Approved: March 6, 2008
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 P.M. on January 28, 2008 in Room 136-N of the Capitol.

Committee members absent: Senator David Haley, excused
Senator Mark Gilstrap, excused

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms. Renae Jefferies, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Ms. Laura Green, Director, Kansas Compassionate Care Coalition
Ms. Shelly Gehshan, Senior Program Director, Nation Academy for State Health Policy
Mr. Andy Snyder, Policy Specialist, National Academy for State Health Policy
Dr. Andrew Allison, Ph.D. Deputy Director, Kansas Health Policy Authority

Others in attendance: Please see attached guest list

Introduction of Bills

Upon calling the meeting to order, Chairperson Wagle introduced Ms. Laura Green, Director, the Kansas Compassionate Care Coalition to request introduction of the Kansas Medical Marijuana Defense Act. The bill would provide a medical marijuana defense for persons who were arrested for the offensive possession of marijuana providing they could bring a written certification frm a licensed physician on the debilitating medical condition of the person being charged and the physician's recommendation that marijuana would alleviate the effect of the disease and/or the condition.

As there were no questions of Ms. Green, the Chair said that she was open for a motion. Senator Brungardt made the motion to introduce the bill. It was seconded by Senator Journey and the motion passed by all but one. Senator Schmidt requested that her nay vote be recorded.

Presentation on Kansas Health Reform: Options for Adding Dental Benefits

The Chair then called upon Ms. Teresa Schwab, Executive Director, Oral Health Kansas, who stated her purpose before the Committee was to introduce Ms. Shelly Gehshan, Senior Program Director, National Academy for State Health Policy, but first offered a little background regarding Oral Health Kansas which was part of the Consumer Councils that the Health Policy Authority created to get input for the health reform recommendation. She stated that along with the United Health Ministry Fund, Oral Health Kansas commissioned the National Academy for State Health Policy to put together a detailed report on ways they could include dental benefits in this health reform discussion.

Ms. Schwab then introduced Ms. Shelly Gehshan who testified why it is important to include oral health benefits in health care reform. She went on to say that poor health is an infectious and chronic disease that is transmittable from mother to child and that adults have fewer options in the dental care safety net than children do. She offered slides of how Kansas was when compared to the rest of the country, including the first three states that tried to offer comprehensive health care reforms. Ms. Gehshan concluded by explaining the link between chronic disease and oral health. A copy of her testimony is attached. (Attachment 1)

Ms. Gehshan then introduced Mr. Andy Snyder, Policy Specialist, National Academy for State Health Policy, who offered three approaches the States can take:

1. Use Medicaid as a vehicle for providing dental benefits;

2 Offer a private dental insurance product; or.

3. Combine Medicaid and private insurance in a "connector."

He went on to say these options were based on the dental options that are available to Kansas State employees and federal employees. Mr. Snyder proceeded to go through the details of these plans, including costs and how they are allocated between state and enrollees. And concluded by offering, "everything you could do if you didn't have the money" for dental insurance. A copy of his testimony is (Attachment2) attached hereto and incorporated into the Minutes by reference.

Also offered with their testimony is a pocket folder that includes two booklets and a fact sheet. The first booklet is entitled, "Kansas Health Reform: Options for Adding Dental Benefits, September 2007." The second is entitled "Talking Points Your Mouth Matters" from Oral Health Kansas. The fact sheet is entitled "Medicaid: Adult Dental Coverage. A copy of the pocket folder with the booklets and fact sheet are filed in Chairperson Wagle's office.

The Chair thanked both conferees and asked for questions from the Committee. Senators Barnett asked if they had some outcome data for states who have paid for Medicaid coverage to see the results, benefits, etc. from the states. Chairperson Wagle mentioned they would be interested in the report when it comes out.

Presentation on the Premium Assistance Plan

The next order of business was the presentation on the premium assistance plan. The Chair called on Dr. Andrew Allison, PhD, Deputy Director, Kansas Health Policy Authority, who began his testimony with an introduction of the Kansas Health Choices, a new health insurance program created by the legislature in 2007 that provided private health insurance to very low income Kansas families. He offered insurance options under Kansas Healthy Choices, its implementation schedule, and its Premium Assistance Program (Statutory authority and Legislative history.) He explained the Kansas Health Choices Options:

1, Employer sponsored private health insurance;

2. State procured private health insurance; and,

3. Piloting health opportunity accounts (HOA).

Dr. Allison concluded by listing some advantages of the Kansas Health Choices/Premium Assistance (Ex. Access to care, support for safety net, and use of Federal and private funds) saying by taking advantage of new Federal options to offer limited benefit packages, Kansas is able to offer more of a transitional program that has the look, feel, and operation of private coverage. A copy of his testimony and a Premium Assistance Fact Sheet are (Attachment 3) attached hereto and incorporated into the Minutes by reference.

The Chair then asked for questions of the Committee about the basic designs. Senators Schmidt wanted to know if the CMS responds to the RFI or the RFP? Referring to page 5 under the heading "How does Kansas Healthy Choices differ from a Medicaid expansion?", Senator Barnett asked for specific examples of how we are going to save money and is that accounting for administrative cost on the part of the State to establish and maintain the Premium Assistance Program and is prescription medicine covered? He went on to ask, "So for people with Kansas Healthy Choice coverage are going to have limited choice for particular prescription medicines or will pharmacists be accepting a lower rate, how does that work out?"

Adjournment

As it was going on Senate session time, the Chair announced they would continue the presentation and discussion tomorrow. The meeting was adjourned. The time was 2:35 p.m.

The next scheduled meeting is Tuesday, January 29, 2008.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

48 in att.

DATE: Monday, January 28, 08

NAME	REPRESENTING
Kathy Weno	KDHE
Shelly Gehsham	NASHP
Andrew Snyder	NASHP
Ted Freiseler	Ks. Optometric Assoc.
Andy Allison	KHPA
Jennie Roe	KCSL
Jim McDonald	KCSL
Larry Magill	KAIA
Sandy Braden	Gaches, Braden, Barbee
Kerri Spielman	KAIA
John Kiefhaber	Ks. Chiropractic Assn.
Cassie Williams	Dodie Wellshear & Associates
Tony Wellever	KAMH
Carolyn Middendorf	Ks St Nurses Assn
Amy Campbell	KMHC
Mary Ellen Conlee	Via Christi Health System
William W Sneed	AHIP
Bob Harder	UMC-KS
Karen Finstad	OHK

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Monday Jan. 28, 2008

NAME	REPRESENTING
Don Murray	Federico Consulting
Sean Miller	Capitol Strategies
Janelle Garrison	KHPA
Christiane Swartz	KHPA
Shelly Lieb	KHPA
Teresa Schwab	Oral Health Kansas
Marci Nielsen	KHPA
Blondell Park	KDOA
Reagan Cussimanio	KHPA
Tracy Russell	KHPA
Daniel Lewien	SRS
Chad Austin	KHA
Stephanie White Buchanan	CMS

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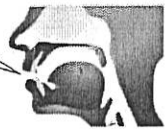
Why Include Oral Health in Health Care Reform?

Shelly Gehshan, Senior Program Director
National Academy for State Health Policy
January, 2008

1

The Mouth: An Essential Body Part

An organ of
- Digestion
- Respiration
- Communication



Home to unique structures
- Teeth
- Gums
- Tongue
- TMJ
- Salivary glands

NATIONAL ACADEMY for STATE HEALTH POLICY

2

Good Oral Health is Fundamental

- **Oral health is integrally linked to the entire body's health and functioning**
- Children can't thrive if they can't eat, sleep, play, or concentrate in school.
- Adults need good oral health so they can get and keep a job.

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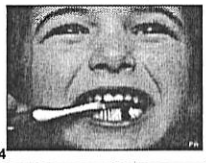
3

Access to Dental Care

- lack of dental care is the single largest unmet need among children
- more than twice as many people lack dental insurance as health insurance.



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Oral Health Disparities

- Disproportionately affect our most vulnerable citizens:
  - low-income
  - rural
  - elderly
  - disabled
  - minority
  - immigrants
  - uninsured

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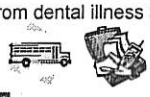
Poor Oral Health: Short-term effects…

- **Pain and discomfort**, which interferes with daily living, such as sleeping, learning in school, and functioning on the job.
- Children lose an estimated **50 million hours from school** and adults lose **160 million hours from work** annually from dental illness and visits.



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Caries, Left Untreated, Will Progress

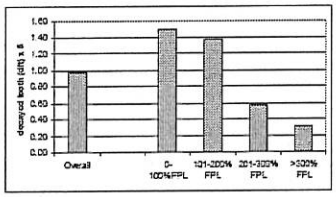
- Major trauma, and even death, have resulted from the lack of access to dental services…

Deamonte Driver, 12
Died February 25, 2007

Deamonte Driver, a 12-year-old Maryland boy, died from complications of a dental infection in early 2007, sparking a national outcry for oral health care reform.

Income Disparities

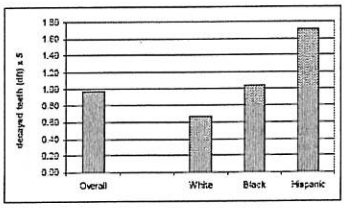
Poor and low-income children have more than twice the number of cavities as their peers.



Source: www.cdhp.org

Racial Disparities

Children of color have more early childhood caries regardless of income.



Source: www.cdhp.org

Children in Kansas

	Kansas	National
Children with dental decay in 1999-2004	55% of 3rd graders (generally ages 8 or 9)	24.5% of children ages 6 to 11
Children with untreated dental decay in 1999-2004	25.1% of 3rd graders	11.1% of children ages 9 to 11
Children with dental sealants	34.2% of 3rd graders	30% of all youths; 40.1% of children ages 9 to 11

- By some measures, children in Kansas have worse oral health than their U.S. peers.
- Approximately 47,000 children in Kansas lack insurance of any type.

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Adults in Kansas

- Roughly 282,000 adults in Kansas lack insurance of any type.
- Approximately 110,000 adults are insured by Medicaid, which provides only emergency dental services to most adults.

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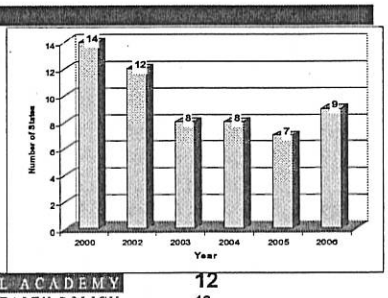
States with Full Medicaid Dental Benefits for Adults



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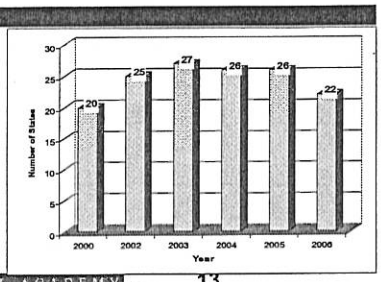
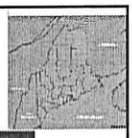
States with Emergency or No Benefits for Adults in Medicaid



Oral Health in Health Care Reforms So Far

- Oral health needs and access to dental care have not been a priority in health care reform—but have not been ignored.
- Concerns about cost, and the separation between medical and dental care, may be at fault. Yet…
- **Dental care costs are small: only 20% of overall health costs; and only 5% of Medicaid.**

Maine



- Dirigo Health Reform Act was enacted in 2003.
- State's subsidized insurance plan – DirigoChoice – was implemented in January 2005.
- Focus on: chronic disease, the Maine Quality Forum (promoting quality and education), voluntary limits on growth of premiums, and electronic claims.
- Sliding scale for premiums and out-of-pocket expenses based on family income.
- Dental benefits only in MaineCare: comprehensive for under age 21, but only emergency/dentures for adults.
- Oral health improvement plan developed by the state was released in late August 2007.

Massachusetts

- Reform established new independent public authority called "the Connector" which designs coverage and works with businesses, insurance companies, providers and consumers.
- Dental benefits are provided in MassHealth (Medicaid) and Commonwealth Care for all adults with income <100% FPL, and parents up to 133% FPL.
- Children up to 300% FPL continue to receive comprehensive oral health benefits.
- Funds added to safety net clinics to provide dental services for those without dental coverage.

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Vermont

- In May 2006, Catamount Health was created and provides comprehensive, state-subsidized coverage through private insurers for families with incomes up to 300% FPL.
- Unclear what dental benefits will be offered in this program.
- Oral health will be addressed in reforms of chronic care management and care coordination programs.
- Reimbursement rates for dental care were raised in Vermont's Medicaid program.
- "Dental Dozen" – 12 targeted initiatives planned to improve oral health for all Vermonters.

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Why Provide Dental Care for Adults?

- Poor oral health is associated with chronic and acute systemic diseases, such as:
  - cardiovascular disease
  - respiratory disease
  - diabetes
  - stroke
  - preterm births



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Why Provide Dental Coverage?

- Research indicates that people with dental coverage are significantly more likely to seek and use regular dental care than the uninsured.
- Studies show private dental insurance is associated with improved clinical oral health status among the insured.
- Children with dental coverage, *either public or private*, show more regular use of preventive care than children without dental insurance.

Coverage and use of preventive care improves the health of the individual, and results in cost savings that are passed along to the consumers and the health system.

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Effects on other diseases

Insurance companies are improving oral health care as a deliberate strategy to reduce overall medical care costs.

Aetna™

Aetna's Dental/Medical Integration program provides enhanced dental benefits to members with targeted health conditions that are impacted by oral disease: pregnancy, diabetes, heart disease and stroke.

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Improving Oral Health Can Lower Costs for Patients with Chronic Illness

History of	Reduced Medical Costs
Diabetes	9%
Coronary Artery Disease	16%
Cerebrovascular Disease	11%

From Aetna-Columbia University study of 144,000 insured.

1 Aetna study found that improving oral health care for patients with diabetes, cardiovascular disease and cerebrovascular disease reduced overall medical care costs.

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Effects on Pre-term Births

- Evidence is not yet conclusive, but eliminating periodontal infections in pregnant women *could* avoid about 45,500 preterm low birthweight newborns a year.
- **That could save neonatal intensive care costs of $22,000 per baby, or almost $1 billion.**

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Dental Care in Reform Could Mean…

- Providing benefits to priority populations
- Setting up structure so people can purchase benefits
- Paying attention to safety net and prevention so uninsured can get care and costs lower down the line.

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Improving Oral Health in Kansas

Access to dental care is the nations' largest unmet need. Health care reform presents an ideal opportunity to improve the whole system of prevention, treatment, and service delivery.

Kansas can be a leader in this effort.

KANSAS

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Options for Adding Dental Benefits

Andy Snyder, Policy Specialist,
National Academy for State Health Policy
January, 2008

NATIONAL ACADEMY for STATE HEALTH POLICY

Kansas Health Reform

- **Kansas Senate Bill 11**: preferred method for achieving goals is premium assistance, private insurance similar to state employee health plan
- NASHP's options are based on dental options available to Kansas state employees, and dental reform experience of other states

Three Approaches States Can Take

- Use Medicaid as vehicle for providing dental benefits.
- Offer a private dental insurance product
- Combine Medicaid and private insurance in a "connector."

Option 1: Expand dental benefits under Medicaid

- Implement an adult dental benefit under the Medicaid program
  - State can use Deficit Reduction Act authority to tailor benefits, and use a "benchmark plan" for different groups of enrollees.
- For non-Medicaid eligibles, use general funds and enrollee contributions to buy in to the program
- Reform program administration and financing along the lines of states like Michigan, Tennessee, and Alabama.

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State reforms show costs & gains

State	Expenditure	Effect
Alabama	Dental expenditures more than tripled in the first 2 years of Smile Alabama! from $11.6 million in 1999 to $38.8 million in 2002.	The percentage of children with visits rose from 26 to 31%.
Indiana	Fee increases to commercial rates raised total dental Medicaid expenditures for children from $7.8 million in 1997 to $37.7 million in 2000.	The percentage of children with visits rose from 18 to 32%; the number of dentists submitting Medicaid claims increased by 42%.
Michigan	Transition from Medicaid to Healthy Kids Dental increased payments per member per month approximately 2.5 times.	The percentage of children with visits rose by one-third, 183 more dentists saw HKD kids, and the average distance traveled to appointments shrank to a level identical to the privately-insured.
Tennessee	Moved reimbursement from 40% of retain fees to rates comparable to retail fees; administrative contract with Doral recently re-bid for $13.5 million over 3 years.	Percentage of children with visits rose from 24 to 47%; number of participating dentists double from 385 to >700 in first two years of program.
Virginia	Rate increase of 30% over 2 years (2005-2006), plus cost of administrative services contract.	Percentage of children with visits rose from 24 to 32%; number of participating dentists increased by 57% from 2005 to 2006.

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Option 1: Expand dental benefits under Medicaid

Advantages	Disadvantages
• Allows state to capture federal funding for services provided to Medicaid enrollees.	• In most states, Medicaid's poor reputation in dental communities would require intense efforts to revamp administrative processes, improve reimbursement and communication with providers.
• Low-income enrollees are protected from high burden of cost-sharing	• Maintaining reimbursement rates requires significant new investment of state funds.

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Option 2: Private dental insurance product

- Contract for a private dental insurance product that is similar to state or federal employee coverage.
- The state could opt to pay for part or all of enrollees' premiums, which on average, are less than $30 per member per month.

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Dental insurance differs from medical

- Much smaller premiums
- Higher cost-sharing
  - Deductibles
  - Coinsurance (20-50%)
- Annual benefits
  - $1000-$1500 average maximum payout
- Different assumptions about risk
  - Dental disease is widespread
  - Dental coverage assumes enrollees will use services
  - Plans are designed to limit the insurer's risk, and transfer significant liability back to the enrollee.

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Kansas state employee dental plan

Features of the Kansas state employee dental plan

Service Type	Delta Pays (PPO/Premier)	Enrollee Pays (PPO/Premier)	Limitations
Diagnostic/Preventive	100%	0%	No deductible.
Amalgam and Composite Fillings	80%/60%	20%/40%	
Oral Surgery, Root Canals, Periodontics	80%/60%	20%/40%	$45 deductible per person per year
Crowns, Dentures, TMJ	50%	50%	
Orthodontics	50%	50%	$1,000 lifetime maximum benefit (separate from the yearly maximum benefit)

Source: State of Kansas, *Benefit Description of Dental Care Coverage* (revised 5/23/06). Available at http://www.khpa.ks.gov/OpenEnrollment/FY2007/BenDescriptions/2007DentalFinal.pdf.

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Dental Insurance Costs in Kansas

Monthly premium for federal employees' dental plans in Kansas

Plan	Self	Self + 1	Self + Family
Least expensive (Met Life Standard)	$15.80	$31.59	$47.41
Average of all 7 plans offered in Kansas	$24.41	$48.82	$73.23
Most expensive (Aetna, outside of Kansas City)	$30.77	$61.58	$92.34

Source: Federal Employees' Dental and Vision Insurance Program (FEDVIP) benefits tables, available at http://www.opm.gov/insure/07/guides/fedvipTables.asp.

- Federal plan: employees pay full premium
- State plan: state pays a portion of premium
- Possible to design a sliding scale for premium assistance

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Option 2: Private dental insurance product

Advantages

- For providers, participation in state program would be similar to private sector, avoid any bad associations with "Medicaid".
- Allows the state to limit its financial exposure.

Disadvantages

- High cost sharing and annual benefit caps may be unaffordable for enrollees
- May cause dentists to move from seeing Medicaid patients to seeing this population

NATIONAL ACADEMY for STATE HEALTH POLICY 11

Option 3: Combine Medicaid and private insurance in a "Connector"

- Modeled on Massachusetts reform, which combines Medicaid and private-sector approaches.
- State would organize group dental coverage
  - Does not rely on the individual market, since individual dental products are poorly regulated
- Would use a freestanding contract with a dental administrator to provide varying levels of coverage based on income

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Types of coverage under a "Connector"

- Medicaid-enrolled children: no premium, no cost-sharing, coverage for all medically-necessary services
- Medicaid-enrolled adults: no premium, limited cost-sharing, but also limited benefits
  - Envisions an expansion of eligibility for adults to 100% FPL
  - Covering groups like childless adults would require a waiver

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Types of coverage under a "Connector"

- Adults and families between 100 and 300% FPL: premium based on sliding scale, private insurance cost-sharing and benefits
- Higher incomes: full premium, open to buy-in for people with medical insurance, but not dental

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Option 3: Combine Medicaid and private insurance in a "Connector"

Advantages

- Narrows the differences between Medicaid and commercial insurance.
- Maintains consistent dental coverage as enrollees move from Medicaid to subsidized coverage through the "Connector."
- Permits buy-in by those with employment-based medical (but no dental) coverage.

Disadvantages

- Problems with the individual market for dental insurance

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Other Measures Kansas can take...

- Expand preventive measures, such as sealants and water fluoridation.
- Expand the safety net and workforce.

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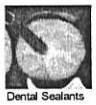
Early Intervention & Prevention

Safe and effective oral disease prevention measures exist that result in significant improvements in oral health at the individual and community levels.


Dental Sealants


Fluoride Varnish


Water Fluoridation

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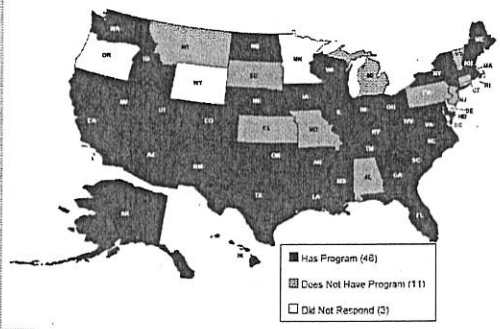
Sealants

- Sealants – plastic coatings that prevent cavities when applied to molars.
- Cost-effective way for Kansas to improve oral health and reduce future restorative costs.
- The United Methodist Health Ministry Fund sponsored a sealant program that ended in 2002.

NATIONAL ACADEMY for STATE HEALTH POLICY 18

States with Programs for Dental Sealants, 2005

Source: The Association of State and Territorial Dental Directors and CDC Division of Oral Health's Synopses of State Dental Programs



Water Fluoridation in Kansas

- In 2002, 62% of Kansas citizens had optimally fluoridated water.
- 130,000 more people in seven more water districts now have community water fluoridation.
- **Speeding up the process of adjusting the fluoride levels would be the most cost-effective investment in oral health that state policy makers could make.**

Strengthen the Safety Net

- Only 550 of 1,350 Kansas dentists participate in Medicaid.
- 14 of 36 clinics provide dental care (up from 4 in 2003), but cannot meet demand for free- or low-care cost.
- The Kansas Association of Medically Underserved (KAMU) is planning expansions. Supporting clinics is an effective way to provide care for underserved patients.

Expand the Workforce

- 11 counties in Kansas have no practicing dentist.
- 23 counties have only one dentist.
- Shortages are acute and are worsening in rural counties.

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Workforce Options

- Train more dentists
- Attract more dentists (licensing, loan repayment, residency programs, e.g. Advanced Education in General Dentistry).
- Develop new providers
- Expand the scope of practice and loosen supervision requirements for dental auxiliaries

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Kansas Progress on Workforce

- Extended Care Permit hygienists (ECP) can perform all the duties in the community settings that they can in a private dental office.
- 55 hygienists have ECPs; 25 are in community settings.
- Allowing hygienists to practice to the full extent of their training would be cost-effective.

NATIONAL ACADEMY for STATE HEALTH POLICY 24

There is much more that can be done to increase dental insurance and to improve the functioning of the current dental delivery system, but we need to start looking beyond the current system in order to meet all the oral health needs of our population.

Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

Testimony on:
Premium Assistance

presented to:
Senate Health Care Strategies Committee

by:
Andrew Allison, Ph.D.
Deputy Director Kansas Health Policy Authority

January 28, 2008

For additional information contact:

Dr. Barb Langner
Kansas Health Policy Authority

Room 900-N, Landon State Office Building
900 SW Jackson Street
Topeka, KS 66612
Phone: 785-296-3981

Senate Health Care Strategies Committee
Date: January 28, 2008
Attachment 3

Testimony to the Senate Health Strategies Committee
January 28, 2008

Premium Assistance
Andrew Allison, PhD, Deputy Director Kansas Health Policy Authority

Introduction

Kansas Healthy Choices is a new health insurance program created by the legislature in 2007 that provides private health insurance to very low income Kansas families. Although children in Kansas are eligible for Medicaid or HealthWave up to 200 percent of the federal poverty level (FPL), Kansas currently has one of the lowest rates of Medicaid eligibility in the nation for poor parents (below 37 percent of the FPL). Premium assistance is the use of public, employer, and potentially individual contributions to purchase private health insurance for Kansas families living in poverty who cannot otherwise afford coverage. Kansas Healthy Choices (KHC) is the program name for the initiative authorized by Senate Bill 11 to use premium assistance to provide access to a range of private health insurance options to eligible families. The program applies minimal restrictions on families' purchase of private insurance, while ensuring:

- State access to 60% Federal matching funds
- Lower cost as compared to both private insurance and more comprehensive Medicaid coverage
- Access to affordable healthcare for families living in poverty
- Protection of benefits to those currently eligible for HealthWave
- Coverage for newly eligible parents on a par with private insurance plans
- Coverage under one plan for each member of the family
- Continuing access to a primary care medical home.

Insurance options under *Kansas Healthy Choices*

Families eligible for Kansas Healthy Choices will receive private coverage through one of the following mechanisms (*subject to pending Federal approvals*):

- Employer sponsored insurance (ESI) buy-in: For families with access to employer sponsored private health insurance, the state would pay the employee share of the health insurance premium for families.
- Competitively bid state-procured health plans: For families without access to a qualifying employer plan, KHPA will provide a choice of three state procured health plans offering high-quality, cost effective benefits. Basic benefits will be tied to the value of state employee benefits.

- Health opportunity account (HOA) pilot: Families in one urban and one rural county will have access to a pilot program testing the application of consumer-driven purchasing in a low-income population. A high-deductible health plan will be coupled with a funded health opportunity account to provide incentives for prudent, prevention-oriented health care choices.

Implementation Schedule for *Kansas Healthy Choices.* KHC options will be available beginning in January 2009. Over three years, the program is expected to provide about 20,000 existing and 24,500 newly eligible caretaker adults and their children with the choice of private insurance options and a "medical home" model of health care services.

Phase-In	**Phase 1 FY 2009**	**Phase 2 FY 2010**	**Phase 3 FY 2011**	***FULL PHASE IN***
Percent of Federal Poverty Level (FPL)	**37- 50% FPL**	**50-74% FPL**	**75-99% FPL**	***Total expanded population under 100% FPL***
Number of newly-eligible parents covered	8,500	7,000	8,500	*24,000*

Poor parents of Medicaid eligible children are the target population for the eligibility expansion associated with premium assistance. They are chronically uninsured or underinsured, have very low incomes, use the emergency room for last-resort care and are not generally in the private insurance market. Their employer may offer insurance but these parents can not usually afford the employee share of the premium and choose to remain uninsured. Current eligibility levels for Medicaid for caretaker adults (e.g., parents) are below 37% of the Federal Poverty Level (FPL), which in 2007 was $3,778 for a single person; $5,065 for a family of two; $6,353 for a family of three; and $7,641 for a family of four.

Developing the Kansas Healthy Choices/Premium Assistance Program

Statutory authority. KHC coverage will be provided through the purchase of employer-sponsored or procured, commercial health insurance. Both options will cover services that are actuarially equivalent to the State Employee Health Plan, as specified in SB 11, which received unanimous support in the Kansas legislature and was signed into law by the Governor on May 10, 2007. Kansas will utilize two provisions of the Deficit Reduction Act of 2005, sections 1937 and 1938, for support of the state's innovative plan design. Section 1937 allows States to provide benefit packages to Medicaid beneficiaries that differ from coverage defined in the state's approved state plan through enrollment in approved benchmark or benchmark-equivalent coverage, such as procured health plans or employer sponsored insurance plans. Section 1938 provides for 10 states to operate their Medicaid benefits to volunteer beneficiaries through a program that is comprised of a Health Opportunity Account (HOA) and High Deductible Health Plan (HDHP).

The authorizing language for premium assistance reads as follows:

> *[The KHPA's health care programs shall include]..." a phased-in premium assistance plan to assist eligible low income Kansas residents with the purchase of private insurance or other benefits that are actuarially equivalent to the Kansas state employee health plan under a program authorized under subsection (a)(1). In program years one and two, subject to appropriation of funds and other eligibility requirements, eligible participants shall consist of families at and under 50% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year three shall consist of families at and under 75% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year four shall consist of families at and under 100% of the federal poverty level. The Kansas health policy authority is authorized to seek any approval from the centers for medicare and medicaid services necessary to accomplish the development or expansion of premium assistance programs for families" Section 4(1)(F) of Senate Bill 11, K.S.A. 2006 Supp. 75-7408*

In addition, SB 11 language "to promote market-based solutions that encourage fiscal and individual responsibility" and "expand consumer responsibility for making health care decisions" is consistent with the philosophy underlying Health Opportunity Accounts.

Legislative history. The basic structure of Kansas Healthy Choices is defined in this legislative language – the use of private insurance to expand coverage to families living (well) below the poverty level, providing coverage to family units as a whole rather than parents alone, tying those private benefits to the level provided in the state employee health plan, and phasing coverage in over three years. Additional program design features were highlighted in fact sheets and explanations provided to legislators and stakeholders during the debate over that legislation. See, for example, the program description offered to the Health For All Kansans health reform Steering Committee on March 11, 2007 on KHPA's website: http://www.khpa.ks.gov/AuthorityBoard/HealthForAllKansans/3-19-HFAKansansSteeringCommittee%20final%20_3_.pdf . The program's basic design is reflected in a core set of goals and objectives that have remained consistent since the deliberations over SB 11, which are to:

- Ensure access to affordable healthcare for families living in poverty by extending coverage to parents of Medicaid eligible children
- Protect benefits offered to children and other current eligibles
- Bring parents and children into the same private health plans
- Increase participation by eligible children
- Expand coverage solely through private health plans
- Put parental benefits on a par with privately-insured families
- Provide health plan choices available to low-income families
- Prepare the way for further reforms

- Explore use of health opportunity accounts and consumer driven purchasing
- Draw in Federal funds and take advantage of Deficit Reduction Act (DRA) flexibility

Design process. To flesh out the design of the premium assistance program, KHPA engaged in a months-long public policy development process, convening an open premium assistance design workgroup to solicit feedback from carriers, providers, and other stakeholders, sharing preliminary plans with the KHPA Board and the health reform advisory councils (Purchaser, Provider, and Consumer), conducting an initial Request For Information (RFI) process with prospective bidders, issuing open invitation and subsequently meeting with health plans, insurance agents, associations, and other stakeholders regarding the program's design, and maintaining a webpage devoted to the design of the program. For details, see http://www.khpa.ks.gov/AuthorityBoard/PremiumAssistance.htm.

The first RFI process provided important feedback on the design of the Kansas premium assistance program. We requested feedback on a number of key program details, including: the nature of the benefits (mandatory versus optional), the number of health plans to be offered to KHC participants, the selection criteria to be applied to the health plans, the coverage area for each health plan (i.e., statewide versus regional), the "lock-in" or health plan selection timeframe for enrolling families, recommended levels of reimbursement for providers contracting with KHC health plans, coordination of benefits and simplification of administrative process for providers and families. Seven health plans responded to the RFI with extensive responses, as did one provider association. The responses were then summarized and shared with the premium assistance design workgroup, along with preliminary program design details as proposed by KHPA staff. The summary and preliminary design was posted on the website at http://www.khpa.ks.gov/AuthorityBoard/PremAsstWrkgrpDocs/RFIMatrix.pdf in November 2007.

Over the next few weeks, KHPA staff completed the design and administrative work necessary to prepare for premium assistance implementation – and provide important details of the program to stakeholders and legislators. We worked to flesh out the program design and prepare both a state plan amendment and a draft request for proposals to procure health plans, each of which requires CMS approval in order to secure 60% Federal matching funds. Those documents were submitted to CMS in December. The program design reflected in these documents (the RFP itself must remain confidential until released as part of the state procurement process) were presented to the KHPA Board for approval at their next meeting January 22, 2008, in the form of a detailed fact sheet [submitted as a part of this testimony] and an follow-up RFI. The purpose of the follow-up RFI is to provide a reasonably complete set of program details as reflected in the materials submitted to CMS for their review, given the restrictions in the procurement process against sharing the draft RFP. A fact sheet and set of "Frequently Asked Questions" has also been prepared for the public.

Program design for Kansas Healthy Choices

Employer Sponsored Private Health Insurance. When a family determined to be eligible for Kansas Healthy Choices has access to an employer-sponsored insurance plan, a review of those benefits will determine whether it is more cost effective for the State to reimburse the family for employer sponsored coverage instead of providing services through the state-procured health plans. The family will provide detailed information about the insurance that is available to them and the State's enrollment broker will perform an evaluation based on the family's cost and the employer sponsored coverage compared to the KHC services. The State will pay the employee's portion of employer-sponsored insurance if it is less expensive than providing KHC coverage through a state-procured plan.

State Procured Private Health Insurance. KHC families determined to be eligible for a KHC procured plan will be sent a choice packet instructing eligible caretakers to select one of the statewide health plans, a plan for themselves and their eligible family members, much as the State Employee Health Plan works today. A limited number of families in two pilot counties will also be able to select the demonstration HOA/HDHP program. The choice packet will contain information about the type of plans, benefits and network coverage available. If a beneficiary does not choose a health plan, the family will be systematically assigned to one of the three benchmark-equivalent health plans. Consistent with Federal requirements – and unlike the private marketplace – KHC participants will be subject to neither waiting periods nor pre-existing condition clauses.

Eligibility Group	**Kansas Healthy Choices Options**			
	Three (3) Procured Private Health Plans		**One (1) Health Opportunity Account Pilot**	**Employer Sponsored Insurance**
	Basic Services actuarially equivalent to state employee plan	**Wrap-around Services**		
Parents up to 37% of the FPL	Yes	Yes	Yes	Yes
Beneficiaries under 21	Yes	Yes	Yes	Yes
Pregnant Women	Yes	Yes	No	Yes
Newly eligible parents above 37% of the FPL	Yes	No	Yes	Yes

Piloting Health Opportunity Accounts (HOA). KHPA is proposing an HOA pilot as a component of the premium assistance program, subject to approval by CMS. HOAs work much like health savings accounts, in that participants pay the full (health plan-negotiated) costs of care up to the level of a deductible, which is anticipated to be $2,500 for adults and $1,000 for children, as specified in Federal guidelines. The goal of the HOA pilot is to give participants a greater role in their own health care decision-making and to facilitate the transition to privately financed health insurance coverage. This pilot program will be limited to 1,000 KHC beneficiaries and their currently eligible HealthWave Title XIX family members in one urban and one rural county, who will test the application of consumer-driven purchasing in a low-income population. A high-deductible health plan will be coupled with a funded health opportunity account to provide incentives for prudent, prevention-oriented health care choices. The HOA program will be voluntary and, therefore, will not receive any beneficiaries during the systematic default process.

Differences with Medicaid. KHC's design is intended to mimic private coverage through an explicit linkage with the state employee health plan, with benefits similar to that provided by most large employers. Families rising out of poverty and leaving premium assistance will find that their individual or employer-based coverage looks much more like premium assistance than Medicaid or HealthWave. With the implementation of Kansas Healthy Choices, KHPA is proposing to move about 20,000 existing and 24,500 newly eligible caretaker adults and their children with the choice of private insurance options and a "medical home" model of health care services. Where possible, families will enroll in employer-sponsored plans. Others will select private health plans that offer coverage explicitly tied to levels of coverage in the state employee health plan, with benefits that best fit their families' needs. Unlike Medicaid plans, the state-procured plans may offer different benefit coverage options for the expansion population of parents above 37% of poverty.

Benefits. Benefits for newly eligible parents above 37% of poverty will differ from Medicaid. The following chart provides a list of optional and required services for new eligibles and those currently eligible for HealthWave Title XIX. Overall, procured health plans must offer a plan that is actuarially equivalent to the State Employee Health Plan.

Service	State Employee Health Plan Coverage	KHC Coverage Level (for newly eligible parents above 37% of poverty)	HealthWave XIX Coverage Level
• Medical, surgical, anesthesia, diagnostic, therapeutic, and preventative services. • These services may be provided at clinics, rural health clinics, federally qualified health clinics or Indian health centers.	Yes	Ear and eye exams are required to be covered at 75% of this service level. All other services at 100%	100%
Inpatient and outpatient hospital services.	Yes	100%	100%
Laboratory services	Yes	100%	100%
Diagnostic and therapeutic radiology	Yes	100%	100%
Emergency room services	Yes	100%	100%
Mental health services, including inpatient and outpatient services, for all nervous or mental illness conditions (other than a biologically based illness).	Yes	75%	100%*
Prescription drugs, including injectable prescription drugs and intravenous drug treatments	Yes	75% Health plans are encouraged to promote the use of generic drugs; e.g., through tiered cost-sharing.	100%
Other Title XIX state plan services	Varies	Vendor's choice	100%
Other State Employee Health Benefits	100%	Vendor's choice	Varies
Services provided by neither the Title XIX state plan or the State Employee Health Benefit Plan	No	Vendor's choice	No

*Those eligible for Medicaid Title XIX under current rules will continue to participate in the Prepaid Ambulatory and Inpatient Health Plans.

Protections for families and children who are currently eligible for HealthWave. KHPA has made continuity in a medical home a priority for children and families enrolled in HealthWave, Medicaid, and KHC. Implementation of KHC will involve the potential transition of some HealthWave enrollees into either employer-sponsored coverage or a procured plan of their choice, depending on whether current HealthWave health plans bid successfully to participate in Kansas Health Choices. Those eligible for HealthWave under current eligibility criteria will continue to receive full Title XIX

benefits, either through the health plan, or by receiving supplemental services from the Medicaid program. Families participating in KHC will have a choice of health plans. Those not selecting a plan will be directed towards a health plan that includes their medical home in the network.

Some Advantages of Kansas Healthy Choices/Premium Assistance:

Access to care. For very low-income families below 100% of the poverty level, health care is unaffordable without aid of insurance coverage from an employer (which is rare) or public dollars. Premium assistance is not a magic bullet ensuring access to care; it is a source of funding to purchase adequate insurance coverage. Health care studies consistently demonstrate that publicly-financed insurance coverage greatly increases access to care, although not to the level of more expensive private coverage. Families' access to care also requires an adequate number of providers willing to participate in available health plans. KHC will provide access to networks of private, public, and safety net providers at the lowest potential cost to taxpayers by relying on the negotiating strength of procured plans, and by ensuring that provider reimbursement remains in line with expected rates for publicly-supported care. Even with KHC coverage, KHPA remains concerned about the availability of primary care medical homes, dentists, nurses, and other health care providers in Kansas.

Support for safety net. KHC health plans will be required by Federal rules to contract with safety net providers, strengthening the financing base for these critical providers with Federal and state dollars. The expansion of coverage to previously-uninsured parents that the premium assistance program enables should expand and stabilize funding for services provided to this population by safety net clinics. KHPA agrees with the need for a strong safety net, but acknowledges that a strategy which depends solely on publicly-financed or publicly-employed providers is by itself insufficient in providing appropriate access to care, especially for those who need specialty services or treatment for chronic illness. The principles of the safety net – subsidized care provided on the basis of need – are precisely the same principles that underlie publicly-financed insurance coverage, except that publicly-financed insurance opens up access to public dollars to all providers, including the much larger base of private providers, rather than restricting those dollars to the limited network of safety net clinics. Expanding health insurance coverage, for example, provides an additional source of stable funding for hospitals, clinics, and the 70% of private physicians who provide some level of charity care. These private providers consist of thousands of additional points of access for Kansas Healthy Choices participants, providing significantly greater access to care for the state's uninsured and extending the geographic reach of the program far beyond the service areas of the states 33 safety net clinics.

Use of Federal and private funds. KHC would be funded with a combination of federal funds, state funds, employer contributions. The premium assistance mechanism could also be used for populations that can afford to make an individual contribution to the premium. Taking advantage of the federal Deficit Reduction Act of 2005 (DRA) flexibility will give Kansas a legitimate opportunity to "catch up" with other states in terms of federal support for increasing access to health care. The core purpose of the premium assistance program is to provide access to insurance coverage – and therefore to medical services – for poverty level families that could not otherwise afford it. This requires a source of funding not currently available to these families. Without government financing, these families will not be able to participate in the private insurance market. Kansas Healthy Choices is designed to draw on all available sources of financing to ensure coverage for poverty-level families and childless adults. Given the extreme financial circumstances of families living below poverty, those sources of funding consist primarily of the federal government, state government, and employers. The Federal government is the largest potential source of financing for this population, offering 60% funding to states willing to abide by applicable rules. Those rules were relaxed somewhat in the DRA-based coverage for certain populations, prompting Kansas to propose Kansas Healthy Choices for parents above 37% of poverty.

Impact on health care spending. By taking advantage of multiple funding streams, KHC will save state dollars. The emphasis on attaching program participants to employer-sponsored coverage, whenever possible, strengthens and expands the small group market and helps to prevent shifting of privately-covered individuals into a publicly-financed program. The program's design also saves significant dollars as compared to the principle alternatives. Due to differences in the benefit package, the cost of KHC coverage for newly covered parents above 37% of poverty is expected to be significantly less expensive than a straight Medicaid expansion (projected costs are 10-15% lower than Medicaid on a per-member-per-month basis). KHPA will procure health plans on behalf of beneficiaries in exactly the same way that large employers, including the state, use their leverage in the marketplace to get the best price. The procured health plans are also expected to cost between 15 and 20% less than the state employee plan due to expected differences in provider reimbursement. An alternative form of premium assistance might be to attempt to finance coverage through the individual health insurance market through some sort of "voucher" process. Other states have not been successful in implementing a voucher program for this population. This program relies exclusively on private sources of coverage. Providing vouchers to beneficiaries for use in purchasing insurance policies in the individual marketplace would; (1) require individual underwriting and much larger insurance costs for each beneficiary, leaving less for actual care; (2) require commercial provider rates for Medicaid-funded beneficiaries, creating inequities with other beneficiaries and inflating program costs by 30% or more; (3) leave higher-risk participants – those most in need of care – without means to participate in the individual market.

While KHC takes advantage of the most efficient program design available, KHPA understands the distinction between minimizing and lowering health care costs. Neither publicly-financed health care programs, nor the private marketplace, have held costs in

check in the United States. Insurance, in and of itself, cannot lower the underlying costs of care. By any reasonable standard, the private marketplace for health care is weakly competitive at best, and plagued with market failures and limitations that are endemic to the nature of medical care itself. It is difficult to come up with a market for goods and services in greater need of the support of public intervention than exists in health care markets, which would likely render most retired, and virtually all disabled and poor Americans, medically destitute were it not for the presence of government intervention through Medicare and Medicaid. KHPA proposes a number of systemic health reforms designed to encourage greater efficiency and lower costs by strengthening and expanding private markets, rather than replacing or eliminating them. The 21-point health care proposals address the source of health care costs in their emphasis on prevention, costly conditions such as obesity, and costly behaviors such as smoking and poor eating habits, and in their emphasis on increasing efficiency and information through health information exchange and smart ID cards. KHPA respects the private marketplace, and intends to enhance, rather than compete, with it.

Conclusion

Since passage of SB 11 in May 2007, KHPA has engaged in an extended, open, and participatory process to flesh out the details of the premium assistance program. The resulting program design extends private coverage to families too poor to be able to afford coverage on their own, taking advantage of Federal, state and private dollars and keeping overall costs below both the traditional Medicaid program as well as comparable private coverage. In the past, the state has been forced to consider coverage expansions as an all-or-nothing bargain between Medicaid or nothing at all. By taking advantage of new Federal options to offer limited benefit packages, Kansas is able to offer more of a transitional program that has the look, feel, and operation of private coverage. We look forward to working with the Legislature to finish the task of providing access to coverage for about 10% of the state's growing uninsured population.

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KANSAS HEALTH POLICY AUTHORITY

Premium Assistance Fact Sheet
"Kansas Healthy Choices"

Kansas Healthy Choices is a new health insurance program that provides private health insurance to very low income Kansas families.

Background:

Although children in Kansas are eligible for Medicaid or HealthWave up to 200 percent of the federal poverty level (FPL), Kansas currently has one of the lowest rates of Medicaid eligibility in the nation for poor parents (below 37 percent of the FPL[1]).

Premium assistance is the use of public, employer, and potentially individual contributions to purchase private health insurance for Kansas families living in poverty who cannot otherwise afford coverage. Kansas Healthy Choices (KHC) is the program name for the initiative authorized by Senate Bill 11 to use premium assistance to provide access to a range of private health insurance options to eligible families. The program applies minimal restrictions on families' purchase of private insurance, while ensuring:

- State access to 60% Federal matching funds;
- Cost-effectiveness as compared to both private insurance and Medicaid;
- Access to affordable healthcare for families living in poverty;
- Protection of benefits to those currently eligible for HealthWave;
- Coverage for newly eligible parents on a par with private insurance plans;
- Coverage under one plan for each member of the family;
- Continuing access to a primary care medical home.

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health
Benefits and Plan Purchasing
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

Insurance options under Kansas Healthy Choices

Families eligible for Kansas Healthy Choices will receive private coverage through one of the following mechanisms (*subject to pending Federal approvals*):

- Employer sponsored insurance (ESI) buy-in: For families with access to employer sponsored private health insurance, the state would pay the employee share of the health insurance premium for families.
- Competitively bid state-procured health plans: For families without access to a qualifying employer plan, KHPA will provide a choice of three state procured health plans offering high-quality, cost-effective benefits. Basic benefits will be tied to the value of state employee benefits.
- Health opportunity account (HOA) pilot: Families in two counties will have access to a pilot program testing the application of consumer-driven purchasing in a low-income population. A high-deductible health plan will be coupled with a funded health opportunity account to provide incentives for prudent, prevention-oriented health care choices.

Participation in Kansas Healthy Choices

KHC options will be available beginning in January 2009. Over three years, the program is expected to provide about 20,000 existing and 24,500 newly eligible caretaker adults and their children with the choice of private insurance options and a "medical home" model of health care services.

Frequently Asked Questions (FAQs) about Kansas Healthy Choices

How do eligible families enroll in Kansas Healthy Choices?

When a family determined to be eligible for Kansas Healthy Choices has access to an employer-sponsored insurance plan, a review of those benefits will determine whether it is cost effective for the State to reimburse the family for employer sponsored coverage instead of providing services through the state-procured health plans. The family will provide detailed information about the insurance that is available to them and the State's enrollment broker will perform an evaluation based on the family's cost and the employer sponsored coverage compared to the KHC services. The State will pay the employee's portion of employer-sponsored insurance if it is less expensive than providing KHC coverage through a state-procured plan.

How do Kansas Healthy Choices families select a health plan?

KHC families determined to be eligible for a KHC procured plan will be sent a choice packet instructing eligible caretakers to select one of the statewide health plans, a plan for themselves and their eligible family members, much as the State Employee Health Plan works today. A limited number of families in two pilot counties will also be able to select the demonstration HOA/HDHP program. The choice packet will contain information about the type of plans, benefits and network coverage available. If a beneficiary does not choose a health plan, the family will be systematically assigned to one of the three benchmark-equivalent health plans. Consistent with Federal requirements – and unlike the private marketplace – KHC participants will be subject to neither waiting periods nor pre-existing condition clauses.

Eligibility Group	Kansas Healthy Choices Options			
	Three (3) Procured Private Health Plans		One (1) Health Opportunity Account Pilot	Employer Sponsored Insurance
	Basic Services actuarially equivalent to state employee plan	Wrap-around Services		
Parents up to 37% of the FPL	Yes	Yes	Yes	Yes
Beneficiaries under 21	Yes	Yes	Yes	Yes
Pregnant Women	Yes	Yes	No	Yes
Newly eligible parents above 37% of the FPL	Yes	No	Yes	Yes

Who will participate in Kansas Healthy Choices?

Poor parents of Medicaid eligible children are the target population for this program. They are chronically uninsured or underinsured, have very low incomes, use the emergency room for last-resort care and are not generally in the private insurance market. Their employer may offer insurance but these parents can not usually afford the employee share of the premium and choose to remain uninsured.

Enrollment efforts will begin in the fall of 2008 for approximately 20,000 current and 24,500 newly-eligible parents and their families with the choice of private insurance options and a "medical home" model of health care services.

Phase-In	Phase 1 FY 2009	Phase 2 FY 2010	Phase 3 FY 2011	*FULL PHASE IN*
Percent of Federal Poverty Level (FPL)	**37- 50% FPL**	**50-74% FPL**	**75-99% FPL**	***Total expanded population under 100% FPL***
Number of newly-eligible parents covered	8,500	7,000	8,500	*24,000*

Will children enrolled in HealthWave need to switch health plans when their family enrolls in KHC?

The HealthWave program covers over 100,000 children, many of whom live in poverty-level families that will become eligible for KHC in either fiscal year 2009, 2010, or 2011. Some have asked whether children already enrolled in HealthWave at the time their family becomes eligible for KHC (i.e., because the parent becomes newly eligible) will be forced to switch to a different health plan. The answer depends on the outcome of the procurement process for the new Kansas Healthy Choices program. Currently, KHPA contracts with two health plans, Children's Mercy-Family Health Partners and UniCare, to provide coverage to children and parents below 37% of poverty through HealthWave. If either plan (or both plans) successfully bids to become one of the three providing health plans under KHC, then children enrolled in that plan through HealthWave at the time their family becomes eligible for KHC can remain enrolled in that same health plan under KHC -- if their parents so choose. In any event, all children enrolled in Kansas Healthy Choices will continue to receive full Medicaid benefits.

H. . does Kansas Healthy Choices *protect families and children* who are currently eligible for HealthWave?

KHPA has made continuity in a medical home a priority for children and families enrolled in HealthWave, Medicaid, and KHC. Implementation of KHC will involve the potential transition of some HealthWave enrollees into either employer-sponsored coverage or a procured plan of their choice, depending on whether current HealthWave health plans bid successfully to participate in Kansas Health Choices. Those eligible for HealthWave under current eligibility criteria will continue to receive full Title XIX benefits, either through the health plan, or by receiving supplemental services from the Medicaid program. Families participating in KHC will have a choice of health plans. Those not selecting a plan will be directed towards a health plan that includes their medical home in the network.

When will Kansas Healthy Choices begin?

In proposing the premium assistance program last session, KHPA built in the minimum ramp-up period required for the design and implementation of a new program of this kind -- about eighteen months – and planned to begin operations January 2009. SB11, the unanimously supported authorizing bill for premium assistance, calls for a phased expansion of premium assistance beginning in the current budget year, FY 2009, subject to the availability of funds at each stage. The KHPA Board and Health For All Kansans steering committee believed that the legislature would need an opportunity to ensure the availability of funds at each step in the expansion. KHPA proposes to implement the three phases of SB 11 according to this original plan in FY 09, FY10 and FY11, and to add childless adults the following year according to the KHPA Board's 21-point health reform proposal, providing legislators with adequate opportunity to ensure support on an ongoing basis.

Will Kansas Healthy Choices offer a Health Opportunity Account (HOA) option?

KHPA is proposing an HOA pilot as a component of the premium assistance program, subject to approval by CMS. HOAs work much like health savings accounts, in that participants pay the full (health plan-negotiated) costs of care up to the level of a deductible, which is anticipated to be $2,500 for adults and $1,000 for children, as specified in Federal guidelines. The goal of the HOA pilot is to give participants a greater role in their own health care decision-making and to facilitate the transition to privately financed health insurance coverage. This pilot program will be limited to 1,000 KHC beneficiaries and their currently eligible HealthWave Title XIX family members in one urban and one rural county, who will test the application of consumer-driven purchasing in a low-income population. A high-deductible health plan will be coupled with a funded health opportunity account to provide incentives for prudent, prevention-oriented health care choices. The HOA program will be voluntary and, therefore, will not receive any beneficiaries during the systematic default process.

How will Kansas Healthy Choices improve *access to care* for Kansas families?

Although children in Kansas are eligible for Medicaid and/or the State Children's Health Insurance Program up to 200 percent of the federal poverty level (FPL), Kansas currently has one of the lowest rates of Medicaid eligibility in the nation for poor parents at *less than* 37% of the FPL. In 2007, 37% of the Federal Poverty Level (FPL) was $3,778 for a single person; $5,065 for a family of two; $6,353 for a family of three; and $7,641 for a family of four. For very poor families like these, health care is unaffordable without aid of insurance coverage from an employer (which is rare) or public dollars.

Premium assistance is not a magic bullet ensuring access to care; it is a source of funding to purchase adequate insurance coverage. Health care studies consistently demonstrate that publicly-financed insurance coverage

greatly increases access to care, although not to the level of more expensive private coverage. Families' access to care also requires an adequate number of providers willing to participate in available health plans. KHC will provide access to networks of private, public, and safety net providers at the lowest potential cost to taxpayers by relying on the negotiating strength of procured plans, and by ensuring that provider reimbursement remains in line with expected rates for publicly-supported care. Even with KHC coverage, KHPA remains concerned about the availability of primary care medical homes, dentists, nurses, and other health care providers in Kansas.

How will Kansas Healthy Choices improve *health outcomes* for Kansas families?

KHC expands access to Kansas parents living in poverty, and is designed to provide care to all family members through a single private health plan of their choosing. Research suggests that better health outcomes are associated with a "medical home" – meaning that all members of a family receive services through a primary care provider who helps coordinate needed health care and preventive services. Having all family members insured as part of the same health insurance plan also helps coordinate care and helps to provide access to a "medical home."

How will Kansas Healthy Choices enhance support for safety net providers?

KHPA agrees with the need for a strong safety net, but disagrees with a strategy that depends solely on publicly-financed or publicly-employed providers. The principles of the safety net – subsidized care provided on the basis of need – are precisely the same principles that underlie publicly-financed insurance coverage, except that publicly-financed insurance opens up access to public dollars to all providers, including the much larger base of private providers, rather than restricting those dollars to the safety-net alone. KHC health plans will be required by Federal rules to contract with safety net providers, strengthening the financing base for these critical providers with Federal and state dollars.

How does Kansas Healthy Choices *differ from a Medicaid expansion*?

KHC's design is intended to mimic private coverage through an explicit linkage with the state employee health plan, with benefits similar to that provided by most large employers. Families rising out of poverty and leaving premium assistance will find that their individual or employer-based coverage looks much more like premium assistance than Medicaid or HealthWave. With the implementation of Kansas Healthy Choices, KHPA is proposing to provide about 20,000 current and 24,500 newly-eligible parents and their children with access to a market-oriented model, with Medicaid protections for children and existing eligibles. Where possible, families will enroll in employer-sponsored plans. Others will select private health plans that offer coverage explicitly tied to levels of coverage in the state employee health plan, with benefits that best fit their families' needs. Unlike Medicaid plans, the state-procured plans may offer different benefit coverage options for the expansion population of parents above 37% of poverty. Due to differences in the benefit package, the cost of KHC coverage for newly covered parents is expected to be significantly less expensive than a straight Medicaid expansion (projected costs are 10-15% lower than Medicaid on a per-member-per-month basis).

How will benefits be different than those provided through Title XIX Medicaid?

Benefits for newly eligible parents above 37% of poverty will differ from Medicaid. The following chart provides a list of optional and required services for new eligibles and those currently eligible for HealthWave Title XIX. Overall, procured health plans must offer a plan that is actuarially equivalent to the State Employee Health Plan.

Service	State Employee Health Plan Coverage	KHC Coverage Level (for newly eligible parents above 37% of poverty)	HealthWave XIX Coverage Level
• Medical, surgical, anesthesia, diagnostic, therapeutic, and preventative services. • These services may be provided at clinics, rural health clinics, federally qualified health clinics or Indian health centers.	Yes	Ear and eye exams are required to be covered at 75% of this service level. All other services at 100%	100%
Inpatient and outpatient hospital services.	Yes	100%	100%
Laboratory services	Yes	100%	100%
Diagnostic and therapeutic radiology	Yes	100%	100%
Emergency room services	Yes	100%	100%
Mental health services, including inpatient and outpatient services, for all nervous or mental illness conditions (other than a biologically based illness).	Yes	75%	100%*
Prescription drugs, including injectable prescription drugs and intravenous drug treatments	Yes	75% Health plans are encouraged to promote the use of generic drugs; e.g., through tiered cost-sharing.	100%
Other Title XIX state plan services	Varies	Vendor's choice	100%
Other State Employee Health Benefits	100%	Vendor's choice	Varies
Services provided by neither the Title XIX state plan or the State Employee Health Benefit Plan	No	Vendor's choice	No

*Those eligible for Medicaid Title XIX under current rules will continue to participate in the Prepaid Ambulatory and Inpatient Health Plans.

How does the purchase of private insurance through Kansas Healthy Choices help *control state health care spending* for the poverty level population?

Neither publicly-financed health care programs, nor the private marketplace, have held costs in check in the United States. Insurance, in and of itself, cannot lower the underlying costs of care. By any reasonable standard, the private marketplace for health care is weakly competitive at best, and plagued with market failures and limitations that are endemic to the nature of medical care itself. It is difficult to come up with a market for goods and services in greater need of the support of public intervention than exists in health care markets, which would likely render most retired, and virtually all disabled and poor Americans, medically destitute were it not for the presence of government intervention through Medicare and Medicaid. KHPA proposes a number of systemic health reforms designed to encourage greater efficiency and lower costs by strengthening and expanding private markets, rather than replacing or eliminating them. The 21-point health care proposals address the source of health care costs in their emphasis on prevention, costly conditions such as obesity, and

costly behaviors such as smoking and poor eating habits, and in their emphasis on increasing efficiency and information through health information exchange and smart ID cards. KHPA respects the private marketplace, and intends to enhance, rather than compete, with it.

Why is it *more cost -effective* to procure private insurance plans rather than offering vouchers to participants to purchase insurance on their own?

This program relies exclusively on private sources of coverage. Two possible mechanisms for the use of private insurance, for the majority of poor families that do not have access to employer-sponsored coverage, are (a) to offer vouchers (credits worth a fixed amount per person or per family) for use in the individual market, or (b) to procure plans that can be made available for their selection. To save costs, KHPA will procure health plans on behalf of beneficiaries in exactly the same way that large employers, including the state, use their leverage in the marketplace to get the best price. This approach is also most likely to provide high-quality care with adequate protection for participating families Providing vouchers to beneficiaries for use in purchasing insurance policies in the individual marketplace would; (1) require individual underwriting and much larger insurance costs for each beneficiary, leaving less for actual care; (2) require commercial provider rates for Medicaid-funded beneficiaries, creating inequities with other beneficiaries and inflating program costs by 30% or more; (3) leave higher-risk participants – those most in need of care – without means to participate in the individual market.

Why is the KHPA planning to procure three insurance plans?

Based on feedback about the anticipated risk-reward trade-off from carriers considering a bid, we reduced our target number of participating plans to three, having considered and discussed participation of five or more plans. Without the prospect of enough covered lives, insurance companies just won't be interested in a cost-effective program. Adding plans would likely add costs, as potential carriers would require larger premiums to offset investments in the development of plans for premium assistance.

How will Kansas Healthy Choices be funded?

KHC would be funded with a combination of federal funds, state funds, employer contributions. The premium assistance mechanism could also be used for populations that can afford to make an individual contribution to the premium. Taking advantage of the federal Deficit Reduction Act of 2005 (DRA) flexibility will give Kansas a legitimate opportunity to "catch up" with other states in terms of federal support for increasing access to health care.

Why is Federal participation in Kansas Healthy Choices so important?

The core purpose of the premium assistance program is to provide access to insurance coverage – and therefore to medical services – for poverty level families that could not otherwise afford it. This requires a source of funding not currently available to these families. Without government financing, these families will not be able to participate in the private insurance market. Kansas Healthy Choices is designed to draw on all available sources of financing to ensure coverage for poverty-level families and childless adults. Given the extreme financial circumstances of families living below poverty, those sources of funding consist primarily of the federal government, state government, and employers. The Federal government is the largest potential source of financing for this population, offering 60% funding to states willing to abide by applicable rules. Those rules were relaxed somewhat in the DRA-based coverage for certain populations, prompting Kansas to propose Kansas Healthy Choices for parents above 37% of poverty.

What is the *statutory authority* behind Kansas Healthy Choices?

KHC coverage will be provided through the purchase of employer-sponsored or procured, commercial health insurance. Both options will cover services that are actuarially equivalent to the State Employee Health Plan, as specified in SB 11. The Deficit Reduction Act of 2005 amends the Social Security Act to include sections 1937 and 1938, the two provisions supporting Kansas' innovative plan. Section 1937 allows States to provide benefit packages to Medicaid beneficiaries that differ from coverage defined in the state's approved state plan through enrollment in approved benchmark or benchmark-equivalent coverage, such as procured health plans or employer sponsored insurance plans. Section 1938 provides for 10 states to operate their Medicaid benefits to volunteer beneficiaries through a program that is comprised of a Health Opportunity Account (HOA) and High Deductible Health Plan (HDHP).

How did KHPA develop *program details* for Kansas Healthy Choices?

The basic structure of Kansas Healthy Choices is defined in SB11, and in accompanying fact sheets and explanations provided to legislators and stakeholders during the debate over that legislation. See, for example, the program description offered to the Health For All Kansans health reform Steering Committee on March 11, 2007 on KHPA's website: http://www.khpa.ks.gov/AuthorityBoard/HealthForAllKansans/3-19-HFAKansansSteeringCommittee%20final%20_3_.pdf . To flesh out the design of the premium assistance program, KHPA engaged in a months-long public policy development process, convening an open premium assistance design workgroup to solicit feedback from carriers, providers, and other stakeholders, sharing preliminary plans with the KHPA Board and the health reform advisory councils (Purchaser, Provider, and Consumer), conducting a Request For Information process with prospective bidders, and developing and updating a webpage devoted to the design of the program. For details, see http://www.khpa.ks.gov/AuthorityBoard/PremiumAssistance.htm.

Who supports the private sector approach reflected in Kansas Healthy Choices?

The Health for All Kansan Steering Committee and the KHPA Board both support advancing a premium assistance plan for Kansas this legislative session to be phased in over four years. The US Secretary of Health and Human Services Mike Leavitt has promoted the use of premium assistance which uses federal matching dollars to help states provide health insurance to the uninsured. There are at least 15 different states using some kind of premium assistance to help improve access to health insurance and help control the cost of health care, including Illinois, Indiana, Iowa, Missouri, Oklahoma, Utah and most recently Massachusetts.

What does the *research* say about the effectiveness of premium assistance plans?

"Premium assistance continues to be one mechanism for covering at least a small portion of the growing uninsured population, and it shows potential to generate cost savings in a time of state and federal budget deficits. The use of premium assistance is of great interest to some states as they attempt to contain Medicaid costs, provide access to workers who want affordable private coverage, and assist employers who might benefit from a healthier and more stable workforce. These efforts also coincide with the federal government's promotion of market principles and increased emphasis on personal responsibility. Despite its many flaws and foibles, the concept of building on public-private partnerships may be a viable mechanism for health coverage expansion in the coming years. As in the past, the Medicaid and SCHIP programs may be well-positioned to serve as a laboratory for continuing such expansion. However, experience seems to indicate that public-private partnerships, even with changes to statutory provisions and flexibility under section 1115, are unlikely to reach significant numbers of the uninsured population given the general reluctance of employers to participate on a voluntary basis and high administrative costs involved in insuring small numbers of workers and their families*.

The recently enacted Massachusetts health reform plan, which hinges on concessions from providers, employers, the state, and individuals in its effort to achieve universal health coverage, may be instructive for the future to determine whether public-private partnerships can truly succeed in covering large numbers of low income uninsured individuals." Shirk, C and Ryan J (July 2006) National Health Policy Forum

Note:
* For this reason, the State of Kansas will also procure competitively bid private health plans for those individuals who do not already have access to employer sponsored health insurance.

Premium Assistance caseload costs ($ millions)
Includes 3 phases of expansion authorized by SB 11
to 50% of the Federal Poverty Level in SFY 09
to 75% of the Federal Poverty Level in SFY 10
to 100% of the Federal Poverty Level in SFY 11

	Revised estimates, January 2008		*Estimates provided during debate of SB11, Spring 2007		Difference of new estimates compared to original estimates	
	SGF	AF	SGF	AF	SGF	AF
SFY 09	4	10	11	27	-7	-17
SFY 10	14	35	20	50	-6	-15
SFY 11	31	77	31	77	0	0
SFY 12	41	102	31	77	10	25
SFY 13	45	111	31	77	14	34

*NOTE: To provide the most straightforward explanation of the program during the deliberation of SB 11, premium assistance cost estimates provided in Spring 2007 represented a single year's cost at full implementation. They were not intended to represent out-year costs, and therefore did not adjust for expected ramp-up to full enrollment, nor did they account for health care inflation beyond 2007

Expanded Premium Assistance caseload costs ($ millions)
Includes health reform (P3) coverage of childless adults below 100% FPL in SFY 12

	Revised estimates, January 2008		*Health reform estimates provided by KHPA on November 1, 2007		Difference of new estimates compared to original estimates	
	SGF	AF	SGF	AF	SGF	AF
SFY 09	0	0	NA	NA	NA	NA
SFY 10	0	0	NA	NA	NA	NA
SFY 11	0	0	NA	NA	NA	NA
SFY 12	26	64	NA	NA	NA	NA
SFY 13	56	140	NA	NA	NA	NA

*NOTE: Initial KHPA estimates of P3 premium assistance in the context of comprehensive health reform represented global health system impacts, not just the state budget impact, and are not comparable to these budget impacts. They also represented a single year's cost at full implementation. They did not adjust for expected ramp-up to full enrollment and were not intended to represent out-year costs. Therefore, they did not account for health care inflation beyond 2007.

Key assumptions for both SB 11 Premium Assistance and Expanded Premium Assistance:

1. 18-month ramp-up to full enrollment for each phase of the expansion

2. Target $325 cost per member per month in FY 2009 compares to:
   $388 Actuarially adjusted PMPM equiavalent value of SEHBP, at full commercial payment rates, in FY 2009
   $359 Average PMPM for similar population in Medicaid during 2007

3. Target cost is estimated to provide limited benefits based on the state employee plan, as mandated by the Federal government
   *Target cost also includes additional funds for benefit flexibility to be included in contract bids and employer plans
   *Funding sufficient for added benefits such as full pharmacy, dental coverage, added mental health, or modest supplementation of provider reimbursement above Medicaid rates.