

KHPA Consumer Advisory Council Meeting  
July 20, 2007, Eisenhower Bldg, Topeka KS  
Minutes - Final

**KHPA Consumer Advisory Council Members Present:**

- Peggy Johnson, Chair – via teleconference
- Al Penner – Vice Chair
- Jane Adams
- Deanne Bacco
- Theola Cooper
- Corrie Edwards
- Shannon Jones
- Bruce Linhos
- Rocky Nichols – Ed Rucker (substitute)
- Teresa Schwab – via teleconference
- Nancy Soeken – via teleconference
- Dinell Stuckey
- Maury Thompson
- David Wilson

**KHPA Consumer Advisory Council Members Unable to Attend:**

- Tim Davis

**KHPA Staff Participants:**

- Dr. Marcia J. Nielsen, Executive Director
- Dr. Andrew Allison, Deputy Director
- Dr. Barbara Langner, Consultant
- Janis DeBoer, Advisory Council Manager

**Welcome by Al Penner, Consumer Advisory Council Vice Chair**

Vice Chair Penner opened the meeting, welcomed members, the public, and KHPA staff. The agenda was reviewed along with handouts (packet information provided to Advisory Council members is available on the KHPA Advisory Council website). Again this month, the objective of the meeting was to facilitate discussion on health reform policy questions with an emphasis on paying for prevention and primary care and promoting personal responsibility. Vice Chair Penner reminded the group of the Council's charge to represent consumers from a "big picture" perspective and acknowledged the handout provided by Rocky Nichols, Executive Director, Disability Rights Center of Kansas.

**"Rising Health Care Costs, Prevention & Primary Care, and Personal Responsibility" – Presented by Dr. Marcia Nielsen, Executive Director**

Dr. Nielsen's presentation focused on the rising costs of health care in the United States and factors that

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impact our overall health. Dr. Nielsen recently attended a conference where Dr. Fienberg, President of the Institute of Medicine, presented the IOM's top ten concerns regarding the US health system and stated that "30 to 40% of every dollar spent in the US on health care is spent on overuse, underuse, misuse, duplication, etc."

Data from a 1975 study indicate four factors influence our health: medical care; genetic make-up; the environment; and how we live (behavior) which explains 51% of our health outcomes (a Purchaser Advisory Council member noted that more recent research indicates the percentage of health outcomes related to behavior has increased to 60-70%).

Kansas specific data was presented as it relates to health behavior and chronic disease. In 2003, 60.5% of Kansans were overweight or obese and childhood obesity has increased 36% in the past 20 years in Kansas. Smoking among adults has remained relatively unchanged from 1992-2003 (although youth rates have declined in the recent past). The prevalence of risk factors for coronary artery disease and stroke in Kansas has also increased.

Recommendations from national research institutes were included in the presentation. Dr. Nielsen noted that the Commonwealth Fund State Scorecard on Health System Performance, 2007, ranks Kansas in the second quartile and we should be proud of that ranking, however, we can do better.

### **Open Discussion of Policy Questions – Facilitated by Dr. Barb Langner**

Dr. Langner led the discussion on the twelve policy questions as follows:

#### **Prevention and Primary Care – Healthy Lifestyles:**

##### **1) What barriers exist that prevent Kansans from having healthy lifestyles?**

Comments/Input/Feedback from members:

- Tobacco use
- Obesity
- Education seems to be the key; consumers need to better understand nutrition labeling.
- Schools are removing physical education programs from the curriculum.
- Barriers seem to parallel with mental health discussion.
- Health plans can be a barrier with regard to who a consumer can or can not see in the health care delivery system.
- Smoking should be banned in all public places.
- Vending machines in schools make it difficult for children to eat healthy foods.
- Healthy food is frequently more expensive; difficult to purchase fresh fruits and vegetables on a limited income.
- Some communities have no safe environments for kids to go out and play.
- Really about habit formation for kids.

Summary: The general consensus of the Consumer Provider Council members was to support increased physical education activities in schools and ban smoking in public places when considering barriers that prevent Kansans from having healthy lifestyles.
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#### **Prevention and Primary Care - Interventions:**

##### **2) Do you have examples of interventions in your organization that have improved health behaviors?**

Comments/Input/Feedback from members:

- Education does work; the wellness program in Great Bend has been very helpful in providing information about reading nutrition labels and encouraging exercise. Also, the recreation center waives membership requirements for those who want to walk the track. And, the city zoo has a walking path.
- Local church encourages use of pedometer for members; encourages members to get out and walk.
- Health plans could provide full coverage on prescriptions for individuals wanting to stop smoking.
- Health plans could cover grab bars for elderly and others.

- Health plans could include health risk incentives with different premiums based on health risk assessment.
- Any Health plan that includes different premiums for different members based on health risk assessment may be guilty of invidious discrimination against the elderly, persons with disabilities and persons who inherit genetic predisposition to a disease or condition. Such plans contradict the core idea of insurance which is to take a small contribution from each individual in a broad pool of participants regardless of their current need; in exchange for the assurance that in the event of need the resources will be there to them as well as their neighbor.
- Incentives and penalties must be carefully designed and fairly applied or such devices will adversely and disproportionately impact the elderly and people with disabilities who may not have the ability to access the carrot or avoid the stick; based not on an unwillingness to pursue a healthy behavior but on a simple inability to do so. Unless a healthy benefit design can be implemented in such a way that it does not negatively impact elderly and people with disabilities Kansas should not implement such a plan.

Summary: The general consensus of the Consumer Advisory Council members was education is a significant component of successful interventions and interventions can include both incentives and penalties, as appropriate for any given population.

### **Prevention and Primary Care – Health Benefit Designs to Incentivize and Reward Health:**

#### **3) What changes might be included in health benefit designs to incentivize and reward health? (The question was modified to replace “should” with “might.”)**

Comments/Input/Feedback from members:

- Modify premiums; premium increases and decreases could be based on behaviors, however, must be cognizant of creating disincentives.
- Disincentives could be mitigated.
- Reduce premium by \$60.00 for example if individuals join and use a gym.
- Health benefit designs should include free dental preventative visits.
- Health benefit designs could be available to cover mental health screening during work hours.
- Encourage insurers pay for classes/educational interventions.
- Health benefit designs should reflect life-style behaviors, but with protections for people with disabilities and seniors. Benefit packages created to reflect life-style behaviors must be carefully designed and fairly applied or such devices will adversely and disproportionately impact the elderly and people with disabilities who may not have the ability to take full advantage of such a benefit design; based not on an unwillingness to pursue a healthy behavior but on a simple inability to do so. Being elderly and having a disability are not life style choices and should not negatively impact a participant's premiums or benefits. Unless a life style behaviors benefit can be implemented in such a way that it does not negatively impact seniors and people with disabilities Kansas should not implement such a plan.

Summary: The general consensus of the Consumer Advisory Council members was health benefit designs should reflect life-style behaviors to incentivize and reward health, as appropriate for any given population.

### **Prevention and Primary Care – Decrease Obesity and Tobacco Use:**

#### **4) What policies should Kansas adopt to decrease obesity?**

#### **5) What policies should Kansas adopt to decrease tobacco use?**

Comments/Input/Feedback from members:

- Cities should be encouraged to look at walking trails.
- Education about healthy eating should begin with preschoolers; education by dietitians and nutritionists needs to be available in schools; grandparents need to be included in educational sessions.
- Utilize Kansas extension offices to assist with education about purchasing healthy foods.
- Work environments, churches, schools, senior centers, etc., are probably the best places for education; physician offices are too stressful.

- Physicians should be encouraged to get more engaged in educating their patients; patients listen to their doctors.

Summary: The general consensus of the Consumer Advisory Council members was that all sectors of society should be involved in the adoption of public policies to decrease obesity and tobacco use with a focus on education.

#### **Prevention and Primary Care – Health Benefit Designs to Manage Chronic Disease:**

##### **6) What changes might be included in health plan benefit designs to better manage chronic disease?**

Comments/Inputs/Feedback from members:

- Provide vouchers to individuals with chronic diseases to incentivize regular visits to their physicians.
- Reduce co-pays and deductibles for individuals with chronic diseases.
- Access is an issue; physician offices are closed after 5:00 and on weekends.
- Difficult to gain access for disabled individuals due to pre-existing conditions.
- Prevention and disease detection services often have high co-pays.
- Persons with a chronic disease or condition have the best healthcare outcomes when they have regular access to their doctor. Eliminating punitive co-pays and deductibles specifically for visits to a physician about a chronic disease or condition will enable and encourage those visits to the physician which are the key to effectively managing the chronic disease or condition.

Summary: The general consensus of the Consumer Advisory Council members was that many consumers can not afford the cost of co-pays and deductibles and therefore chronic disease is not well managed, in addition to access concerns.

#### **Prevention and Primary Care – Patient-Centered Medical Home:**

##### **7) What barriers exist that prevent Kansans from having a medical home?**

##### **8) What changes might be included in health plan benefit designs to drive the delivery of care to a patient-centered medical home?**

Comments/Input/Feedback from members:

- Medical debt can prevent an individual from having a medical home.
- A lack of health care providers can prevent an individual from having a medical home; workforce issue.

Summary: The general consensus of the Consumer Advisory Council members was support for a patient-centered medical home delivery system.

#### **Prevention and Primary Care – Prevention Effort Priorities:**

##### **9) Given the state's limited resources, what prevention efforts should the state focus on first?**

Comments/Input/Feedback from members:

- Start with kids, then parents.
- Focus on parent advocacy groups; empower the parents
- Educate our children, but include parents in the education efforts.

Summary: The general consensus of the Consumer Advisory Council members was to focus on prevention education for children, but also educate and empower parents.

#### **Personal Responsibility:**

##### **10) What policies should Kansas adopt to encourage Kansans to embrace healthy behaviors?**

##### **11) What policies should Kansas adopt to encourage the use of cost-effective health care services?**

## **12) What policies should Kansas adopt to promote contributions to the cost of health insurance, based on ability to pay?**

Comments/Input/Feedback from members:

- Consumers are paying their “fair share.”
- Prevention should be the focus of policies; first dollar coverage should be included in health plans to encourage cost-effective health care services.
- Counseling services designed to support weight loss, for example, should be considered a cost-effective health care service in health plans.
- Co-Pays are devices to make consumers aware of the costs of their treatments and to discourage wasteful use of health care system resources, but when confronted with the reality of a person living with a disability, often with a low or moderate income, co-pays become a disproportionate burden in access to health care for the disabled who do not have a choice in seeking medical care.
- Wellness programs. These programs offer discounts to individuals to take action to maintain a more health lifestyle, such as losing weight, quitting smoking, or taking up exercise. In return the consumer is offered a discount on the cost of the coverage. The problem here is that this program shifts additional burdens to persons with disabilities who may not be in a position to fully participate in the wellness program in the first place. While founded with the reasonable goal of promoting healthy living such programs run counter to the basic reason for insurance, to shift the risk from the individual to the broad pool of participants who each pay a little of the cost for the assurance that in the event of need the resources will be there to them as well as their neighbor. A wellness program is a mechanism which drives adverse selections wherein the public sector programs or products are abandoned by younger (relatively low cost of service) individuals lured into a private insurance market by companies who may or may not be in the market in the next month year or decade. There is no reason to build into a public product a device which works counter to the basic risk shifting purpose of insurance.
- Any solution on this topic must not punish people with disabilities or seniors because of their disabilities or health conditions.

Summary: The Consumer Advisory Council supports the notion of viewing health differently; as opposed to viewing health as the absence of disease the group prefers adopting policies that: 1) encourage Kansans to embrace behaviors that result in the highest level of individualized health potential, 2) encourage the use of individualized cost-effective health care services, and 3) promote contributions to the cost of health insurance, based on ability to pay.

The group was reminded of the agenda for the August meeting which is to review the summary statements for each of the policy questions presented at the June and July meetings. The summary statements, once consensus is reached, will be reflected in the interim report presented to the Kansas Health Policy Authority Board on August 20 by the Council Chairs.

### **Next Steps**

- The Advisory Council grid will be used to prioritize the issues that the council will consider for health reform, focusing first on health insurance reform options, as identified by SB 11 (June meeting).
- Other health reform options, such as those developed in collaboration with other agencies, will be considered subsequent to the health insurance reforms (July meeting).
- Advisory councils will begin to “fill in the grid,” identifying the advantages and disadvantages of various health reform options (August meeting).
- The KHPA Board and Health for All Kansans Steering Committee will then use the grid to inform their development of health reform options (August meetings).
- The development of health reform options will be iterative, in that the Board and Health for All Kansans steering committee will direct/provide feedback to the Advisory Councils as they consider reform options (September meetings).
- Independent consultants and KHPA staff will analyze various reform options in order to identify the economic costs (to consumers, to business, to state government, to federal government) as well as to identify the number of individuals who will get access to health care under each reform option

(September meeting).

- The Joint Oversight Committee for the KHPA will be apprised/consulted on health reform options (September meeting).
- The KHPA Board will present the final health reform options to the legislature (KHPA Oversight Committee and legislative leadership) and Governor on November 1 2007.

**Adjournment**

Next Meeting: Friday, August 17, 10:00 – 12:00, Eisenhower Building, 4<sup>th</sup> floor conference room