

Testimony on:
SB 387: Premium Assistance &
2007 Short Term and Long Term Consensus Package

presented to:
Senate Committee on Ways and Means

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March 28, 2007

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Senate Committee on Ways and Means
March 28, 2007

Good morning, Chairman Umbarger and members of the Committee. I am Marcia Nielsen, Executive Director of the Kansas Health Policy Authority (KHPA). With me today is Andy Allison, Deputy Director and Acting Medicaid Director. I appreciate the opportunity to talk to you today about the premium assistance language proposed in Senate Bill 387. I'd also like to provide some background on and the results of the process for health reform the Health for All Kansans Steering Committee and the Kansas Health Policy Authority Board has participated in over the last couple of months.

2007 Short Term and Long Term Consensus Package
Health for All Kansans Steering Committee & Kansas Health Policy Authority Board

The Health for All Kansans Steering Committee began meeting in early February and included four legislators and several board members. Consensus was achieved on a short term legislative package for adoption this session as well as enabling legislation that directs the KHPA to develop health reform options for consideration by the 2008 legislature and implementation in 2009 and 2010. The full KHPA board voted to endorse both proposals. The plan and timeline for broad health reform will be developed *this year* with the input from a wide array of stakeholders through the Advisory Councils recently adopted by the KHPA Board. All health policy options that will be developed will include an independent economic analysis in order to help legislators understand (a) the costs of any proposals (to the state, to the federal government, employers, and individuals) and (b) who will gain access to health insurance as a result of the policy option. This is the kind of information that policymakers need and deserve before advancing health reform plans for the state – Kansas specific policy requires Kansas specific information and input.

Short term legislative package for action this year

1. Early detection and screening for newborns – *legislation already moving*

Expands screening for newborns from our current level of four tests to twenty-nine. This effort represents a true and meaningful step in the direction of early diagnosis and early intervention that will pay immeasurable benefits in future years.

FY 2008 SGF: \$191,000; All Funds: \$1,189,942

Recent Action: The House and Senate budget conference committee reached an agreement on two health care related issues over the weekend. Committee members agreed to budget \$8.0 million and 2.0 FTEs for expanded newborn screening in Kansas. These funds will allow all newborns in Kansas to receive screening for the 29 treatable conditions.

2. Medicaid outreach and enrollment expansion – *need appropriation*

Expands the marketing of programs available to the public in order to educate Kansans about the HealthWave program and about health and wellness by: (1) designing an online application and screening tool for potential beneficiaries, (2) developing and implementing a targeting marketing campaign and (3) employing additional outreach workers.

Enrollment in the Kansas HealthWave and Medicaid Programs

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3. Consider Deficit Reduction Act (DRA) Flexibilities – *no legislation needed*

Supports the opportunities provided through the DRA to allow moving waiver services into the Medicaid state plan, designing benchmark benefit packages with more cost sharing, and exploring innovative reform models through Medicaid Transformation Grants.

Recent Action: The Kansas Medicaid program has received a Medicaid Transformation grant for \$910,000 which will combine predictive modeling with training by KU clinicians to assist case managers in coordinating preventative care for disabled Medicaid beneficiaries with the goal of improved health outcomes. We have also submitted a Long Term Care Partnership grant together with the Kansas Department of Insurance and the Department on Aging. Other DRA flexibilities will be explored in broader health reform as outlined the enabling legislation.

4. Promoting price and quality transparency – *needs appropriation*

Promotes transparency for Kansas consumers and purchasers through a two phased approach that collects data currently available in one convenient location (through KHPA and State libraries), and then adds health care pricing and quality data (as determined by the KHPA Data Consortium – comprised of providers, consumers, and purchasers). This kind of information will also help to reduce utilization of care that is not evidence-based or is of questionable quality, which will serve to reduce overall health care costs.

SGF: \$425,682 (FY 2008) All Funds: \$543,790 (FY 2008)

5. Increasing Health Information Technology/Health Information Exchange (HIT/HIE) – *need appropriation.*

Building on the work of the Health Care Cost Containment Commission (H4C) and the KHPA, the state will develop and establish an “Implementation Center for HIE” in Kansas through a public/private entity in order to have a single coordination point for Kansas HIE efforts. Adoption of HIT and HIE will help to improve patient safety, cut down on administrative costs, promote evidence-based health care and help to reduce overall health care costs.

SGF: \$750,000 (FY 2008) All Funds: \$1 M (FY 2008)

6. Premium Assistance for Low Income Families – *need legislative language: SB 387*

Creates a phased-in premium assistance program in order to help low income uninsured families in Kansas to purchase private health insurance, either through their employer or through state procured health insurance plans. Research suggests that better health outcomes are associated with all family members receiving access to care or health insurance through the same plan, and thus, have a “medical home”. 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 (less than 38 percent of the FPL). In 2006, 37% of the Federal Poverty Level (FPL) was \$3,626 for a single person; \$4,884 for a family of two; \$6,142 for a family of three; and \$8,658 for a family of four.

Details on Premium Assistance: Premium assistance in Kansas will be phased in over four years, with a “legislative trigger” after the first two years to evaluate the program and ensure that funding is available. Premium Assistance programs can be implemented to two ways:

Enrollment in the Kansas HealthWave and Medicaid Programs

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- Competitively bid state-procured health plans: For low income uninsured families, Medicaid (state and federal share) would pay for premiums for state-procured private health insurance to be offered to low income children and their parents. Because children eligible for Medicaid are required by federal law to receive certain services, the private insurance plans would be supplemented by “wrapping around” private health insurance coverage with fee-for-service Medicaid.
- Employer-sponsored insurance (ESI) buy-in: For low income uninsured parents who have access to employer sponsored private health insurance, Medicaid would pay the employee share of the health insurance premium for families and then “wrap around” children’s coverage with fee for service Medicaid.

Reduces the number of uninsured Kansans

- Phases-in health insurance coverage to families who are uninsured with Medicaid-eligible children (i.e. those at approximately 37% of the federal poverty level)
- Creates a “medical home” for families because premium assistance brings parents and children into the same private health insurance plan
- Protects health care benefits currently offered to children on Medicaid

Expands private health insurance coverage

- Expands coverage solely through private health plans, promoting competition in the health insurance marketplace
- Increases health plan choices available to low-income families, similar to the State Employee Health Benefits Plans (includes HSA)
- Puts Medicaid benefits for parents on a par with privately-insured families
- Prepares the way for further reforms to improve markets and expand health insurance coverage
- Can be used to incentivize health promotion and disease prevention within private plans
- Will be “phased in” to dovetail with additional health insurance market reforms, such as a health insurance connector

Leverages federal dollars toward broader health reform

- Draws in federal matching funds and takes advantage of Deficit Reduction Act Flexibilities – giving Kansas an opportunity to “catch up” with other states in terms of federal support for increasing access to health care
- Together with increased transparency of health care cost and quality as well as information technology, can create partnerships with the US Department of Health and Human Services

Cost and Coverage Premium Assistance Plan – preliminary estimates only

Phase-In	Year 1	Year 2	Year 3	Year 4	FULL PHASE IN
Percent of Federal Poverty Level (FPL)	Ramp up (Those under 37% FPL)	Under 50% FPL	50-74% FPL	75-99% FPL	Total under 100% FPL
Number of parents covered	N/A	8,500	7,000	8,500	24,000
Estimated administrative costs	\$.5M	\$1.5M	\$2M	\$2.25M	\$2.25M
SGF: Premium costs		\$11M	\$9M	\$11M	\$31M
Federal Matching Funds		\$16M	\$14M	\$16M	\$46M
Total Costs		\$27M	\$23M	\$27M	\$77M

Long Term Health Insurance Reform: Enabling legislation for action this year

The KHPA supports enabling legislation this session to direct development of “Health for all Kansans” legislation for adoption in 2008 and implementation in 2009 and 2010. The Steering committee thus endorsed the Substitute for SB 309 proposal, which was authored by Senator Jim Barnett and was passed the Senate 40 to 0.

Guiding Principles for Health Reform in Kansas:

- Every Kansan should have access to patient-centered health care and public health services ensuring the right care, at the right place, and the right price.
- Health promotion, education, and disease prevention should be integrated directly into these services.
- The financing of health care and health promotion in Kansas should be equitable, seamless, and sustainable for consumers, providers, purchasers and government.
- Reforms to the health system in Kansas should be fiscally responsible, market based, and promote individual responsibility.
- Reforms to the health system in Kansas must protect the health care safety net..

Time frame agreed upon the Steering Committee:

- By March 19th 2007: Advise the KHPA Board, the Governor, and legislative leadership on a proposed legislative package that could be considered during the 2007 session.
- By March 19th 2007: Advise the KHPA Board, the Governor, and legislative leadership on proposed enabling legislation that would charge the KHPA with the development of health reform options that achieve access to care for all Kansans.
- March 20th, 2007: Share proposed legislative package and enabling language for consideration by the KHPA Board.

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- April 1 through November, 2007: The KHPA will develop health reform options as outlined in the enabling legislation, in collaboration with the Advisory Councils. Economic impact analysis for these reform options will be provided by national experts with experience in state health reform. KHPA will update the Board, Governor, and legislative leadership on progress.
- By November 1, 2007: The KHPA staff will deliver the health reform options to the KHPA Board, Governor, legislative leadership (including the Oversight Committee) for their consideration. This package will include: 2 or 3 options; a feasible timeline; a cost analysis; an estimate on administrative costs (contract and staff expenses); and an economic analysis on the impact of these proposals to populations served.
- 2008 Legislative Session. The Governor and Legislature will consider health reform options for adoption by 2008 legislature.
- 2009 and 2010. KHPA to implement health reforms – continue to collaborate and refine policies with the Advisory Councils and Steering Committee.

Fact Sheet: Premium Assistance for Low-Income Families

What is Premium Assistance?

Premium assistance uses federal and state Medicaid and/or SCHIP funds to subsidize the purchase of private health insurance or through a state procured health insurance plan. Some states are moving toward this model to encourage low-income families' participating in private health insurance coverage, shore-up the private coverage market and prevent crowd-out, and achieve cost savings by bringing in employer contributions to help offset costs.

How would premium assistance work with private health insurance coverage?

Premium assistance would actually expand private health insurance coverage and promote competition in the health insurance marketplace. An increased number of health plan choices would be available to low-income families, similar to the State Employee Health Benefits Plan. In addition, it would put Medicaid benefits for parents on par with privately-insured families.

How would premium assistance 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 (less than 38 percent of the FPL). In 2006, 37% of the Federal Poverty Level (FPL) was \$3,626 for a single person; \$4,884 for a family of two; \$6,142 for a family of three; and \$8,658 for a family of four. By providing parents with medical coverage, there is a greater likelihood the children will also have health benefits.

How would premium assistance improve *health outcomes* for Kansas families?

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 as part of the same health insurance plan also helps coordinate care and helps to provide a "medical home".

How would premium assistance programs be implemented in Kansas?

Premium assistance in Kansas will be phased in over four years, with a "legislative trigger" after the first two years to evaluate the program and ensure that funding is available. It will be implemented in two ways:

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Benefits and Plan Purchasing:
Phone: 785-296-6280
Fax: 785-368-7180

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

- Competitively bid state-procured health plans: For low-income uninsured families, Medicaid (state and federal share) would pay for premiums for state-procured private health insurance to be offered to low-income children and their parents. Because children eligible for Medicaid are required by federal law to receive certain services, the private insurance plans would be supplemented by “wrapping around” private health insurance coverage with fee-for-service Medicaid.
- Employer-sponsored insurance (ESI) buy-in: For low-income uninsured parents who have access to employer sponsored private health insurance, Medicaid would pay the employee share of the health insurance premium for families, and then, “wrap around” children’s coverage with fee for service Medicaid.

How many Kansans would receive benefits from premium assistance?

Cost and Coverage Premium Assistance Plan – preliminary estimates

Phase-In	Year 1	Year 2	Year 3	Year 4	FULL PHASE IN
Percent of Federal Poverty Level (FPL)	Ramp up (Those under 37% FPL)	Under 50% FPL	50-74% FPL	75-99% FPL	Total under 100% FPL
Number of parents covered	N/A	8,500	7,000	8,500	24,000

How would a premium assistance program in Kansas be funded?

A premium assistance program in Kansas would be funded with federal matching dollars. It takes advantage of Deficit Reduction Act (DRA) flexibility by giving the state an opportunity to “catch up” with other states in terms of federal support for increasing access to health care. Together with increased transparency of health care cost and quality as well as information technology, we can create partnerships with the US Department of Health and Human Services. This program would be phased in over four years, with a “legislative trigger” after the first two years to evaluate the program and ensure that funding is available. Below is a graph indicating the cost of the premium assistance plan.

Cost and Coverage Premium Assistance Plan-- preliminary estimates

Phase-In	Year 1	Year 2	Year 3	Year 4	FULL PHASE IN
Percent of Federal Poverty Level (FPL)	Ramp up (Those under 37% FPL)	Under 50% FPL	50-74% FPL	75-99% FPL	Total under 100% FPL
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Federal Matching Funds		\$16M	\$14M	\$16M	\$46M
Total Costs		\$27M	\$23M	\$27M	\$77M

* Because we expect to phase in the program for those under 50 percent FPL beginning in January of 2009 (half of the fiscal year), the SGF costs for FY 2009 per the fiscal note are \$5.5 million.

Who supports premium assistance?

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, Iowa, Oklahoma, Utah and most recently Massachusetts. Evaluations of these programs are on-going.

How does premium assistance fit into the long-term health reform plans in Kansas?

A premium assistance program expands private health insurance coverage, and thus, helps prepare the way for further reforms by improving the marketplace. As the discussion surrounding the need for prevention and health promotion, premium assistance can be used to incentivize health promotion and disease prevention within private plans. Most importantly, the premium assistance program will be “phased in” to dovetail with additional health insurance market reforms, such as a health insurance connector.

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

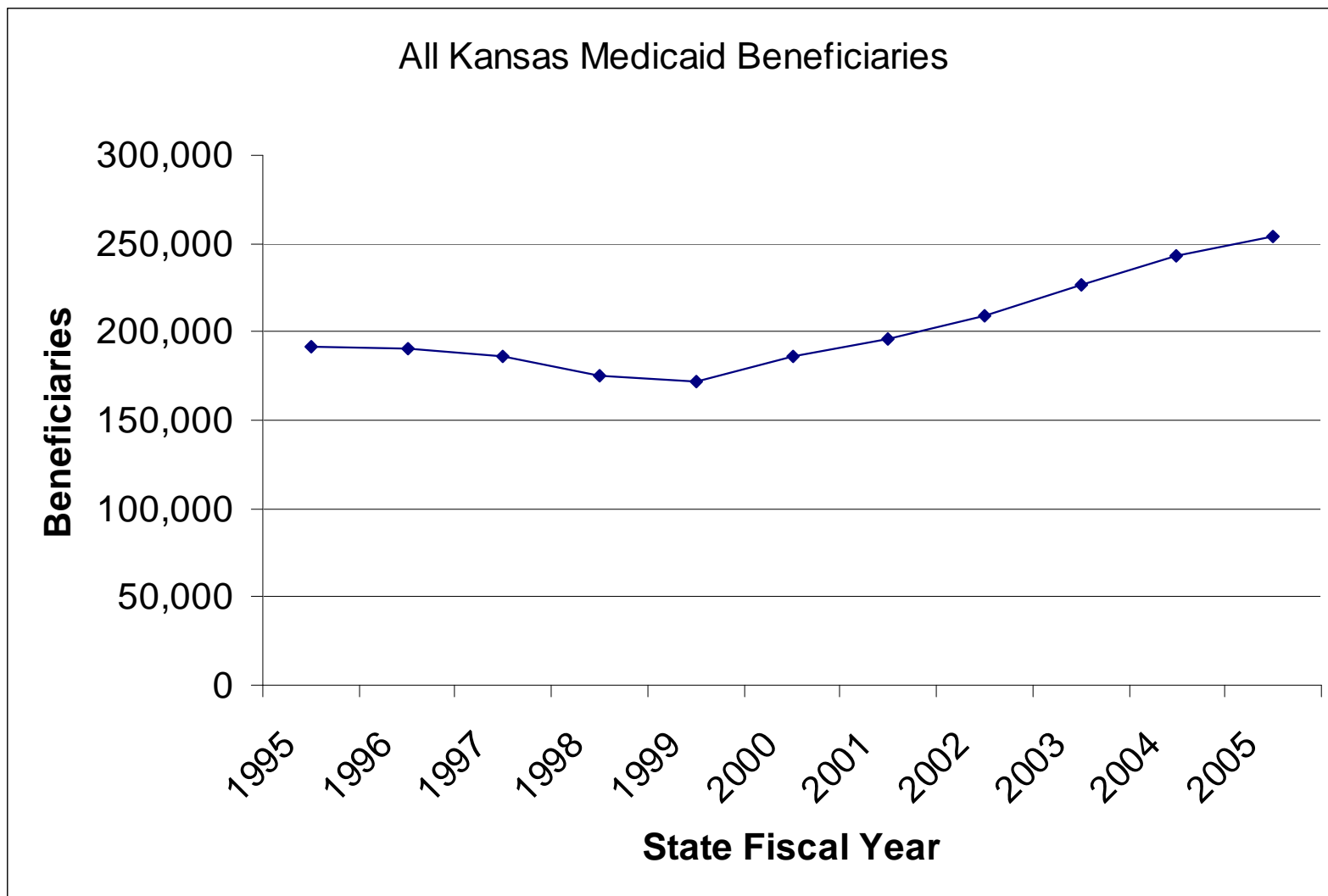
* For this reason, the State of Kansas will also procure competitively bid plans for those individuals who do not already have access to employer sponsored health insurance.



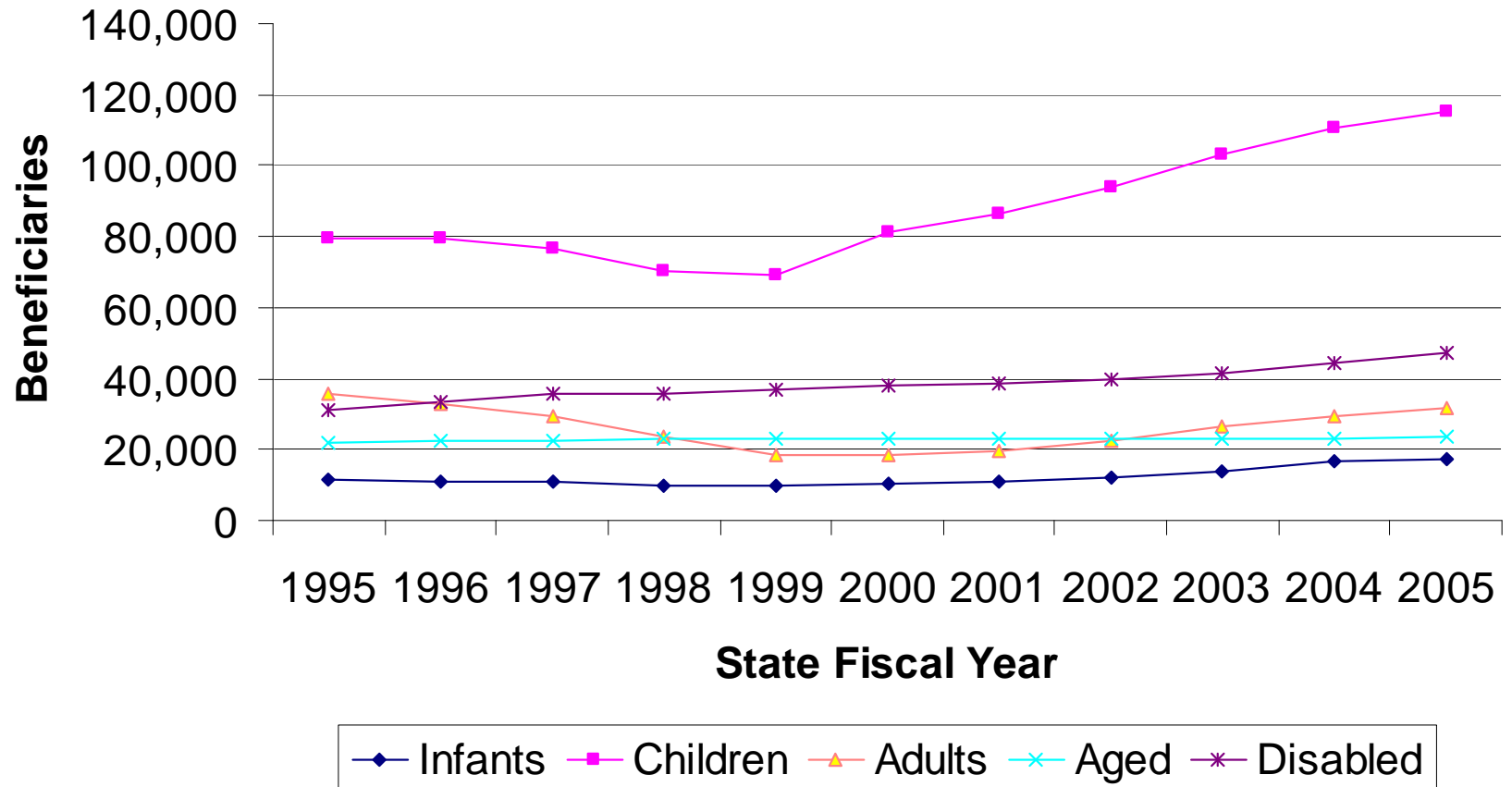
Medicaid and SCHIP Eligibility Historical Trends

Marcia J. Nielsen, PhD, MPH

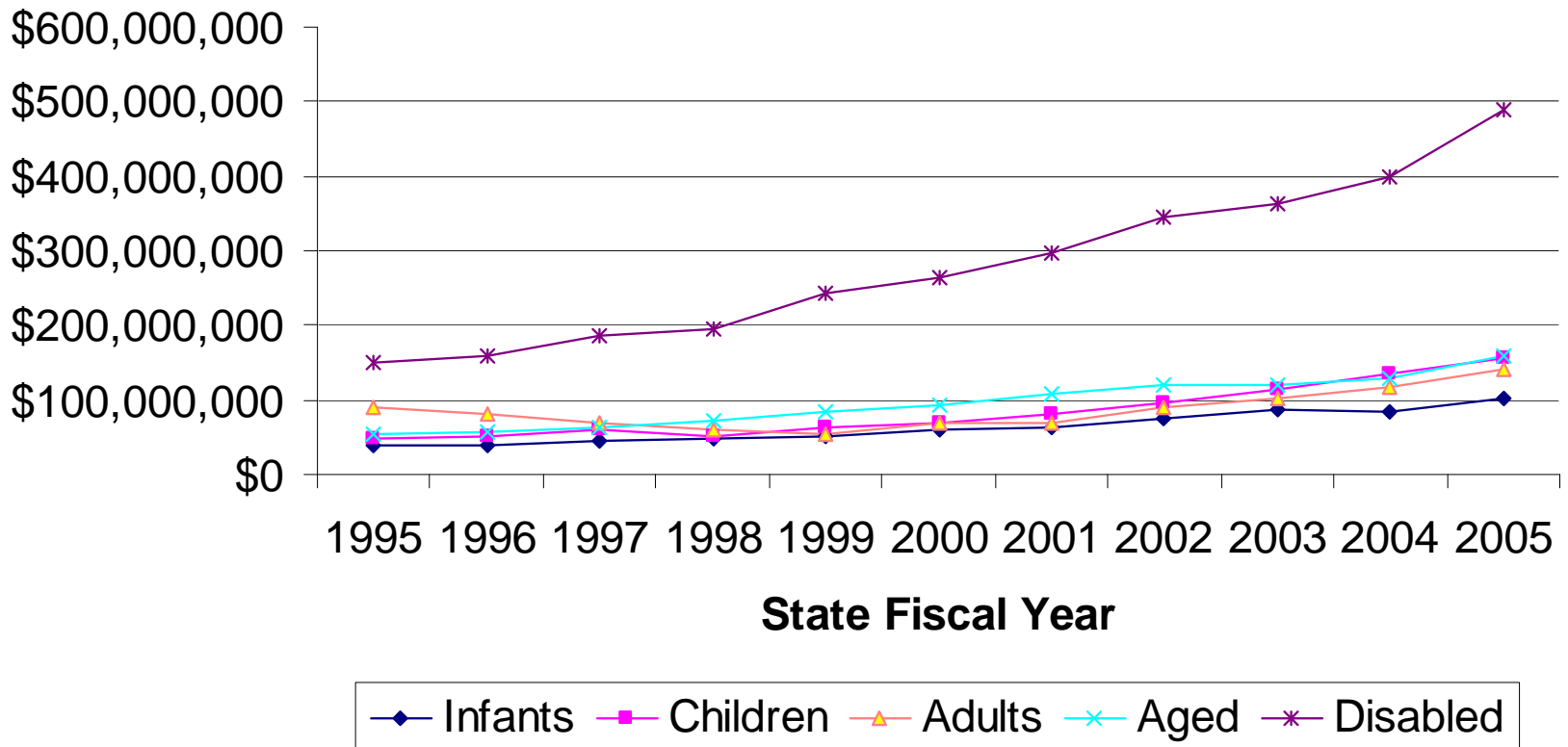
Andrew Allison, PhD



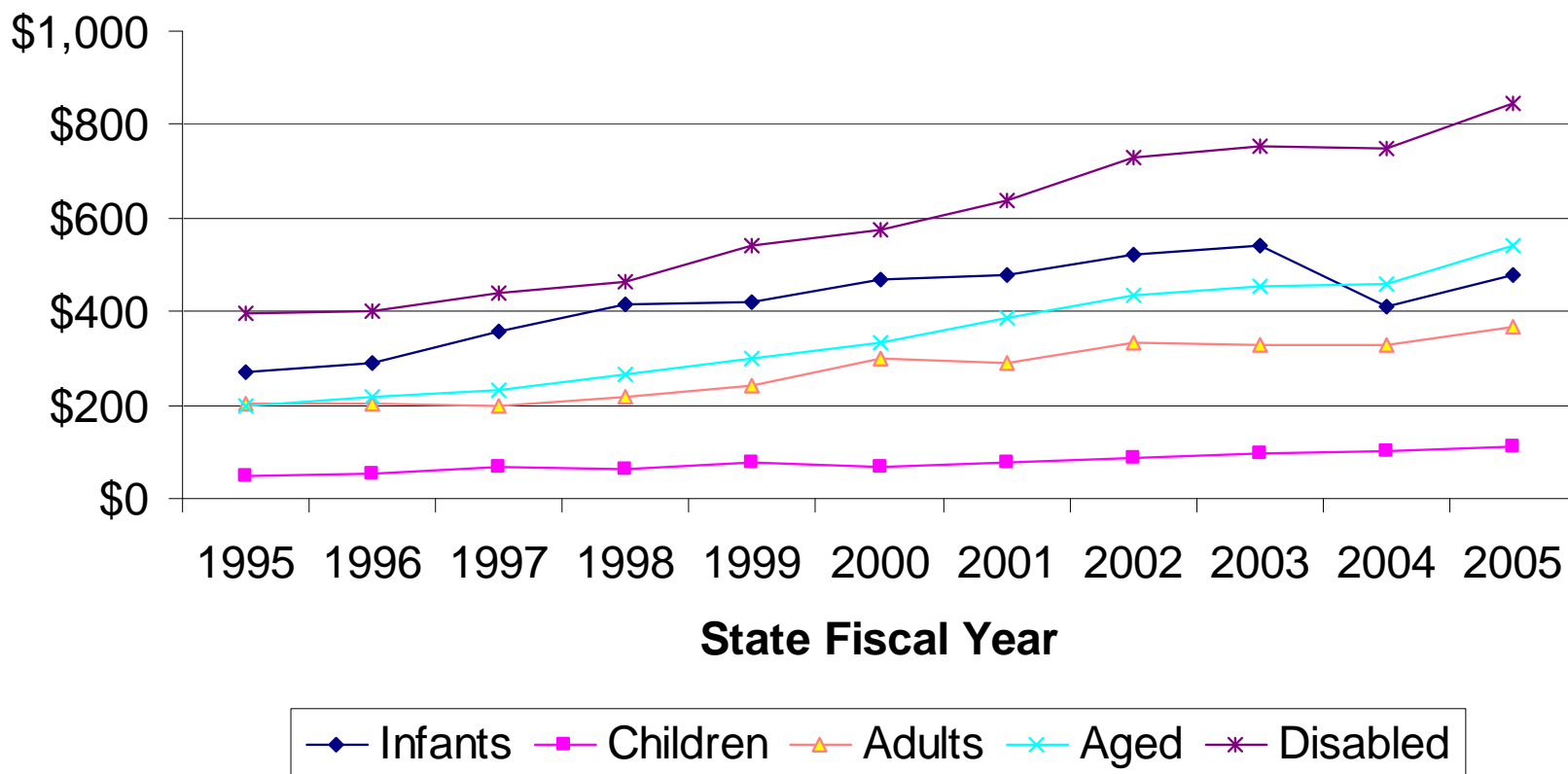
Kansas Medicaid Populations Groups



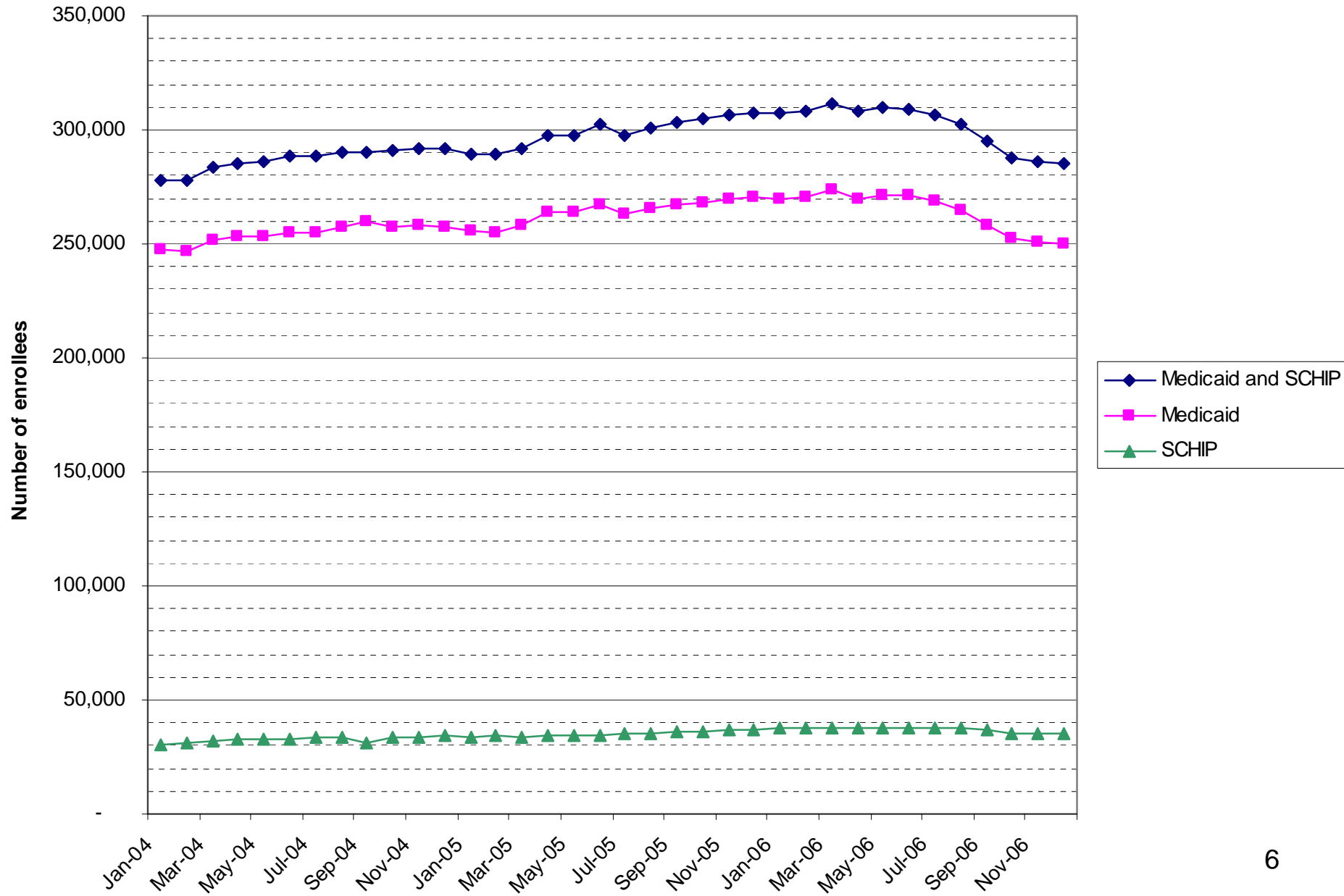
Kansas Regular Medical Medicaid Expenditures by Population Groups Excluding LTC



Regular Medical Medicaid Expenditures Per Person Per Month per Population Group

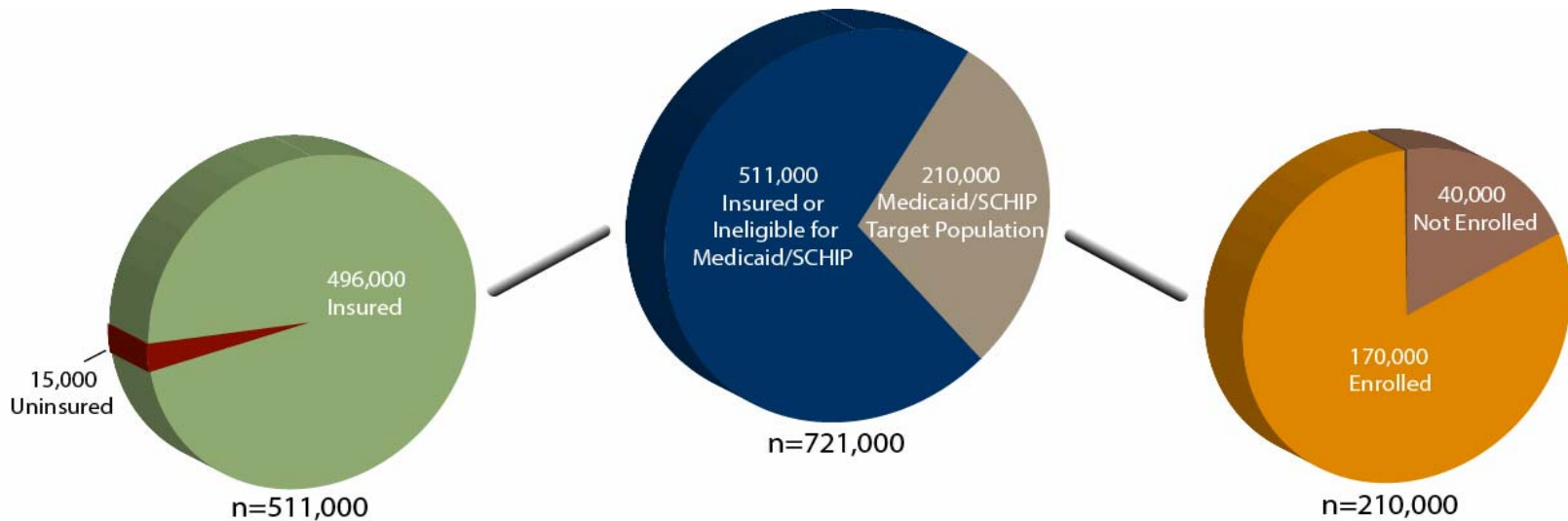


Enrollment in Medicaid and SCHIP: FY 2004-2007



Health Insurance Status of Kansas Children

Kansas Children Under the Age of 19



Insured or Ineligible for Medicaid/SCHIP

Medicaid/SCHIP Target Population

- Kansas Medicaid/SCHIP programs insure 81 percent of target population