



# Bill Guide For Health Reform Recommendations

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## SECTION BY SECTION BILL GUIDE

# Insurance Reforms

**Section 1: Establishing Very Small Employer.** This section defines and creates a group for very small employers. Very small employers are defined as employers who employ at most 10 employees and includes sole proprietors.

**Section 2: Creating Young Adult Policies.** This section defines and creates a separate group for young adults for the purposes of health insurance. A young 2 adult is defined as an individual who has attained the age of 18 through the age of 25 (under the age of 26). Creating a specific group in insurance law for young adults will lead to creation of more affordable insurance products with benefit packages tailored to the needs of young adults and will expand health insurance access among the 20% of young adults who are uninsured.

**Sections 3, 4, & 5: Increasing Age of Dependents on Parent's Health Insurance.** These sections amend current insurance law by permitting that parents can keep their children on their insurance plan until the children reach the age of 26, as long as the children are dependents. Allowing individuals who are under the age of 26 to remain on their parent's health insurance policy will reduce the 20% of young adults who are uninsured.

**Sections 6, 7, 8, & 9: Creating the Kansas Small Business Health Policy Committee.** These sections reorganize the Kansas Business Health Partnership Act (BHP) by (1) establishing the Kansas Small Business Health Policy Committee and (2) removing the subsidy function of the BHP (which was not operational) . The purpose of this new committee is to establish a voluntary health insurance clearinghouse for small businesses to assist with the acquiring of insurance for their employees and accessing cafeteria plans (Section 125 plans) and also analyze the use of reinsurance. The committee will report to the KHPA Board and provide annual reports to the Board and Commissioner of Insurance.

**Sections 10 & 11: Transfer Cafeteria Plan Promotion Program From Commerce to KHPA.** Sections 10 and 11, moves from the Department of Commerce to the Kansas Health Policy Authority the section 125 cafeteria plan promotion that was established as part of SB 11. The newly created Kansas Small Business Health Policy Committee will direct the cafeteria plan promotion with the goal of encouraging and expanding the use of cafeteria plans.

**Policy**

For children, target and enroll the children up to 200% FPL currently eligible but not enrolled in Health-Wave 19 and 21. For young adults, change Kansas insurance law to allow parents to keep young adults (through age 25 years) on their family insurance plan and develop specific Young Adult Plans (YAPs) that provide health care insurance options with limited benefit packages and lower premiums. (Note: In the United Methodist Health Ministry Fund report, YAPs are discussed within the third initiative describing voluntary insurance market reforms.)

The policy would include specific targets and timelines for the improved enrollment for children that if not met, would trigger additional review by the KHPA Board. This trigger mechanism will initiate the KHPA Board's review of further policy options, including the consideration of mandating health insurance coverage for children in Kansas .)

**Background**

States that have been successful at increasing enrollment penetration for eligible but not enrolled in government-funded health care have extended their outreach programs operationally and included web based enrollment, public-program coordination/collaboration, school-based outreach programs, and out-stationing eligibility workers with culturally competent community partners. Each of these efforts entails moving the point of engagement with the child or family into the family's everyday life through a known contact, local geography or both.

Just as with the broader uninsured population, there are many reasons young adults lack health care coverage, but key differences of the young adult population can be capitalized upon. First, young adults are more likely than their uninsured older counterparts to live at home, be supported by their parents, or be enrolled in secondary education institutions. Secondly, young adults typically enter the workforce in lower paying jobs and are more likely to work in jobs where health insurance is not offered. Third, young adults are, in general, healthier than their older counterparts and may see less benefit in paying top dollar for comprehensive health insurance plans. A change in Kansas insurance law to allow parents to keep dependent young adults on their family insurance plan through age 25 would assist in providing transitional insurance to young adults as they leave home, enter the workforce, and gain employer-sponsored coverage. Development of YAPs – health insurance products specifically designed for adults aged 19-24 years old – would be a voluntary program aimed at offering a market specific insurance product with a limited benefit package and correspondingly lower premiums. These plans would be developed by the state in conjunction with private health insurers. This again would require changes to Kansas insurance law. Kansas would need to develop regulations covering areas such as who could sell the product, minimum coverage standards, and rating requirements for the product.

**Population Served**

15,000 additional children would enroll in Medicaid and approximately 5,000 additional children would enroll in SCHIP as a result of an extremely visible and effective outreach, web-based enrollment and facilitated enrollment processes specifically targeting uninsured lower income children eligible for public programs.

Developing Young Adult Plans (YAPs) with limited benefits targeted at young adults ages 19-24 years old would insure 15,000 additional young adults.

**Recommendation:**

Change Kansas insurance law to allow parents to keep young adults, through age 25 years, on their family insurance plan and develop specific Young Adult Plans (YAPs) that provide health care insurance options with limited benefit packages and lower premiums.

**Legislative Action:**

Enact legislation extending the age limit for dependent coverage and establishing YAP health insurance coverage

**How many young adults in Kansas lack insurance coverage?**

Approximately one quarter (24 percent) of young adults 18 to 25 years of age are uninsured – the highest sub-group of the uninsured in the state. Nearly two of five college graduates and one-half of high school graduates who do not go on to college will be uninsured for a period during the first year after graduation.

**What kind of policies will be implemented to deal with the problem of uninsured youth?**

The KHPA is looking at two types of policies. The first policy is designed specifically with young adults in mind, focusing on health promotion, disease prevention and catastrophic coverage. This policy would be more affordable than more comprehensive health insurance that would typically be offered to families in Kansas. The second policy focuses on allowing young adults to remain on their parents' policy as long as they are dependents through the age of 25.

**Why aren't young adults choosing to purchase insurance when they become uninsured?**

Although many believe that young adults simply choose not to purchase health insurance to spend their money elsewhere, research indicates that 70 percent of young adults regard health insurance as a very important factor when choosing a job. Compared to 62 percent for older age groups, only 42 percent of workers aged 19-29 have access to job-based health benefits. Among 19-23 year olds, only 1/5 have insurance coverage through their employer, partly because a majority work part-time - only 1/3 work full-time during the year. Many of the rest find the cost of health insurance too expensive.

**What is the KHPA doing to educate young people about the availability of health insurance and encourage them to make the purchase of health insurance a personal financial priority?**

The KHPA is recommending the creation of a web-based health insurance clearinghouse to educate consumers about policies available to them, including information about tax advantaged health insurance (Section 125 plans). The clearinghouse would not operate as a regulatory entity, but as an educational tool to compare health insurance plans. In addition, Kansans should be provided with information about the cost and quality of health care services as well as the appropriate use of medical services ("evidence based medicine") which will be provided online in collaboration with the State's libraries through the Transparency for Consumers: Health Care Cost and Quality Project. All of these initiatives would be linked to the KHPA website and focus on outreach so that Kansans are aware that these tools are available.

**Policy**

Help small employer better access health insurance by developing a voluntary health insurance clearinghouse to assist small employers to access health insurance and tax-preferred health insurance premiums through Section 125 plans. Stabilize and lower health insurance rates for the smallest and newest businesses by creating a new "micromarket" for sole proprietors and very small employers (VSG - one to ten employees) within the small group market. Establish a reinsurance program to spread the risk of this new micro-market among all carriers and the State.

On January 23, 2008 KHPA received notice that the Robert Wood Johnson Foundation had awarded them a grant of \$199,858 to further develop the elements of the reformed individual and small group health insurance model. The proposed refinement project would encompass two phases:

1. Development of a detailed sole proprietor/very small employer health insurance reform implementation plan
  - Convening a stakeholder advisory panel
  - Additional health insurance data collection related to sole proprietors and micro-firms in Kansas
  - Consultation with national health insurance experts
  - Chronic disease burden mapping for Kansas with consultation on construction of chronic care management strategies
2. Modeling of the refined Updated Sequential Health Insurance plan to estimate cost and impact of the detailed plan

**Legislative Action:**

Amend Kansas business health partnership act K.S.A. 40-4701 through 40-4707 deleting the Business Health Partnership duties and assigning the former Business Health Policy Committee, now titled the Small Business Health Policy Committee, the voluntary health insurance clearinghouse duties. The clearinghouse functions include assisting sole proprietors and very small businesses in accessing health insurance and tax-preferred health insurance premiums.

**Population Served**

Overall, the new VSG market would insure 5,900 working Kansans and their families prior to the impact of the reinsurance program. The introduction of the reinsurance program and the subsequent drop in premium would result in an additional 6,000 working Kansans and their families insured.

The newly established voluntary insurance clearinghouse will be available to assist all of Kansas' small employer groups but has no direct population impact.

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## SECTION BY SECTION BILL GUIDE

# KHPA Reforms

**Section 1: Adding Commissioner of Education to KHPA Board.** This section adds the Commissioner of Education to the KHPA Board as a non-voting ex officio member. The KHPA Board understands the importance of promoting healthy behaviors at an early age and the addition of the Commissioner of Education will provide a source of knowledge for the implementation of any school programs.

**Section 2: Medical Home Definition.** This section sets out a framework for defining a medical home in Kansas for state-funded health programs in order to increase care coordination, improve health outcomes, and decrease health care costs.

**Section 3: Small Business Wellness Program.** This section establishes within the Kansas Health Policy Authority a small business wellness grant program. The purpose of this section is to develop a community grant program that provides technical assistance and funds to assist small businesses in establishing wellness programs for their employees.

**Section 4: Expansion of Premium Assistance.** This section expands on the premium assistance program passed in SB 11 – slated to begin January 2009 – to include low income adults without children. Premium Assistance, called Kansas Healthy Choices, is a new health insurance program that provides private health insurance to very low income Kansas families. After full phase in of the premium assistance for low income families up to 100% of the Federal Poverty Level (in FY 2011), childless adults under 100% of poverty (about \$10,700 in 2007) will be eligible to participate (in FY 2012).

**Section 5: Creating the Health Reform Fund.** This section creates a “Health Reform Fund” within the State treasury. Revenues from a proposed increase in the state tobacco user fee will be deposited in the interest bearing fund and the funds will be utilized solely to pay for health reforms. (Also referenced in SB 542 Section 8)

**Policy**

Expand the KHPA Board to include an ex-officio seat for the Kansas Commissioner of Education.

**Background**

The KHPA Board is comprised of nine appointed voting members and seven ex-officio members representing government agencies with critical roles in the promotion and development of health care policies, administration of health care programs, and resources throughout Kansas. Inclusion of the education community in fulfilling this mission is essential to establishing a healthy future for our children. From an implementation perspective, the KHPA Board does not have the authority to implement this addition and should make known its intention to the Legislature due to the statutory origin of the KHPA.

**Population Served**

Kansas school children will be the greatest beneficiaries of a KHPA Board composition that recognizes the importance of health care policies that include the insight of the education community.

**Legislative Action:**

Statutory change is necessary to add the Education Commissioner to the KHPA board.

**Summary:** The KHPA board currently consists of nine voting members and seven ex-officio government employees. The mission of the Board is to develop and maintain a coordinated health policy agenda that combines the effective purchasing and administration of health care with promotion oriented public health strategies. The KHPA Board’s role is to set policy direction for the agency and to provide oversight to the budget and operation of the Medicaid, HealthWave, and State Employees Health Benefit programs. The seven ex-officio Board members serve as a resource and support for the nine voting members. In addition, the inclusion of other state agencies on the KHPA board enables a coordinated effort across the many disciplines that encompass the health of Kansans.

**Why should the Kansas Commissioner of Education be included on the KHPA Board?**

We develop many of our health habits as children. One of the central focus areas in these reforms is encouraging healthy behaviors in schools. Specifically, the reforms address school lunches, vending machines, and physical education. The Kansas Commissioner of Education could provide expert advice on implementing these initiatives to achieve success.

**What is the state of our children’s health?**

Obesity has become the second greatest threat to the long-term health of children. It is projected that one of every three children born in 2000 will develop diabetes in their lifetime due to obesity.

**Is it appropriate for schools to play a significant role in our children’s health?**

Improving our children’s health requires a coordinated effort of home and school. Children spend a significant portion of their day at school and it is critical that this environment promotes good health through food offerings and physical activity.

**Policy**

Develop a statutory or regulatory definition of a medical home for state-funded health programs (Medicaid/HealthWave and the SEHBP).

**Background**

One of the components of Kansas health reform is to promote a person-centered medical home as a way to improve the quality of primary health care, promote improved health status, and ultimately help to control the rising costs of health care. The designation of the medical home is a cornerstone of support for other areas of the KHPA preventive health agenda. Defining in statute the meaning of a medical home in Kansas will provide the framework for further development and implementation of a medical home model.

Promoting the development and use of medical home practices will help to organize health care services through a medical home model with the goal of improving health outcomes and containing health care costs. States, such as Colorado, Washington, Missouri, and Louisiana, are advancing the medical home model and passing legislation to organize Medicaid programs around the medical home concept. North Carolina has used existing legislative authority to extend the medical home concept to its Medicaid and State Children’s Health Insurance Program (SCHIP) populations. A number of states have defined a medical home in statute, such as Louisiana, Colorado, and Massachusetts.

The medical home in Kansas should recognize the importance of mental health services and the relationship between physical and mental health. In addition, addressing the appropriate services and continuum of care over the life span is critical to the medical home, which should include a focus on improvement on end-of-life care.

**Population Served**

The population served are all beneficiaries of state-funded health care plans (Medicaid/HealthWave and the SEHBP), as well as Kansas health care providers.

**What is the definition of a medical home?**

A "Medical Home" refers to a model of health care delivery that is person centered and family centered, providing accessible and continuous evidence-based, comprehensive, preventive and coordinated health care guided by a personal primary care provider who coordinates and facilitates preventive and primary care to improve health outcomes in an efficient and cost effective manner.

**What specific kinds of care are offered in a medical home?**

In addition to offering health care services, a medical home model of care includes features such as: (a) a focus on patient communication; (b) patient tracking with reminders for providers and patients about needed health care; (c) use of evidence based medicine and prevention; (d) coordination of care/follow up for patients who receive inpatient or outpatient health care services; (e) support for patients in the self-management of their health conditions; (f) electronic prescribing of pharmaceuticals; (g) tracking of lab tests, particularly for abnormal results or for duplicate tests; (h) tracking of referrals to other health providers; (i) surveys patients for satisfaction and goals for provider performance; (j) use of advanced electronic communications such as an interactive website, email communications, or electronic care management support.

**Aren't all primary care providers already providing medical homes today?**

Many primary care providers offer some features of a medical home, but there are few incentives in our health care system for providing access to the full range of medical home services. Recent research demonstrates that providing care through this model improves health outcomes in children and adults, and can help control the rising cost of health care. The Institute of Medicine has determined that the medical home is one of six aims for our health system and is the foundation of patient centered care.

**How is this different from the managed care gatekeeper model of care?**

"Managed care" was a model of health services delivery largely driven by health insurers and employers. Rather than managing health care, many believe that the focus of "managed care" was "managing cost." Patients and providers often felt that managed care limited access to needed health services. In contrast, the medical home model of care is not designed to limit care but rather better coordinate care among providers, through a personal primary care provider. This creates a culture of preventive care and facilitates patient health which, in turn, improves quality of life and reduces health care costs.

Goals of a medical home are to provide consumers with increased access to needed health services, more information about self-management of health conditions, and personalized help in navigating the complex health care system.

**Why is it important to provide coordinated, personalized care?**

Because our health system is so fragmented – with patients, providers, and purchasers operating under a different set of financial incentives – health care costs in Kansas and across the United States continue to rise at an unsustainable rate. Indeed, we pay double per capita any other industrialized country in the world, but with far worse health outcomes. A medical home model of health care places at the center of our health system the consumer-provider relationship, improved overall health status, and increased personal responsibility for our health.

**Who is interested in advancing a medical home model of health care?**

The support for a medical home has been endorsed by the Kansas Chapters of the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), the American Osteopathic Association (AOA), the American Medical Association (AMA), and the Kansas Association of the Medically Underserved (KAMU), representing safety net clinics across our state. As part of determining the measures and standards for a medical home in Kansas, stakeholder feedback will be solicited from all of these organizations and other various health care practitioners, such as nurse practitioners and physician assistants, rural health clinics and safety net health care clinics, and organizations with specific expertise in various aspects of the continuum of care. Expanding the person-centered medical home will require partnership with mid-level practitioners and safety net clinics, which are critical to serving the needs of rural communities and underserved areas in Kansas.

**How much money will it cost the State of Kansas?**

This legislation directs the Kansas Health Policy Authority and the Kansas Department on Health and Environment to work with state stakeholders on developing measures and standards for a medical home in the Kansas Medicaid/HealthWave programs and State Employee Health Plan Kansas. *There is no associated fiscal note.*

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**Policy**

Develop a community grant program to provide technical assistance and start-up funds to small businesses to assist them in the development of workplace wellness programs.

**Background**

Large employers have frequently embraced workplace wellness programs as mechanisms to improve employee health, decrease absenteeism, and enhance productivity. The costs of starting such programs are prohibitive for small employers who often do not have adequate resources and economies of scale to pay for these kinds of programs. The component of “personal responsibility” within health care reform encompasses not only individual choice, but establishing an environment which facilitates the choice for health. Workplace wellness programs embody this strategy.

Well-designed worksite health interventions can have an enormous impact on disease prevention and control, resulting in significant savings in health care spending, improved presenteeism, and increased productivity. A comprehensive worksite wellness program consists of health education, supportive social and physical environments, integration of programs into the organizational structure, linkage to related programs such as employee assistance programs (EAP), and screening programs linking to health care. Comprehensive worksite health promotion programs can yield a \$3 to \$6 return on investment (ROI) for every dollar spent over a 2–5 year period. Worksite health promotion programs can reduce absenteeism, health care, and disability workers’ compensation costs by more than 25% each.

Over 80% of businesses with over 50 employees have some form of health/wellness programs, but they are much less available in small businesses. Small businesses have limited resources and their lack of staff, budget, and wellness knowledge are barriers to providing wellness programs. Once established, however those wellness programs are quite economical costing \$30-\$200 per employee per year.

**Population Served**

The population served is employees working for small Kansas firms.

Data from the US 2000 Census detailing industry employment by size of industry documents the prevalence of small employers in Kansas. Of the 67,900 establishments with employees in Kansas, over 79% are in the under 100 employee size category. Business establishments (28,144) with one to four employees comprise 41.5% of the total, establishments (10,892) with five to nine employees comprise 16% of the total, establishments (6,969) with 10 to 19 employees comprise 10.3% of the total, and businesses (7,833) with 20 to 99 employees comprise 11.5% of the total.

**Legislative Action:**

\$100,000 SGF appropriation.

**Summary:** Over 80% of businesses with over fifty employees offer health/wellness programs to their employees. Because small businesses may not have the same financial resources, staff, and wellness knowledge as large businesses, it is important to assist them in establishing workplace wellness programs.

**What is a worksite wellness program?**

A wellness program may take many forms and should be left to the individual business to determine the best program to meet employee needs. Some components might include health education, a supportive environment, and access to employee assistance and screening programs.

**Is a grant program of this size significant enough to have an impact for small businesses?**

This is a first step in trying to integrate health and wellness as part of a lifestyle. Applying a local approach by making funds available to small businesses may lead to a groundswell of other businesses adopting wellness programs. This is a critical sector to target because over 79% of Kansas businesses have less than 100 employees. Wellness opportunities need to be available at work, where adults spend the majority of the day. By providing funds for technical assistance and funding for start-up programs employees can engage in for healthy habits at work as well as home.

**Why should a competitive grant system be used to encourage small business wellness?**

Competition of ideas leads to innovative outcomes. Allowing businesses to compete for funding allows the flexibility to adopt unique programs that fit a particular business' employees and infrastructure.

**Is there a cost benefit to adopting workplace wellness?**

It is estimated that wellness programs only cost \$30-\$200 per employee per year. Compare that cost to the reduced absenteeism, increased employee productivity, and improved health care costs that result from wellness program and the conclusion is that it is a wise investment.

**Policy**

Expand population for the Premium Assistance program to include adults (without children) earning up to 100% FPL (\$10,210 annually).

**Background**

This voluntary program is aimed at integrating the poorest childless adults into the health care system by providing them with subsidized access to private health care insurance. Adults without children do not fit within Medicaid’s traditional eligibility categories, although the Centers for Medicare & Medicaid Services (CMS) have provided states with additional options within the Deficit Reduction Act (DRA). States have taken a variety of approaches to covering childless adults, typically either through state-only programs like Connecticut’s State Administered General Assistance (SAGA) program or by pursuing waiver authority through the federal government and the CMS waiver process.

The structure for this initiative would be an expansion of the covered population eligible for Premium Assistance as specified in SB 11. The newly eligible individuals could be served within the same administrative structure that is being developed for the current SB 11 Premium Assistance program.

Kansas Healthy Choices:

- **Saves money.** The purchase of private insurance through Kansas Healthy Choices helps control state health care spending for the poverty level population by providing broader access to preventive care, and strengthens and expands private markets, rather than replacing or eliminating them.
- **Prudently partners with other funding resources.** This program ensures state access to 60% Federal matching funds. In addition, this wrap-around assistance strategically relies on employer contributions when available.
- **Unites families in health care.** Kansas Healthy Choices provides coverage for each member of the family under one plan, strengthening a family culture of prevention, health literacy, and care.
- **Breaks a vicious cycle.** Those without insurance use fewer preventive and screening services, are sicker when diagnosed, receive fewer therapeutic services and have poorer health outcomes in terms of mortality and disability rates. In addition, this group has lower earnings due to poor health.
- **Makes an impact.** Over the next three years, Kansas HealthChoices 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.

**Population Served**

The population served are adults (without children) earning up to 100% FPL (\$10,210 annually). 39,000 low income Kansans would become insured.

**Recommendation:**

Kansas Healthy Choices is an effective, prudent use of public funds to save public dollars in the long-term, strengthen private insurance markets, and improve the quality of life and access to health care for thousands of Kansas families. Supporting Kansas Healthy Choices means providing a smart path to private insurance for those who would otherwise be unable to attain coverage by themselves.

**Legislative Action:**

Statutory change to expand premium assistance eligibility.

**Premium Assistance.** Kansas Healthy Choices—previously known as premium assistance—was authorized by the Legislature and Governor in May 2007 with the signing of Senate Bill 11. It targets health insurance assistance to low-income families.

**Premium Assistance Expansion.** The 21 reform recommendations currently being proposed include *expanding* premium assistance to include health insurance assistance to low income adults without children.

**Summary:** 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.

Since passage of SB 11 in May 2007, KHPA has engaged in an extended, open, and participatory process to complete the program design and implementation of the premium assistance program Kansas Healthy Choices. The program will be implemented in January 2009.

**How do families enroll and select a health plan under Kansas Healthy Choices (KHC)?**

When a family is determined to be eligible for KHC, and has access to an employer-sponsored insurance plan, the benefits and cost effectiveness of the plan are reviewed. If it is determined that the employer-sponsored plan is cost effective, the family will be reimbursed for the employee portion of the premium. However, if the employer-sponsored plan is not cost effective, the family will be eligible to enroll in the KHC procured plan. KHC families eligible for the procured plan will receive a packet of information along with instructions on how to select one of the statewide health plans, a plan for themselves and their eligible family members. If a beneficiary does not choose a plan, the family is systematically assigned to the most appropriate plan. KHC participants will not be subject to waiting periods or pre-existing condition clauses.

**How does premium assistance save the State of Kansas money?**

Premium assistance provides insurance to low-income families, targeting those who tend to cost the most to public assistance programs. Those without insurance use fewer preventive and screening services, are sicker when diagnosed, receive fewer therapeutic services and have poorer health outcomes in terms of mortality and disability rates.

In addition, this group has lower earnings due to poor health. It is important to note federal regulations state that insurance provided through a premium assistance program cannot be more expensive than the cost of providing services for eligible members than through Medicaid or SCHIP.

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## SECTION BY SECTION BILL GUIDE

**Section 1: Fee Increase on Cigarettes.** This section increases the tax on a package of cigarette by \$.50 to \$1.29, beginning on July 1, 2008. It includes an increase of the tax on cigarettes by 4 cents annually (to adjust for inflation) for the following five years, to a total increased tax of \$1.49 in 2013. Increasing the fee on cigarettes will help to reduce the number of adults and teens who smoke, thereby improving health and reducing health care costs. In Kansas, tobacco related deaths and illness are associated with \$930 million health care costs annually.

**Section 2, 3, and 4: Preventing Stockpiling of Cigarettes and Offsetting Cost to Wholesalers.** These sections require all wholesale dealers, retail dealers and vending machine operators to file a report detailing all cigarettes, cigarette stamps and meter imprints on hand at 12:01 a.m. on July 1, 2008 and increases the tax imposed on such items from \$.575 to \$.625. The provisions of this section will apply to each July 1st prior to subsequent increases in the cigarette tax in order to prevent stockpiling of cigarettes that have been marked with the previous tax stamp. In addition, it provides for discounted tax stamps for wholesale dealers in order to offset the cost of requiring the application of new tax stamps each year the tax is increased, and permits wholesale dealers to sell back any unused tax stamps to the state for a period of 6 months after time of purchase.

**Section 5: Fee Increase on Smokeless Tobacco products.** This section raises the tax on the distribution of tobacco products from a rate of 10% of the wholesale sales price to 57%.

**Section 6: Preventing Stockpiling of Smokeless Tobacco. This section** requires all distributors to report the tobacco products on hand as of July 1, 2008 and imposes a 47% tax on those products. This section is intended to prevent the stockpiling of tobacco products to be sold under the lower previous tax.

**Section 7: Accounting for all Tobacco Products Within the State. This section** every distributor with a place of business in Kansas file a return to the director of taxation on or before every 20th day of each calendar month detailing the quantity and wholesale sales price of each tobacco product brought, made, and sold in this state during the prior month.

**Section 8: Creating the Health Reform Fund.** This section creates the new Health Reform fund within the state treasury with the Kansas Health Policy Authority or its designee approving vouchers from the fund. The section also requires certain transfers to be made out of the State General Fund to the Health Reform Fund with \$61.57 million in 2009, \$68.62 million in 2010, \$68.24 million in 2011, \$67.8 million in 2013, and \$66.95 million in 2014. With the revenue generated from the cigarette and smokeless tobacco tax going directly into the State General Fund this section requires only the amount needed for health reform is actually placed within the Health Reform fund. Therefore, if the tobacco tax takes in more than expected the State General Fund will reap the benefits and not the Health Reform Fund. (Also referenced in SB 541 Section 5)

**Policy**

Institute an increase in the tobacco user fee. It is proposed that the current excise tax on cigarettes be raised \$.50 per pack and an increase in the tax rate of other tobacco products (chewing tobacco, snuff, dip, cigars, etc.) to 57% of the wholesale price.

**Background**

The burden of tobacco use in Kansas is great. Each year tobacco causes over 4,000 Kansas deaths, and generates nearly \$930 million in health care costs (\$196 million within the Medicaid program alone). Policy research has shown that raising the cost of tobacco products is an effective means to decrease the rates of tobacco use. A 10% increase in the price of a pack of cigarettes is associated with a 4% drop in tobacco use (in real terms, an increase of \$.50 per pack of cigarettes may result in 20,000 of the current 400,000 adult smokers in Kansas quitting). The effect is even more pronounced among price-sensitive teens, where a similar price rise results in a 7% reduction in smoking rates.

Fifty percent of tobacco smokers begin their tobacco use before the age of 14. Not only do the habits of adults begin in childhood, but tobacco also serves as a gateway to other substance use among youth. Children and adolescents consume more than one billion packs of cigarettes a year. An increase in the excise tax on tobacco products has been one of the most effective ways to discourage youth from starting to smoke. Such a policy not only serves as an effective deterrent to tobacco use, but as an acknowledgement of the health costs that all Kansans incur as a result of usage.

**Population Served**

The entire Kansas population, including the 20% who currently smoke, would benefit in a reduction of the \$930 million health care cost associated with tobacco consumption. The 21% of high school students and 6% of middle school students who currently smoke would benefit from having a substantial barrier to smoking. The 9.3% of adult males and the nearly 20% of high school males who currently use some type of other tobacco products would benefit from a substantial barrier to using other tobacco products.

Tobacco use is the leading cause of preventable deaths and health care costs. Increasing levels of imposed tobacco user fees have been demonstrated to decrease smoking rates, resulting in long-term savings in lives and costs. At the end of 2005, the average state excise tax on cigarettes was \$.922 per pack and by early 2007 that figure had risen to about \$1.03 per pack. Currently the excise tax on a pack of cigarettes in Kansas is \$.79 per pack. Tobacco use costs Kansans the equivalent of \$.86 per pack of cigarettes sold to pay for the tobacco-related illness of Medicaid recipients alone. However, Kansas currently collects only \$.79 per pack of cigarettes in health impact fees to offset this expenditure (KDHE). An increased excise tax on all tobacco products would both reduce the number of youth who take up smoking and diminish the annual \$930 million health care costs associated with tobacco consumption.

Similarly, increasing the state tax on non-cigarette tobacco products will raise new state revenues and help to reduce tobacco use levels, especially among youth, thereby reducing related harms and costs as well. Put simply, the increased revenue per package of each tobacco product sold brings in far more new revenue than are lost by the reduction in tobacco product consumption and sales prompted by the tax increase.

Over 9% of adult males in Kansas currently use chewing tobacco or snuff. In rural areas, prevalence is known to exceed 17%. Among high school males, nearly 1 in 10 reports using chewing tobacco, snuff or dip and 2 in 10 report smoking cigars. These other tobacco products are currently taxed at a rate of 10% of wholesale price. To avoid making less-expensive other tobacco products gateway to cigarette addiction or an alternative to quitting or cutting back for smokers, it is important that state tax rates on other tobacco products parallel the state's tax rate on cigarettes.

**Recommendation:**

Increase the tobacco user fee by \$.50 per pack for a total of \$1.29 and the smokeless tobacco excise tax by 47 percent. Both increases will adjust annually according to inflation.

**Legislative Action:**

Change statute to increase fees and designate Health Reform fund for proceeds.

**Summary:** Increasing tobacco user fees results in three benefits for the state of Kansas. The first and most important is a reduction in smoking and better health outcomes. Second is a corresponding reduction in smoking-related health care costs paid for by all Kansans. Third is a revenue stream that will allow us to pay for health reform. Kansas currently ranks 33<sup>rd</sup> among states in amount of the tobacco user fee at \$.79. In comparison to our neighboring states, only two have lower tobacco fees than Kansas. More important than these rankings are the statistics related to usage and death due to smoking. Twenty-one percent or 34,000 Kansas high school students smoke daily. Over 17% of high school males use smokeless tobacco. 17.8% or 356,000 adult Kansans smoke. The outcome of these usage statistics is that 3,900 Kansans die annually from the results of smoking. It is estimated that 54,000 Kansas children who smoke will die prematurely. In addition to the human toll is a financial one that is borne by Kansas taxpayers. Annual health care costs in Kansas that are directly caused by smoking total \$927 million. The Medicaid portion of this amount is \$196 million. These expenditures cost Kansas taxpayers \$582 per household annually. The revenue generated will be over \$61 million in the first year and will increase to \$71 million by the fifth year. This amount is sufficient to pay for the health reform recommendations.

**How does an increase in the tobacco user fee act as a deterrent to use?**

Data indicates that for every 10% increase in the fee, there is a corresponding 7% reduction in youth smoking and a reduction in overall smoking of 4%. The reason for a higher reduction with kids is because they tend to be lighter smokers and the increased price makes the product less desirable. There is also a reduction in use among pregnant women and low-income smokers as a result of fee increases. This linkage between price and consumption is supported by a 2000 Surgeon General's report. In filings with the Securities and Exchange Commission, tobacco companies point out the link between increased cost and reduced use. Wall Street tobacco industry analysts also point to this correlation.

**How will the fee increase produce sufficient revenue if usage is declining?**

In every state that has enacted an increase; the fee has proved to be an extremely stable source of revenue. In many cases, it is less volatile than even income tax projections, which change with economic cycles. One of the reasons for the stability of the revenue stream is that the increased price per pack offsets the reduction in total purchases. National statistics indicate an annual 2% decline in tobacco fee revenue. The KHPA proposal includes an annual \$.04 price increase for five years to ensure revenue stability and the effectiveness of price as a deterrent. We will review revenues generated from the tax annually.

**Why is tobacco the only product targeted for an increase?**

Smoking is the number one preventable cause of death. In fact, smoking causes more deaths than alcohol, illegal drugs, murder, suicide, accidents and AIDS combined. The KHPA recognizes the impact of obesity on health outcomes and addresses that issue in several reform recommendations. While the KHPA does not oppose a tax on food with little nutritional value, there are numerous causes of obesity in addition to poor food choices. The link between smoking and lung disease shows a direct, causal relationship.

**What does the term "tobacco user fee" refer to?**

This is a fee that will only be paid by users of tobacco, which is approximately 20% of Kansans. These revenues will go into a designated health reform fund to pay for the costs of health reform. It is not unusual for users of products or services to bear the costs of usage. This is not unlike the toll that drivers on the turnpike pay daily to maintain transportation infrastructure. There is a considerable health care cost to all Kansans as a result of smoking. Tobacco users would pay for more of these costs through an increased fee since they utilize more health care services. A Sunflower Foundation poll shows that 64% of Kansans support raising the tobacco user fee.

Other

# Components of Health Reform

**Policy**

Enact a statewide smoking restriction in public places, coupled with a Governor's Executive Order requiring state agencies to hold meetings in smoke-free facilities will allow Kansans to work and gather without exposure to the negative consequences of secondhand smoke on their health.

**Population Served**

In Kansas, 1.4 million working adults would benefit from working and living in a smoke-free environment.

**Background**

This policy option recommends that legislation be enacted that prohibits smoking in all public places. Based on the health impact on cities that have enacted strict clean indoor air laws, a statewide law in Kansas could result in 2,160 fewer heart attacks and \$21 million less in associated hospital charges for heart attacks alone. A recent poll indicated that 73% of Kansas adults favor such a state law or local ordinance.

Secondhand smoke is ingested in two ways: 1) through the lit end of the cigarette; and 2) by the exhaled smoke of the smoker. Cigarette smoke contains over 4,000 chemicals and is a known carcinogen. At its most severe impact, secondhand smoke results in 3,000 annual cancer deaths in the US and 35,000 deaths from heart disease. This statistic represents a stark consequence of secondhand smoke, but fails to show the full impact. Exposure to cigarette smoke also results in an increase of asthma attacks, lower respiratory tract infections in children under 18 months old, coughing, and reduced lung function. Pregnant women are particularly susceptible to having low birth weight babies as a result of secondhand smoke exposure. A 2006 Surgeon General's report notes that, "the scientific evidence indicates there is no risk-free level of exposure to secondhand smoke." The National Institute for Occupational Safety and Health (NIOSH) recommends that secondhand smoke be considered as a potential occupational carcinogen.

Enactment of smoke free policies at the state level would address the issue of business owners who believe that local control of smoking bans results in an uneven playing field as businesses compete with other jurisdictions that may have no ban in place. In Kansas, 72% of the working population is protected by worksite nonsmoking policies. (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006). More than 40 states have imposed restrictions on smoking in public places. (National Conference of State Legislatures 2004).

Smoking is the number one preventable cause of death in Kansas and 83% of Kansas adults believe it is a serious health hazard. (Sunflower Foundation 2007). Evidence has shown that statewide smoking bans decrease the smoking rate among active smokers by 10%, a potential decrease of 40,000 smokers in Kansas (KDHE).

**Recommendation:**

Enact a statewide smoking restriction in public places so that Kansans can gather and work without exposure to secondhand smoke and the health consequences that result.

**Legislative Action:**

Adopt a statewide smoking restriction in public places.

**Summary:** Twenty-six states have adopted smoke-free ordinances in response to the harmful effects of secondhand smoke. In a Kansas Adult Tobacco Survey conducted in 2002-2003, 94% of those polled believe that secondhand smoke is harmful to health. This belief is supported by the data. A 2006 Surgeon General’s Report states “scientific evidence is indisputable that secondhand smoke causes premature death and serious disease in both children and adults who do not smoke.” The Report goes on to state that secondhand smoke is a proven cause of heart disease and lung cancer in nonsmoking adults, as well as a cause of SIDS, low-birth weight, acute respiratory infections, ear infections, and asthma attacks in infants and children. The Surgeon General noted that there is no safe level of exposure to secondhand smoke. In Kansas, 17 communities have adopted clean indoor air ordinances and several others are considering them.

**Should state government set this policy?**

KHPA supports local ordinances that have been adopted in the absence of a statewide standard. However, a uniform policy would ensure protection from secondhand smoke for all Kansans. A statewide policy would address the concern of business owners who believe that local control of smoke free policies results in an uneven playing field as businesses compete with other jurisdictions that may not have a smoke free policy in place. State government often takes the lead in pre-empting local control when public health is at stake.

**Will a statewide smoke free law have an economic impact on hospitality businesses?**

The data from other states and localities does not indicate a negative financial impact. The Surgeon General’s 2006 Report examined several studies and concluded “smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry.” In a 2006 Zagat Survey of America’s top restaurants, 58% of respondents stated they would dine out at the same frequency if restaurants were smoke free and 39% indicated they would dine out more frequently if smoke-free. Only 3% claimed they would dine out less often. Again, a statewide, uniform standard helps businesses attract clientele.

**Are smoke free policies an infringement on individual rights?**

An absence of a smoke free policy is an infringement on the rights of 80% of the population that does not smoke. The data confirms that there are health consequences to secondhand smoke exposure. Workers and the general public should be allowed to work and gather in places without taking on the risk of secondhand smoke. Seventy-six percent of white collar workers already have protection from secondhand smoke, but only 52% of blue collar workers have the same opportunity.

**Policy**

Design a statewide CHR to promote the coordination and exchange of health information for state funded health programs (Medicaid/HealthWave and the SEHBP).

**Background**

Improving the coordination of health care is a key component of a medical home model and the utilization of health information technology is a primary means to improve coordination. The clinical care of state-funded health plan beneficiaries is fragmented between different providers, clinics, and other health care facilities. This fragmentation leads to discontinuities in care related to lack of effective information exchange and significant inefficiency in the health care system. Similar difficulties exist in the transmission of health plan eligibility and benefit information.

Promoting a statewide exchange of clinical and financial health care information can improve efficiency; enhance the process of health care delivery, and promote patient safety. Moreover, as one of the largest payers of health care services in the state, we would leverage our considerable purchasing power to promote the use of health information technology and exchange through a statewide CHR. Improving access to personal health information by consumers will also help to promote self-management of care and personal responsibility. A statewide CHR in Kansas should integrate consumer access to allow consumers to review their personal health information (PHI) to further promote personal responsibility and self-management of care. As such, ensuring consumer privacy and security must be a key consideration in the development of health information exchange, and consumers must be given ultimate authority in who is allowed to view their health information.

Nearly two years ago, the state of Kansas implemented a pilot project to use a CHR to help deliver timely and accurate health information for Medicaid beneficiaries. The current CHR pilot project is built on administrative claims data (from health plans) and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, demographics, allergies and sensitivities, immunizations, vital signs, and lead screening and health maintenance data (includes Early and Periodic Screening, Diagnosis and Treatment [EPSDT] status). The record also contains an e-Prescribing component that enhances the clinician’s workflow, reduces the risk of medication error caused by inadequate or unavailable patient information, and increases safety and health outcomes associated with prescription generation.

**Population Served**

The population served are all beneficiaries of state-funded health care plans (Medicaid/HealthWave and the SEHBP), as well as Kansas health care providers.

**Recommendation:**

Implement statewide Community Health Record

**Legislative Action:**

\$383,600 SGF is requested in the KHPA budget.

**What kind of information is contained in the record?**

Community Health Records allow clinicians access to a patient's medical history aggregated across multiple provider sites including claimed medical visits, procedures, diagnoses, medications, demographics, allergies and sensitivities, immunizations, and lead screening and health maintenance data, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) evaluators. In addition, the record also contains an e-Prescribing component.

**What are the benefits of the CHR and e-prescribing component?**

By allowing clinicians to access this information, cost savings can be realized by avoiding duplicative tests and procedures, lowering emergency department expenditures and reducing inpatient admission and outpatient visits due to incomplete data. With regard to providers, efficiencies due to the reduced time on the phone getting lab results and with pharmacies clarifying prescriptions or obtaining prior authorization are realized. The end result is increased efficiency due to time savings. Lastly, a current immunization schedule and a child's immunization record aid in the prevention of disease and the costs associated with those preventable diseases.

The e-Prescribing component incorporates drug information so that if there is a contraindication to the prescribed therapy, the clinician is alerted at the time of prescribing, rather than after the prescription is received in the pharmacy, allowing for adverse drug event savings and avoiding medication waste. This also reduces the time spent by both physicians' offices and pharmacies clarifying prescription orders and handling problems related to the prescribed drug. The CHR also incorporates the preferred drug list, generic alternatives, and general cost information, so the prescriber is aware at the time of prescribing if the drug has a generic alternative, is on the preferred drug list, and if it is a high or low cost drug. Ultimately, the e-Prescribing component reduces the risk of medication error caused by inadequate or unavailable patient information and increases safety and health outcomes associated with prescription generation.

**Is a Community Health Record the same as an Electronic Medical Record?**

No, the Community Health Record is a claims-driven, web-based application that allows clinicians to easily access a patient's information. The Health Record allows access to very basic information such as procedures, diagnoses, allergies and sensitivities, and immunizations. An Electronic Medical Record is software based and is composed of the clinical data repository, clinical decision support, controlled medical vocabulary, order entry, computerized provider order entry, pharmacy, and clinical documentation applications. The data is much more detailed and not as easily accessed as the Community Health Record.

**Policy**

Establish a pilot program to provide payment incentives to Medicaid/HealthWave providers who adopt health literacy enhancement initiatives in their practice settings.

**Background**

An informed purchase of health care services requires health literacy by the consumer. Health literacy is the skill set required for an individual to gain access to and understand and use information in ways which promote and maintain good health. The health care system needs to improve consumers' access to health information and their capacity to use it effectively.

Nearly half of all adults have a health literacy problem. Consumers with limited literacy skills have less knowledge about, and poorer adherence to, medication and self-care regimens for certain chronic conditions; have less knowledge and less likelihood of getting specific preventive tests and exams; have poorer self-reported health and poorer health outcomes; and have increased hospitalizations and costs.

A large gap exists between the health literacy level of people and much of the health information produced by the health care industry; creating a situation where many consumers cannot understand the health information they receive from providers. In 1998, inadequate health literacy cost the US health system an estimated \$30-\$73 billion. A small number of states have specific projects focused on health literacy, but these initiatives are in their infancy and much more needs to be done if consumers are to achieve optimal health, particularly if they are living with chronic disease.

As part of a 2002 Council of State Governments (CSG) comprehensive study of health literacy, researchers identified "best practice" models, including the development of adult and school-age health literacy toolkits. The Kansas Consumer Health Care Cost and Quality Transparency Project will include a curriculum and toolkits for both adults and children to improve health literacy designed by the University of Kansas Medical Center and state librarians.

**Population Served**

The population served is Medicaid/HealthWave enrollees who are under the care of providers adopting the health literacy enhancement strategies.

**KANSAS-SPECIFIC DATA**

A 2007 survey by Health Literacy Innovations of Medicaid agencies indicated that Kansas was among 56% of states who had set readability guidelines for their Medicaid materials at a 6th grade reading level.

**Recommendation:**

Establish a pilot project that provides payment incentives to Medicaid and HealthWave providers who adopt health literacy enhancements in their practice settings.

**Legislative Action:**

\$140,000 SGF appropriation

**Summary:** Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. According to the American Medical Association, poor health literacy is a stronger predictor of a person's health than age, income, employment status, education level, and race. By improving health literacy, individuals become knowledgeable consumers and not merely patients navigating a complex process during a period of illness.

**Is health literacy a widespread problem for consumers?**

Yes, The Institute of Medicine reports that 90 million people in the United States, nearly half of the population, have difficulty understanding and using health information. As a result, patients often take medication on erratic schedules, miss follow-up appointments, and do not understand instructions such as "take this medicine on an empty stomach."

**What types of items fall under the umbrella of health literacy?**

It encompasses a broad spectrum of issues related to health, health care systems, and cost/access topics. Health topics include recommended preventive care and chronic-disease management, as well as the elements comprising a complete health history. Health care systems issues include the identification of providers, health care services, and settings, as well as an ability to navigate through those complex systems, completing the requisite forms and other processes. Cost and access issues related to health literacy involve a comprehension of health insurance benefit design, including coverage levels and cost sharing provisions (copayments, deductibles, and coinsurance).

**Are there other benefits to health literacy in addition to informed consumers and better health outcomes?**

There should be a significant cost savings for consumers if they have access to information that allows them to make good health choices by providing them with tools to evaluate the quality and value of the health services. For every other purchase that consumers make, there is an expectation that information on quality and value will be available so that consumers can comparison shop and make the best choice for their needs. A lack of information translates to a lack of competition. The data indicates that in 1998, inadequate health literacy cost the U.S. health system an estimated \$30-\$73 billion.

**How will financial incentives to providers that practice health literacy aid consumers?**

Doctors want to share information with their patients but often lack the tools or the time. Financial incentives to providers to devote time to assist consumers in better understanding treatment regimens and health promotion recommendations as well as assisting them to navigate the health care system is a first step in creating a consumer mindset in the practice setting.

**Policy**

Include coverage of dental health services for pregnant women in the Kansas Medicaid program.

**Background**

Recent studies continue to show that poor oral health has an effect on overall systemic health. One of the most convincing links is between oral infections and poor birth outcomes, specifically low birth weight babies. Providing dental benefits for pregnant women may help reduce this problem.

Kansas Medicaid pays for roughly 40% of births in Kansas. Efforts have been made with Head Start, Women, Infants, and Children (WIC), and in local health programs to educate women on the importance of good oral health during pregnancy, but without dental coverage, pregnant women are without resources to pay for oral health care. Recent evidence based studies have shown a relationship between periodontal disease and premature births and cardiac disease. Avoidance of even one premature birth can save the state from future years of medical services and disability payments.

Currently, Kansas Medicaid coverage only provides emergency dental coverage (mainly tooth extractions) for most adults on Medicaid, including pregnant women. Providing a complete dental benefit for pregnant women on Medicaid in Kansas will allow them to receive routine cleanings, fillings, and periodontal (gum disease) treatment. This type of treatment will prevent oral health emergencies and oral infections during pregnancy in many women.

Kansas pays the costs of several "million dollar" premature babies a year. The March of Dimes reports that an average premature birth costs as much as \$500,000 over the lifetime of a child. The costs savings of preventing just a few of these births would easily cover the cost of the benefit. Providing additional Medicaid dental funding would support the community health clinics or "dental hubs" as they would receive compensation for treating these previously uninsured patients. The Kansas Legislature has appropriated \$2 million in new money for the state's primary care safety net clinics in FY2008. It includes 500,000 earmarked for developing access to oral health care through "dental hubs."

**Population Served**

The population served is pregnant women enrolled in Medicaid.

Enrollment of dentists in the Kansas Medicaid has improved since the state changed from a capitated managed care plan to fee-for-service. However, when discussing increasing dental benefits for Medicaid beneficiaries, there is concern about the lack of capacity of dental Medicaid providers and low dental reimbursement rates. Oral Health Kansas and the Kansas Dental Association are also preparing cost estimates to increase dental reimbursement rates to help provider enrollment.

**Recommendation:**

Include dental coverage for pregnant Medicaid beneficiaries.

**Legislative Action:**

\$524,000 SGF appropriation

**Summary:** Kansas Medicaid currently covers only emergency dental care (mainly tooth extractions) for most adults on Medicaid, including pregnant women. There are 6,600 pregnant women enrolled in Medicaid.

**Why do pregnant women need dental coverage?**

Pregnant women are much more prone to experience problems with teeth and gums. Approximately half of women experience pregnancy gingivitis, which can lead to more serious periodontal disease. Periodontal disease can result in poor birth outcomes.

**What are the potential birth outcomes?**

There is a link between periodontal disease and premature babies. Premature birth is the leading cause of neonatal death (within the first month of life) and can lead to lifelong health problems such as mental retardation, blindness, chronic lung disease, and cerebral palsy. There may also be delays in physical and psychological growth. Children may also have infectious disease transmitted from the mother.

**How will providing dental services to pregnant women save money?**

The March of Dimes estimates that the cost of services for the lifetime of a premature child is \$500,000. The cost to the Kansas Medicaid program to provide dental care would be \$500,000 annually. The cost savings of preventing even one of these births would cover the cost of the benefit.

**Hasn't the Legislature already provided dental coverage funding?**

The legislature recognized the importance of oral health care by earmarking \$500,000 for dental hubs within community health clinics in FY2008. Adding a Medicaid reimbursement may encourage more dentists to participate in these hubs.

**Policy**

Improve access to tobacco cessation programs (medications and counseling) in the Kansas Medicaid program in order to reduce tobacco use, improve health outcomes, and decrease health care costs.

**Population Served**

The approximate 83,200 Kansas Medicaid beneficiaries who smoke would benefit from the increased coverage of tobacco cessation, improving health and lowering health care costs. The Kansas population overall would benefit from a less prevalent smoking environment.

**Background**

In Kansas, smoking-attributed costs for Medicaid reached \$196 million in 2004 (Figure 7) (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006) and 49% of Kansas adult smokers attempted to quit and failed in 2004 compared to 55% nationwide. Kansas Medicaid currently covers the medication, Chantix, for up to 24 weeks in a year, but does not cover cessation products, such as inhalers and nasal sprays. Kansas Medicaid also does not cover group, individual, or telephone counseling.

According to the 2004 National Health Interview Survey, approximately 29% of adult Medicaid beneficiaries were current smokers. This figure was higher than the 2005 estimated rate of 20.6% for current smoking among the general population. The smoking rate for adults in Kansas is approximately 17.8%, and national data suggests the rate for Kansas Medicaid beneficiaries is higher than that of the general state population. (<http://www.statehealthfacts.org>).

In order to decrease smoking rates, the 2000 Public Health Service Clinical Practice Guidelines recommended tobacco-dependence treatment, which included medication and counseling. One of the 2010 national health objectives is to increase insurance coverage of evidence-based treatments for tobacco dependence among all 51 Medicaid programs. Kansas Medicaid currently provides reimbursement for some pharmaceuticals products to treat smoking cessation; however, the state does not reimburse for smoking cessation counseling. This proposal would expand reimbursement for smoking cessation treatment to include counseling in an individual and/or group setting. The expansion would be consistent with the changes occurring within the SEHBP which will include coverage of pharmaceuticals, as well as specific smoking cessation programs.

**Recommendation:**

Offer tobacco cessation counseling within the Medicaid program to reduce tobacco use, improve health, and decrease health care costs.

**Legislative Action:**

\$200,000 SGF appropriation.

**Summary:** The Kansas Medicaid program currently covers pharmacotherapy for tobacco cessation but does not cover cessation counseling. The 2000 Public Health Service Clinical Practice Guidelines recommends offering both cessation methods to improve quit rates. One of the 2010 national health objectives is to increase insurance coverage of evidence-based treatments for tobacco dependence among all state Medicaid programs.

**Why is it necessary to provide this service to the Medicaid population?**

This population is disproportionately more likely to smoke than the general population. According to the *Journal of the American Medical Association*, smoking prevalence among Medicaid recipients is 39% higher than the general population. In Kansas, approximately 29% of Medicaid recipients smoke compared to less than 18% of the general population. Nearly 40% of Kansas Quitline callers report an annual income under \$15,000.

**Why Should Kansans pay for this type of service?**

The reality is that Kansans are already paying substantially for health care costs associated with smoking. In the Medicaid program alone, Kansas taxpayers pay \$196 million annually in health care costs related to smoking by Medicaid recipients. Investing \$200,000 annually to help people quit smoking should reduce some of these costs and lead to healthier outcomes. According to the *Journal of the American Medical Association (JAMA)*, in a study that assessed the impact and cost-effectiveness of preventive services, smoking cessation treatment was among the top ranked clinical preventive treatments, along with childhood immunizations and aspirin for adults at risk of cardiovascular disease, as the treatments that could save the most in health care costs.

**What are the health benefits to Kansans who quit smoking?**

According to the American Cancer Society, as soon as one year after quitting smoking, the nonsmoker will reduce the excess risk of having a heart attack and dying from heart disease in half. From 5 to 15 years after quitting, the risk of having a stroke is reduced to that of a nonsmoker. Smokers who quit before 50 may enjoy a longer life span because their risk of dying within the next 15 years is cut in half.

**Why is counseling necessary if pharmacotherapy is already available?** All of the tobacco policies included in the reform package target young smokers as the group most likely to quit smoking if these policies are adopted. Data indicates that young smokers are unlikely to utilize cessation medication as a stand alone option. At the same time, young people are more likely to have attempted quitting than adults in the previous year. These attempts are less successful than adults. In the young adult group, those who combined medication with counseling had the highest quit success rates.

**Recommendation:**

Target and enroll the children up to 200% FPL currently eligible but not enrolled in HealthWave (Medicaid/SCHIP)

**Legislative Action:**

\$1,302,716 SGF appropriation.

**What services are covered by HealthWave?**

Office visits, regular checkups, immunizations, hospital services, inpatient and outpatient hospital, lab and x-ray, prescription drugs, eye doctor exams and glasses, hearing services and speech, and physical and occupational therapy. In addition dental services such as checkups, cleanings, sealants, x-rays and fillings are provided. Mental Health services such as inpatient and outpatient mental, behavioral and substance abuse services are also provided.

**Is the outreach and enrollment effort an expansion of Medicaid?**

No, it is not an expansion of Medicaid. The outreach and enrollment expansion effort targets those already eligible for HealthWave but not currently enrolled.

**How many additional children would be enrolled?**

It is estimated that approximately 15,000 additional children would be enrolled in Medicaid and approximately 5,000 additional children would be enrolled in SCHIP as a result of the effort.

**How will the KHPA achieve this?**

The KHPA plans to aggressively market the program through a visible and effective outreach, web-based enrollment and facilitated enrollment process specifically targeting the uninsured children eligible for public programs. Web-based enrollment will allow those children who are identified as eligible to be enrolled on the spot without delay.

**Policy**

Strengthen physical education (PE) requirements and expand Coordinated School Health (CSH) programs.

**Background**

The Governor’s Council on Fitness has developed a set of recommendations that calls for minimum physical activity and PE requirements that are consistent with the Kansas Wellness Policy Builder developed by the Kansas CSH program. Collaboration is underway between KDHE and the Kansas Department of Education to implement an evidence-based CSH model that provides schools with a framework to address the health and wellness needs of their students and staff.

Some of the recommendations include a minimum of 100-150 minutes of PE per week at the elementary and middle school levels, maintaining the current one unit requirement for high school graduation, and 20 minutes of recess for elementary students daily. Current law mandates PE at the elementary level, but only requires one credit unit total from middle through high school. In addition to requirements of students, the recommendations also emphasize the importance of PE teachers who are specifically trained in the PE field.

Schools are often concerned about taking away instructional time for PE classes, especially in the context of the importance of standardized testing results. However, research is emerging that indicates that improved health and physical activity status of children translates into improvement in standardized test scores. Currently, 11 states mandate physical activity for elementary schools, seven do so for middle/junior high schools, and 10 do so for high schools. Among states that mandate physical activity for elementary schools, only two (Louisiana and New Jersey) meet the national recommendation of 150 minutes or more per week (commonly “daily physical activity”).

**Population Served**

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12.

Policies aimed at increased physical activity in schools have achieved significant attention in recent years. In 2006, legislation was enacted and signed by the Governor on March 10; this Bill supports PE classes for all grades from K-12 and urges the State Board of Education to require some type of scheduled PE class for grades K-12. In 2007, House Bill 2090 (HB 2090) proposed to require the collection of fitness data on students in grades 4, 7, 9, and 12 in order to benchmark the fitness of Kansas students and guide local and state policymakers. The Bill was heard, but did not pass out of the House Education Committee.

**Recommendation:**

Strengthen physical education requirements and physical fitness of students for Kansas public schools.

**Legislative Action:**

\$550,728 SGF appropriation.

**Summary:** Since 1980, obesity rates in the U.S. have more than tripled, making obesity the second greatest threat to the long-term health of children. Based on these factors, it has been projected that one of every three children born in the year 2000 (and one of every two Hispanic children) will develop diabetes during their lifetime. Not only will rising rates of obesity result in a decline in our nation’s health, but also an increase in health care costs. By 2020, one of every four dollars will be spent on obesity-related health care treatments. In Kansas, nearly 30% of children aged 10-17 are either overweight or at risk for becoming overweight.

**Don’t schools already require PE?**

Physical Education is currently required at the elementary level, but there is no requirement for daily PE. In addition, PE is not required in middle school. Only one credit of PE, which may include health education, is required for graduation from high school.

**What are the benefits of increased physical fitness?**

In addition to healthier children, there is a link between physical fitness and test performance. Research shows that standardized test scores improve when health and physical fitness are optimized.

**Will increasing physical fitness requirements result in an unfunded mandate for schools?**

No, this is not an initiative that would require school compliance. The reform encourages participation by providing schools with the opportunity to apply for funds if they choose to implement a physical fitness program. Through the Kansas Coordinated School Health Program, 224 schools, serving 80,736 students have received funding for physical fitness. Because of this success, this proposal would make funds available for implementation statewide.

**CONTINUED**

## ***FROM PREVIOUS***

### **How will this policy further recent improvements to physical education and fitness in Kansas public schools?**

The recommendation is to meet basic levels of physical activity and physical education (PE) on the Kansas Wellness Policy Builder Part, 3 Physical Activity. The “basic” level recommends that all students K-12 receive a minimum of 100-150 minutes of physical education per week, of which 75 minutes per week (15 minutes per day) is physical activity; the physical education provided is sequential and meets the State Board of Education’s teaching standards; is taught by licensed PE teachers with a student/teacher ratio that is consistent with other class sizes in the school; and the school provides a physical and social environment that encourages safe and enjoyable physical activity for students, including those who are not athletically gifted. Details of the “basic” level of wellness guidelines can be found at:

[http://www.ksde.org/kneat/SNP/SNPDocs/Wellness/Wellness\\_Policy\\_Guidelines\\_Booklet\\_Final.pdf](http://www.ksde.org/kneat/SNP/SNPDocs/Wellness/Wellness_Policy_Guidelines_Booklet_Final.pdf)

This policy option would utilize the existing Kansas Coordinated School Health grants program. Grants are currently awarded to Kansas schools on a competitive basis to address physical activity, nutrition and tobacco use. However, current funds are able to support activity in only 52 school districts. With additional funding, this proposal would be developed in phases over 5 years. During the first year, 100 school districts will be involved, during the second year, 150 school districts will be involved, during the third year, 199 school districts will be involved, during the fourth year, 248 school districts will be involved and by the fifth year, all 296 Kansas school districts will be served and participating

**Policy**

Increased screenings for breast, cervical, prostate, and colon cancer through expansion of the Early Detection Works (EDW) program.

**Background**

One of the most significant ways of improving health and decreasing health care costs is to remove barriers to preventive care. Screenings are an effective way to identify those at risk of future disease, or to detect the disease while still in the earliest stages. Disease found early leads to improved efficacy of treatment and decreased long-term morbidity, mortality, and health care costs.

The expense of cancer screening is often raised as a concern. While short-term costs for screening and treatment may rise to a small degree, the long-term savings resulting from treating cancer in its early stages as opposed to costly treatment that accompanies advanced cases will provide for greater cost savings overall. The cost of these screening recommendations pertains only to data addressing need in FY2009. Changes in health care programs, including potential expansions of Medicaid and Premium Assistance programs, may alter funding needs and eligibility levels in future budget cycles.

- **Breast and Cervical Cancer.** Studies show that breast and cervical cancers that result disproportionately in death among women who are uninsured or underinsured could be significantly reduced by increasing screening rates among at-risk women. Timely mammography screening among women 40 or older may prevent 15% to 30% of all deaths from breast cancer. In Kansas, nearly 400 women die of breast cancer every year, yet access to timely screening could prevent between 60 and 120 of those deaths. If detected early, the survival rate is 90%. The survival rate plummets to 20% when detection is late.

Similarly, cervical cytology or pap smears results in detection

**Population Served**

All three programs are targeted to those at high clinical risk but lacking the income and insurance resources to access screenings. Expansion of the EDW program at the cost indicated below may allow a total of approximately 7,500 women to be served, which is an increase of 1,700 over the current service population. Funding of a prostate cancer screening program is estimated to serve just over 6,100 men at risk. The colorectal cancer screening effort may provide care for over 12,000 Kansans.

and treatment of precancerous lesions and cervical cancer at an early stage. In the last five years, an average of 35 women has died annually. Approximately 50% of those deaths would be prevented with adequate screening.

The EDW program is funded by a cooperative agreement between the CDC and KDHE. The program helps low-income, uninsured, and underserved women between the ages of 40 and 64 gain access to lifesaving, early detection screening services for breast and cervical cancers. The EDW program served 7,200 women in FY2006 and an estimated 6,200 Kansas women in FY2007. These results are encouraging but the need is significant. Over 27,000 women may qualify for EDW services in Kansas.

- **Prostate Cancer.** Prostate cancer is the most common cancer diagnosed in men. More than 1,800 cases are annually diagnosed in Kansas, and 250 men die from prostate cancer each year. Screening for patients at high risk of prostate cancer based on race, age, lifestyle, and family history will result in greatly increased survival rates. While prostate cancer occurs more frequently at age 50, screening should begin at age 40 for those who are at high risk. Based on income, lack of insurance and age, it is estimated that 21,000 men would qualify for prostate cancer screening.

- **Colorectal Cancer:** Colorectal cancer usually develops from precancerous polyps in the colon or rectum. Screening tests detect precancerous polyps so that they can be removed before becoming cancerous. Screening can also detect colorectal cancer early, when treatment is most effective. Screening should occur for all persons over age 50. In Kansas, an average of 550 persons died each year of colorectal cancer. The CDC indicates that routine screening for colorectal cancer can reduce this number by at least 60%.

## Improve Access to Cancer Screening

### Recommendation:

Increase screenings for breast and cervical cancer and expand screenings for prostate and colon cancer through the Early Detection Works (EDW) program.

### Legislative Action:

\$6.6 million SGF appropriation.

**Summary:** The federal Breast and Cervical Cancer Treatment Act (BCCTA) of 2000 established a federal/state partnership in getting uninsured women access to screening and treatment if necessary. In order to qualify for this program, women must be uninsured or insured with a high, unmet deductible of at least \$2,500. They also must fall between the ages of 40-64. Since the program's inception, more than 20,000 Kansas women have been screened. Of these, 500 cases of pre-cancerous and/or invasive breast or cervical cancers have been detected. Over 200 women have received treatment. Because of the successful outcomes of these screenings it is appropriate to expand the program to prostate and colon cancer screenings to save more lives.

### Why is an expansion necessary for prostate and colon cancer in Kansas?

Colon cancer is the second leading cancer killer in Kansas. As of 2004, it is estimated that 1480 individuals were diagnosed with colon cancer and 890 died. Despite this grim statistic, the evidence points to very favorable survival rates when it is detected early. In fact, colon cancer is preventable when early detection measures are used. Prostate cancer affects 1900 Kansas men annually, of whom 300 will die. This is also a slow growing cancer that should not prove fatal if detected early.

**Will enactment of expanded screenings result in excessive costs for Kansas taxpayers?** The initial investment in preventive care will more than offset costly health care services that are necessary in treating late-stage cancer. This is a population that is currently uninsured. If they seek late-stage treatment because screening is unaffordable, there may already be cost-shifting to insured patients that would be alleviated under this program. More importantly, lives will be saved.

### Is there a difference in cancer outcomes between the insured and the uninsured?

The American Cancer Society has released a study on this issue in *A Cancer Journal for Clinicians*. Researchers analyzed nearly 600,000 cases from the National Cancer Data Base, as well as a nationwide in-person survey of 40,000 households that the National Center for Health Statistics and the Centers for Disease Control and Prevention conducted. Nearly half of the uninsured either postponed health care or went without due to cost. The researchers found that "for all cancers combined, uninsured patients were 1.6 times as likely to die within 5 years compared to individuals with private insurance." Insured women were twice as likely to get mammograms as the uninsured. The contrast is even greater with colon cancer screenings. Only 19% of the uninsured aged 50-64 got screened, as opposed to 48% of the insured. The data also indicates that the insured are much more likely to be diagnosed in the early stages of cancer.

**Policy**

Analyze and increase specific reimbursement for primary care services consistent with a medical home model and “value-based health care purchasing” for the Kansas Medicaid/HealthWave program.

**Background**

The concept of value-based health care purchasing is that purchasers should focus on outcomes, cost, and quality of health care through the informed use of health care services. In Kansas, value-based purchasing can focus on incentives for health services delivered through a primary care medical home, thus, reducing inappropriate and inefficient care. The health care system and its patterns of reimbursement currently serve as disincentives for providers to take time to provide those preventive services not associated with a technical procedure. Even those technical procedures associated with prevention activities are often not paid for at the optimal rates. Health care reform should include a commitment to analyze the reimbursement rates of health providers serving beneficiaries of state-funded health plans for a wide range of screening activities and preventive care.

**Population Served**

The populations served are beneficiaries and health care providers in the Kansas Medicaid/HealthWave program.

**Policy**

Support the second phase of the Kansas Consumer Health Care Cost and Quality Transparency Project which will begin to collect and make available existing health and health care data resources to the Kansas consumer.

**Background**

In FY 2008, KHPA approved a two-phase Health Information Transparency (HIT) Initiative for consumers. In Phase I of this project, the State Library of Kansas is working with other libraries to create a web-based portal of existing health and health care resources for Kansas consumers. The portal is called Kansas Health Online. Access to this information is available from the KHPA website and through the libraries. Kansas Health Online will be marketed to all public libraries in Kansas as “the icon for health care” and training in the use of the Portal commenced after January 1, 2008. The development of the Portal was functionally implemented on January 15, 2008 and will be fully implemented by June 2008. A health information curriculum will also be established to educate Kansans about the use of health information and available health resources.

In Phase II of this Project, Kansas-specific health quality and cost measures recommended to the KHPA Board by the Data Consortium (which consists of health care stakeholders in Kansas) will be developed and made available to consumers through Kansas Health Online, allowing consumers to compare cost and quality of health providers and plans.

**Population Served**

The population served is all Kansans with access to the Internet or public libraries. The entire population of the state (2,764,075) has access to the public libraries in their community or communities nearby.

**KANSAS-SPECIFIC DATA**

There are 327 public libraries located across the state of Kansas. The public library system is regionalized into seven districts — Central, North Central, Northeast, Northwest, South Central, Southeast, and Southwest. The public libraries have long served as a focal point in the community for information exchange. Simultaneously, the National Library of Medicine is developing a “Go-Local” feature, which brings information about local health care services and support groups to Kansas consumers. The Go-Local feature of this project will localize resources pertinent to the seven library districts.

**Legislative Action:**

\$200,000 SGF included  
in the FY 2009 KHPA  
budget

**Summary:** In FY2008, KHPA approved a two-phase Health Information Transparency (HIT) initiative. The first phase involved the State Library of Kansas working with other libraries to create a web-based portal — called Kansas Health Online — of existing health and health care resources for Kansas consumers. The second phase is to develop Kansas-specific health quality and cost measures and make them available to consumers.

**Why is consumer transparency so important?**

Consumers currently have limited access to meaningful information from which informed health decisions can be made. As result, there is little assurance that consumers are receiving an optimal return on investment when purchasing health care services. Consumers have access to information for other purchases. When it comes to health, it is critical that information should be available to allow an informed decision. Publishing standard pricing and quality information can empower consumers and purchasers to use resources more efficiently and consider the cost/benefit factor, driving them to providers that offer the highest quality care.

**Have other states implemented this type of program?**

A number of health information library-driven initiatives are underway across the country to facilitate consumer access to health care information. In 2004, the National Library of Medicine announced that over 40 projects in 24 states were funded to improve consumer access to reliable and authoritative online health information. The American Libraries Association (ALA) also announced their partnership with Walgreens in 2004 to promote consumer health education and libraries as a source of health information. Initial efforts focused on providing public libraries with information to increase knowledge and understanding of the Medicare Drug Discount Card Program. The Medical Library Association (MLA) offers a “User’s Guide to Finding and Evaluating Health Information.” The guide incorporates the collective wisdom of medical librarians who regularly search the internet for quality information in support of clinical and scientific decision making by doctors, scientists, and other health practitioners. This guide is available at the Kansas Health Online site <http://www.kansashealthonline.org>

**How will this initiative work in Kansas?**

The key to consumer-driven decisions is to make sure that the data is accurate, easy to understand, and accessible. Through the creation of the web portal, access will be available to Kansans using the Internet at the 327 libraries located across the state. In Phase II, indicators developed by the Data Consortium, a broad stakeholder advisory panel to KHPA, will be available to consumers through the Health Transparency Portal. This will allow consumers to compare cost and quality of health providers and plans.

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**Policy**

Include a standardized format for health insurance cards for Medicaid/HealthWave beneficiaries and for SEHBP enrollees to decrease administrative costs, improve efficiency, and increase health care coordination.

**Background**

One-third of every health care dollar is spent on administrative costs, and a lack of standardized electronic health insurance cards contributes specifically to these costs.

Most insured Kansans carry around one or more health insurance cards in their wallet. However, unlike debit cards, credit cards, or even grocery store discount cards, these health insurance cards are not electronic, which results in physician offices investing more time on paperwork, and resources diverted away from patient care. Improving the coordination of health care services will lower administrative costs and is a key component of a medical home.

A health insurance ID card is a patient's entry point into the health care system. A study completed by the Governor's Health Care Cost Containment Commission found that approximately 20% of claims were denied due to inaccurate or incomplete information about a patient's coverage. Presently, ID card technology has advanced to the point that it can be used as a "key" for providers to unlock a patient's financial and insurance eligibility information and reduce errors in claim denial. Not only will the new card save the administrative costs of processing denied claims, it will also make the patient's registration process easier. This information could be accessed via the electronic cards, reducing claim denials that currently result in significant administrative costs for physicians, hospitals, and health plans – costs that are ultimately passed on to patients and employers.

For the Medicaid/HealthWave program, the KHPA currently issues paper ID cards monthly. Under this plan, the KHPA would substitute plastic "advanced ID cards" that utilize a magnetic stripe or bar code technology. These cards will allow a provider the ability to instantly determine if a member qualifies for a Kansas Medical Assistance Program (KMAP) or future program, such as Premium Assistance, by swiping or scanning a patient's card. For the SEHBP, the use of advanced ID cards will be required in future contracts with health plans.

**Population Served**

The population served is Kansans who qualify for Medicaid/HealthWave and state employees. Kansans participating in the SEHBP will be affected as the KHPA renews contracts with health plans.

**Recommendation:**

Include a standardized format for health insurance cards for Medicaid/HealthWave beneficiaries and for State Employee Health Benefit Plan (SEHBP) enrollees to decrease administrative costs, improve efficiency, and increase health care coordination.

**Legislative Action:**

None. \$86,000 cost will be absorbed within the existing KHPA budget.

**Summary:** A study by the Governor's Health Care Cost Containment Commission discovered that around 20% of all medical claims were denied due to inaccurate or incomplete information regarding patient insurance coverage. Modern technology has made it possible for doctor offices to scan insurance cards using magnetic strips or bar codes to store the patient's coverage information. By using electronic "advanced ID cards," health care offices will allow technology to scan these cards for patient information about health insurance coverage and thereby reduce human errors.

**How much is spent on administrative costs including processing multiple insurance cards?** About one third of every dollar spent on health care in Kansas goes to pay for administrative costs. The purpose of standardizing health insurance cards is to decrease these administrative costs which are incurred by having multiple insurance card formats that are not electronic and promote confusion and mistakes among health care facilities.

**How does ID card standardization improve efficiency within health systems?**

Standardization can improve efficiency among administrative staff and improve coordination among providers and facilities. While many Kansans have multiple health insurance cards (e.g., health, dental, vision, prescription, etc.), these cards are not electronic. Therefore, physician offices have to spend significant amounts of time on paperwork, which leads to less time providing health care services to their patients.

**How will ID Card Standardization Benefit Me Personally?**

Due to significant amounts of paperwork, there is less time available for providers to spend with their patients tending to their health care needs. In addition, when claims are incorrectly denied due to inaccurate or incomplete insurance information, these unnecessary administrative costs are passed along to patients and employers who purchase coverage for their workers. Because the three targeted programs, Medicaid, HealthWave, and the State Employee Health Benefit Plan, use state dollars to finance health care costs, all taxpaying Kansans serve to benefit by reduced administrative health care costs.

**Will this Standardization be Universal?**

The format of the Advanced ID card is being developed using standards developed by Kansans, soon to be adopted nationally. The standards govern the transmission and receipt of information and focuses on specifications of applying ID card technology to patient ID cards. The KHPA recommendation is for Advanced ID cards to be implemented within State funded programs, Medicaid, HealthWave, and the State Employees Health Benefit Plan and pays for itself within one year. Implementation is also expected to move the market forward with more widespread adoption and utilization of Advanced ID Card technology in Kansas.

**How will this be implemented?**

Through a multiple stakeholder process (Mid-America Coalition on Health Care funded project), the standards for Advanced ID cards has already been developed. The input provided by this collaborative process has helped to prepare stakeholders for utilization of these ID cards. All beneficiaries will be mailed plastic cards with bar-code technology that will store eligibility information for real-time payment.

**Policy**

Expand the volume of community-based wellness programs through partnerships between state agencies and community organizations.

**Background**

Partnerships are the key to develop effective community-based wellness programs. There are many examples of these types of successful partnerships throughout the state. Kansas is in a unique position, in that there are significant foundations within the state with a keen interest in health promotion. This advantage gives Kansas the flexibility to adopt new and innovative strategies to promote health care that are not confined by strict federal funding rules. Kansas can also benefit from the experience of other states. For example, the state of Vermont has developed a successful community engagement strategy aimed at promoting community infrastructure to support healthy lifestyles. Initiatives focus on the built environment (walking trails, bike paths, etc.), physical activity programs in pilot communities, and awarding grants to communities for programs that support chronic disease prevention and management, and developing a toolkit for sharing successful evidence-based projects.

Support for additional organizations can improve health outcomes at the local level. For example, the Kansas Association of Counties (KAC) and the Kansas Association of Local Health Departments (KALHD) are seeking to improve birth outcomes by increasing access to early prenatal care through care coordination services and improved outreach efforts. Other examples of local partnerships:

- Partnerships with Local Health Departments. In 2004, the state of Kansas awarded grants to 36 local health departments to promote healthy eating practices and tobacco use prevention in addition to promoting physical activity initiatives within their communities. Additional training was later provided on using walking paths as catalysts to promote physical activity and better nutrition. Community grants such as these should be continually promoted across the state to provide needed funding for the construction of fitness centers, biking paths, and other wellness activities.

**Population Served**

The populations served are all residents and visitors to the state of Kansas.

- Partnerships with business groups. In 2004, the state of Kansas and Mid-America Coalition on Healthcare (MACHC) collaborated to implement a pilot worksite wellness project in the Kansas City metropolitan area involving 14 large and medium-sized employers. The 5-year project consists of four phases focusing on blood pressure, cholesterol, physical inactivity, obesity, poor nutrition, and tobacco use. The unique public-private partnership has engaged employers collaboratively with health plans, health care providers, universities, media, pharmaceutical companies, national researchers and various governmental agencies.
- Partnerships with other state agencies. The Kansas Department of Health and Environment partnered with the Kansas Department of Commerce in 2006 to start a worksite Farmer's Market in downtown Topeka to increase access to fresh, locally grown produce to downtown workers. This Farmer's Market has continued into 2007 with greater success. Similarly, the KHPA could partner with Kansas Department of Aging's (KDOA) successful STEPS program to encourage physical activity among seniors, Farmer's Market voucher initiative, and the Lifelong Communities program promoting successful aging among seniors.
- Partnerships with faith communities. The state of Kansas partners with the Center for Health and Wellness (CHW) to provide community-based hypertension reduction activities in African American churches in Sedgwick County. The program targets undiagnosed cases of hypertension and refers those identified clients for treatment. Monthly blood pressure screenings are conducted in over 35 churches and senior centers. Other faith-based partnerships in Kansas include the United Methodist Healthy Congregation program, providing technical assistance to United Methodist churches to develop a health plan for their congregations.

**Recommendation:**

Expand the volume of community-based wellness programs through partnerships between state agencies and community organizations.

**Legislative Action:**

None.

**Summary:** Successful partnerships are key to the development of effective community-based wellness programs and improving health outcomes locally. These partnerships involve more than government entities. They involve cooperation between the local business community and the faith community to succeed. The Centers for Disease Control (CDC) has long valued these partnerships and has invested in them in Kansas.

**What are some examples of state/local partnership opportunities?**

The Kansas Association of Counties and the Kansas Association of Local Health Departments have proposed working together to improve birth outcomes through increased access to prenatal care services.

**What about business partnerships?**

In 2004, the Mid-America Coalition on Healthcare partnered with the state to implement a pilot worksite wellness project in the Kansas City metropolitan area that focuses on addressing blood pressure, cholesterol, physical inactivity, obesity, poor nutrition, and tobacco use. This 5-year pilot project was implemented in 14 large and medium-sized employers.

**What about state agency cooperation?**

In 2006, the Kansas Department of Health and Environment and the Kansas Department of Commerce started the worksite Farmer's Market in downtown Topeka to increase access to fresh and locally grown produce to downtown workers, which continued into 2007 with even greater success.

**Are there examples within the faith community?**

Kansas also partners with faith based communities; the Center for Health and Wellness works with African American churches in Sedgwick County to reduce hypertension.

**Policy**

Support the establishment of a state-based surveillance system to monitor trends of overweight, obesity, and fitness status on all public school-aged children in Kansas, as recommended by Governor’s Council on Fitness.

**Background**

Obesity has become the second greatest threat to the long-term health of children, second only to tobacco. The percentage of young people who are overweight has more than tripled since 1980. As a result, it is projected that one of every three children born in 2000 (and one of every two Hispanic children) will develop diabetes in their lifetime. By 2020, one of every four dollars spent on health care will be used for obesity-related treatments. Data on childhood obesity in Kansas is currently gathered through surveys. While the current method of self-reporting gives the state a subjective view of the issue, data is lacking on the demographics of the children most affected. The lack of information means that programs are unable to appropriately target the most vulnerable populations in a cost-effective manner. Schools will need assistance in implementing this policy, as they expressed concern with loss of instructional time to perform the measurements, and with the time and fiscal costs of instituting such a program.

**Population Served**

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12.

**Recommendation:**

Collect information on health and fitness of Kansas school children.

**Legislative Action:**

None.

**Summary:** Since 1980, obesity rates in the U.S. have more than tripled, making obesity the second greatest threat to the long-term health of children. Based on these factors, it has been projected that one of every three children born in the year 2000 will develop diabetes during their lifetime. In 2007, HB 2090 was introduced which would require the collection of fitness data on students in grades 4, 7, 9, and 12 in order to benchmark the fitness of Kansas students and guide local and state policymakers. The legislation did not pass.

**What is the cost of obesity?**

By 2020, one of every four dollars will be spent on obesity-related health care treatments.

**What are the obesity rates for Kansas children?**

Nearly 30% of Kansas children aged 10-17 are either overweight or at risk for becoming overweight. Currently, data on childhood obesity is collected through self-reported surveys, which is subject to misrepresentation and misclassification of overweight and obesity.

**How will collecting fitness and weight measurements promote health prevention?** In order to get a true picture of the occurrence and demographics of obesity among our children, an objective measurement collection must be utilized. By obtaining accurate data, we can appropriately target the most vulnerable populations in a cost-effective manner.

**Which communities already collect health and fitness measurements?**

Historically, there has been no systematic reporting for which schools collect health and fitness information, but a growing number of schools statewide indicate they have begun to measure Body Mass Index (BMI) and fitness of their students. What we know about current school practices with regard to collecting BMI is from anecdotal reports or from program progress reports from grantees. The Coordinated School Health (CSH) Program has a direct relationship with 43 school district grantees and of the 22 districts that have responded to a survey about collecting this information, 16 indicated they are collecting BMI measures. The grantees collecting BMI on students in some form include: Atchinson County Community Schools, Buhler, Dighton, Dodge City, Fort Scott, Greiffenstein, Goddard, Hoisington, Holcomb, Maize, Parsons, Sacred Heart, Scott City, Seaman, Sterling Grade School, and Ulysses.

The Kansas Department of Health and Environment (KDHE) has successfully collected self-reported height and weight data on a random sample of students in grades 6-12 as part of the YTS (Youth Tobacco Survey). Additionally, KDHE and the Kansas Department of Education (KSDE) jointly administer the Youth Risk Behavior Survey (YRBS) to a random sample of high school students, grades 9-12. This survey provides state estimates on the prevalence of common health risk factors for adolescents including, but is not limited to, physical activity, nutrition, and tobacco use.

**Is the collection of this data an unfunded mandate to schools?** This proposal does not require school participation, it encourages it. According to a study by the Kansas State Department of Education (KSDE) and the Kansas Health Institute (KHI), more than 80% of public school and school district staff support the collection of BMI.

**Policy**

Adopt policies that encourage Kansas school children to select healthy food choices in school by competitively pricing and marketing these foods and restricting access to foods with little or no nutritional value.

**Background**

Childhood obesity rates are climbing at an alarming pace. In Kansas, 14% of children aged 10-17 are overweight (Kaiser State Health Facts – Data based on the National Survey of Children’s Health). Another 14% are at risk for becoming overweight (Youth Risk Behavior Surveillance System Data). Measures should be taken to reverse this trend through the adoption of school policies that encourage healthy eating.

Many students have access to vending machines and a la carte menus that facilitate unhealthy food choices. In Kansas, 45% of school food service programs offer a la carte items. Over 90% of public high school students have access to vending machines. Some of the most common purchases are soda, chips, and candy. As greater emphasis is placed on individual responsibility in adopting healthy behaviors, consideration must be given to support children and provide an environment of making healthy food at school a priority.

Policy initiatives in schools are recommended that support implementation of the Kansas School Wellness Policy Model Guidelines for Nutrition (Guidelines). The Guidelines provide recommendations to improve the nutritional quality of all foods and beverages available to students on school premises throughout the school day by addressing competitive pricing and promotion of healthy foods, portion size limitations, restricting access to foods of minimal nutritional value; all of which are effective strategies in reducing amount of soda consumed per week, increasing purchases of fruits, vegetables, and low-fat foods, and reducing overall energy intake.

**Population Served**

For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12.

Because school districts may utilize vending and other competitive foods sales revenue to support extracurricular activities in the face of decreased funding from other sources, it is important to change the food options to those that are nutritious. Studies have generally demonstrated positive or neutral fiscal results when contents of school vending machines have been changed to provide more healthy choices.

**Legislative Action:**

None.

**Summary:** Since 1980, obesity rates in the U.S. have more than tripled, making obesity the second greatest threat to the long-term health of children. Based on these factors, it has been projected that one of every three children born in the year 2000 (and one of every two Hispanic children) will develop diabetes during their lifetime. Not only will rising rates of obesity result in a decline in our nation's health, it means that our health care costs will increase. By 2020, one of every four dollars will be spent on obesity-related health care treatments.

In Kansas, nearly 30% of children aged 10-17 are either overweight or at risk for becoming overweight. Because children are at school for a large portion of the day and are beginning to form habits of health and nutrition that will impact the rest of their lives, targeting food options available in schools allow children an opportunity to form healthier eating habits.

Currently, 45% of Kansas schools offer a la carte items and over 90% of high schools have vending machines that students can access. The most common purchases from vending machines and a la carte lunches include sodas, chips, and candy that are high in calories but low in nutritional value.

**Will access to healthier foods change behaviors?**

Children, like adults, make food choices based on what is available, affordable, and convenient. Students are eating lunch at school, which is why the offering of nutritious food and restricting access to non-nutritional food is so critical. If the vending machine and a la carte menu are not as accessible, children are left with healthier lunch choices that will redefine one of three meals that they eat. We establish many of our habits and behaviors as children and reinforcing healthy eating behaviors in school is a way to develop lifelong healthy eating habits.

**Don't parents impact food behaviors more than schools?**

Schools do not take the place of parents modeling healthy eating habits. What schools can do is reinforce, through healthy food offerings, what parents may already be doing at home. Currently, nearly four of every five Kansas students do not meet the FDA recommendation of eating five fruits and vegetables a day. If families and schools work together, this trend may improve.

**Will there be a financial impact to schools?**

School districts may utilize vending and other competitive food sales revenue to support extracurricular activities. Studies indicate that the financial impact of offering healthy choices in schools is neutral or positive.

**Policy**

Expand healthy food choices in state agency cafeterias and vending machines. State government has an opportunity to lead by example by providing greater in-house healthy food selections for employees.

**Background**

Obesity is a key contributor of many chronic diseases, including some cancers, cardiovascular disease, and diabetes. Both nationally and locally, obesity rates have increased sharply in the past 20 to 30 years (Figure 6). According to the Centers for Disease Control and Prevention (CDC), the obesity rate among adults aged 20-74 increased from 15% of the population in 1976 to 33% of the population in 2003-2004. The estimated total cost of obesity in the US as of 2000 was approximately \$117 billion.

These statistics are even more sobering in Kansas. In 2006, over 36% of adults were overweight and nearly 26% were obese. Obesity has increased since 2000 when 21% of adult Kansans were obese. Promoting regular physical activity and healthy eating and creating an environment that supports these behaviors are essential to addressing the problem. Research shows that good nutrition can help to lower risk for many chronic diseases, including heart disease, stroke, some cancers, diabetes, and osteoporosis. However, a large gap remains between healthy dietary patterns and what Americans actually eat. In 2005, only one-fourth of US adults ate 5 or more servings of fruits and vegetables each per day. In Kansas as of 2000, 23% of adults consumed 5 servings of fruits and vegetables per day. This proportion has since declined with less than 20% of adult Kansans meeting recommended levels of fruit and vegetable consumption in 2005. Providing more healthy food options in state cafeterias and vending machines at competitive prices might begin to reverse current trends.

**Population Served**

On Oct. 5, 2007 there were 38,130 full-time and 3,416 part-time employees (total of 41,546). Other populations impacted would include contract workers and employee guests who frequently visit state agency facilities.

Other states have utilized state government as a starting point for healthy eating options. One program is Arkansas' chronic disease plan in which approximately 10,000 state employees completed the Healthy Employees Lifestyle Program (HELP) pilot. The Arkansas Department of Health provides nutrition related information to its vendors in order to promote stocking vending machines with healthier options. They also have a worksite wellness program "Fit with 5" that encourages workers to get the recommended levels of physical activity of 30 minutes on five or more days of the week and to eat five fruits and vegetables every day.

**Recommendation:**

Provide healthy food choices in the cafeterias and vending machines to state employees.

**Legislative Action:**

None.

**Summary:** In 2006, over 36% of Kansas adults were overweight and 26% were obese. Kansas is no exception to escalating obesity trends that have more than doubled in the last thirty years. Our obesity rates have increased 10% since 2001. Nationally, 15% of the population fell into the obese category in 1976, compared to 33% in 2004. Engaging in physical activity and healthy eating are the ways to reverse this trend. As of 2000, 23% of Kansas adults ate five servings of fruits and vegetables daily. This proportion dropped to only 20% in 2005. Not only are we not eating enough of the right foods, but portion sizes have increased simultaneously.

**Why target state employees?**

State employees comprise a substantial portion of the workforce in Kansas. Providing this population with the food choices that enable a healthy lifestyle sets an example for other employers to follow our lead and improve worker health outcomes. Reversing obesity trends result in taxpayer savings as state employee health costs decline.

**What are the health outcomes associated with obesity?**

Many chronic conditions result from obesity including heart disease, stroke, some cancers, diabetes, and osteoporosis. These conditions come with a steep price tag for everyone. Nationally, the estimated total cost of obesity was \$117 billion in 2000.

**Are healthy foods just a matter of sufficient selection?**

No, there is also a cost component. Healthy foods must be available at an affordable price. In other words, it should not cost less to buy a cheeseburger and fries than a salad in the cafeteria.

**Are other states offering healthy choices?**

Arkansas has implemented a comprehensive approach to nutrition and exercise through the Healthy Employees Lifestyle Program (HELP) pilot. The Arkansas Department of Health provides nutrition-related information to its vendors to promote stocking vending machines with healthier options. Approximately 10,000 state employees participated in HELP.



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