MINUTES

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
Round Table Discussion

December 14, 2010
Room 346-S—Statehouse

Members Present

Representative Brenda Landwehr, Chairperson
Senator Laura Kelly
Senator Roger Reitz
Representative Don Hill
Representative Peggy Mast
Representative Jim Ward

Members Absent

Senator Vicki Schmidt, Vice-chairperson
Senator Pete Brungardt
Senator Jeff Colyer
Senator David Haley
Representative Bob Bethell
Representative Louis Ruiz

Round Table Participants Present

Representative Gene Suellentrop
Bob Finuf, Family Health Partners
Bill Sneed, America's Health Insurance Plans
Sunee Mickle, Blue Cross Blue Shield of Kansas
Cathy Harding, Executive Director, Kansas Association for the Medically Underserved
Sandy Praeger, Commissioner, Kansas Insurance Department
Jerry Slaughter, Executive Director, Kansas Medical Society
Tom Bell, President, Kansas Hospital Association
Andy Allison, Executive Director, Kansas Health Policy Authority

Staff Present

Kathie Sparks, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department

Amy Deckard, Kansas Legislative Research Department
Nobuko Folmsbee, Office of the Revisor of Statutes
Ken Wilke, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Doug Wells, Office of the Revisor of Statutes
Sean Ostrow, Office of the Revisor of Statutes
Kathy Letch, Committee Secretary

Chairperson Landwehr called the meeting to order at 10:15 a.m. She stated the purpose of having a roundtable discussion is to be able to discuss details on topics which would be too time consuming or detailed for a different legislative format.

The Chairperson began the roundtable discussion by asking Insurance Commissioner Sandy Praeger how the exchange (dealing with insurance plans) will be run.

Insurance Commissioner Praeger stated that the decision on how to operate the exchange has not been made, as that decision must be made by the Legislature and the Governor. However, federal law provides several options for the operation of the exchange:

- In an existing state agency;
- In a stand-alone, new state agency; or
- In a private, nonprofit entity, governed by an appointed board.

Commissioner Praeger explained that, as a member of a national association and as a representative of Kansas, she had met with staff and members of Congress numerous times throughout the debate, arguing on behalf of state regulation and the ability for states to be able to implement, regulate, and set up the various aspects of this new health reform law. The National Association of Insurance Commissioners has developed a template for the model law.

The Commissioner stated that the deadline for beginning to accept enrollees is the fall of 2013. The exchanges must be operating and paying claims beginning January 2014. Some of the key decisions do not have to be made immediately, but when the time comes, Kansas will need to be prepared to make them. With open enrollment in 2013—is not too early to make a plan and begin making decisions.

Representative Peggy Mast asked how the recent court decision impacted the bill enactment, and if there is a severability clause.

Dr. Andy Allison, Kansas Health Policy Authority (KHPA), stated the recent court ruling is not solely to do with the right of the federal government to impose a tax penalty or individual mandate regarding the purchase or nonpurchase of insurance. He has received a preliminary legal analysis that it is a severable clause, but will defer to the Attorney General's office for an opinion.

Commissioner Praeger stated the law, as passed, does not have a severability clause, however, the courts can impose severability, if they so choose. The opinion is the federal government will be using the Commerce Clause to issue an insurance mandate across state

borders. This will be decided later, probably by the U.S. Supreme Court. Tom Bell, Kansas Hospital Association, stated it is possible that major provisions will be implemented in the future.

Senator Reitz stated it is important to begin immediately on this matter. Commissioner Praeger said the planning process has begun. She has a time line and has been working with the Health Policy Authority. The exchange has to incorporate the Medicaid program; it has to incorporate a new eligibility program for the new subsidies; and it has to have a private insurance component. At some point, the Legislature will have to determine how it wants this operated. There is concern that the law will not be fully enacted, so there will be pushback in terms of thinking the state is doing more than it should be doing. Right now, though, Kansas is not spending any state dollars on the project. The state has applied for and received a planning grant for exchanges. Kansas may qualify for an early innovative grant. Commissioner Praeger explained that the state is not behind, but is looking at options and input about the exchange. The Commissioner said she has been working on the application for the Early Innovation Grant with Dr. Andy Allison.

There is no award amount listed for the innovative grants; they have no ceiling. Dr. Allison said he expects it to be several million dollars, at a minimum. The five leading states will create the mechanism for other states to copy or follow. The award would make it cost-effective at this stage. The market for eligibility systems to support health care nationally is estimated to be $1 billion to $2 billion.

Dr. Allison said KHPA has been focused on two areas:

- Operational—making sure that the mechanics of health reform, the expansion of Medicaid, administration of subsidies, and the exchange, among other things, will function. Kansas does have a head start due to a grant it received over a year ago allowing the state to meet the deadlines, be more efficient and more effective; and

- Working to ensure policymakers have information when the key policy choices come to them, over the next two to three years.

When asked what the pros and cons are for establishing regional exchanges, Commissioner Praeger stated that one of the opportunities with the early innovative grant would be to have other states participate in the system Kansas establishes. If Kansas does a state-based exchange, whatever rules are in place in Kansas would remain in place and govern the private insurance marketplace. States could create interstate compacts. The compact would be a way for states to harmonize their insurance regulations among the states.

Bill Sneed, America's Health Insurance Plans (AHIP), stated that if the plan is to adopt a certain type of insurance criteria (*i.e.* take all comers, no pre-existing conditions), for the process to work, every person must be insured. If the U.S. Supreme Court ultimately decides this component is unconstitutional, AHIP contends it will have a dramatic effect on the individual market and "uninsurables." It is essential that products be constructed carefully as the nation continues to move forward on national health care reform. Whatever happens, AHIP believes it will be decided, by the Supreme Court ultimately.

Commissioner Praeger stated that with the legal challenges that have ended with two in favor and one against with different wordings in the decisions, most observers believe the matter will end up in the U.S. Supreme Court.

Representative Ward stated that if the judge that ruled on the case today was appointed by a Democrat, the law would be ruled as good; the judge in Virginia that determined the law unconstitutional, was a Republican appointee. Also, all the attorneys general that have filed lawsuits have been Republicans; the legal process will continue working on these bills for several years. He said his point was that Kansas should not stop planning due to the district court in Virginia ruling a provision unconstitutional.

Commissioner Praeger stated that many uninsured individuals will continue to be treated in the emergency rooms and those of us with insurance will continue to pay more. It is not a sustainable practice. As everyone tries to keep the cost of insurance under control, those insurance companies and self-insured companies are less likely to have their insureds absorb those costs. So it becomes more difficult for hospitals and physician offices to maintain the level of revenue they need to maintain in order to keep their doors open for business. There is pushback from private insurance and self-insured employer groups saying they are not going to pay that cost shift anymore. They want a premium that reflects their actual costs. That puts substantial stress on the delivery system.

Jerry Slaughter, Kansas Medical Society (KMS), stated that uninsured people represent one part of the problem of cost shifting. Public programs account for the greatest part of cost-shifting that health care providers have to bear. In Kansas, with 320,000 people on Medicaid and nearly 450,000 people on Medicare, when health reform is fully implemented, the state will have nearly one million people whose health care is paid for by public programs and very few uninsured. This will be one of those inconvenient truths that in four or five years will become evident.

Representative Suellentrop stated one move the government needs to make is to redirect a large number of people away from emergency room treatment. The state needs to rethink its mandate on care, taking only those that are emergencies.

Representative Mast asked Tom Bell, Kansas Hospital Association, if anyone has done a study of emergency rooms and how many treated patients are uninsured versus how many are on government programs. Mr. Bell answered saying a higher percentage of patients of emergency rooms are uninsured than the general population.

Bob Finuf, Family Health Partners (FHP), made the following points about an exchange and the ongoing discussions about payment models.

- There are numerous ads for short wait-times in emergency rooms, which defeats the system;

- Providers communicating with Medicaid recipients, must keep communications simple and consistent;

- FHP sees benefit in limiting standardized benefit options; and

- On the administrative end, there should be consistency between Medicaid, HealthWave, and the exchange, such as, if eligibility changes, do not mandate selection of another health plan; allow insureds to stay with same coverage without having to do anything.

Dr. Allison said KHPA's latest step was to send out the Request for Information (RFI) in October to find Medicaid savings ideas that come from private sector solutions. KHPA received 19 responses to the RFI. Many of the responses pertained to topics such as: how to coordinate

multiple product conditions; and how to address the lack of care management coordination efforts for medical care received by the disabled and elderly. Recommendations included the following: extending full-managed care product to our aged and disabled population, modest investments in health and medical care for the home, new uses of technology to reduce costs, and expanded management of our pharmacy program.

There may be opportunities with the cost issue presented by the Affordable Care Act. The state needs to think in advance, if the bill is implemented, how to use the bill to its advantage; and if the bill is not implemented, how do we implement payment reforms. There are limited opportunities through the Affordable Care Act to help fund innovation that are being pursued to the extent that the state has the resources to pursue them. Some of the ideas from the RFI are likely to become proposals before policymakers. Ideally, some of the ideas are sustained through implementation of reform. The program is sustainable whether health care reform goes through or not.

Representative Mast stated that one of the things she has seen is the continuing expanding of Medicaid spending, and now we hope the federal government is going to step in to take over most of the burden for the states—except one of the top priorities to balance the federal budget is to cut Medicaid spending; where does this leave the states?

Dr. Allison said Medicaid funding, on the average, nationally, is 57 percent federal money and 43 percent state money; in Kansas, it is 60 percent federal money and 40 percent Kansas money. The way it is set up in the vast majority of cases, if the federal government saves money, the states save money. The distinction comes with who is making the rules; there are some options; there are some mandates. There are cases where federal policy has an impact on financing and on that percentage split, pointing to the mechanisms some states use to generate federal match without the same level of state tax effort. There are proposals in those deficit reduction packages being considered by federal panels to address those provisions in Medicaid law. It is analogous to a tax code, but specific to the Medicaid program. When the tax code is changed, it has the impact of changing the match rate; those are the circumstances where the federal government would shift the burden to states.

Chairperson Landwehr stated, with full implementation of the way the law is today, the federal government will pay a larger portion in the front end, but this starts to phase out; then the burden will shift to the states to carry a new expense, which is what has been happening the last few years with the stimulus packages.

Representative Mast said Kansas has the potential of putting more of the financial burden and responsibility in the hands of the federal government, even though it says it is cutting $4 trillion from the federal budget by 2019 or 2020, and Medicaid is one of its targets; and, at the same time, it says it is going to pay 100 percent of Medicaid. A new Congress is coming in which, most likely, will have different initiatives and goals. Some of the new Congressmen are saying they are not going to choose to fund the big expansion. Where does that leave the states, in the event Congress does not go along with the expansion?

Jerry Slaughter stated that some of what causes the people he works with anxiety about the future and all the promises that have been made, is that for the last 10 to 15 years, all the nation has known is a time of growing robust economy. The new reality is a much slower growing economy, maybe not stagnant, but much slower growth. The promise of this entitlement program is a bit near-sighted in perceiving the federal government as a bottomless pit of resources. Kansans have been living from hand-to-mouth. States and the federal government need to plan for the reality; the care cannot be provided or promised without knowing how to pay for that care. It is a different economy now; it will be much more difficult to meet obligations.

Commissioner Praeger stated that one criticism of the healthcare reform is that it does not do enough to address the health care costs. The system is fee-for-service for health care costs, presently, which rewards doing more, instead of allowing the healthcare professionals to do the right thing and deliver the right care. Accountable care organizations are aligned to deliver the right care, at the right times, for the right reasons. The easy way for government to look at health care cost control is to cut reimbursement rates. If government just cuts reimbursement rates, but does not control the volume of services being delivered, it does not control the cost; it shifts it around. How realistic is it to believe it is possible to move to a more rational, thoughtful way of delivering care, and is it possible to get to that system in time to redirect the dollars to appropriate care? A key component is tort reform.

Chairperson Landwehr asked if KHPA and the Insurance Department could provide flowcharts showing scenarios of the new Medicaid recipients, HealthWave, uninsured, and what happens with waivers, because some of those will be under the insurance requirements. The flowcharts need to be simplified for clarity.

Dr. Allison said policymakers need to see the choices they face in a comprehensive context, so they can know the impacts of those choices they make for the Medicaid program, for the structure of the exchange, how that impacts coverage and state spending in the long run. KHPA hopes to have that information for the Legislature within the next six months.

Chairperson Landwehr asked if they would provide the beginnings of a flowchart that would simplify all the options, the ramifications of every option, looking at the spending mechanisms of the 100 percent vs. the 90 percent, and what has to be restructured on the HCBS waivers, because there are 165 legislators to educate on the issues, so they can make informed decisions. She stated that the decisions need to be made by 2012.

Dr. Allison stated the flowcharts that he has seen or attempted to produce tend to be too complex, too expansive to draw, and too many arrows to fit on a page. The device that has started being used boils it down to the dollars and cents telling stakeholders and policymakers the net impact of all of it (*i.e.,* broken out by different populations, services, payors, state vs. federal). So far, that is the simplest device KHPA has found.

Chairperson Landwehr asked if, outside the Insurance Department and KHPA, should other agencies be engaged in this discussion.

Dr. Allison answered, initially, yes, other agencies have been somewhat involved in the administrative and operational sides of the discussion. The Medicaid program involves several different agencies and, clearly, those agencies need to be involved in the work. The agency has focused on using foundation dollars to accomplish the task.

Commissioner Praeger said inter-agency coordination is needed and Governor-elect Brownback could create the ongoing dialogue between entities that is required. It would need to be done by legislation through joint resolution or the Governor's office.

Representative Ward said medical malpractice is an issue that needs to be resolved. Another provision is for providers to help with costs by providing ownership of equipment, and referring to that equipment for second and third tests that are done. If providers would step up, create a matrix, and determine when tests are done, instead of involving the government in these issues. Representative Ward also asked for a history of Kansas provider rates, and how much flexibility Kansas has to change provider rates under Medicaid.

Dr. Allison said there are both savings and costs that can result from the federal reform; if viewed as a package deal, provider rate increases could be a use of those savings. KHPA has the authority to change provider rates, but not appropriation authority, which comes only from the Legislature. So KHPA tends to make only small or minor changes, which would have nominal impact. There are regulations that might affect both increases and decreases.

Mr. Slaughter has seen good intentions on the legislatures' and governors' parts to pay providers, so that they are encouraged to participate, thereby reducing problems of access to care. A problem is the program has grown, both in numbers of individuals and scope of benefits provided. It has become increasingly difficult to keep pace with the cost of providing those services. Until the hospital provider tax was enacted, it had been 30 years since there had been an increase in fees paid to physicians in Medicaid. The provider community is somewhat skeptical that Kansas or the federal government will be able to make good on the promise to encourage access, and to get the maximum number of providers in the program, so that they can care for all those patients, at a time when the federal government says they are going to cut costs. Nearly 70 percent of Medicaid dollars go to people with chronic, expensive, debilitating conditions. If the nation is to get a handle on Medicaid spending, it needs to address this, and find a fundamental, foundational solution. In Kansas, with effective healthcare reform, another 230,000 Kansans will have medical cards that assure them access to the system, so they can begin utilizing the system at the rate of insured individuals. There is a cost associated with that action, though; the state has done nothing about supply.

Commissioner Praeger asked if there has been a study done to determine how many of those chronic conditions are due to not having been treated earlier in the progression of their condition.

Dr. Allison answered that the disabled community says Kansas and the country could improve incentives and supports that determine whether individuals stay in the workforce, or move into the disabled community to receive benefits that their conditions require. Too often, policy has forced them into making that choice. If there is a way to use health reform to provide a safety net to remain in the workforce and not make that choice, his opinion is that more would choose to stay in the workforce.

Representative Suellentrop stated being able to see a flowchart would be helpful. He would not be opposed to an insurance exchange or the establishment of the exchange being a stand-alone, nonprofit entity; eventually, it could be turned over to another entity; and open up the market to other products.

Bob Finuf, Family Health Partners, stated he would highly encourage the connectivity and coordination between all facets of the health care industry, statewide.

Cathy Harding, Executive Director, Kansas Association for the Medically Underserved, stated if people would access care earlier care would be less costly. As it is now, people put off seeking care, as long as possible. Primary care workforce issue is a big issue. If there are enough medical providers in the workforce, so that people are able access primary care affordably and early, it will save the system money.

Commissioner Praeger stated the Insurance Department needs assurances that the state wants it to move forward on the exchange. If Kansas does nothing, the federal government will administrate the exchange for it. Legislatively, the Department needs some demonstration that the state is going to implement a state exchange.

Sunee Mickle, Blue Cross Blue Shield of Kansas (BCBSKS), stated that BCBSKS members and employer groups are needing to know what direction the state is planning, so the company is able to plan for the next year.

Chairperson Landwehr asked, if funding is not done on a federal level, how does Kansas protect itself.

Senator Laura Kelly asked if there is any reason Kansas would not want to establish the exchange.

Chairperson Landwehr answered that she personally sees a positive in the exchange, but only from a non-profit perspective, instead of a governmental-run exchange.

Senator Kelly said the point she wanted to make is that Kansas needs to come to an agreement that, from this point forward, this is something it is wanting to do. Then it is possible to move forward with planning.

Commissioner Praeger stated the Early Innovative Grant has an ambitious time frame, but the advantage of getting the grant is that it would give the Kansas Insurance Department the opportunity to get some of that early planning money and to work in cooperation with KHPA in designing the systems that will make the programs work.

Chairperson Landwehr said she thinks the Committee needs to hear from insurance companies and providers what their ideas are of the exchange. Should Kansas pursue looking at an exchange, if federal health care reform becomes history?

Mr. Sneed stated the AHIP, in general, would support a state-run exchange, typically set up in a not-for-profit mode vs. creating a bureaucracy. He would support Commissioner Praeger getting some general overall authority to start the process, so that coming back in 2012, a lot of the work is done.

Mr. Slaughter agreed with Mr. Sneed. He stated that, if there is going to be an exchange, KMS would much prefer the control be local, not federal. The Commissioner has KMS's confidence. However the Legislature would want to express support or show encouragement, it would send a positive message to the community. If the federal law goes away, an exchange is not a bad idea, if run properly, and run by Kansans. Mr. Bell concurred that the state should move forward on the exchange.

Representative Hill stated the pursuit of the exchange plans is a win, win situation. The best practice is to positively impact our healthcare delivery system. He said he was wholeheartedly in support of the Insurance Department and Kansas pursuing the Early Innovative Grant.

Representative Mast stated that several years ago, she and then-Representative Colyer worked on an exchange model. She was sure that he would be 100 percent in support of the exchange.

Chairperson Landwehr stated that, with regard to the exchange, the Committee's charge is to protect the State of Kansas and its citizens the best they can. She will attempt to meet with the Governor-elect's staff within the next week to share the discussion with them.

Commissioner Praeger suggested they also look at other options, besides just not-for-profit options.

Ms. Harding distributed a handout regarding restructuring their staff and an $11 billion expansion for community health centers, nationally (Attachment 1).

Chairperson Landwehr said the Legislature needs to hear from all stakeholders. She thanked all participants for coming, listening, and speaking.

The meeting was adjourned at 12:25 p.m.

Prepared by Kathy Letch
Edited by Kathie Sparks

Approved by the Committee on:

January 14, 2011
(Date)

JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT

Tuesday, December 14, 2010

NAME	REPRESENTING
Rob Mealy	Kearney & Assoc.
[illegible]	GBA
Pat [illegible]	Phrma
Kenneth [illegible]	Kansas Foundation for Medical Care
Anne Lambertson	Kansas Health Consumer Coalition
John Kiefhaber	Ks. Chiropractic Assoc.

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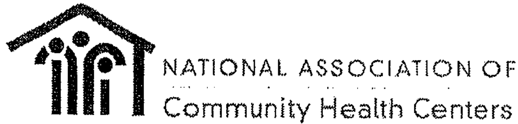

HEALTH CENTERS AND HEALTH CARE REFORM:

HEALTH CENTER FUNDING GROWTH

The Reconciliation Act of 2010 makes changes to Patient Protection and Affordable Care Act (PPACA). Together, the Reconciliation Act and PPACA are considered the final health care reform package.

The health reform package contains provisions that will significantly grow the Health Centers program over the coming years. These provisions include both dedicated, direct funding through a new Trust Fund and a permanent authorization.

THE COMMUNITY HEALTH CENTERS TRUST FUND

Operations

The health reform package contains a total of $11 billion in *new, dedicated funding* for the Health Centers program over five years. $9.5 billion of this funding will allow health centers to expand their operational capacity to serve nearly 20 million new patients and to enhance their medical, oral, and behavioral health services. The Community Health Centers Trust Fund is in addition to existing discretionary funding, which was $2.19 billion in FY 2010.

Community Health Center Operations Funding, 2011-2015				
FISCAL YEAR	**Trust Fund +**	**Discretionary Funding (est.)**	**Total Annual Funding (est.)**	**Total Annual Increase**
FY 2011	$1 Billion	$2.19 Billion	**$3.19 Billion**	$1 billion
FY 2012	$1.2 Billion	$2.19 Billion	**$3.39 Billion**	$200 million
FY 2013	$1.5 Billion	$2.19 Billion	**$3.69 Billion**	$300 million
FY 2014	$2.2 Billion	$2.19 Billion	**$4.39 Billion**	$700 million
FY 2015	$3.6 Billion	$2.19 Billion	**$5.79 Billion**	$1.4 billion

Capital

In addition to funding for operations, the Community Health Centers Trust Fund also includes $1.5 billion that will allow health centers to begin to meet their extraordinary capital needs, by expanding and improving existing facilities and constructing new buildings. While the capital funding is also available from FY 2011 to FY 2015, annual allocations for this spending are not outlined in the law. NACHC will continue to work with Congress and HRSA to ensure that the potential of these funds are fully maximized.

PERMANENT AUTHORIZATION

The law also reauthorizes the Health Centers program at significantly increased levels permanently. For FY2010-2015, the law authorizes specific funding levels (more than $8 billion in FY2015) and then in the succeeding years it authorizes increased spending based on a formula. The formula is based on cost and patient growth. The authorization levels, which typically serve as a ceiling on funds that can be provided by Congress, will remain well above the actual funding levels needed to sustain and continue to grow the Health Centers program.

Joint Committee on
Health Policy Oversight
December 14, 2010
Attachment 1