Approved: February 15, 2011
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairperson Carolyn McGinn at 10:30a.m. on January 19, 2011, in Room 548-S of the Capitol.

Senators Schmidt and Emler, excused

Committee staff present:
Jill Wolters, Office of the Revisor of Statutes
Daniel Yoza, Office of the Revisor of Statutes
David Wiese, Office of the Revisor of Statutes
Alan Conroy, Director, Legislative Research Department
J. G. Scott, Chief Fiscal Analyst, Legislative Research Department
Aaron Klaassen, Senior Fiscal Analyst, Legislative Research Department
Dorothy Hughes, Fiscal Analyst, Legislative Research Department
Brea Short, Intern, Senator McGinn's Office
Jan Lunn, Committee Assistant
Josh Lewis, Chief of Staff

Conferees appearing before the Committee:
Suzanne Cleveland, J.D., Kansas Health Institute
Amy Deckard, Senior Fiscal Analyst, Kansas Legislative Research Department

National Health Care Reform: How it impacts Kansas

Suzanne Cleveland, Kansas Health Institute (KHI), distributed her written testimony (Attachment 1) and commented that KHI is a non-profit health policy and research organization. Its mission is to inform policymakers by identifying, producing, analyzing and communicating timely, relevant, and objective information.

She described the three components in the Affordable Care Act (ACA): public health; cost containment, payment, and delivery reform; and access to coverage and care. The potential economic impact of these components was reviewed. In addition, the creation of state-based health insurance exchanges; new limits on rating practices and cost-sharing; guaranteed access to health insurance coverage regardless of health status; and the expansion of Medicaid to 133 percent of the Federal Poverty Level (FPL) was discussed. Ms. Cleveland also reported on the costs (by payor) prior to and following implementation of the Federal Health Care Reform Act.

Senator McGinn requested additional information related to health care exchanges. Ms. Cleveland elaborated there can be numerous exchanges within each state (i.e., regional, interstate, multiple exchanges within the state). Many details related to how the exchanges and the market outside of the exchanges will operate is unknown, and much discretion is left to the states in determining how to design the health insurance marketplace.

Discussion was heard regarding the mandate for purchasing health care insurance, what religious and other exemptions exist, and what penalties or consequences exist for the individual not purchasing health care insurance. Ms. Cleveland will research and provide the language related to religious exemptions to Committee members.

Senator McGinn requested information related to how the federal government would backfill the loss of mental health dollars in individual state budgets. Ms. Cleveland indicated she would investigate and provide information related to available federal grants or other possible funding options.

Senator Lee inquired whether ACA reform contained provisions related to accidents and specifically, if the Act identifies the payor when liability insurance overlaps health insurance. Ms. Cleveland will provide additional information at a later time.

Senator Taddiken asked how the new Medicaid and Children's Health Insurance Program (CHIP) beneficiaries will be paid under ACA reform. Ms. Cleveland indicated newly eligible Medicaid enrollees will be paid at 100 percent federal match from 2014 to 2016 at which time the match begins to taper until 2020 where the match will be 90 percent.

Senator Teichman indicated there was an information sheet, "Minimum Requirements for Health Insurance Plans Offered through Health Insurance Exchanges under the Affordable Care Act." This information sheet, from the Kansas Health Institute, was distributed in the Senate Financial Institutions and Insurance Committee. Ms. Cleveland will submit this document to members of the Senate Ways and Means Committee.

Caseload Estimates Update

Amy Deckard, Legislative Research Department, distributed an information sheet, "Human Services Consensus Caseload Estimates for FY 2011 and FY 2012" (Attachment 2). Ms. Deckard explained the caseload estimates include expenditures for nursing facilities, regular medical assistance, temporary assistance to families, general assistance, reintegration/foster care contracts, psychiatric residential treatment facilities, and out of home placements. She indicated a chart summarizing estimates for FY 2011 and FY 2012 was included in the handout.

Discussion was heard regarding eligibility criteria for different programs. Ms. Deckard explained there are criteria such as income guidelines and various medical and/or psychosocial assessments to determine eligibility. Ms. Deckard will provide additional information related to eligibility criteria and the qualified provider who performs assessments.

Senator Kelly asked if the Legislative Research Department had tracked their caseload estimates for accuracy and compared actual variances to estimated variances over periods of time. Ms. Deckard indicated this type trend analysis could be developed.

Ms. Deckard verified that the increase in all funds ($176.7 million) for FY 2011 and FY 2012 compared to the State General Fund (SGF) increase of $296.1 million is due to the elimination of American Recovery and Reinvestment and Act (ARRA) funds.

Senator Kelly expressed interest in the maintenance of effort issues and how they change as a result of the elimination of ARRA funds. Ms. Deckard explained maintenance of effort resets to the date the ACA was signed (March 2010); however, Kansas made no changes to eligibility from the beginning date of ARRA . Ms. Cleveland added that the penalty for making changes is stiffer under the ACA maintenance of effort requirement; with the ARRA maintenance of effort penalty was loss of Medicaid dollars. Senator Kelly requested information on where we were in October 2008 related to program status compared to the current time. Ms. Deckard indicated it was her understanding that optional population eligibility could not be changed or eliminated until ARRA stimulus dollars ended (December 31, 2010); however, states were not required to provide certain services under the "optional services" category.

Senator Huntington questioned what the provisions are in the "Health Care Cost Containment Contract." Ms. Deckard explained provisions were contained in the appropriations bill which required the Kansas Health Policy Authority (KHPA) to contract for cost recovery. The contract with Health Data Insight resulted in recoveries in which the contractor retains a percentage of any monies recovered. Both Senators Huntington and Taddiken requested more detailed information on any recoveries. Dustin Moyer, government liaison for KHPA, indicated he would provide that information.

The meeting was adjourned at 11:30 a.m.

The Affordable Care Act: How would it impact Kansas?

Testimony Prepared for the
Senate Ways and Means Committee
January 19, 2011

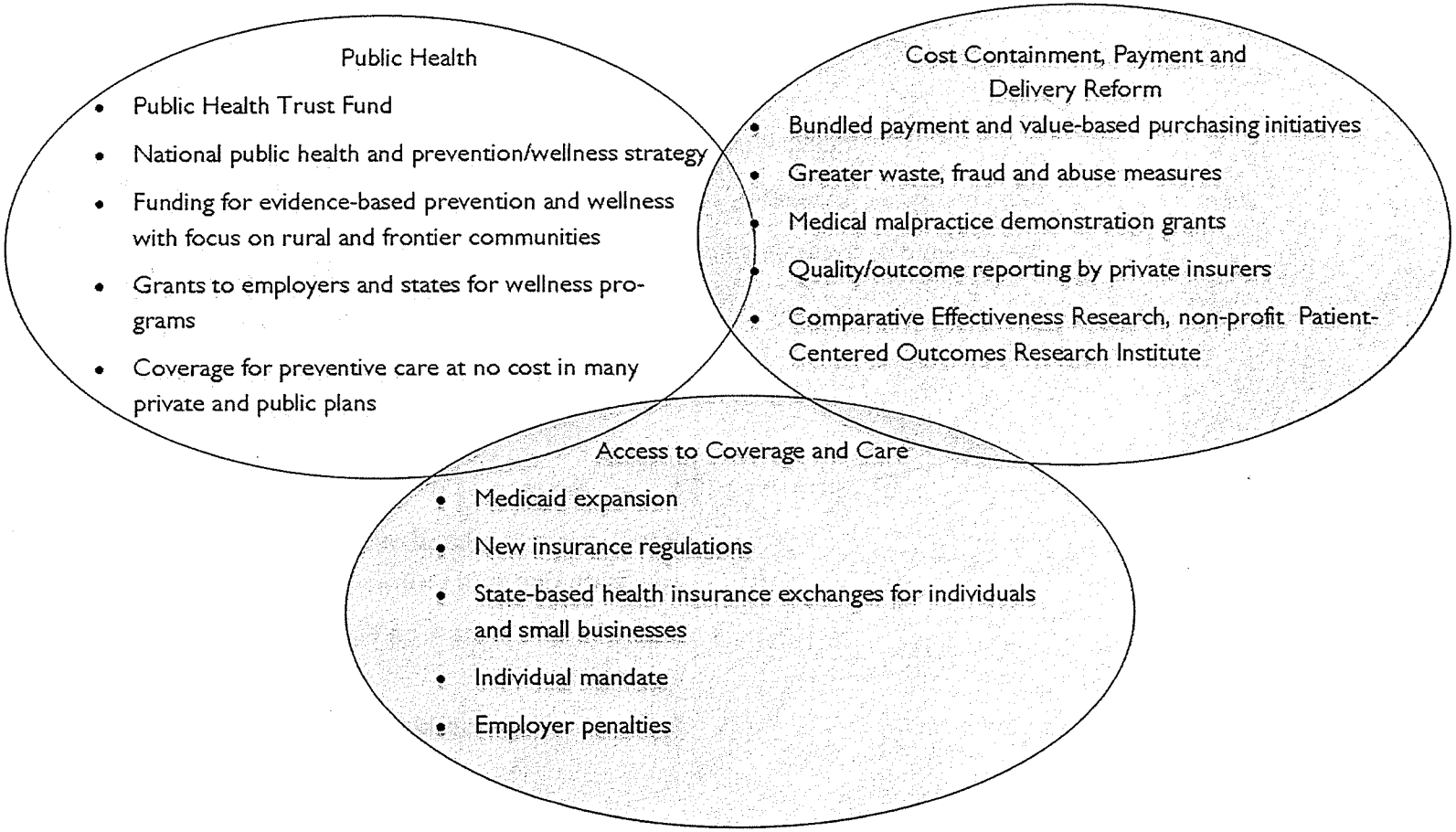
Suzanne Cleveland, J.D.
Kansas Health Institute

Kansas Health Institute

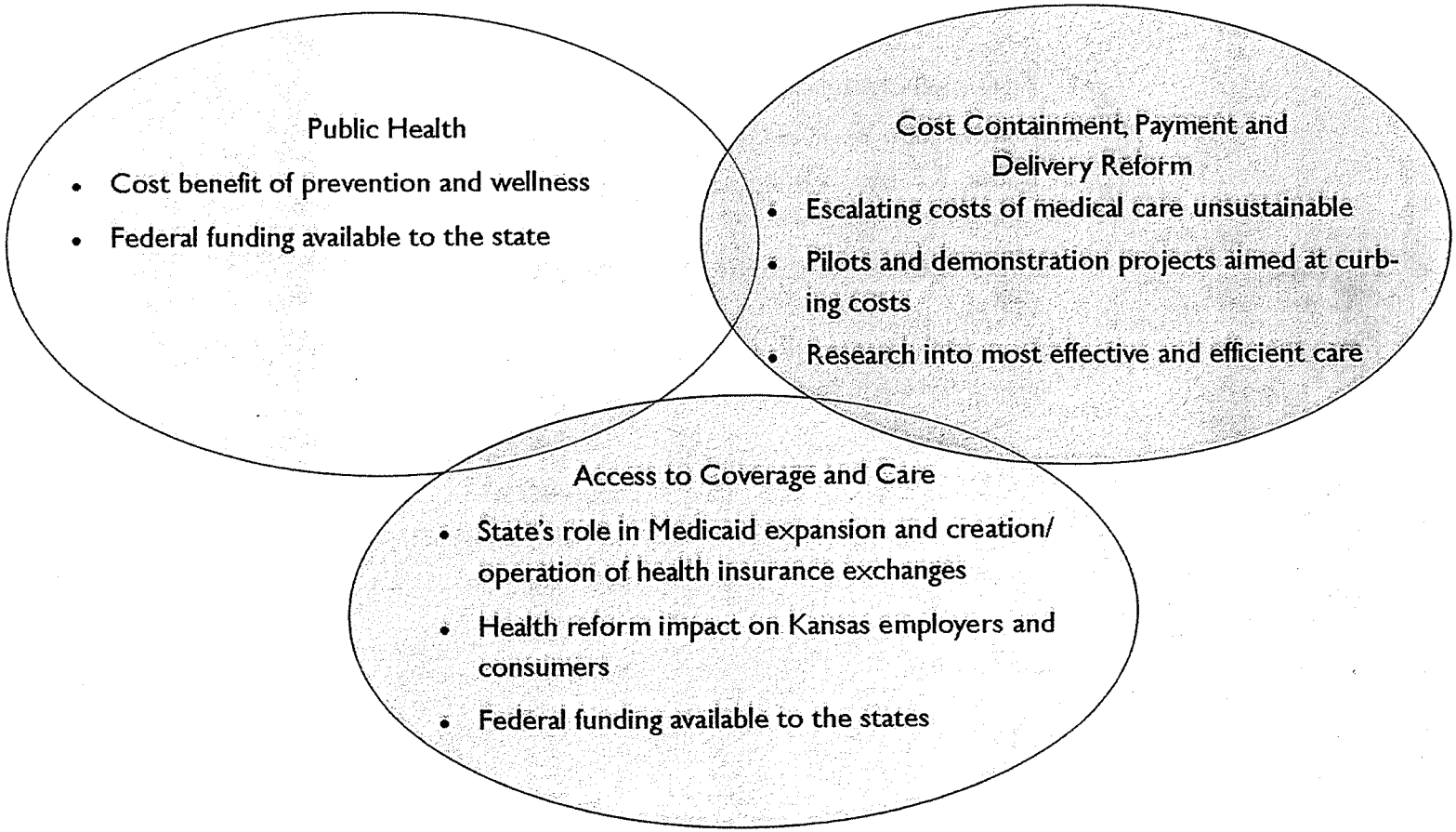
The Kansas Health Institute is an independent, nonprofit health policy and research organization that informs policymakers about important issues affecting the health of Kansans.

Our mission is to inform policymakers by identifying, producing, analyzing and communicating information that is timely, relevant and objective.

Three Primary Components of the ACA



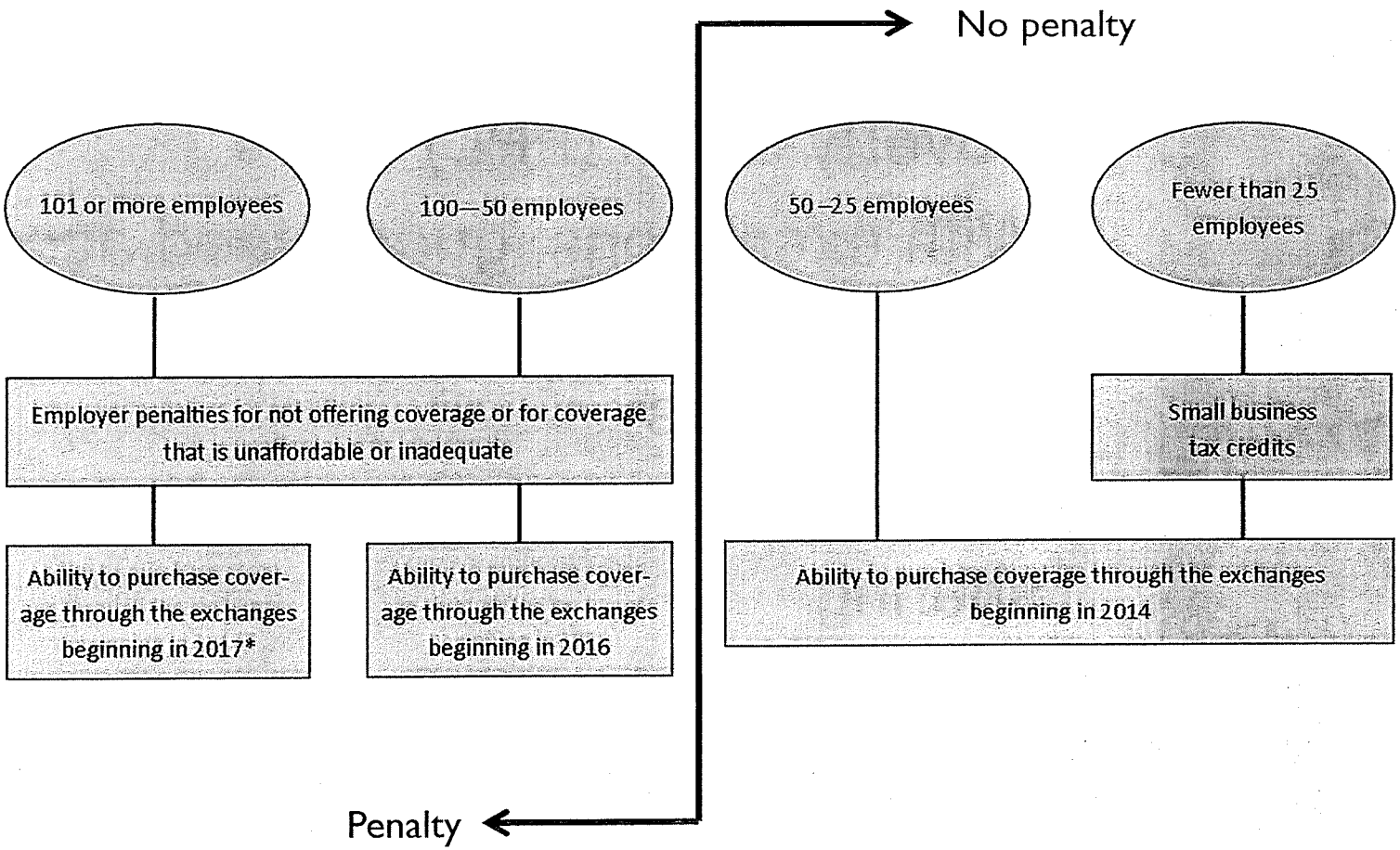
Potential Economic Impacts



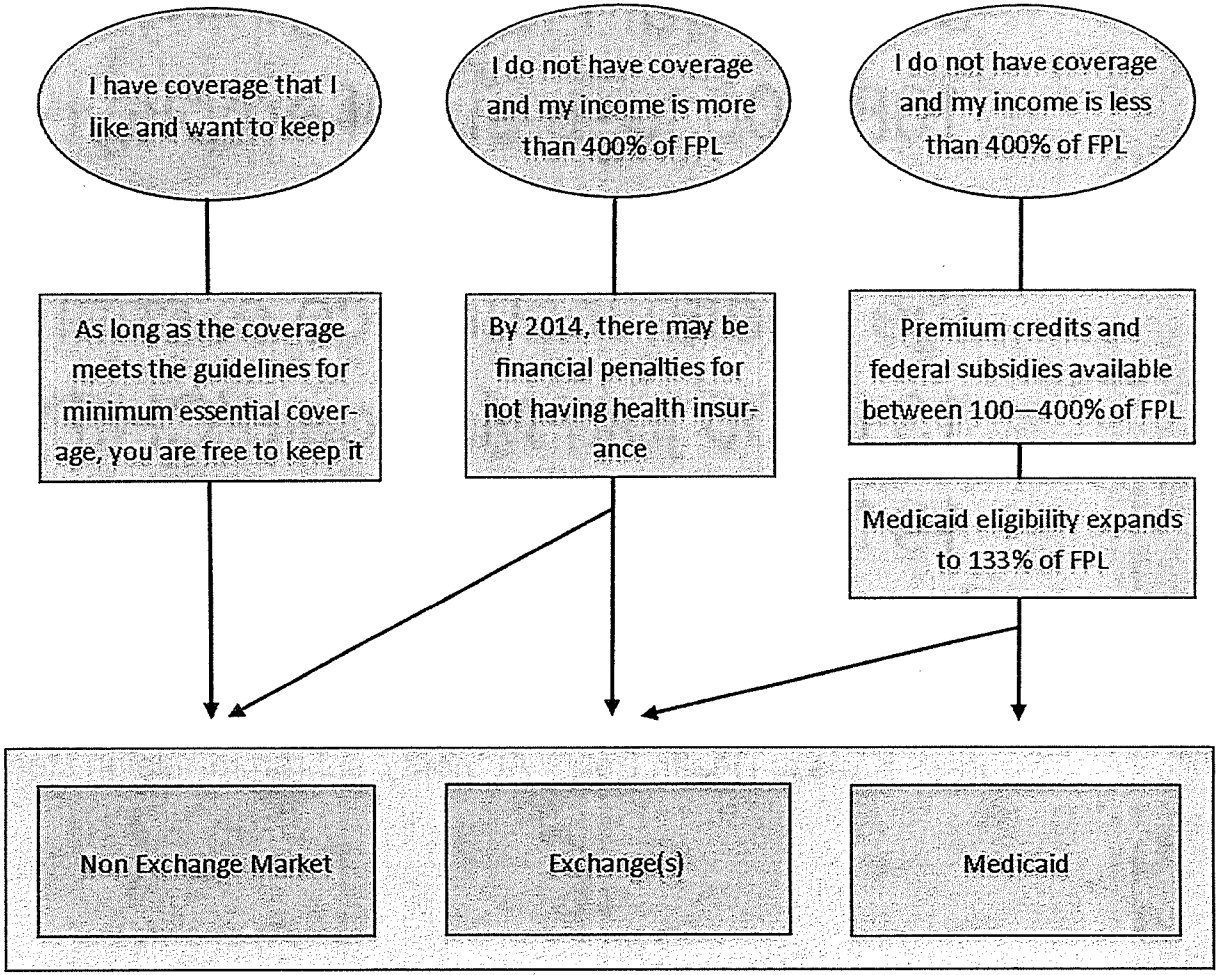
The ACA and Health Insurance

- Medicaid expansion to 133% of Federal Poverty Level (FPL)
- With exceptions, guaranteed access to health insurance coverage regardless of health status
- New limits on rating practices and cost-sharing
- State-based health insurance exchanges for individuals and small businesses

The Employer Experience



The Consumer Experience



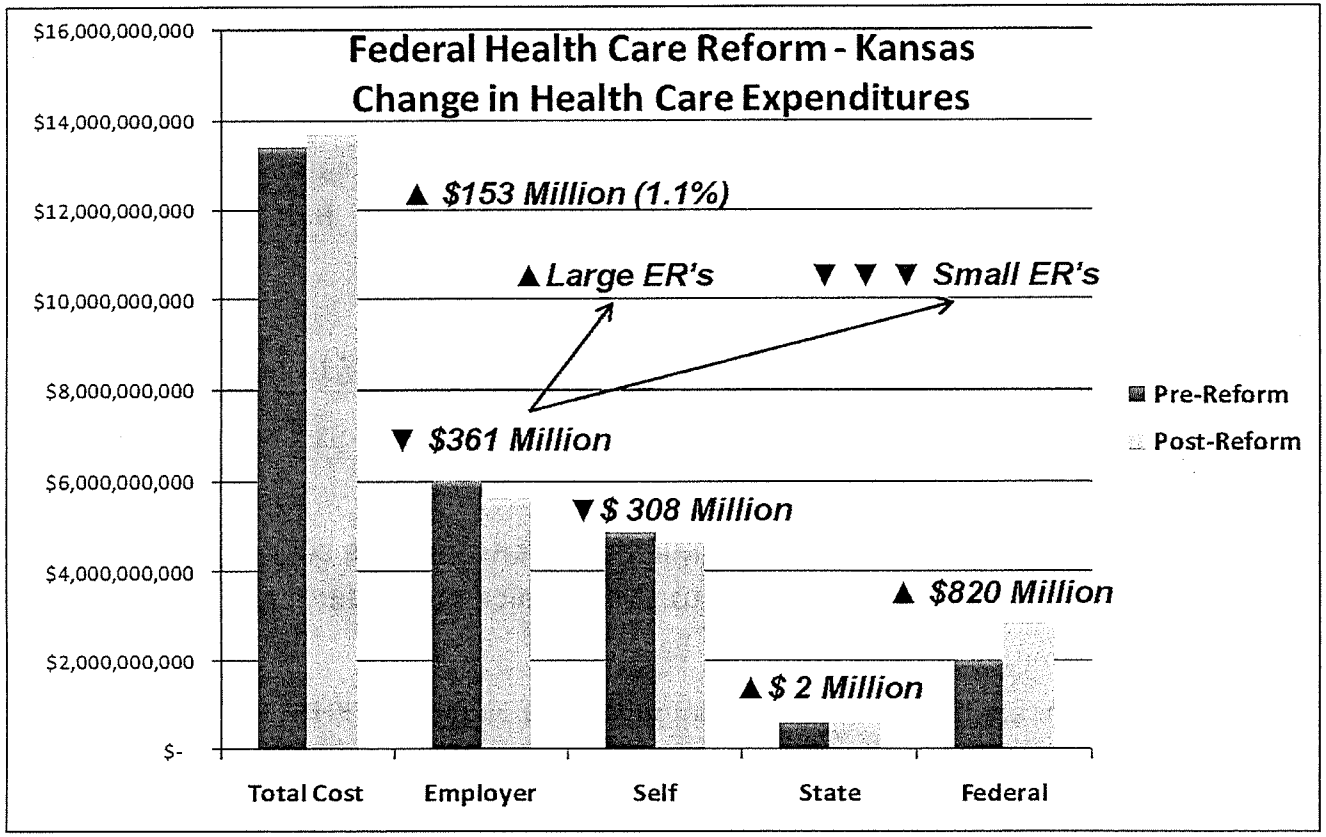
Impact on Coverage

- 96,000 gain large employer coverage
- 108,000 lose small employer coverage
- 73,000 enroll in individual plans (mostly in the health insurance exchange)
- 131,000 join Medicaid/CHIP
- 191,000 of the currently uninsured, become insured

Source: Kansas Health Policy Authority, schramm-raleigh Health Strategies

Costs of Coverage

Kansas — Pre-FHCR vs. Post-FHCR Health Care Expenditures by Payor (Sc2)



Source: Kansas Health Policy Authority, schramm-raleigh Health Strategies

Impact on State Spending

Federal Reforms: Impact on State Spending at Full Implementation in 2020

State options regarding direct spending for the safety net*

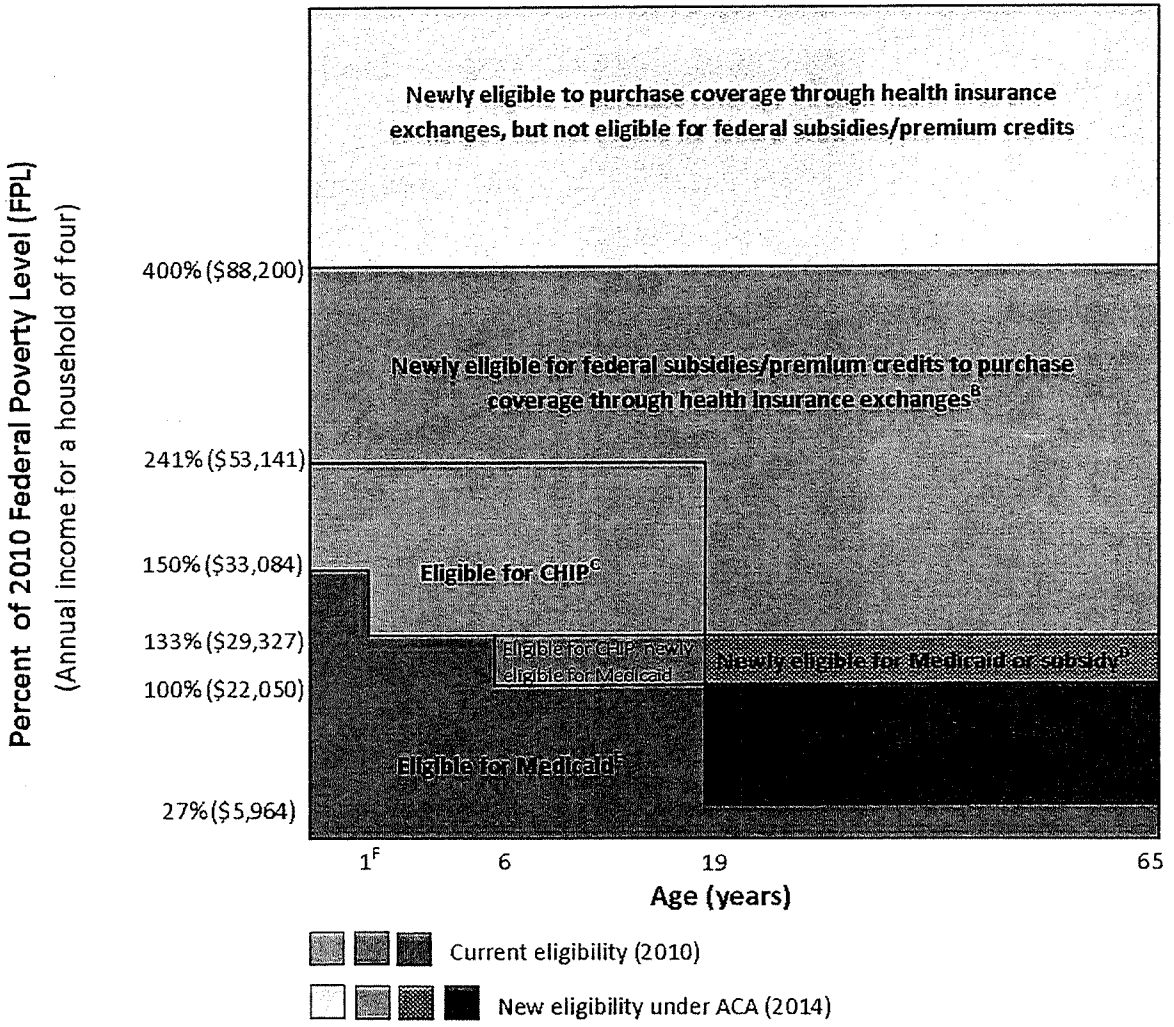
	Maintain all state spending on the safety net	Reduce state spending on the safety net by half	Eliminate state spending on the safety net
Point estimate plus 5% provider rate increase	$35 M	$12 M	-$8 M
Point estimate	$4 M	-$19 M	-$39 M

Additional risk: +/- $15 million variance in true cost of Medicaid benefit package. Impact subject to state choice and federal regulation over covered benefits.

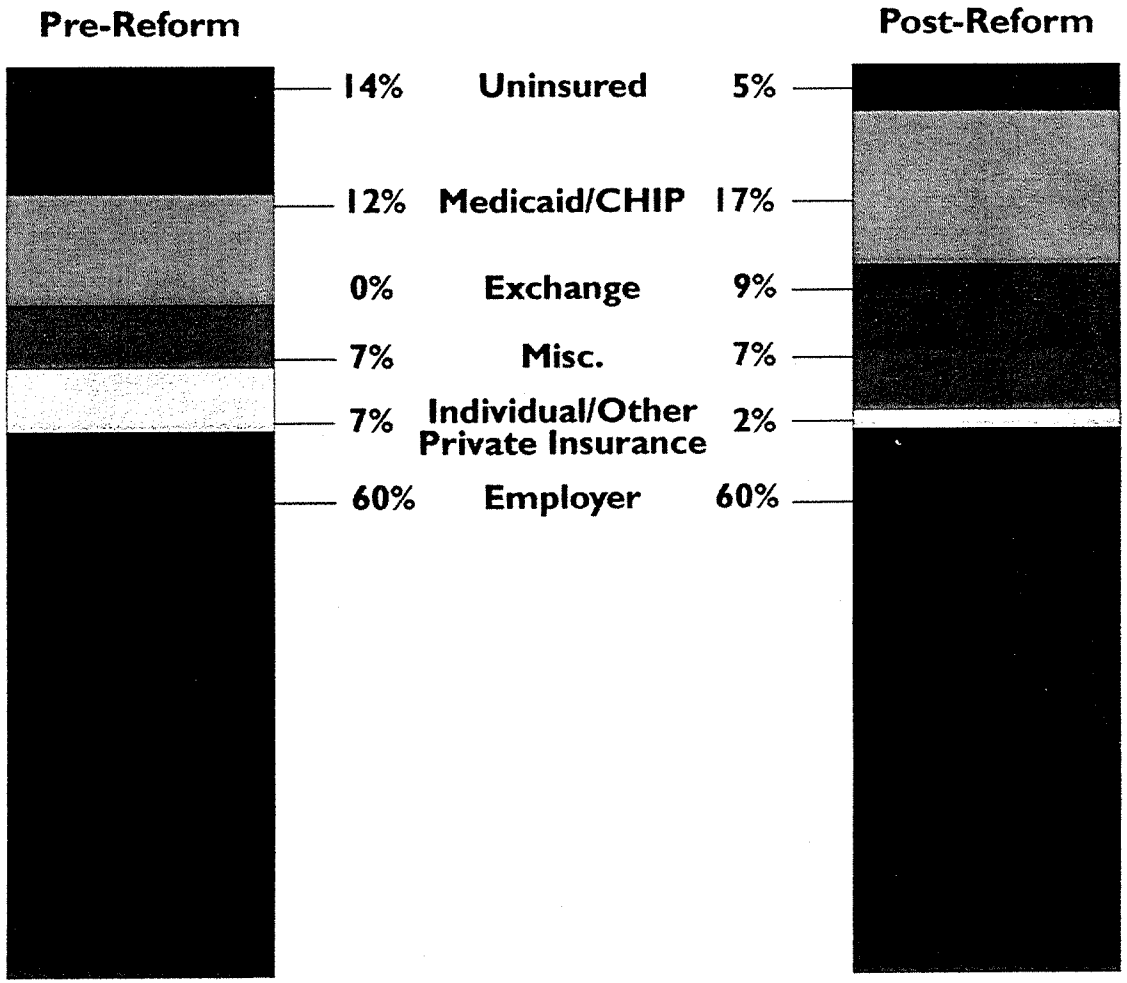
*Options are illustrative and do not reflect the opinions of KHPA staff, nor the KHPA Board. State spending totals for the uninsured through the safety net are preliminary ($40-$45 million annually) .

Source: Kansas Health Policy Authority

Current Eligibility (2010) and New Eligibility Under ACA (2014)



Changes in Projected Sources of Insurance Coverage in Kansas



Data courtesy of Georgia Health Policy Center, 2011

The ACA and Public Health

- On average, 75% of health care dollars in America are spent on treating chronic illness, 4% on prevention
- In Kansas, $11 billion on health care for chronic diseases each year (and rising)
- Cost break down by common causes of disease:
  - Tobacco use, $927 million in direct medical costs ($196 million paid by Medicaid)
  - Obesity, $567 million in direct medical costs ($143 million paid by Medicaid)

Public Health and Medical Spending

Even a modest reduction (5%) in rates of diabetes and hypertension could substantially reduce medical spending in Kansas

- Almost $120 million in 1-2 years
- Nearly $277 million in 5 or more years

These savings were achieved through diet, exercise, and reduced smoking

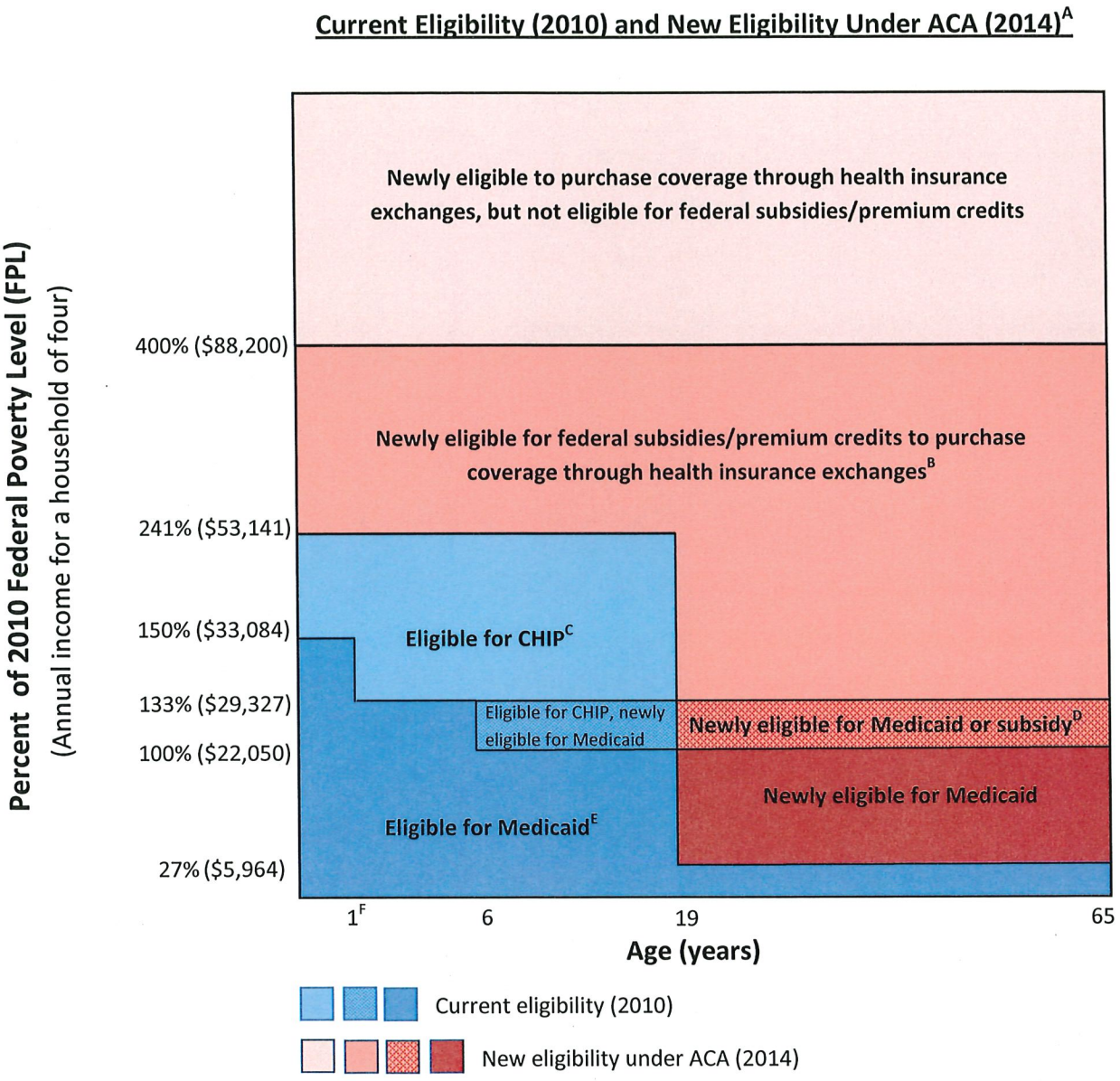
Federal Funding Available

- Grants for public health initiatives
  - Medicaid personal responsibility program and chronic disease prevention
  - State and community grants for public health
- Grants for coverage and access efforts
  - "Innovator Grant"
  - Consumer-Operated and Oriented Plan (CO-OP)
- To date, $10.9 million to Kansas

Looking Ahead

- Infrastructure and financial needs for health insurance exchanges and Medicaid expansion
- Economic impact of insurance and health care system changes
- Health professional workforce; substantial federal funding for workforce development
- Federally subsidized coverage offsets state costs, but Kansans are federal taxpayers

ELIGIBILITY FOR INSURANCE COVERAGE UNDER HEALTH REFORM



A. This chart represents eligibility guidelines based on income, but does not represent eligibility for individuals that may qualify based on disability or other conditions/criteria.

B. Eligibility for subsidies is tied to the lack of affordable employer-sponsored coverage.

C. A monthly premium between $20 and $75 applies to families with income between 150 percent to 241 percent of FPL.

D. In the legislation, there appears to be overlap between the populations eligible for Medicaid and those eligible for federal subsidies/premium credits between 100 to 133 percent of FPL.

E. Some parents are eligible to receive Medicaid up to about 27 percent of FPL, income guidelines vary slightly by county. Childless adults are not eligible.

F. Pregnant women also are eligible for Medicaid up to 150 percent of FPL.

Updated 1.10..11

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November 2, 2010

To: Legislative Budget Committee and Governor Mark Parkinson

From: Kansas Legislative Research Department and Kansas Division of the Budget

Re: Human Services Consensus Caseload Estimates for FY 2011 and FY 2012

The Division of the Budget, Department of Social and Rehabilitation Services, Kansas Health Policy Authority, Department on Aging, Juvenile Justice Authority, and the Legislative Research Department, met on October 28, 2010, to revise the estimates on human services caseload expenditures for FY 2011 and to make initial estimates for FY 2012. The caseload estimates include expenditures for Nursing Facilities, Regular Medical Assistance, Temporary Assistance to Families, General Assistance, the Reintegration/Foster Care Contracts, psychiatric residential treatment facilities, and out of home placements. A chart summarizing the estimates for FY 2011 and FY 2012 is included at the end of this memorandum. The estimate for FY 2011 is increased by $49.3 million from the State General Fund and $98.0 million from all funding sources. The new estimate for FY 2012 then increases by $248.8 million from the State General Fund, and $78.7 million from all funding sources. **The combined increase for FY 2011 and FY 2012 is an all funds increase of $176.7 million and a State General Fund increase of $298.1 million**.

The estimates include Medical Assistance expenditures by both the Kansas Health Policy Authority (KHPA) and the Department of Social and Rehabilitation Services (SRS). Most health care services for persons who qualify for Medicaid, MediKan, and other state health insurance programs were transferred to the KHPA on July 1, 2006, as directed in 2005 Senate Bill 272. Certain mental health services, addiction treatment services, and services for persons with disabilities that are a part of the Regular Medical Assistance Program remain in the budget of SRS.

FY 2011

For FY 2011, the estimate is an all funds increase of $98.0 million and a State General Fund increase of $49.3 million as compared to the budget approved by the 2010 Legislature. The amount approved for Medicaid programs by the 2010 Legislature assumed the full extension of the American Recovery and Reinvestment Act (ARRA) for all of FY 2011. The original Act authorized enhanced federal match until December 2010. The actual extension passed by Congress reduces the across-the-board federal match increase from 6.2 percentage points under the original act to 3.2 percentage points from January 1, 2011-March 31, 2011, and 1.2 percentage points from April 1, 2011-June 30, 2011. The portion of the State General Fund increase in FY 2011 totaling $43.0 million, is attributable to the lower than originally anticipated funding from the American Recovery and Reinvestment Act (ARRA) funding. The decrease in anticipated federal match rate also impacts Medicaid programs not included in the caseload process. The total amount of reduced federal funds due to the reduced ARRA funding totals $53.9 million.

The remaining State General Fund increase totaling $6.3 million is attributable to caseload growth above the approved amount for FY 2011. The all funds increase is due largely to increased estimates for Mental Health expenditures, regular medical expenditures and nursing facilities expenditures, partially offset by a decrease in out of home placements and Psychiatric Residential Treatment Facilities. The SRS Mental Health increase of $13.4 million in all funds and $5.8 million State General Fund increase in FY 2011 reflects an increase in beneficiaries and an increase in the payment rates for both the Prepaid Ambulatory Health Plan (PAHP) and the Psychiatric Residential Treatment Facilities. Expenditures for the regular medical program have increased by $8.4 million from all funding sources, including $30.5 million from the State General Fund. Estimates of Nursing Facilities expenditures increased by $72.0 million, including $10.1 million from the State General Fund, attributable to increased estimated cost per person and the addition of $64.1 million from all funding sources to account for funds generated by the nursing facility provider assessment.

FY 2012

The FY 2012 initial estimate is $2.4 billion, including $1.0 billion from the State General Fund. The estimate is an all funds increase of $78.7 million and a State General Fund increase of $248.8 million as compared to the revised FY 2011 estimate. The portion of expenditures anticipated to be funded by the federal government for the Medicaid program have decreased due to the end of the American Recovery and Reinvestment Act (ARRA) funding at the end of June 2011. The increased amount of State General Fund required for matching in FY 2012 for caseload expenditures is estimated to be $175.6 million. The total amount of funding needed to replace federal funds for caseload and non-caseload programs as a result of the elimination of ARRA enhanced Medicaid funding totals $216.0 million in FY 2012. The base Medicaid matching rate for federal contribution, excluding ARRA funding, was reduced by 1.6 percent between FY 2011 and FY 2012. The estimated impact of this reduction in FY 2012 is $35.3 million for caseload expenditures. The impact of the base federal match rate on non-caseload items is estimated to be increased State General Fund expenditures of $9.1 million in FY 2012. The remaining increases reflect caseload growth, for both increased individuals and cost increases, totaling $94.9 million from all funding sources and $37.9 million from the State General Fund in FY 2012.

Regular Medical expenses for KHPA were increased by $168.3 million from the State General Fund and $65.4 million from all funds due to estimated increases in caseloads and higher per person expenditures. This estimate includes a decrease in fee fund expenditures for the state match and a corresponding increase of State General Fund expenditures attributable to decreased fee fund revenue projections for the Kansas Health Policy Authority for FY 2012. The fee fund revenue projection does include an assumption of continued revenue from the health care cost containment contract in FY 2012 at a lower amount than FY 2011.

Nursing Facility expenditures were decreased by $7.8 million all funds, but increased by $43.0 million from the State General Fund, due to increased cost per person, partially offset by a decreased estimate for the second year of the provider assessment expenditures. Caseloads for Temporary Assistance for Families have increased by $3.0 million, from all funding sources, due to increased estimates regarding the numbers of persons accessing services. The SRS Mental Health increase of $9.7 million in all funds and the $28.0 million State General Fund increase in FY 2012 generally is tied to estimated increases in beneficiaries and cost per person for the Prepaid Ambulatory Health Plan (PAHP). In addition, the estimate for the foster care contract is estimated to increase by $5.5 million from all funding sources, due to an estimated increase in the number of children receiving services and an increased cost per child.

Human Services
November 2, 2010
Consensus Caseloads Estimates

Program		FY 2011 Approved	November Revised FY 2011	Difference from Approved	November Estimate FY 2012	Diff. From FY 2011 Estimate
Nursing Facilities	SGF	$ 112,857,112	$ 123,000,000	$ 10,142,888	$ 166,000,000	$ 43,000,000
	AF	373,700,000	445,706,642	72,006,642	437,900,247	(7,806,395)
Targeted Case Management (Aging)	SGF	$ 1,532,869	$ 1,634,935	$ 102,066	$ 2,200,000	$ 565,065
	AF	5,092,093	5,072,712	(19,381)	5,169,173	96,461
Psychiatric Residential Treatment Facilities (PRTFs) (JJA)	SGF	$ 2,439,439	$ 2,151,953	$ (287,486)	$ 2,979,200	$ 827,247
	AF	7,816,022	6,676,862	(1,139,160)	7,000,000	323,138
Out of Home Placements (JJA)	SGF	$ 20,892,477	$ 17,843,651	$ (3,048,826)	$ 19,000,000	$ 1,156,349
	AF	23,718,873	21,622,100	(2,096,773)	22,000,000	377,900
Nursing Facilities for Mental Health (NFMH)	SGF	$ 14,000,000	$ 14,000,000	$ 0	$ 14,500,000	$ 500,000
	AF	16,258,274	18,562,101	2,303,827	18,742,269	180,168
Temporary Assistance for Families	SGF	$ 29,821,028	$ 29,821,028	$ 0	$ 29,821,028	$ 0
	AF	54,039,150	54,500,000	460,850	57,500,000	3,000,000
General Assistance	SGF	$ 3,024,000	$ 3,024,000	$ 0	$ 3,200,000	$ 176,000
	AF	3,024,000	3,024,000	0	3,200,000	176,000
Reintegration/ Foster Care	SGF	$ 86,586,575	$ 91,000,000	$ 4,413,425	$ 91,000,000	$ 0
	AF	136,165,704	139,000,000	2,834,296	144,450,000	5,450,000
Regular Medical (KHPA)	SGF	$ 351,204,882	$ 381,731,500	$ 30,526,618	$ 550,000,000	$ 168,268,500
	AF	1,336,228,635	1,344,600,000	8,371,365	1,410,000,000	65,400,000
Mental Health (SRS)	SGF	$ 74,181,170	$ 80,000,000	$ 5,818,830	$ 108,000,000	$ 28,000,000
	AF	241,920,135	255,300,000	13,379,865	265,000,000	9,700,000
Community Supports and Services (SRS)	SGF	$ 9,955,014	$ 10,979,652	$ 1,024,638	$ 14,600,000	$ 3,620,348
	AF	32,837,496	34,066,560	1,229,064	34,304,511	237,951
AAPS/PIHP* (SRS)	SGF	$ 5,729,724	$ 6,300,000	$ 570,276	$ 9,000,000	$ 2,700,000
	AF	18,900,000	19,547,006	647,006	21,146,617	1,599,611
TOTAL	**SGF**	**$ 712,224,290**	**$ 761,486,719**	**$ 49,262,429**	**$ 1,010,300,228**	**$ 248,813,509**
	AF	**2,249,700,382**	**2,347,677,983**	**97,977,601**	**2,426,412,817**	**78,734,834**

SGF – State General Fund
AF – All Funds
* Addiction and Prevention Services (AAPS)/Prepaid Inpatient Health Plan (PIHP)