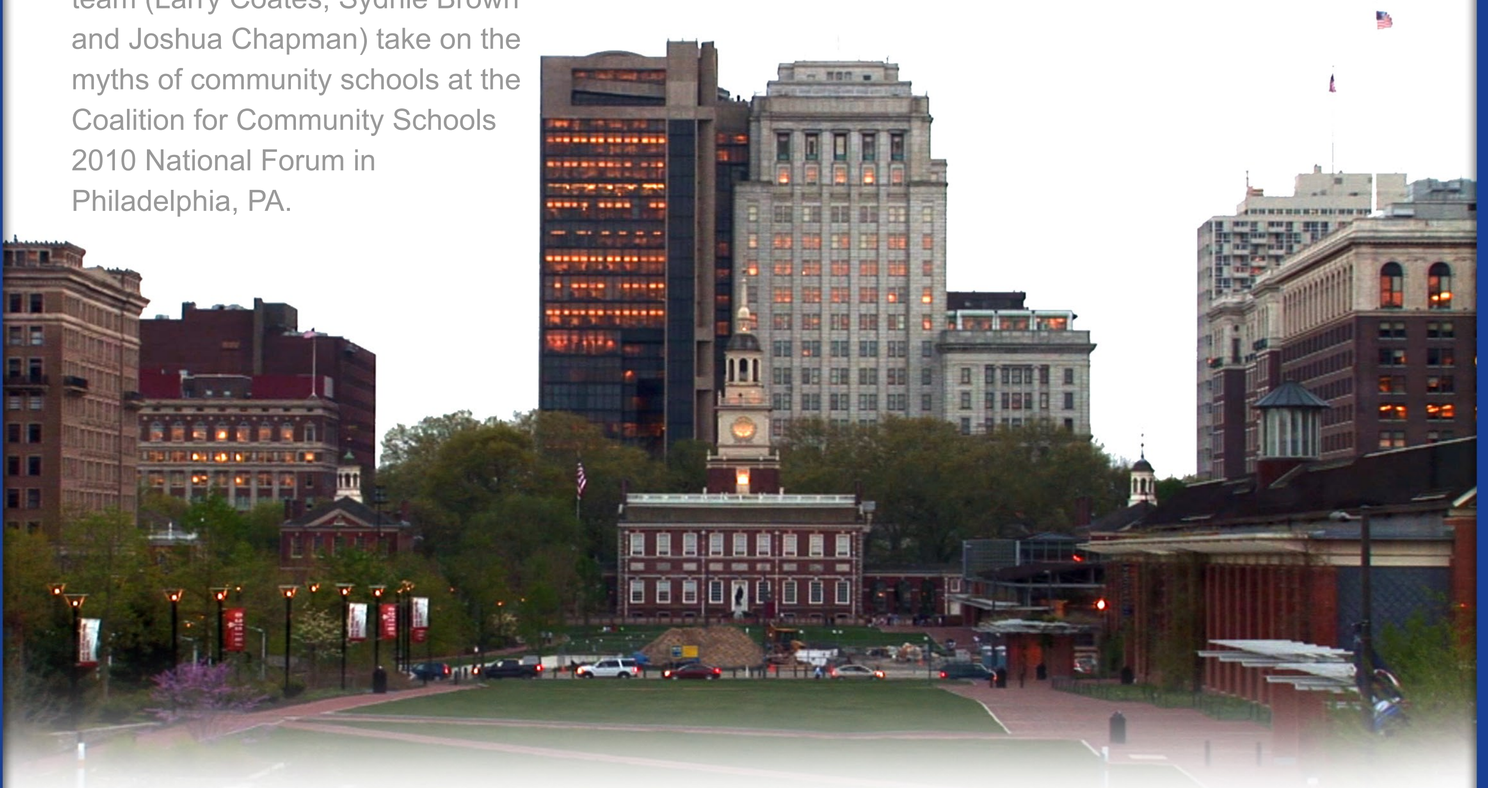
LINC Commission Meeting

April 26, 2010

The Central High School Debate team (Larry Coates, Sydnie Brown and Joshua Chapman) take on the myths of community schools at the Coalition for Community Schools 2010 National Forum in Philadelphia, PA.



3100 Broadway, Suite 1100 - Kansas City, MO 64111 - (816) 889-5050 - www.kclinc.org

Local Investment Commission (LINC) Vision

Our Shared Vision

A caring community that builds on its strengths to provide meaningful opportunities for children, families and individuals to achieve self-sufficiency, attain their highest potential, and contribute to the public good.

Our Mission

To provide leadership and influence to engage the Kansas City Community in creating the best service delivery system to support and strengthen children, families and individuals, holding that system accountable, and changing public attitudes towards the system.

Our Guiding Principles

1. COMPREHENSIVENESS: Provide ready access to a full array of effective services.
2. PREVENTION: Emphasize "front-end" services that enhance development and prevent problems, rather than "back-end" crisis intervention.
3. OUTCOMES: Measure system performance by improved outcomes for children and families, not simply by the number and kind of services delivered.
4. INTENSITY: Offering services to the needed degree and in the appropriate time.
5. PARTICIPANT INVOLVEMENT: Use the needs, concerns, and opinions of individuals who use the service delivery system to drive improvements in the operation of the system.
6. NEIGHBORHOODS: Decentralize services to the places where people live, wherever appropriate, and utilize services to strengthen neighborhood capacity.
7. FLEXIBILITY AND RESPONSIVENESS: Create a delivery system, including programs and reimbursement mechanisms, that are sufficiently flexible and adaptable to respond to the full spectrum of child, family and individual needs.
8. COLLABORATION: Connect public, private and community resources to create an integrated service delivery system.
9. STRONG FAMILIES: Work to strengthen families, especially the capacity of parents to support and nurture the development of their children.
10. RESPECT AND DIGNITY: Treat families, and the staff who work with them, in a respectful and dignified manner.
11. INTERDEPENDENCE/MUTUAL RESPONSIBILITY: Balance the need for individuals to be accountable and responsible with the obligation of community to enhance the welfare of all citizens.
12. CULTURAL COMPETENCY: Demonstrate the belief that diversity in the historical, cultural, religious and spiritual values of different groups is a source of great strength.
13. CREATIVITY: Encourage and allow participants and staff to think and act innovatively, to take risks, and to learn from their experiences and mistakes.
14. COMPASSION: Display an unconditional regard and a caring, non-judgmental attitude toward, participants that recognizes their strengths and empowers them to meet their own needs.
15. HONESTY: Encourage and allow honesty among all people in the system.

Monday, April 26, 2010 | 4 – 6 pm
Gem Theater
1615 E. 18th St.
Kansas City, Mo. 64108

Agenda

I. **Welcome and Announcements**

II. **Approvals**
   a. March minutes (motion)

III. **LINC President's Report**

IV. **Community Schools**
   a. National Forum - Philadelphia
   b. Central High School Debaters

V. **Caring Communities**
   a. Summer School
   b. Fall

VI. **Health Care**
   a. South Kansas City Clinic
   b. Health reform – Policy Brief
   c. KCPT special

VII. **Other**

VIII. **Adjournment**

THE LOCAL INVESTMENT COMMISSION – MARCH 8, 2010

The Local Investment Commission met at the Kauffman Foundation, 4801 Rockhill Rd., Kansas City, Mo. Chairman **Landon Rowland** presided. Commissioners attending were:

Bert Berkley
Sharon Cheers
Jack Craft
Steve Dunn
Herb Freeman
SuEllen Fried
Rob Givens
Anita Gorman
Bart Hakan
Adele Hall
Rosemary Smith Lowe
Sandy Mayer (for Mike Sanders)
Mary Kay McPhee
Richard Morris
Margie Peltier
David Ross
Gene Standifer
Bailus Tate

Rowland invited the school superintendents in attendance to report on budget concerns in their respective school districts. **Dr. Mark Enderle** reported the Fort Osage School District is expecting cuts of $3 million. **Dr. Ralph Teran** of the Grandview School District reported cuts are expected to be even greater than previously thought, due to state budget cuts. **Dr. Bob Bartman** reported the Center School District is concerned by still greater cuts in future budget years.

SuEllen Fried, whose book *Banishing Bullying Behavior* was recently published, reported on her work with students addressing bullying.

A motion to approve the Feb. 22, 2010, LINC Commission meeting minutes was passed unanimously.

Schools First

Gayle A. Hobbs led a discussion of LINC and the Schools First proposal of Kansas City Mayor **Mark Funkhouser**. As an organization serving families, children and neighborhoods, and as a partner to 80 schools, LINC affirms the value of community investment in schools and of strengthening relationships between schools and other community stakeholders, including municipal government. LINC is supportive of efforts by the Kansas City, Mo. municipal government to benefit schools and the families and neighborhoods they serve. Nonetheless, in the interest of preserving its integrity as a nonpartisan organization LINC must not become involved in partisan contests but must rather remain neutral with respect to voter questions.

Joan Pu, policy director for the Office of the Mayor (Kansas City), clarified points of the Schools First plan.

LINC staff will draft a public statement on Schools First. Commissioner input will be sought prior to publication.

Family and Community Trust

Hobbs reported on a recent Jefferson City meeting of the Family and Community Trust Community Partnerships. LINC will work with area legislators as well as department staff to help them make informed decisions and offer support as needed. LINC staff is developing FACT

informational materials, customized for each Community Partnership, to aid in educating legislators and others about work done by the community partnerships.

Discussion followed.

Community Work Support

LINCWorks co-chair **Terry Ward** reported on the LINC welfare to work effort. LINCWorks is developing a Community Work Support proposal for leveraging state funds with federal Dept. of Health and Human Services dollars.

Hobbs reported that LINC staff will be working with state agency staff on the value of child care development block grant dollars – a major funding source for LINC's work in schools.

Kansas City, Mo. School District

Hobbs gave an update on the Kansas City, Mo. School District. All KCMSD LINC site coordinators met last week to plan for moving forward helping children and families while the district makes decisions to close schools. LINC staff will prepare plans for reallocation of staff and resources following district decisions. Commissioners will be updated.

Health Care

LINC Professional Cabinet member **Cathy Davis** reported the Kansas City Quality Improvement Consortium released data on health care quality in Kansas City. The KCQIC website www.qualityhealthtogether.org and a video were viewed.

The meeting was adjourned.

Los Angeles Times

March 19, 2010

Schools are out -- forever

The Kansas City, Mo., district is closing nearly half its campuses after 10 years of dwindling student population. It's what happens when a district loses support of the public it is meant to serve.

By Nicholas Riccardi

During the warm months, when students at Westport High School got too hot, they cooled down by moving to one of the many vacant classrooms on campus. It was one of the advantages of having 400 students assigned to a school that could hold 1,200.

The downside became apparent last week, though, when the Kansas City school board voted to close Westport and 25 other schools -- nearly half of the district's campuses.

Big-city districts shutter schools all the time. Cities such as Denver and Portland, Ore., have seen childless young families repopulate their urban cores and have adjusted accordingly.

But what is happening in Kansas City is different in scale than anywhere else in the country. It's an extreme example of what happens when a school system loses the support of the public it's meant to serve.

The Kansas City, Missouri School District lost half of its student population in the last 10 years as parents fled to the suburbs or placed their children in private or non-district-run charter schools. District test scores have long lagged behind the rest of the state's.

Meanwhile, the district continued to operate 61 schools capable of holding 75,000 students. It now has about 17,000 students. By comparison, the Los Angeles Unified School District has 678,000 students, including those in charter schools, and 891 schools and facilities.

"This is a day of reckoning for this community," said Supt. John Covington, predicting other districts will confront similar problems. "They're going to have to face it one way or the other."

Indeed, on Wednesday, Detroit announced it would close 45 public schools -- a smaller percentage of its campuses than Kansas City, but a significant number nonetheless.

"These hard economic times are going to cause school boards and school districts to look at the issue of school closings," said Anne Bryant, president of the National School Boards Assn.

But the problems in Kansas City started before the recession. They resulted from decades of neglect, bad decisions and the hollowing of the city's core.

"This is pretty historic," said Wanda Blanchett, dean of the School of Education at the University of Missouri-Kansas City. "I can't think of any other district that has this level of concern."

The district started losing students after a lengthy desegregation battle was launched in federal courts in the 1970s, which led to busing and other attempts to balance enrollments. First came

white flight. Then came middle-class flight, as black families joined whites in moving to more suburban districts for better schools.

Meanwhile, those outer districts extended their attendance boundaries into Kansas City. The city is now divvied up among more than a dozen districts.

Most of the children in the district, officials agree, attend because their parents have no other option. About 80% of students receive free or partially subsidized lunches.

"You've got kids who can't go anywhere else," said former school board member Al Mauro. "These are not kids who are intellectually deficient. [But] they're bringing a lot of baggage into the classroom."

About 50,000 school-age children live in the district's boundaries, but only 17,000 go to its schools. As the district educated fewer and fewer of the city's children, it got less and less public support. The public hasn't approved a school bond measure since 1969.

"If the majority of the people within our boundaries aren't patrons, it's more complicated to get support," said Airick West, a school board member.

Exacerbating the problem has been long-running turmoil within the district. A teachers' strike in the 1970s drove many parents away. In the 1980s, the district launched a building spree, erecting state-of-the-art schools with Olympic-size swimming pools to lure students back.

It didn't work.

Every few years a superintendent left -- voluntarily or ousted by the board -- to be followed by a replacement with new priorities. "We've had just a revolving door of superintendents," said Andrea Flinders, president of the teacher's union.

Previous superintendents tried to close schools only to be overruled by the school board. Covington, who came from Pueblo, Colo., last July, argued that the district had to stop spending money on maintaining half-empty buildings.

The board approved his plan, which closes 26 schools and three other buildings, by a 5-4 vote after months of tumultuous forums. The plan, which also cuts 700 jobs, is projected to save $50 million from a $300-million budget.

West, who voted for the plan, said he got more than 500 e-mails the next day -- only seven from people opposed to the closings. "We've all known this needed to happen for a long time," he said.

But the debate may not be over. Five school board seats will be determined in elections on April 6. One slate of candidates is running to reverse the closures; another slate supports them.

Some parents have vowed to pull their children from the district rather than transfer them to other schools.

One concern is the consolidation of an "Afrikan-Centered Education" program, which has a curriculum guided by African cultural concepts. Students from three schools, divided by kindergarten through fifth grade, sixth grade, and seventh through 12th, will be placed at one school.

The program is popular in a district that is 61% black; 30% of Kansas City's population is African American.

"Who's going to be left with our children packed into those buildings, like slave ships?" asked Ron Hunt, a neighborhood activist with three children in an Afrikan-Centered Education school. Hunt is calling for parents to pull their children from the district.

Jamekia Kendrix already did. She pulled her daughter out this year -- while running a nonprofit to improve education in the district.

She did so with mixed feelings. As a child she attended public schools before transferring to a private high school. She felt alienated there and had vowed to keep her children in public schools.

Now, Kendrix is worried about more empty buildings blighting the struggling Kansas City core, where 25% of homes are unoccupied, including seven on her block.

Nonetheless, she supports Covington's plan.

"My hopes are in the next two years I can get my children back into the district" once it improves, she said.

At Westport, a hulking brick building in a modest neighborhood of turn-of-the-century houses, students are not as optimistic. The high schoolers don't follow the minutiae of school board policy, but they said they realized change was inevitable as the student body shrank. "You could see it coming," said sophomore Chandra Swatosh, 16.

Since the closures were approved, students have had trouble focusing on their work and wonder where they will end up next year. Robert Young, another 16-year-old sophomore, worried what would happen to the relationships he's forged at Westport with both teachers and other students.

"This is such a small school, we all know each other," he said. "All of us are going to be split up."

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THE WALL STREET JOURNAL.
WSJ.com

MARCH 11, 2010

School Crisis Rattles Missouri

Kansas City Board Approves Plan to Shutter Nearly Half of District's Buildings

By DOUGLAS BELKIN

The Kansas City Missouri School Board voted Wednesday night to shutter nearly half of its schools in an effort to avoid going broke.

The action closes 28 of 58 campuses and eliminates about 700 of the district's 3,300 jobs, including 285 teachers.

"None of us like doing this but it was necessary, it had to be done," said board member Arthur Benson after a tense five to four vote that was interrupted several times by upset parents.

The plan comes as school districts around the country, battered by the recession and budget cutbacks, are closing facilities to save money. Detroit closed 29 schools before classes began this fall, leaving the district with 172 schools, according to the Associated Press.

The Kansas City School District, which serves 18,000 students, was twice as large a decade ago. That decrease has led to cuts in state funding. The district now runs a $12 million monthly deficit and expects to run out of money by 2011.

The plan, dubbed "Right Sizing the District," aims to end the deficit and address poor academic performance by consolidating services and cutting under-performing staff.

Less than one third of elementary school students are reading at or above grade level. In nearly three quarters of the schools only one quarter of the students are characterized as "proficient," according to the district.

School Superintendent John Covington told the board months ago the cuts were necessary and has spent weeks trying to sell the plan to its concerned citizens. Along with the 28 schools, the district's administration center and an adult basic education center will be closed. The buildings will be sold in batches to avoid flooding the market.

In a statement, Mr. Covington said the plan would "dramatically enhance education for each of our students by combining our very best teachers and very best resources in fewer schools."

On Wednesday night, the vote drew sharp outcries from some parents and community leaders who complained the school closings would gut many predominantly African-American neighborhoods that have already been hit by discrimination and the real-estate collapse.

At the meeting, Kansas City Councilwoman Sharon Sanders Brooks said that the "urban core" has suffered since the mid-1950s from a flight of the middle class as well as unscrupulous practices by banks and real-estate companies.

Many students have left for publicly funded charter schools, private and parochial schools and the suburbs. "And now the public-education system is aiding and abetting in the economic demise of our school district,'' Ms. Brooks said. "It is shameful and sinful.''

Fewer students have translated into less money from the state. For the past few years, the district has been spending its way through the reserves it built up when money from a $2 billion court-ordered desegregation plan was flooding its coffers, according to the Associated Press. School administrators have said big cuts were needed to balance the budget.

School Board President Marilyn Simmons, who voted against the plan, said she feared it would mean "more bussing and the crumbling of neighborhoods."

Write to Douglas Belkin at doug.belkin@wsj.com

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THE WALL STREET JOURNAL.
WSJ.com

MARCH 9, 2010

Why I Changed My Mind About School Reform

Federal testing has narrowed education and charter schools have failed to live up to their promise.

By DIANE RAVITCH

I have been a historian of American education since 1975, when I received my doctorate from Columbia. I have written histories, and I've also written extensively about the need to improve students' knowledge of history, literature, geography, science, civics and foreign languages. So in 1991, when Lamar Alexander and David Kearns invited me to become assistant secretary of education in the administration of George H.W. Bush, I jumped at the chance with the hope that I might promote voluntary state and national standards in these subjects.

By the time I left government service in January 1993, I was an advocate not only for standards but for school choice. I had come to believe that standards and choice could co-exist as they do in the private sector. With my friends Chester Finn Jr. and Joseph Viteritti, I wrote and edited books and articles making the case for charter schools and accountability.

I became a founding board member of the Thomas B. Fordham Foundation and a founding member of the Koret Task Force at the Hoover Institution, both of which are fervent proponents of choice and accountability. The Koret group includes some of the nation's best-known conservative scholars of choice, including John Chubb, Terry Moe, Caroline Hoxby and Paul Peterson.

As No Child Left Behind's (NCLB) accountability regime took over the nation's schools under President George W. Bush and more and more charter schools were launched, I supported these initiatives. But over time, I became disillusioned with the strategies that once seemed so promising. I no longer believe that either approach will produce the quantum improvement in American education that we all hope for.

NCLB received overwhelming bipartisan support when it was signed into law by President Bush in 2002. The law requires that schools test all students every year in grades three through eight, and report their scores separately by race, ethnicity, low-income status, disability status and limited-English proficiency. NCLB mandated that 100% of students would reach proficiency in reading and math by 2014, as measured by tests given in each state.

Although this target was generally recognized as utopian, schools faced draconian penalties—eventually including closure or privatization—if every group in the school did not make adequate yearly progress. By 2008, 35% of the nation's public schools were labeled "failing schools," and that number seems sure to grow each year as the deadline nears.

Since the law permitted every state to define "proficiency" as it chose, many states announced impressive gains. But the states' claims of startling improvement were contradicted by the federally sponsored National Assessment of Educational Progress (NAEP). Eighth grade students improved not at all on the federal test of reading even though they had been tested annually by their states in 2003, 2004, 2005, 2006 and 2007.

Meanwhile the states responded to NCLB by dumbing down their standards so that they could claim to be making progress. Some states declared that between 80%-90% of their students were proficient, but on the federal test only a third or less were. Because the law demanded progress only in reading and math, schools were incentivized to show gains only on those subjects. Hundreds of millions of dollars were invested in test-preparation materials. Meanwhile, there was no incentive to teach the arts, science, history, literature, geography, civics, foreign languages or physical education.

In short, accountability turned into a nightmare for American schools, producing graduates who were drilled regularly on the basic skills but were often ignorant about almost everything else. Colleges continued to complain about the poor preparation of entering students, who not only had meager knowledge of the world but still required remediation in basic skills. This was not my vision of good education.

When charter schools started in the early 1990s, their supporters promised that they would unleash a new era of innovation and effectiveness. Now there are some 5,000 charter schools, which serve about 3% of the nation's students, and the Obama administration is pushing for many more.

But the promise has not been fulfilled. Most studies of charter schools acknowledge that they vary widely in quality. The only major national evaluation of charter schools was carried out by Stanford economist Margaret Raymond and funded by pro-charter foundations. Her group found that compared to regular public schools, 17% of charters got higher test scores, 46% had gains that were no different than their public counterparts, and 37% were significantly worse.

Charter evaluations frequently note that as compared to neighboring public schools, charters enroll smaller proportions of students whose English is limited and students with disabilities. The students who are hardest to educate are left to regular public schools, which makes comparisons between the two sectors unfair. The higher graduation rate posted by charters often reflects the fact that they are able to "counsel out" the lowest performing students; many charters have very high attrition rates (in some, 50%-60% of those who start fall away). Those who survive do well, but this is not a model for public education, which must educate all children.

NAEP compared charter schools and regular public schools in 2003, 2005, 2007 and 2009. Sometimes one sector or the other had a small advantage. But on the whole, there is very little performance difference between them.

Given the weight of studies, evaluations and federal test data, I concluded that deregulation and privately managed charter schools were not the answer to the deep-seated problems of American education. If anything, they represent tinkering around the edges of the system. They affect the lives of tiny numbers of students but do nothing to improve the system that enrolls the other 97%.

The current emphasis on accountability has created a punitive atmosphere in the schools. The Obama administration seems to think that schools will improve if we fire teachers and close schools. They do not recognize that schools are often the anchor of their communities, representing values, traditions and ideals that have persevered across decades. They also fail to recognize that the best predictor of low academic performance is poverty—not bad teachers.

What we need is not a marketplace, but a coherent curriculum that prepares all students. And our government should commit to providing a good school in every neighborhood in the nation, just as we strive to provide a good fire company in every community.

On our present course, we are disrupting communities, dumbing down our schools, giving students false reports of their progress, and creating a private sector that will undermine public education without improving it. Most significantly, we are not producing a generation of students who are more knowledgable, and better prepared for the responsibilities of citizenship. That is why I changed my mind about the current direction of school reform.

Ms. Ravitch is author of "The Death and Life of the Great American School System: How Testing and Choice Are Undermining Education," published last week by Basic Books.

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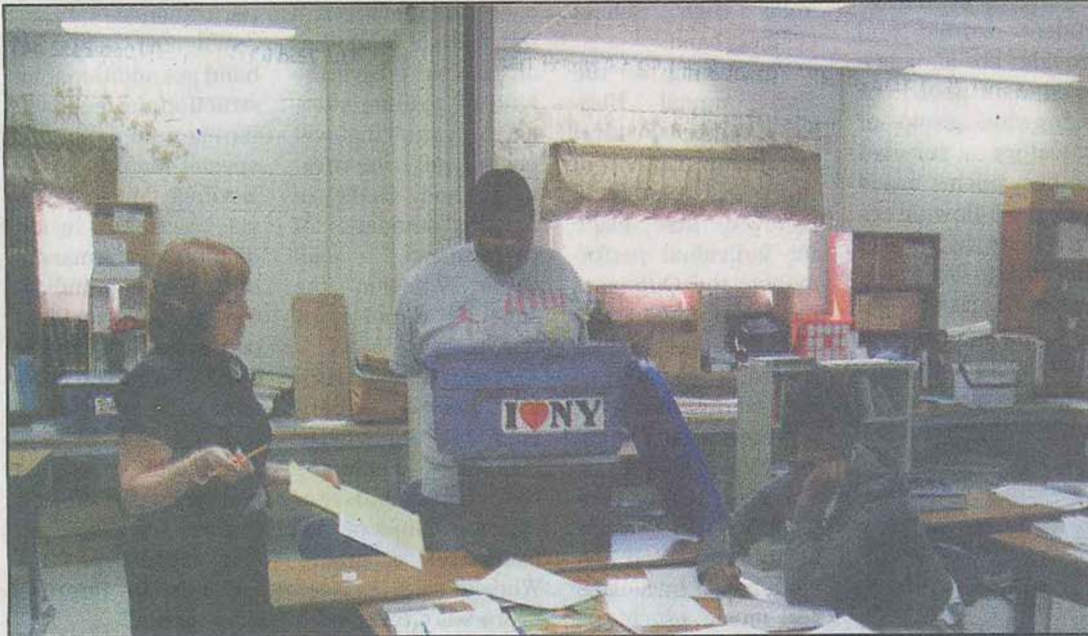
Central Debaters Learn Valuable Life Lessons



DEBATERS KEEP SUCCESS GOING. . . For those who compete on the Central High debate team, success never seems to fade. This season, Eagles debaters have proven they are worthy of national respect. In the left photo, Debate Coach, Jane Rinehart, works with Marquieze Waldrup Banks and Sydnie Brown, as they prepare to compete in the upcoming Urban Debate Nationals in New York City from April 22-25. -- CALL photo by Tracy Allen

By Tracy Allen
CALL Staff Writer

Next to baseball practice, you won't find Marquieze Waldrup Banks too many other places outside of Jane Rinehart's classroom.

Same can be said for Sydnie Brown, Joshua Chapman and Larry Coates.

You see, when they're not attending classes throughout Central High school, then these four youth can surely be seen either debating their next topic inside a neatly cluttered computer classroom or taking some pointers from the master of debate coaches, the lady everyone respectfully calls "J.R.", a.k.a., Central High Debate Coach Jane Rinehart.

It's in J.R.'s classroom that Sydnie, Josh, Marquieze and Larry, among other Blue Eagle high students have learned the art of constructive argument, the kind that doesn't lead to bad behavior, as Marquieze will remind you. No, these arguments involve trophies and trips that few of J.R.'s kids may ever experience in their lifetime.

Even if they're constantly pounded by the naysayers and nyone down on inner city life, the idea that little good resides around their public high school, will convince these Central High debaters that they can't overcome those obstacles. With J.R. on their side, and a high school debate team classified as one of the best in America, no doubt, anyone who walks into the Blue Eagles' debate program or into Mrs. Rinehart's classroom will think that they can't be something greater.

Facts are there to prove it. Year in and out, Central High debaters have won competitions all over America. Students from Mrs. Rinehart's program have received college scholarships to some of the finest debate programs in the country. Many of her former debaters have gone on to successful careers in business and education. But most importantly, in J.R.'s class, the black youth that some say surely can't make it in a rough environment, somehow find a way to do it in spite of their skeptics.

Take this year's debate squad. Josh, Sydnie and Larry just got back from the Coalition for Community Schools 2010 National Forum, April 7-9, in Philadelphia. They participated with Philadelphia student debaters to "Debunk Community School Myths." It was the first time that the three had been to the East Coast city and they are proud that not only did they represent the Kansas City, Mo., School district but more importantly, Central High school.

Continued on page 12

Central Debaters Learn Continued from front page

school.

"Before debate, I didn't even know there were so many opportunities out there for young people," said Joshua, a sophomore." Ever since I've been in debate, I've had so many tons of opportunities. Opportunities to go out of town. Opportunities for internships. Opportunities to do various things I didn't think I could do before I started debating. Before debate, I thought there was nothing out there for me. I'm young, I'm a black male, and statistics prove I'm going to be in jail by 18 or 21. So it didn't look bright for my future and debate changed that."

Even Larry echoed Josh's comments.

"When I came to Central, we went to nationals," said Larry, who once debated while a student at Lincoln College Prep. "We got to see different things, go to different places and actually see that there is life outside of Missouri, that's been good."

Same goes for Sydnie and Marquieze, who will take an even giant step next week as they head with J.R. to the "Big Apple", New York City, to compete in the Urban Debate Nationals, from April 22-25. This won't be the first time that Central High has had debaters attend the nationals which have also been held in cities like Chicago and Atlanta. But just the thought of another set of Central students heading off to a national meet says that even in the midst of a District faced with massive school closures, unwelcomed budget troubles, loss of students and faculty, and yes, the continual battle to erase that negative image that has often hit the Kansas City district, these Central High youth are all about pride. Pride for their District, pride for their school, and pride for themselves and their families, who have all played a major role in their efforts.

Next week, Sydnie and Marquieze are looking to make sure that what they've gained from recent debate tournaments can carry with them to New York. Oh sure, there's some nervousness. Sydnie's not sure if she and Marquieze will get it down pat as to what needs to be corrected before heading to the "Big Apple", but she still is proud to be going to the national debate championships even if she and Marquieze aren't able to bring home a trophy.

"The first thing I thought when I won (Debate K.C.) City Championships, we're on our way to New York," said Marquieze, who is heading to Johnson County Community college next year on a Debate scholarship. "But then, when I realized we're going to New York on a debate tournament, not just a two or four-day tournament, not just a vacation, I thought, 'hey, New York is not as big as I thought it was.' Yeah, I realized it's different now. We're not going to go around and see the Statue of Liberty but to compete, be competitive and win."

BACK FROM PHILADELPHIA. . .Central High school debaters Larry Coates, Joshua Chapman and Sydnie Brown, are all smiles showing off the many trophies Central debaters have won through the years. The trio had a strong showing at the Coalition for Community Schools 2010 National Forum, April 7-9, in Philadelphia. - - CALL photo by Tracy Allen

According to Sydnie, "A lot of kids from Central High qualify for nationals every year so it is our goal to be just like them, to qualify for nationals. So, it's great we're going. I'm grateful for it."

According to Sydnie saw it, "I really didn't think I was going to win (at City Championships)," she said. "I changed partners at the last minute as soon as we got to the tournament, and I never debated with Marquieze as far as Debate KC this year. My partner, Larry, who I debated with, had never lost a round. That was my partner. I ended up having someone else as my partner, but I ended up getting first place speaker, and I was really surprised by it."

"I enjoy being on the team," said Sydnie, who joined the Central debate team her sophomore year. Currently, she is a senior, just like Marquieze.

Marquieze, well, he's glad that he can finally accomplish something without getting into trouble.

In the earlier years, Marquieze found himself, at times, in troubled spots not good for a young boy had more promise than he realized. It wasn't until his sophomore year in an Algebra II class that he learned that those arguments that he had with some kids in a classroom could actually turn into valid work. He was sent to Mrs. Rinehart class for an "argument" he had with a girl, who was challenged to join the debate team herself. So, what did Marquieze do: just like any teenage boy arguing with a girl, he followed her to Mrs. Rinehart class. Once inside J.R.'s classroom, it was clear to Marquieze that J.R. meant business. Marquieze was encouraged to show up to a debate practice after school. He questioned the thought but obliged. He soon learned a hard lesson, though. "I got here and she told me, I'm not your baby sitter," said a smiling Marquieze.

"Quite frankly, I didn't know anything about debate before I got here," said Marquieze. "Neither did I care at the time what the Central debate program had accomplished previously." But Marquieze did what he felt was right. He showed up at J.R.'s debate practice and hasn't left the program

since.

No, J.R. was more than just a "classroom sitter" for kids like Marquieze. She was a caring teacher who has always had a special interest in the students of Central High school. That interest included kids like Marquieze, who while not the most graceful speaker, did learn that he could become better in front of audiences and too, he could also challenge the "status quo" as far as conversation without erupting into behavior that leads to negative outcomes.

For Marquieze, Sydnie, Josh, and Larry, "J.R." has been the small little fire that has made these four black youth aware that they can be somebody.

"Through debate, I learned how to use proper grammar," said Marquieze. "For a minute there, I was almost on a speech impediment level to where I could barely talk. Three years of debate is starting to help me work on that. I know grammar well enough so I can have an interview. I also learned public speaking skills, talking in front of a big group of people, at once. At first, I couldn't even talk in front of a classroom before I joined debate."

"Mrs. Rinehart has taught me a lot of things," said Marquieze. "She taught me how to say words. She even taught me table manners like which is salad fork and the regular fork you eat with, stuff like that. It's just a long list of things to think about the things Mrs. Rinehart has done for me."

Same for Sydnie, who is still trying to get excited about the New York trip over the Philadelphia journey, credits Mrs. Rinehart for helping her understand that there's more to life than the community and streets that surround her in urban Kansas City.

The Philly trip definitely was her shining moment. Just ask Sydnie what she thinks of the Pennsylvania trip and she perks up pretty quick, "I was a star in Philly", said a smiling Sydnie. "Philly really had a good impact on me."

But, even Sydnie knows that there will be even bigger opportunities ahead, especially with the trip to New York. She's just glad she found Mrs. Rinehart class to realize her dreams.

"She has helped me a lot," Sydnie said of Mrs. Rinehart. "She's shown me different things so I don't have to always live in this little box i.e., the inner city. She tells me there are always these little windows of opportunities in this little box, but a lot of us never look out of them. There's just so much Mrs. Rinehart has shown me on a personal level, I'm just grateful for her. I might not act like it all the time, but I am really grateful for her."

Thanks to J.R., these youth know they have someone "watching their back" and wishes the best for them.

"I really am glad I came to Mrs. Rinehart," said Marquieze. "I was really so sorry as a novice. I was losing back, left to right, front to back. My speeches were horrible. I was just sucky. I stuck with it and now I'm not sucky anymore."

And Sydnie hopes that doesn't happen in New York. "The only way for us not to be sucky is if we keep practicing," she said. "I'm used to losing a lot but Marquieze, he was on a winning team last year. Hopefully, we can win this year. I know he's not used to losing. As long as we work together than everything will work out fine for us."

It's working out for most of the Central debaters. It's the reason why Joshua believes he'll be successful because of J.R.'s love for her kids.

"J.R. always made me feel that I should never settle for less," said Joshua. "She always wants the best for me. Having someone behind me, who cares for me and not just about me, but my future, that has changed my whole mindset."

"I'm really grateful for Mrs. Rinehart," said Larry.

According to J.R., "Mrs. Rinehart goes through a lot for us. She stretches her neck for us. She makes sure that we become the best we can."

FOCUS on Health Reform

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HEALTH REFORM IMPLEMENTATION TIMELINE

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following timeline provides implementation dates for key provisions. It reflects provisions in the new law and incorporates modifications to the law included in the Health Care and Education Reconciliation Act of 2010 passed by the House and the Senate.

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.

Medicare

- Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.
- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity.
- Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.

Medicaid

- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).

Prescription Drugs

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

Quality Improvement

- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.
- Establish Teaching Health Centers to provide Medicare payments for primary care residency programs in federally qualified health centers.

2010 (continued)

Tax Changes

- Impose additional requirements on non-profit hospitals. Impose a tax of $50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011

Long-term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare; increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10% Medicare bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates.
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Reduce annual market basket updates for Medicare providers beginning in 2011.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Quality Improvement

- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.
- Establish a new trauma center program to strengthen emergency department and trauma center capacity.
- Improve access to care by increasing funding by $11 billion for community health centers and the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

2011 (continued)

Tax Changes

- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.
- Impose new annual fees on the pharmaceutical manufacturing sector.

2012

Medicare

- Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care.
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
- Create the Medicare Independence at Home demonstration program.
- Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Provide bonus payments to high–quality Medicare Advantage plans.
- Reduce rebates for Medicare Advantage plans.

Medicaid

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Quality Improvement

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013

Insurance Reforms

- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)

Medicare

- Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3% on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
    - o 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);
    - o 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);
    - o 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).
- Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)
- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- Require qualified health plans to meet new operating standards and reporting requirements.

Premium Subsidies

- Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges.

Medicare

- Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019);
- Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. (Issue recommendations beginning January 2014)
- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided.
- Require Medicare Advantage plans to have medical loss ratios no lower than 85%.

Medicaid

- Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI).
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments.

Prevention/Wellness

- Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Tax Changes

- Impose fees on the health insurance sector.

2015 and later
Insurance Reforms
• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016)
Medicare
• Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)
Tax Changes
• Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. (Effective January 1, 2018)

For additional information, see http://www.kff.org/healthreform/8060.cfm.

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SUMMARY OF NEW HEALTH REFORM LAW

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary of the new law, and changes made to the law by subsequent legislation, focuses on provisions to expand coverage, control health care costs, and improve health care delivery system.

	Patient Protection and Affordable Care Act (P.L. 111-148)
Overall approach to expanding access to coverage	Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level.
INDIVIDUAL MANDATE	
Requirement to have coverage	• Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).
EMPLOYER REQUIREMENTS	
Requirement to offer coverage	• Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee. (Effective January 1, 2014) • Exempt employers with 50 or fewer employees from any of the above penalties. • Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)
Other requirements	• Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.
EXPANSION OF PUBLIC PROGRAMS	
Treatment of Medicaid	• Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law and in the House and Senate-passed bills undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but

	Patient Protection and Affordable Care Act (P.L. 111-148)
EXPANSION OF PUBLIC PROGRAMS (continued)	
Treatment of Medicaid (continued)	were not enrolled), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014)
Treatment of CHIP	• Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.
PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS	
Eligibility	• Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.5% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.
Premium credits	• Provide refundable and advanceable premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels: Up to 133% FPL: 2% of income 133-150% FPL: 3 – 4% of income 150-200% FPL: 4 – 6.3% of income 200-250% FPL: 6.3 – 8.05% of income 250-300% FPL: 8.05 – 9.5% of income 300-400% FPL: 9.5% of income • Increase the premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, further adjust the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed .54% of GDP. • Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014.
Cost-sharing subsidies	• Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level: 100-150% FPL: 94% 150-200% FPL: 85% 200-250% FPL: 73% 250-400% FPL: 70%
Verification	• Require verification of both income and citizenship status in determining eligibility for the federal premium credits.
Subsidies and abortion coverage	• Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or cases of rape or incest (Hyde amendment). If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.

	Patient Protection and Affordable Care Act (P.L. 111-148)
PREMIUM SUBSIDIES TO EMPLOYERS	
Small business tax credits	• Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit. – *Phase I:* For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. – *Phase II:* For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.
Reinsurance program	• Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program. (Effective 90 days following enactment through January 1, 2014)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM	
Tax changes related to health insurance	• Impose a tax on individuals without qualifying coverage of the greater of $695 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014. • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2011) • Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount. (Effective January 1, 2011) • Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment. (Effective January 1, 2013) • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016. (Effective January 1, 2013) • Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income taxpayers (thresholds are not indexed). (Effective January 1, 2013) • Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage. (Effective January 1, 2018) • Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. (Effective January 1, 2013)

	Patient Protection and Affordable Care Act (P.L. 111-148)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM (continued)	
Tax changes related to financing health reform	• Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule: – $2.8 billion in 2012-2013; – $3.0 billion in 2014-2016; – $4.0 billion in 2017; – $4.1 billion in 2018; and – $2.8 billion in 2019 and later. • Impose an annual fee on the health insurance sector, according to the following schedule: – $8 billion in 2014; – $11.3 billion in 2015-2016; – $13.9 billion in 2017; – $14.3 billion in 2018 – For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth. For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer. (Effective January 1, 2014) • Impose an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012) • Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009) • Impose a tax of 10% on the amount paid for indoor tanning services. (Effective July 1, 2010) • Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. (Effective January 1, 2010) • Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance. (Effective upon enactment)
HEALTH INSURANCE EXCHANGES	
Creation and structure of health insurance exchanges	• Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)
Eligibility to purchase in the exchanges	• Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.
Public plan option	• Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.
Consumer Operated and Oriented Plan (CO-OP)	• Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)

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HEALTH INSURANCE EXCHANGES (continued)	
Benefit tiers	• Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets: – *Bronze plan* represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010); – *Silver plan* provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Gold plan* provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Platinum plan* provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Catastrophic plan* available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market. • Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels: – 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family); – 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family); – 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family). These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.
Insurance market and rating rules	• Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange. • Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)
Qualifications of participating health plans	• Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information. • Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.
Requirements of the exchanges	• Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges. • Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.
Basic health plan	• Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.
Abortion coverage	• Permit states to prohibit plans participating in the Exchange from providing coverage for abortions. • Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no

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HEALTH INSURANCE EXCHANGES (continued)	
Abortion coverage (continued)	less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.
Effective dates	• Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.
BENEFIT DESIGN	
Essential benefits package	• Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014) • Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)
Abortion coverage	• Prohibit abortion coverage from being required as part of the essential health benefits package. (Effective January 1, 2014)
CHANGES TO PRIVATE INSURANCE	
Temporary high-risk pool	• Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010). Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)
Medical loss ratio and premium rate reviews	• Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) • Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)
Administrative simplification	• Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)
Dependent coverage	• Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)
Insurance market rules	• Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. Prohibit pre-existing condition exclusions for children. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary. • Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to adult children up to age 26, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days. Require grandfathered group plans to eliminate lifetime limits on coverage and beginning in 2014, eliminate annual limits on coverage. Prior to 2014, grandfathered group plans may only impose annual limits as determined by the Secretary. Require grandfathered group plans to eliminate pre-existing condition exclusions for children within six months of enactment and by 2014 for adults. (Effective six months following enactment, except where otherwise specified) • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market. (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014)

	Patient Protection and Affordable Care Act (P.L. 111-148)
CHANGES TO PRIVATE INSURANCE (continued)	
Insurance market rules (continued)	• Require all new policies (except stand-alone dental, vision, and long-term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. (Effective January 1, 2014) • Limit any waiting periods for coverage to 90 days. (Effective January 1, 2014) • Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling $25 billion over three years. (Effective January 1, 2014 through December 2016) • Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)
Consumer protections	• Establish an internet website to help residents identify health coverage options (effective July 1, 2010) and develop a standard format for presenting information on coverage options (effective 60 days following enactment). • Develop standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment)
Health care choice compacts and national plans	• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2016)
Health insurance administration	• Establish the Health Insurance Reform Implementation Fund within the Department of Health and Human Services and allocate $1 billion to implement health reform policies.
STATE ROLE	
State role	• Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas. • Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in 2011), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. (Federal grants available beginning fiscal year 2010) • Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. (Effective January 1, 2014) Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. (Effective January 1, 2017)

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COST CONTAINMENT	
Administrative simplification	• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)
Medicare	• Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modify rebate system with rebates allocated based on a plan's quality rating. Phase-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Cap total payments, including bonuses, at current payment levels. Require Medicare Advantage plans to remit partial payments to the Secretary if the plan has a medical loss ratio of less than 85%, beginning 2014. Require the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years. • Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary) • Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. (Effective January 1, 2011) • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided (Effective fiscal year 2014) • Eliminate the Medicare Improvement Fund. (Effective upon enactment) • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012) • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011) • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012) • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)

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COST CONTAINMENT (continued)	
Medicaid	• Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price. (Effective January 1, 2010) Extend the drug rebate to Medicaid managed care plans. (Effective upon enactment) • Reduce aggregate Medicaid DSH allotments by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers. (Effective October 1, 2011) • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)
Prescription drugs	• Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)
Waste, fraud, and abuse	• Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities. (Effective dates vary)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE	
Comparative effectiveness research	• Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)
Medical malpractice	• Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)
Medicare	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)
Dual eligibles	• Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)

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IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)	
Medicaid	• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. (Effective January 1, 2011) • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015). • Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)
Primary care	• Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2013) • Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015. (Effective for five years beginning January 1, 2011)
National quality strategy	• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)
Financial disclosure	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)
Disparities	• Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)
PREVENTION/WELLNESS	
National strategy	• Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) • Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and immunization programs. Appropriate $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015. (Effective fiscal year 2010) • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)
Coverage of preventive services	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective January 1, 2011) For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services. Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011)

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PREVENTION/WELLNESS (continued)	
Coverage of preventive services (continued)	• Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. (Health risk assessment model developed within 18 months following enactment) Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010) • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)
Wellness programs	• Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011) • Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)
Nutritional information	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)
LONG-TERM CARE	
CLASS Act	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)
Medicaid	• Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014). • Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010) • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2011) • Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)
Skilled nursing facility requirements	• Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)

	Patient Protection and Affordable Care Act (P.L. 111-148)
OTHER INVESTMENTS	
Medicare	• Make improvements to the Medicare program: – Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 (Effective January 1, 2010); – Phase down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020: • For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013) • For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011); Between 2014 and 2019, reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage; – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012); – Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment); – Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and – Provide payments totaling $400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending; and – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)
Workforce	• Improve workforce training and development: – Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010) – Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. (Initial appropriation in fiscal year 2010) – Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010) – Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011) – Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)

	Patient Protection and Affordable Care Act (P.L. 111-148)
OTHER INVESTMENTS (continued)	
Community health centers and school-based health centers	• Improve access to care by increasing funding by $11 billion for community health centers and the National Health Service Corps over five years (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed health clinics (effective fiscal year 2010).
Trauma care	• Establish a new trauma center program to strengthen emergency department and trauma center capacity. Fund research on emergency medicine, including pediatric emergency medical research, and develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated beginning in fiscal year 2011)
Public health and disaster preparedness	• Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)
Requirements for non-profit hospitals	• Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)
American Indians	• Reauthorize and amend the Indian Health Care Improvement Act. (Effective upon enactment)
FINANCING	
Coverage and financing	The Congressional Budget Office (CBO) estimates the new health reform law will provide coverage to an additional 32 million when fully implemented in 2019 through a combination of the newly created Exchanges and the Medicaid expansion. CBO estimates the cost of the coverage components of the new law to be $938 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise $32 billion over ten years. CBO also estimates that the health reform law will reduce the deficit by $124 billion over ten years.
Sources of information	www.democraticleader.house.gov/

This publication (#8061) is available on the Kaiser Family Foundation's website at www.kff.org.

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The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

March 11, 2010

Text of Gov. Nixon's remarks on right-sizing and refocusing state government to Springfield business leaders

SPRINGFIELD, Mo. -- **Gov. Jay Nixon** today delivered the following remarks to the annual meeting of the **Springfield Business Development Corporation**:

(As prepared for delivery)

Good afternoon.

It's a pleasure to be here today. I'd like to thank all of you in the Springfield Chamber for your strong leadership in this community.

I just arrived from Poplar Bluff, where I had the honor of meeting with 73 soldiers from the 205th Military Police Battalion, who are being deployed to Afghanistan.

Looking into the faces of those brave patriots, who are putting their lives on the line to fight terrorism more than seven thousand miles from home… leaving their spouses and children behind for months at a stretch...it puts our troubles on the home front in perspective mighty quick.

To all the men and women of our armed forces, thank you for your commitment, and God bless you in your service.

There's a major challenge staring us in the face in state government. Three months after we prepared next year's budget, our economic models are becoming clearer. While our state economy is starting to tick upward, state revenue is not. And it probably won't for some time.

That means we've got a $500 million hole in next year's budget. Some have suggested that the most expedient way to plug that hole and balance the budget is to make across-the-board cuts of 10 percent.

Across-the-board cuts are a simplistic solution − not a thoughtful, responsible course of action. And they're simply not the right way forward.

Because there are vital services government always has to provide.

No matter what, we still have to have teachers in our classrooms… state troopers on our highways… and corrections officers keeping violent offenders off the street.

To get the savings we need, we must right-size state government by cutting programs, trimming the workforce, and consolidating departments while maintaining excellence in our services.

Every state is grappling with this downturn, and twenty-nine states have raised taxes. But one thing is off the table here in the Show-Me State. We will hold the line on taxes.

Today, I am going to outline my blueprint for getting the budget savings we need, downsizing where we have to, and delivering vital services to the people of Missouri.

That's a lot of heavy lifting, and I'm going to need the help of the legislature to get this done.

We have worked together from day one, and we've weathered some of the roughest waters our state has ever seen.

We can − and we will − do it again.

And when we get this right, we'll come out the other side with a government that is leaner, nimbler and more efficient. That will put us in a stronger position to lead the nation, and accelerate out of this downturn.

Tackling tough challenges is nothing new.

From the moment I took office, I have focused on turning this economy around; creating jobs; and building a foundation for future growth.

In the 14 months I've been Governor, I've had to make cuts totaling more than $1.2 billion to balance the state budget, including $125 million in cuts I authorized this morning.

We've also taken some common sense steps, like conserving energy, and have saved more than three million dollars on our utility bills.

I also had to reduce the size of state government by 1,800 positions. That wasn't a decision I made lightly.

But our early action and fiscal discipline helped us avoid the meltdowns we've seen in other states, and earned us national respect.

Moody's continues to rate Missouri one of the top states to lead the nation in economic recovery. And we are the only state in the Midwest with a spotless, Triple A rating from all three ratings firms: Moody's, Standard and Poors, and Fitch.

Even in these challenging times, Missouri's unemployment rate – while still too high – also remains lower than the national average.

While taking steps to get the government's house in order, we've also focused on improving Missouri's business climate. Over the past 14 months, I've sat down with business owners from one end of the state to the other, including a very valuable roundtable discussion with several of you.

Last year, we came up with new economic tools to help businesses large and small. And we've got a new comprehensive jobs package for 2010 that will drive more growth in the future.

One of the things I'm most proud of is that we worked together to freeze tuition at state colleges and universities, because education is key to our economic prosperity.

For Missouri to thrive in the long-term, we have got to right-size government, zero in on our priorities and focus on the future.

That's what this blueprint is all about.

Let's start with right-sizing.

As I've said, our challenge is to cut $500 million out of next year's budget.

When you're confronted with a number that large, across-the-board cuts may seem appealing. But that's simplistic and short-sighted. It wouldn't solve the problem, and it would hurt the people of Missouri.

Just think about it.

We need the Highway Patrol to get drunk drivers off the road.

We need night guards walking the halls of our prisons.

And we need inspectors to protect our elderly loved ones in nursing homes.

Birth certificates, driver's licenses, tax refunds.

I could go on. There are numerous examples of essential services we depend on state government to provide.

But by taking a careful look across departments and programs, we can lean up government without sacrificing those vital services.

And that's exactly what we're going to do.

We're going to find wasted office space and sell unnecessary buildings.

We're going to sell 2,000 cars out of the state fleet.

We're going to eliminate three extra state holidays, including Truman's birthday. Every holiday costs us about $1.2 million; we're talking about real savings in tough times.

As one fiscally conservative Democrat to another, Harry, I hope you understand.

And we are going to have to downsize the state workforce again, and eliminate another 1,000 positions. Again, this will be a difficult process, and we'll be there every step of the way to help provide training and support as these folks transition to new careers.

But this still won't be enough to get us to $500 million.

We need to find more savings by consolidating functions. Wherever we can reduce the bureaucracy and streamline services for the taxpayers, we must do it – and we will.

Let me give you a few examples.

Missouri has a Department of Elementary and Secondary Education, and a Department of Higher Education.

We need to have one Department of Education that prepares students from the day they walk into pre-school to the day they walk across the stage with their college diplomas.

State law enforcement can be made more efficient as well. Missouri has one full-time agency that enforces state laws on our highways 365 days a year, and an entirely separate agency that enforces state laws on our waterways.

We need to consolidate the Highway Patrol and the Water Patrol, so that our dedicated law enforcement agents can provide the citizens of Missouri with seamless protection, whether they're traveling our highways or floating our lakes and streams. We can achieve these administrative efficiencies while maintaining the full force on our roads and our waterways.

The same consolidation efforts should apply to other services, including environmental permits. Right now, businesses have to deal with numerous separate bureaucracies within the DNR to get the required permits.

That's time-consuming, redundant and, frankly, maddening. We need a one-stop shop that streamlines the permitting process, while ensuring that Missouri has clean water and clean air. There are many other ways we can make government leaner.

We can consolidate state labs.

We can put more government services online.

We can fold up the sprawling bureaucracy of the Family Support Division, which has offices in every one of Missouri's 114 counties, and create regional offices. We can privatize the collection of child support, and make that system work better for families.

We can follow the lead of the private sector, and modernize pension and health care programs for state employees.

These sorts of structural changes will move the needle. But they're not enough. We need to more clearly define the scope of what we can do – and can't do – for our citizens.

We've taken a hard look at state programs that aren't delivering a return on investment. It's time to retool them, or get rid of them.

Take tax credits, for example.

Over the last 10 years, our use of tax credits has ballooned to $585 million a year; that's 86 percent growth.
Tax credits of all types were passed with good intentions, and were intended to create jobs and spark economic development. In many cases, tax credits are producing a positive return on our investments. But there are some that aren't.

When it comes to economic development, we have a responsibility to look at the ROI, and determine which tax credits are delivering for Missouri taxpayers.

The answer right now is obvious. The state is overpaying, and tax credits are underperforming. That must change.

We need to reshape state tax credits to improve our ROI. We need to use tax credits strategically and make sure they are moving our economy forward.

That means putting caps on some tax credits, and giving the Department of Economic Development more discretion over which projects we will be investing in.

However, we will NOT touch the circuit-breaker tax credits that help seniors and disabled folks stay in their homes. They'll still be protected, as they should be.

We also need to make changes in another well-intentioned area: financial aid for higher education.
Currently, many of our state college scholarship programs – both for merit and for need – provide financial support to students whether they choose to attend public or private colleges. In some cases, students at private schools actually get larger scholarships than students at public institutions.

Missouri has wonderful colleges and universities, both public and private. But in times like these, we simply can't continue to subsidize the choice to attend a private school.

Refocusing also means making difficult choices about where to invest our limited resources.
For instance, our investment in biofuels. We will continue to fund biodiesel for the rest of this

year, but the current subsidy levels are not sustainable. I will work with the legislature to develop a plan for this industry that fits with our energy goals and stays within our means.

My blueprint for change will recalibrate the size and scope of state government, giving us government that is leaner, nimbler, and less costly. Government that is focused on the right priorities:

- Educating our children in first-rate public schools, from pre-school through graduate school;
- Protecting our families and communities, responding to emergencies, and locking up violent criminals; and
- Making sure our most vulnerable citizens – children, the elderly, the disabled – get the services they need.

Folks, we have a real opportunity to transform our government, and to streamline its operations.

Yes, that means we are going to do fewer things. But we are going to do them more efficiently, and more effectively, and with greater accountability to the taxpayers.

That's what my blueprint for change is all about.

It contains some new ideas that have been well thought out. This blueprint is the right plan, at the right time, to move Missouri forward.

I'm an optimist. Always have been, always will be.

Times may be tough, but Missourians are tougher. And when we work together, we can accomplish anything.

Every idea I have mentioned today is a product of my firm belief that Missouri's brightest days still lie ahead.

As Governor, I can accomplish some of these reforms on my own. But it will take teamwork and cooperation to accomplish everything that's called for in my blueprint.

I need the support and energy of every person in this room, and every person in this state, to move it forward. I am confident that when the legislature comes back next week, we can get this done.

And when we do, Missouri will be more innovative … more competitive … and more prosperous … for generations to come.

Thank you.

Available Now

Inspiring Greatness

A Community's Commitment to a Brighter Future

The Independence, Missouri School District Board of Education, and Superintendent, Dr. Jim Hinson

I believe every community is home to concerned citizens, whose inspiration and commitment to cause are perhaps latent, kindling awaiting a spark. The good work of Independence, Missouri – chronicled here – should serve admirably to provide that spark!

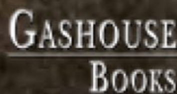
David L. Katz, MD, MPH, FACPM, FACP
Director, Prevention Research Center
Yale University School of Medicine

A fine example of a grassroots movement that ignited positive momentum for change. Community cooperation can achieve glorious goals!

Pastor Bob Spradling
Maywood Baptist Church
Independence, Missouri

Informative, dramatic, and spellbinding!
Dr. Edward Zigler, Ph.D.

isdinspiringgreatness.org



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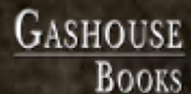
one community made history with an annexation of seven schools. Follow this community, committed to their students, as they struggle to regain their neighborhood schools. Read how they triumphed at the voting polls, then worked to revitalize neglected school buildings. A true story of volunteerism at its best!

"Inspiring Greatness" is not only the motto of the Independence School District; it is the legacy of those people, young and old, rich and poor, who dedicated their time and talents to realize their dream of creating a brighter future for their schools and generations of children to come."

Dr. Jim Hinson
Superintendent,
Independence School District

isdinspiringgreatness.org



Cinco de Mayo

Wed., May 5, 5:00 - 7:30 pm

Northeast Elementary, 4904 Independence Ave, Kansas City, MO 64124

LINC Caring Communities

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