Session of 2005

HOUSE BILL No. 2371

By Representatives Swenson and Powers

2-9

AN ACT concerning insurance; establishing the Kansas Health Security Act.

Be it enacted by the Legislature of the State of Kansas:

Section 1. This act shall be called the Kansas Health Security Act.

Sec. 2. (a) For purposes of sections 1 through 4 of this act:

(1) "Dependent" means a spouse, an unmarried child under 19 years of age, a child who is a student under 23 years of age and is financially dependent upon a plan enrollee or a person of any age who is the child of a plan enrollee and is disabled and dependent upon that plan enrollee.

(2) "Eligible business" means a business that employs at least two but not more than 50 eligible employees, the majority of whom are employed in the state, including a municipality that has 50 or fewer employees. After one year of operation of the health security program, the Secretary may, by rules and regulations, define "eligible business" to include larger public or private employers.

(3) "Eligible employee" means an employee of an eligible business who works at least 20 hours per week for that eligible business. "Eligible employee" does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

(4) "Eligible individual" means:

(A) A self-employed individual who works and resides in the state and is organized as a sole proprietorship or in any other legally recognized manner in which a self-employed individual may organize a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income;

(B) an unemployed individual who resides in this state; or

(C) an individual employed in an eligible business that does not offer health insurance.

(5) "Employer" means the owner or responsible agent of a business authorized to sign contracts on behalf of the business.

(6) "Health insurer" shall have the meaning acribed to it in K.S.A. 40-4602, and amendments thereto.

(7) "Health security program" or "the program" means the health security program established by this section within the insurance

department.

(8) "Participating employer" means an eligible business that contracts with the health security program pursuant to this section.

(9) "Plan enrollee" means an eligible individual or eligible employee who enrolls in the health security program.

(10) "Provider" means any person, organization, corporation or association that provides health care services and products and is authorized to provide those services and products under the laws of this state.

(11) "Commissioner" means the commissioner of insurance.

(12) "Third-party administrator" means a person who, on behalf of a health insurance plan covering residents, receives or collects charges, contributions or premiums for or settles claims on residents in connection with any type of health benefit provided in or as an alternative to insurance; and

(13) "unemployed individual" means an individual who does not work more than 20 hours a week for any single employer.

(b) The health security program is established within the insurance department to provide comprehensive, affordable healthcare coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals, on a voluntary basis.

(1) The health security program shall:

(A) Determine the comprehensive services and benefits to be included in the program and develop the specifications for the program's insurance coverage;

(B) establish administrative and accounting procedures as recommended by the Commissioner of Insurance for the operation of the program;

(C) develop and implement a plan to publicize the existence of the program, including eligibility requirements and enrollment procedures;

(D) arrange the provision of plan benefit coverage to eligible individuals and eligible employees through contracts with one or more qualified bidders;

(E) develop a high-risk pool for plan enrollees; and

(F) purchase prescription drugs from any source whatsoever, including, but not limited to, vendors located outside the United States to be disseminated under the program.

(2) The health security program may:

(A) Enter into contracts with qualified third parties, both private and public, for any service necessary to carry out the purposes of this section;

(B) take any legal actions necessary to avoid the payment of improper claims against the coverage provided by the program, to recover any amounts erroneously or improperly paid by the program, to recover any amounts paid by the program as a result of mistake of fact or law, to

recover or collect savings, offset payments due the program or that are necessary for the proper administration of the program and to recover other amounts due the program;

(C) establish and administer a revolving loan fund to assist health care practitioners and health care providers in the purchase of hardware and software necessary to implement the requirements for electronic submission of claims. The program may solicit matching contributions to the fund from each health insurer licensed to do business in the state of Kansas;

(D) apply for and receive funds, grants or contracts from public and private sources; and

(E) conduct studies and analyses related to the provision of health care, health care costs and quality.

(c) (1) The health security program shall provide health insurance coverage through one or more health insurers not later than July 1, 2006. The program:

(A) Shall issue requests for proposals from health insurers;

(B) shall require participating health insurers to offer a benefit plan that meets the program's requirements;

(C) shall make payments to participating health insurers to provide insurance benefits to plan enrollees;

(D) may set allowable rates for administration and underwriting gains;

(E) may include quality improvement, disease prevention, disease management and cost-containment provisions in the contracts with participating health insurers or may arrange for the provision of such services through contracts with other entities;

(F) may administer continuation benefits for eligible individuals from employers with 20 or more employees who have purchased health insurance coverage through the program for the duration of their eligibility periods for continuation benefits pursuant to the federal consolidated omnibus budget reconciliation act, Public Law 99-272, Title X, private health insurance coverage, Sections 10001 to 10003; and

(G) may administer or contract to administer the United States internal revenue code of 1986, section 125 plans for employers and employees participating in the program, including medical expense reimbursement accounts and dependent care reimbursement accounts.

(2) To qualify as a health insurer for the health security program, a health insurer must:

(A) Provide the health services and benefits as determined by the program, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under K.S.A. 40-2,154, and

amendments thereto, and any supplemental benefits the program decides to make available;

(B) ensure that providers contracting with an insurer under the program do not charge plan enrollees or third parties for covered health care services in excess of the amount allowed by the insurer, except for applicable copayments, deductibles or coinsurance;

(C) ensure that providers contracting with an insurer under the program do not refuse to provide coverage to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status; and

(D) ensure that providers contracting with an insurer under the program are reimbursed at the rates negotiated between the insurer and its provider network.

(3) Health insurers that seek to qualify to provide services for the program must also qualify as health plans under K.S.A. 40-2,154, and amendments thereto.

(E) The health security program shall contract with eligible businesses to provide for health benefits coverage for employees and their dependents. The program shall collect payments from participating employers and plan enrollees to cover the costs of:

(A) Insurance for enrolled employees and dependents in contribution amounts determined by the board;

(B) quality assurance, disease prevention, disease management and cost-containment programs;

(C) administrative services; and

(D) other health promotion costs.

(2) The program shall establish the minimum required contribution levels to be paid by employers toward their aggregate payment, not to exceed 60%. The minimum required contribution level to be paid by employers must be prorated for employees who work less than the number of hours of a full-time equivalent employee. The program may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of enrolled employees.

(3) The program shall require participating employers to certify that at least 75% of their employees who work 30 hours or more per week and who do not have other creditable coverage are enrolled in the program's insurance and that the employer group otherwise meets the minimum participation requirements of this section.

(4) The program shall reduce the payment amounts for plan enrollees eligible for a subsidy.

(5) The program shall require participating employers to pass on any subsidy to the plan enrollee qualifying for the subsidy, up to the full

amount of payments made by the plan enrollee.

(6) The program may establish other criteria for participation and may limit the number of participating employers.

(e) (1) The health security program may permit eligible individuals to purchase the program's insurance for themselves and their dependents.

(2) The program may collect payments from eligible individuals participating in the program's insurance to cover the cost of:

(A) Enrollment for eligible individuals and dependents;

(B) quality assurance, disease prevention, disease management and cost-containment programs;

(C) administrative services; and

(D) other health promotion costs.

(3) The program shall reduce the payment amounts for individuals eligible for a subsidy.

(4) The program may require that eligible individuals certify that all their dependents are enrolled in the program's insurance or are covered by another creditable plan.

(5) The program may require an eligible individual who is currently employed by an eligible employer that does not offer health insurance to certify that the current employer did not provide access to an employer-sponsored benefits plan in the 12-month period immediately preceding the eligible individual's application.

(6) The program may limit the number of plan enrollees and may establish other criteria for participation.

(f) (1) The health security program shall establish sliding-scale subsidies for the purchase of insurance paid by individuals or employees whose income is under 300% of the federal poverty level and who are not eligible for medicaid. The program may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than 50 employees whose income is under 300 percent of the federal poverty level and who are not eligible for medicaid.

(2) Individuals eligible for a subsidy must:

(A) Have an income under 300% of the federal poverty level, be a resident of the state, be ineligible for medicaid coverage and be enrolled in the programs insurance; or

(B) be enrolled in a health plan of an employer with more than 50 employees. The health plan must meet any criteria established by the program. The individual must meet other eligibility criteria established by the program.

(3) The program shall limit the availability of subsidies to reflect limitations of available funds.

(4) The program may limit the subsidy to 40% of the payment made

by individual plan enrollees to more closely parallel the subsidy received by employees. In no case may the subsidy granted to eligible individuals exceed the maximum subsidy level available to eligible employees.

(g) (1) After a hearing, the insurance commissioner shall determine annually the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs, to health care providers in this state as a result of the operation of the program, and any increased coverage in medicaid or the state child health insurance program coverage funded with the program.

(2) The insurance commissioner shall establish a savings offset amount to be paid by health insurers and third-party administrators, not including insurers and third-party administrators for accidental injury, specified disease, hospital indemnity, dental, vision, disability, income, long-term care, medicare supplement or other limited benefit health insurance, annually at a rate that may not exceed the aggregate measurable cost savings. Payment of the savings offset amount must begin 12 months after the program begins providing health insurance coverage. Savings offset payments must be made quarterly and are due not less than 30 days after written notice to the health insurers and third-party administrators and must accrue interest at 12% per annum on or after the due date.

(3) Each health insurer must pay a savings offset in an amount not to exceed 4% of annual health insurance premiums on policies that insure residents of this state. The savings offset payment may not exceed the aggregate measurable cost savings.

(4) The insurance commissioner shall make reasonable efforts to ensure that premium revenue or claims plus any administrative expenses and fees with respect to third-party administrators is counted only once in any savings offset payment. The program shall allow a health insurer to exclude from its gross premium revenue reinsurance premiums that have been counted by the primary insurer for the purpose of determining its savings offset payment. The program shall allow each health insurer to exclude from its gross premium revenue the amount of claims that have been counted by a third-party administrator for the purpose of determining its savings offset. The program may verify each health insurer and third-party administrator's savings offset payment based on annual statements and other reports.

(5) The insurance commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any health insurer or the license of any third-party administrator to operate in this state if the insurer or administrator fails to pay a savings offset payment. In addition, the insurance commissioner may assess civil penalties against any health insurer or third-party administrator that fails

to pay a savings offset payment or may take any other enforcement action to collect any unpaid savings offset payments.

(6) On an annual basis, the program shall prospectively determine the savings offset to be applied during each 12-month period. Annual offset payments must be reconciled to determine whether unused payments may be returned to health insurers and third-party administrators according to a formula developed by the board. Savings offset payments must be used solely to fund the subsidies authorized by this section and may not exceed savings from reductions in growth of the state's health care spending and bad debt and charity care.

(7) Every health insurer and health care provider shall demonstrate that best efforts have been made to ensure that a carrier has recovered savings offset payments made pursuant to this section through negotiated reimbursement rates that reflect health care provider's reductions or stabilization in the cost of bad debt and charity care as a result of the operation of the program. A health insurer shall use best efforts to ensure health insurance premiums reflect any such recovery of savings offset payments as those savings offset payments are reflected through incurred claims experience.

(8) During any negotiation with a health insurer relating to a health care provider's reimbursement agreement with that health insurer, a health care provider shall provide data relating to any reduction or avoidance of bad debt and charity care costs to health care providers in this state, as a result of the operation of the program.

(h) (1) The program shall establish a health high-risk pool.

(2) A plan enrollee must be included in the high-risk pool if:

(A) The total cost of health care services for the enrollee exceeds $100,000 in any 12-month period; or

(B) the enrollee has been diagnosed with one or more of the following conditions: acquired immune deficiency syndrome (HIV/AIDS), angina pectoris, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkins disease, Huntingtons chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease requiring open-heart surgery, Parkinson's disease, polycystic kidney disease, psychotic disorders, quadriplegia, stroke, syringomyelia and Wilson's disease.

(3) The program shall develop appropriate disease management protocols, develop procedures for implementing those protocols and determine the manner in which disease management must be provided to plan enrollees in the high-risk pool. The program may include disease management in its contract with participating carriers for insurance, contract separately with another entity for disease management services or provide

disease management services directly through the program.

(i) (1) Any personally identifiable financial information, supporting data or tax return of any person obtained by the program under this section is confidential and not open to public inspection.

(2) Health information obtained by the program under this section that is covered by the federal health insurance portability and accountability Act of 1996 or information covered by Title 22, section 1711-C, is confidential and not open to public inspection.

Sec. 3. If any provision or clause of this act or application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.