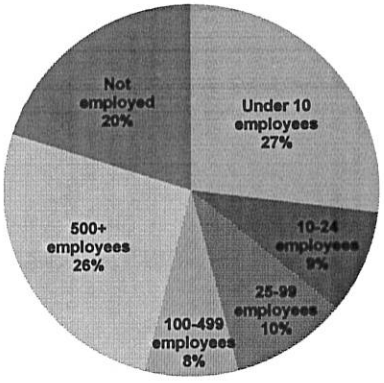
*A large share of uninsured adults work full-time, year-round.**



Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.
*Full-time work is defined as 35 hours or more per week, not necessarily in a "full-time" position or for one employer.

Uninsured adults by employer size

*About one-fourth of uninsured adults work for employers with fewer than 10 employees and one-fourth work for employers with 500+ employees.**



Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.
*This includes both full-time and part-time employees.

Uninsured adults within employer size categories

Adults who work for small employers with fewer than 25 employees are more likely to be uninsured than adults who work for larger employers.

	Under 10 employees	10-24 employees	25-99 employees	100-499 employees	500+ employees	Not employed
# Uninsured	68,120	22,962*	25,976*	19,770*	64,526	49,906
Total #	269,871	108,848	189,312	215,768	590,552	245,361
% Uninsured	25%	21%	14%	9%	11%	20%

Source: KHI estimates are two-year averages based on the March Current Population Survey, 2006 and 2007.

*This estimate is unreliable due to the small sample size.

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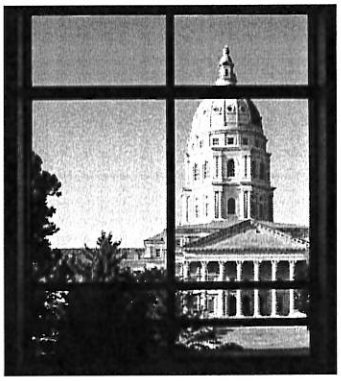
Acknowledgements

Sunflower Foundation
HEALTH CARE FOR KANSANS

UNITED METHODIST HealthMINISTRYFund

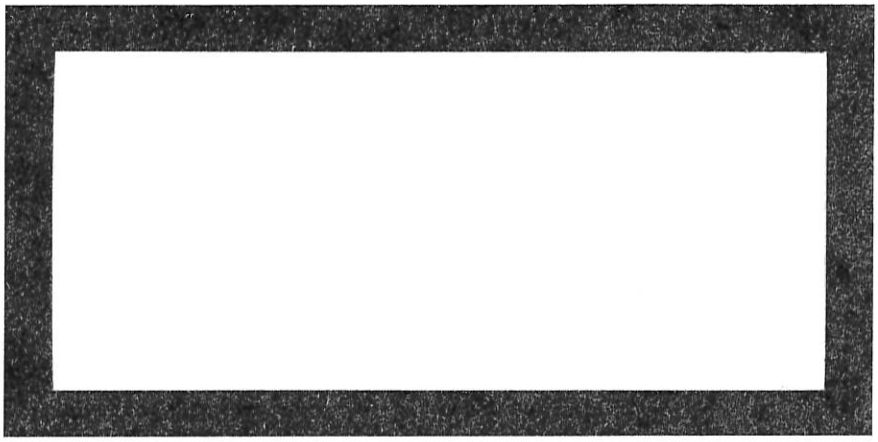
28

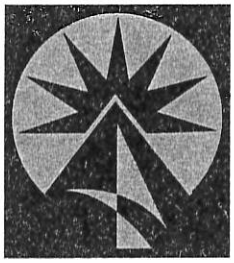
Kansas Health Institute



Information for policy makers. Health for Kansans.

29





KANSAS HEALTH INSTITUTE

Healthier Kansans through informed decisions

Health + Human Services Committee
1-23-08
Attachment 2

Health Reform in Kansas: Looking East to Missouri

A Summary of
MISSOURI HOUSE BILL 818 and
SENATE BILL 577

September 2007

KHI/07-11

Sarah Carkhuff Fizell

KANSAS HEALTH INSTITUTE

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Topeka, Kansas 66603-3936
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www.khi.org

2-2

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

TABLE OF CONTENTS

INTRODUCTION

As Kansas policymakers consider health care reform legislation in our state, there has been an interest in the changes adopted in Missouri earlier this year. This document provides a summary of the recently passed health reform legislation in Missouri.

During the 2007 legislative session, the Missouri General Assembly passed two bills pertaining to health coverage that were subsequently signed into law by Governor Matt Blunt:

- House Bill (H.B.) 818: The Health Insurance Portability and Accessibility Act — making changes to group health insurance coverage; and
- Senate Bill (S.B.) 577: The Missouri Continuing Health Improvement Act of 2007 — modifying the state's Medicaid program.

Initially hailed as major reform initiatives, the bills were changed significantly during the legislative process and as a result are more limited than as originally drafted. Nonetheless, they make important changes that address the dual challenges of rising health care costs and a growing number of uninsured in the state.

Missouri has been considering health system reform for several years. In 2005, the Missouri General Assembly passed S.B. 539, which set the stage for the current reforms by establishing the Medicaid Reform Commission. This commission was tasked with making recommendations to the General Assembly on the best way to accomplish the task of "reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system" to replace the current state Medicaid system.[1] The reform bills enacted in the 2007 session were based on recommendations from the reform commission.

Along with the creation of the reform commission, a provision in S.B. 539 set a sunset date of June 30, 2008, for the state Medicaid program — a provision that was intended to pressure the Assembly into making changes to the program on an expedited basis. However, the sunset provision was repealed through provisions in S.B. 577.[2]

HOUSE BILL 818:
THE HEALTH INSURANCE PORTABILITY AND ACCESSIBILITY ACT

SUMMARY

Although it is not the comprehensive market-based health reform that many had hoped it would be, H.B. 818 does accomplish many goals for health reform in Missouri, especially with regard to the small group market. It offers solutions that address some of the concerns of the business community as it struggles to provide benefits to workers and their families.

H.B. 818 originally included an entity called the "Health Insurance Exchange," which was modeled after the "Health Insurance Connector" recently established in Massachusetts.[3] The proposed Health Insurance Exchange sparked national interest from health policymakers in the Missouri reform effort. However, the proposed Health Insurance Exchange was removed from the final legislation during Assembly debate.

The final bill, as signed into law, addresses the insurance market by:

- Establishing compliance with HIPAA regulations within state programs,
- Allowing employers to help pay for the individual health insurance policies of their employees through contributions to Section 125 plans,
- Creating favorable tax incentives for the purchase of health insurance to lower costs for employees and the self-employed,
- Expanding the definition of a small group from 2–25 employees to 2–50 employees,
- Requiring the state to offer high deductible health plans and health savings accounts to state employees and participants in the state high-risk pool, and
- Reducing the maximum rates allowed in the state high-risk pool.

Most of these changes are geared toward small employers and the self-employed in an attempt to make it easier for employers to provide coverage for their employees. Most H.B. 818 implementation issues are being handled by the Missouri Department of Insurance, Financial Institutions and Professional Registration and/or the Missouri Department of Social Services.

HEALTH INSURANCE PORTABILITY — HIPAA COMPLIANCE

Most of the language in H.B. 818 pertains to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law that deals with a wide range of issues including the privacy of patient information and the ability of workers to maintain health coverage as they change jobs. Since HIPAA has been in use for about a decade, most companies are already compliant. However, it is important for states to ensure that their own laws are also compliant. The changes to these provisions make it possible for Missouri residents to maintain coverage when they change jobs. These provisions have not generated significant discussion or debate — mostly because they do not have a direct effect on the benefits available to most people. This topic is discussed again later in this paper in the section about the Missouri Health Insurance Pool.

SECTION 125 — CAFETERIA PLANS[4]

Internal Revenue Code (IRC) Section 125 plans, sometimes called "cafeteria" plans, allow employers and their employees to pay for health insurance premiums and certain other health care expenses not covered by insurance using pre-tax dollars. Section 125 plans were established and are regulated by the federal government although states are given flexibility in deciding who can or must offer these plans. H.B. 818 requires employers that offer small group coverage to their employees, and to which employees are required to make a contribution to the premiums, to also establish premium only Section 125 plans for their employees. This allows employees to take advantage of the pre-tax treatment of their premium contributions. Self-insured and self-funded plans are exempt from this requirement.

H.B. 818 also allows employers who offer group health insurance to their employees to make a defined contribution to a Section 125 plan on behalf of an employee who already has an individual health insurance policy from another source and prefers to keep that policy rather than enroll in the employer's health insurance plan. This provision is designed to improve portability for those employees who already have insurance coverage. Under H.B. 818, employers are able to assist these employees in paying for their individual policies without being subject to the regulatory requirements otherwise established for group coverage. As currently written, this bill allows only employers who offer group insurance plans to make contributions on behalf of the employees who wish to continue their individual policies. There is interest in expanding this provision to also allow employers not currently offering group health insurance to make such contributions to individual premiums on behalf of their employees. One concern with this approach is that healthy individuals may prefer to maintain

individual coverage with fewer mandated benefits, which also may be less expensive, leaving individuals in poorer health disproportionately represented in the small group market. This could result in adverse selection leading to increased premiums in the small group market.

CONSUMER-DIRECTED HEALTH AND HIGH DEDUCTIBLE PLANS[5]

H.B. 818 requires the Missouri Consolidated Health Care Plan (MCHCP) to offer all qualified state employees and retirees the option of obtaining coverage through a high deductible health plan (HDHP) with a health savings account (HSA). The MCHCP is a group that includes all state employees as well as all public entities (e.g., state-sponsored institutions of higher learning, political subdivisions or governmental entities which were created as a direct result of a state statute or local ordinance[6]). This option will be available beginning with the 2009 open enrollment period.

The option of enrolling in a HDHP will also be offered to individuals who participate in the state high-risk pool. This is a noteworthy change because the high-risk pool contains a significant number of individuals who expect to experience high health care costs. However, HDHPs generally have lower premiums because more of the costs are paid by the participants. If the HSA contribution doesn't meet the deductible (i.e. leaves the insured with a "donut hole" in coverage), it is unlikely to be an attractive option for the chronically ill and others who anticipate high health care costs.

The lower costs in these plans are generated by increased cost-sharing with the participants and the resulting financial incentive to manage their use of services and reduce overall expenditures. This incentive-driven behavior may be more difficult to achieve in the population eligible for the high-risk pool, and the consequences of inappropriate reductions in necessary health care could be harmful to this population. On the other hand, individuals who are frequent users of health care services may be better-informed of their choices and therefore able to make more value-driven choices.

TAX DEDUCTIONS AND TAX CREDITS[7]

H.B. 818 creates tax incentives that encourage the purchase of health insurance by making it possible for taxpayers to deduct 100 percent of the premiums that they pay for health coverage from their state taxable income. It also allows those who are self-employed to receive a tax credit for 100 percent of the amount of premiums that they pay annually.

SMALL EMPLOYERS

The bill changes the definition of a small group from 2–25 individuals to 2–50 individuals. It is estimated that this change will bring a considerable number of businesses that were formerly a part of the large group market into the small group market.

MISSOURI HEALTH INSURANCE POOL

Individuals who are unable to obtain coverage in the individual market due to pre-existing conditions that make coverage unattainable or unaffordable are eligible for coverage through the high-risk pool. The Missouri Health Insurance Pool (MHIP), like other high-risk pools, provides insurance products with premiums that are higher than those found in the individual market. Even though participants pay substantial premiums to participate in the high-risk pool, the state also provides considerable subsidization. The MHIP has historically been one of the more expensive high-risk pools in the country.[8] Most of the changes made to the high-risk pool by H.B. 818 affect the pool's rate structure and claims experience. The intended result is lower premiums for those who are enrolled in the plan and a lower threshold at which an individual becomes eligible for coverage through the pool.

The new provisions that pertain to the high-risk pool serve a wide range of purposes. The first is to bring MHIP into compliance with federal HIPAA regulations, which means that the pool will become a "HIPAA-qualified pool," qualifying it for grant funding of up to $75 million annually. In addition, having a HIPAA-qualified pool means that individuals who have lost their jobs or been forced into retirement due to outsourcing can deduct 65 percent of the premiums that they pay to receive health coverage through the high-risk pool.[9]

The other change made by H.B. 818 is to the rate structure for premiums. The premium paid for participation in the MHIP was previously set at 175 percent of the standard rate in the individual market. H.B. 818 requires that the rates cannot be less than 125 percent and no more than 150 percent of the standard individual rate. It is anticipated that this change will cost the state approximately $26.1 million dollars in the first year. In addition to changing the rate structure for premiums, the legislation also makes individuals eligible for the pool if they are unable to obtain coverage on the individual market for less than 150 percent of the standard rate.

The intended result of these changes is an overall reduction in premiums which will result in fewer individuals in the state who are unable to afford health insurance.

SENATE BILL 577:
THE MISSOURI CONTINUING HEALTH IMPROVEMENT ACT OF 2007

SUMMARY

S.B. 577 began as an outline for comprehensive Medicaid reform and repealed the existing sunset of the current Medicaid program. As introduced, this bill provided specific details for the creation of three health plan options that would become available to Medicaid beneficiaries on July 1, 2008, and created a deadline of July 1, 2013, for all Medicaid beneficiaries to be enrolled in one of the three plans. The original version of the bill also provided a health care home for Medicaid beneficiaries, established incentives for developing healthy lifestyles, encouraged low-income workers to purchase private insurance, and encouraged older adults to purchase long-term care insurance. It also created a premium offset program, which established provisions intended to guide the MO HealthNet Division in their administration of the program.

Most of the provisions mentioned above remain in the final bill in some form, but were modified significantly. Specifically, the implementation of most provisions was referred to various state agencies for further research and analysis. Only a handful of provisions are fully funded through FY08.

The final bill, as signed into law, modifies the Medicaid program by:

- Changing the name of the Missouri Medicaid program to MO HealthNet,
- Creating health improvement plans in which every Medicaid beneficiary will be enrolled after completing a mandatory health risk assessment,
- Establishing a Ticket to Work Health Assurance program that is designed to encourage disabled individuals to pursue employment without the risk of losing their health coverage,
- Changing the definition of "affordable employer-sponsored health coverage" and thus restoring coverage to more than 6,000 children,
- Extending coverage for foster children through age 21, and
- Establishing a "premium offset" program, otherwise known as premium assistance.

MO HEALTHNET

S.B. 577 changes the name of the Missouri Medicaid program to MO HealthNet in all applicable state statutes, and changes the name of the Division of Medical Services to the MO HealthNet Division. Although the provision that enacts this change in name does not go into effect until June 30, 2008, the new name is already in use by all applicable divisions and programs.[10]

It is important to note that the bill does not affect the provision of services at this time. Repeal of the sunset clause removes much of the immediate pressure to enact changes and allows the Assembly and other agencies more time to research and implement programs created or significantly changed by S.B. 577.

HEALTH IMPROVEMENT PLANS[11]

The Division of Social Services will oversee the creation of health improvement plans in which every Medicaid beneficiary will be enrolled, after completing a mandatory health risk assessment. The goal is for every beneficiary to have a medical home, which is intended to work in tandem with health improvement plans to provide improved access to preventive care and wellness initiatives. Plans for administration and funding of this program will be developed by the newly created MO HealthNet Oversight Committee through a public process. S.B. 577 indicates that these plans will include a sliding scale of payment for emergency room visits and use of "nurse help lines" in order to keep costs and emergency room visits to a minimum, but does not provide any further specifics.

TICKET TO WORK HEALTH ASSURANCE PROGRAM[12]

Authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999, the Ticket to Work Health Assurance Program will provide MO HealthNet coverage to individuals who meet the definition of "Permanently and Totally Disabled"[13] and have a gross income of 300 percent or less of the federal poverty level. Individuals with incomes above 100 percent of the federal poverty level will be required to pay premiums on a sliding scale for participation in the program. This program makes it possible for disabled individuals to maintain employment and still receive health benefits. If these individuals have access to employer-sponsored coverage that is more affordable than MO HealthNet coverage, then the Division of Social Services will be responsible for the costs associated with participating in the employer's program. It is estimated that this program will cover more than 3,000 individuals.[14]

HEALTH INSURANCE FOR UNINSURED CHILDREN

The bill changes the eligibility requirements for participation in the State Children's Health Insurance Program — called MC+ for Kids — by changing the definition of "affordable employer-sponsored health insurance." The new definition establishes guidelines that will make it possible for families who have access to employer-sponsored coverage to participate in that coverage with the benefit of a subsidy from the state if they fall into certain income categories. If an employer's insurance plan does not cover an eligible child's pre-existing conditions, it does not qualify as "affordable employer-sponsored health insurance" and thus makes the child eligible for the MC+ for Kids program. It is estimated that this will restore coverage for more than 6,000 children who lost coverage due to cutbacks in the state budget.

COVERAGE FOR FOSTER CHILDREN[15]

Previously, foster children lost their health benefits at the age of 18 — which is the same age at which they exit the foster care program. This act allows foster children to remain eligible for MO HealthNet coverage until the age of 21.

PREMIUM OFFSET PILOT PROGRAM

The bill sets in motion the development of a premium assistance program. In Missouri, this program will be called a premium offset program, and will be developed by the MO HealthNet Division. The legislation indicates that a pilot program will be put into place in one urban and one rural region in the state and that no employer may participate in the program for more than five years. The pilot program is set to expire on June 30, 2011.

CONCLUSION

As Kansas continues to look at options for health reform, the recent changes in Missouri may be helpful in informing the process on our side of the state line. The changes underway in Missouri are not comprehensive, but do offer some relevant approaches to the issues we are facing in Kansas. Going forward, we will keep an eye on our neighbor to the east as Missouri continues on its road to health reform.

ENDNOTES

[1] From the text of S.B. 539. Retrieved September 19, 2007, from http://www.senate.mo.gov/05info/billtext/tat/SB539.htm

[2] Ferber, J., & Frost, J. (2007, July 27). *MO HealthNet and SB 577: A Preliminary Analysis of Revisions to the Missouri Medicaid Program.* St. Louis, MO: Legal Services of Eastern Missouri.

[3] Missouri Foundation for Health. (2007). *Missouri Health Improvement Act of 2007 Senate Bill 818.* Retrieved September 19, 2007, from http://www.mffh.org/bill_analysis.html

[4] H.B. 818 — Section 379.940.

[5] H.B. 818 — Sections 376.987, 103.080 and 103.085.

[6] Missouri Consolidated Health Care Plan. (2007). *Public Entity.* Retrieved September 19, 2007, from http://www.mchcp.org/pe_member/index_choose.htm

[7] H.B. 818 — Sections 143.121 and 143.119.

[8] Pollitz, K. (2006). *The Missouri Health Insurance Pool: Issues for Policymakers.* Prepared for the Missouri Foundation for Health. Retrieved September 19, 2007, from http://www.mffh.org/UIfactsheet6Final.pdf

[9] ibid

[10] Missouri Department of Social Services (2007). *MO HealthNet Division.* Retrieved September 19, 2007, from http://www.dss.mo.gov/mhd/index.htm

[11] S.B. 577 — 208.950.7. Retrieved September 19, 2007, from http://www.senate.mo.gov/07info/pdf-bill/tat/SB577.pdf

[12] S.B. 577 — 28.146.1. Retrieved September 19, 2007, from http://www.senate.mo.gov/07info/pdf-bill/tat/SB577.pdf

[13] Definition of Permanently and Totally Disabled: A disability which renders a person unable to engage in any gainful work.

[14] Missouri General Assembly, Committee on Legislative Research, Oversight Division. (2007, June 4). *Fiscal Note for the House Committee Substitute for S.B. 577.* Retrieved September 19, 2007, from http://www.moga.mo.gov/oversight/OVER07/fispdf/2227-16T.ORG.PDF

[15] S.B. 577 — 208.151.1(26). Retrieved September 19, 2007, from http://www.senate.mo.gov/07info/pdf-bill/tat/SB577.pdf

Obesity Prevalence and Risk Factors among Kansas Minorities

Topeka, Kansas • January 23, 2008

Candace Ayars, Ph.D.
John Rule
Kansas Health Institute

Introduction

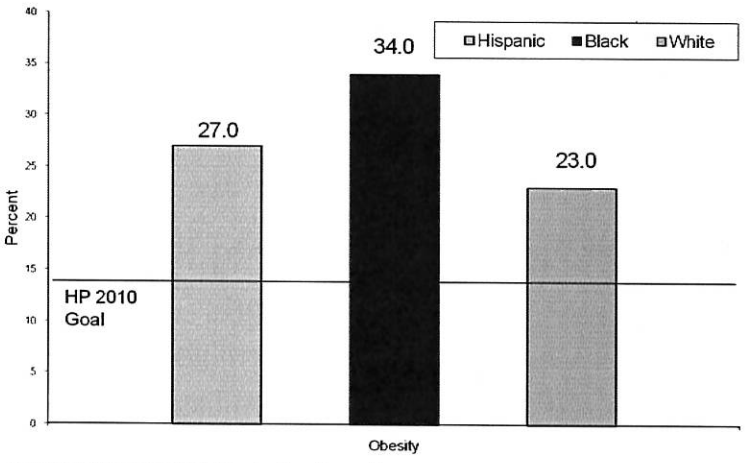
- In 2001, The Surgeon General of the United States issued a 'Call to Action' to prevent and reduce overweight and obesity
- Costs of Obesity to Kansas
  - Total: $657 million
  - Medicare: $138 million
  - Medicaid: $143 million

Health + Human Services Comm.
1-23-08
Attachment 3

Background/Need

- Overweight and Obesity prevalence is a leading health indicator for HP2010
- HK2010 goal: Identify, reduce and eliminate racial and ethnic health disparities
- Data were available nationally for minority groups, but they were not available in Kansas

National Data



Source: 2005 Behavioral Risk Factor Surveillance Survey

Project Goals

- To provide precise estimates of the prevalence of obesity in Kansas
- To obtain information about risk behaviors and health factors related to obesity among the Hispanic, Black and White populations
- To make the results of this survey readily available for use

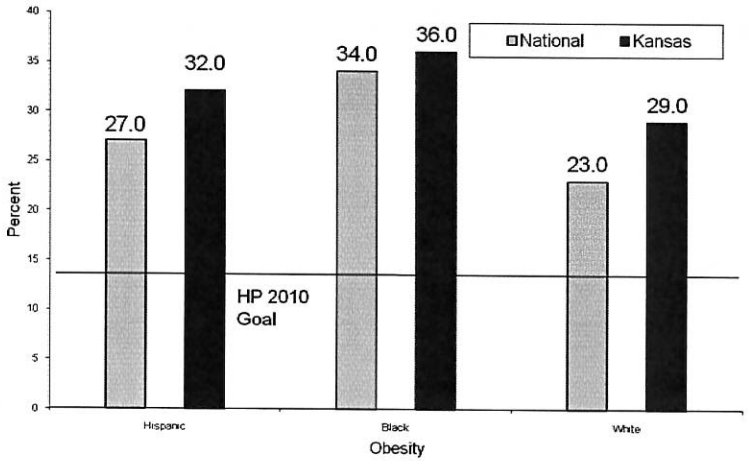
Who Is Involved?

- Sunflower Foundation
- Kansas Department of Health and Environment, Office of Health Promotion
- Kansas Health Institute

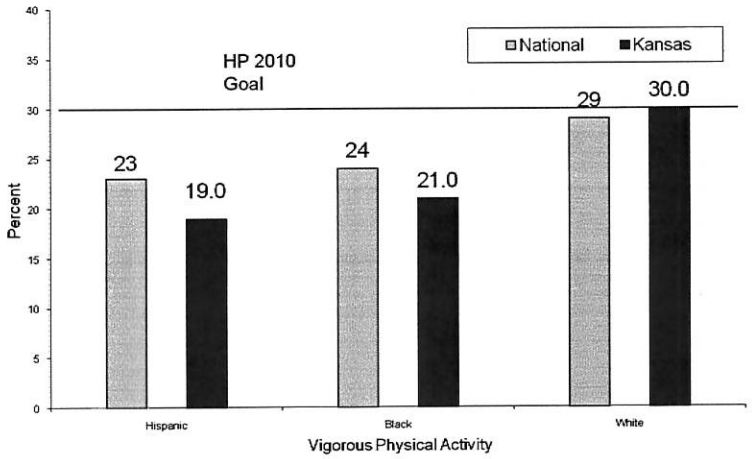
Who is Involved? Cont.

- Kansas Association of Local Health Departments
- State and local service providers, program managers and policy makers who are interested in a better understanding of obesity-related issues among minority groups in Kansas

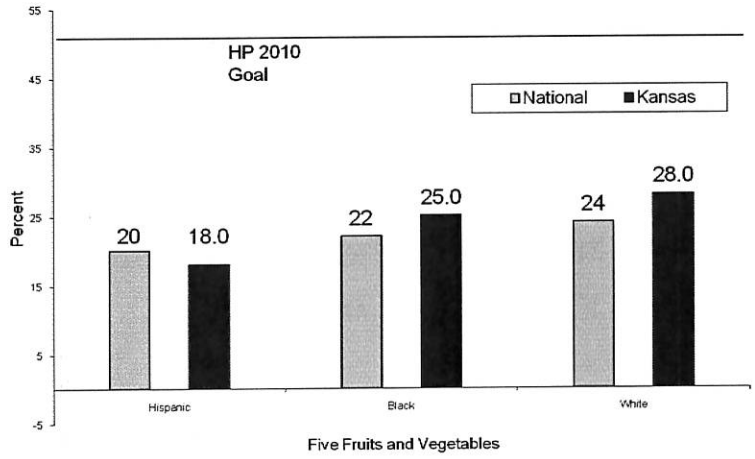
Results – Obesity Comparison



Results – Physical Activity Comparison



Results – Five Fruits and Vegetables Comparison



Example of Ethnic/Racial Differences

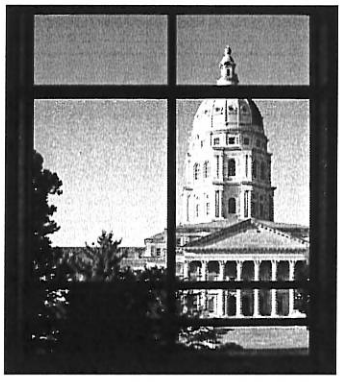
Expected Impact and Application of Data

- Estimation of obesity prevalence, evaluation of any changes
- Identification of risk factors can lead to targeted health promotion and intervention efforts
- Reduce disability and healthcare costs; save lives

Publication of Results

- Breakdown of survey questions can be found at the Health Risk Studies website of KDHE (http://www.kdheks.gov/bhp/HealthRiskStudies/KhansSurvey0506/KhanSurvey.htm)
- The report on this survey is available at the Kansas Health Institute website (http://www.khi.org)

Kansas Health Institute



Information for policy makers. Health for Kansans.