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KANSAS HEALTH POLICY AUTHORITY

Premium Assistance Fact Sheet
"Kansas Healthy Choices"

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

Background:

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

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

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

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Insurance options under Kansas Healthy Choices

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

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

Participation in Kansas Healthy Choices

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

Frequently Asked Questions (FAQs) about Kansas Healthy Choices

How do eligible families enroll in Kansas Healthy Choices?

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

How do Kansas Healthy Choices families select a health plan?

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

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

Who will participate in Kansas Healthy Choices?

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

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

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

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

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

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

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

When will Kansas Healthy Choices begin?

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

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

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

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

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

Premium assistance is not a magic bullet ensuring access to care; it is a source of funding to purchase adequate

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Why is the KHPA planning to procure three insurance plans?

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

How will Kansas Healthy Choices be funded?

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

Why is Federal participation in Kansas Healthy Choices so important?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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