Approved: March 4, 1998
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on February 20, 1998 in Room 529-S of the Capitol.

All members were present except:

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Tom Wilder, Kansas Insurance Department
Tom Bell, Kansas Hospital Association
Callie Jill Denton, Kansas Association of Health Plans
Ann Koci, SRS

Others attending: See attached list

Hearing on Sub SB 424--Kansas insurance coverage for kids

Senator Praeger presented a copy of the proposed substitute for the bill and explained that the $12 million that Kansas is expected to pledge in return for the $31 million in matching federal funds can be rolled over up to three years (Attachment 1). Ann Koci of SRS verified that Kansas will have three years to spend three years of allocation and more funding will be eligible after an audit of the program is conducted. All of the above is based upon the federal approval of the submitted Kansas insurance plan which can be amended or drastically changed, depending upon available state funding or resources. Specificity for eligibility is not contained in the bill. At this point there are no plans to change Medicare or Medicaid eligibility so it is not considered an expansion entitlement of either program. Should the funding be reduced, the number of services per individual would not be reduced--the number of children eligible for enrollment will be reduced. Children will be moved over to Title XXI coverage if their families receive more income, therefore taking advantage of the seamless coverage component of the bill. Children will lose coverage if their parents do not pay their portion of the premium in an effort to promote self-sufficiency as part of the education part of the program. The problem of physician and hospital reimbursement was discussed by the Committee. The Chairman of the Ways and Means Committee discussed the issue with the Republican caucus. Many physicians do not want to deal with the Medicaid side of this program.

Senator Biggs moved to report the bill favorably with the appropriate language changes. Motion was seconded by Senator Praeger. Motion carried.

Continued Hearing on HB 439--Medicare provider organizations, regulations and creations

Tom Wilder, Kansas Insurance Department, stated this bill would give KID the authority (through licensure) to regulate Medicare providers as established through the Medicare+Choice plans offered through HMO's and provider sponsored groups. He reviewed the plan, the proposed changes, and amendments as were proposed in his original testimony dated February 18, 1998. The federal government appears to be seeking privatization for Medicare enrollees through this program. It is unknown how economically feasible it would be for private agencies to be developed following the prescribed authority. The requirement of solvency for these proposed groups should be the same as existing agencies providing such services--hospitals, care centers, etc.

Tom Bell, Kansas Hospital Association, explained that the goals of the Medicare+Choice plan was to give Medicare beneficiaries more choice of health plans, while moving the program toward a managed care model (Attachment 2). He explained the procedure for seeking licensure, deadlines, and the problems of development of this program as federal standards have not been set or published at this time. He advised the Committee that the first priority should be to make sure consumers are protected. He personally did not think many Medicare providers will be interested in becoming the "plan" for Medicare+Choice.

Callie Jill Denton, Kansas Association of Health Plans, voiced concern that persons enrolled in Medicare now will pull out and move over to the new program (Attachment 3). She advised caution in the development of this program. Committee members again addressed their concern with solvency rules not being clearly defined.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

MINUTES OF THE Senate Committee on Financial Institutions & Insurance, Room 529-S Statehouse, on February 20, 1998.

Senator Praeger moved to report the bill favorably with the proposed amendments from the Kansas Insurance Department and technical changes as recommended by the Revisor's Office. Motion was seconded by Senator Becker. Motion carried.

The meeting was adjourned at 10:00 a.m. The next meeting will be held on February 23, 1998.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2-20-98

NAME	REPRESENTING
Carolyn Middendorf	KSNA
J. Gerling?	SRS
Ann Koci	SRS
Tom Wilder	Kansas Ins. Dept.
Robin Lehman	Kansas Action for Children
Sally F. Frossman-Cecil	Kansas Mental Health Coalition Grassroots Legislative Coordinator
[illegible] Otte	D.P.S.
Susan Anderson	Hein + Weir
Janet Schalansky	SRS
Mary Ellen Conlee	Via Christi Health System
Kathy Peterson	YMCAs / Prudential
Meg Draper	KS Medical Society
Robert Epps	HCFA
Venesa Sitlenaue	HIAA
R. Guthrie	Health Midwest
[illegible]	Senate
Dawn Reid	KSNA
[illegible]	KCA
Linda J. DeCoursey	KS Insurance Dept.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: ____________________

NAME	REPRESENTING
Ella Peck-Ha[illegible]	Assoc. of CMHCs
Bob Alderson	Ks. Pharmacists Assoc.
Bob Williams	Ks Pharmacists Assoc.
Danielle Noe	Governor's Office
John Federico	Humana
Brad Smoot	BCBS

PROPOSED SUBSTITUTE For SENATE BILL NO. 424

AN ACT relating to Kansas insurance coverage for children; duties of the secretary of social and rehabilitation services.

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

Section 1. (a) The secretary of social and rehabilitation services shall develop and submit a plan consistent with federal guidelines established under section 4901 of public law 105-33 (42 U.S.C. 1397aa *et seq.*; title XXI).

(b) The plan developed under subsection (a) shall be a capitated managed care plan covering Kansas children from zero to 19 years which:

(1) Contains benefit levels at least equal to those for the early and periodic screening, diagnosis and treatment program;

(2) provides for presumptive eligibility for children based upon, but not limited to, children who:

(A) Receive free or reduced school lunches;

(B) may be eligible for title XIX;

(C) received supplemental security income but lost such benefits under P.L. 104-193;

(D) receive services from headstart; or

(E) receive a preliminary determination of eligibility until a final determination is made.

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(3) provides continuous eligibility for 12 months once a formal determination is made that a child is eligible subject to subsection (e);

(4) has performance based contracting with measurable outcomes indicating appropriate utilization of plan services to include, but not limited to, such measurable services as immunizations, vision, hearing and dental exams, emergency room utilization and annual physical exams; and

(5) will provide targeted low-income children, as defined under section 4901 of public law 105-33 (42 U.S.C. 1397aa, et seq.) and amendments thereto, coverage subject to appropriations.

(c) The secretary is authorized to contract with insurance companies, health maintenance organizations or nonprofit hospital and medical insurance corporations authorized to transact health insurance business in this state to implement the health coverage plan in subsection (a) providing for several plan options to enrollees which are coordinated with federal and state child health care programs.

(d) When developing and implementing the plan in subsection (a), the secretary to the extent authorized by law:

(1) May include provisions that contracting insurers utilize and coordinate with existing community health care institutions and providers;

(2) may work with public health care providers and other community resources to provide educational programs promoting healthy lifestyles and appropriate use of the plan's health

services;

(3) shall plan for outreach and maximum enrollment of eligible children through cooperation with local health departments, schools, child care facilities and other community institutions and providers;

(4) shall provide for a simplified enrollment plan;

(5) shall provide cost sharing as allowed by law;

(6) shall not count the caring program for children, the Kansas health insurance association plans or any charity health care plan as insurance under subsection (e)(1); and

(7) may provide for payment of health insurance premiums if it is determined cost effective, taking into account the number of children to be served and the benefits to be provided.

(e) A child shall not be eligible for coverage and shall lose coverage under the plan developed under subsection (a) of section 1, and amendments thereto, if:

(1) During the prior six months, the child was covered with a comprehensive health insurance policy by an insurance company, health maintenance organization or nonprofit hospital and medical insurance corporation authorized to do business in this state and such insurance is still available to the child; or

(2) such family has not paid the enrollee's applicable share of any premium due.

If the family pays all of the delinquent premiums owed during the year, such child will again be eligible for coverage for the remaining months of the continuous eligibility period.

(f) The plan developed under section 4901 of public law 105-33 (42 U.S.C. 1397aa *et seq*., and amendments thereto) is not an entitlement program. The availability of the plan benefits shall be subject to funds appropriated.

Sec. 2. The secretary of social and rehabilitation services shall adopt rules and regulations as necessary to implement and administer the provisions of section 1 through 4, and amendments thereto.

Sec. 3. (a) (1) None of the funds appropriated to implement this act shall be expended for any abortion.

(2) None of the funds appropriated to implement this act shall be expended for health benefits coverage that includes coverage of abortion.

(3) The term "health benefits coverage" means the package of services covered by an insurance company, health maintenance organization or nonprofit hospital and medical insurance corporation authorized to transact health insurance in this state pursuant to a contract or other arrangement entered into under sections 1 through 4, and amendments thereto.

(b) The limitations established in subsection (a) shall not apply to an abortion:

(1) If the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the

pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Sec. 4. The secretary in contracting for capitated managed health care for children shall include in the pool of persons to be covered those eligible children covered by the Kansas medicaid program as law allows.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

Memorandum

Donald A. Wilson
President

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kansas Hospital Association
Thomas L. Bell, Senior Vice President/Legal Counsel

RE: Senate Bill 439

DATE: February 18, 1998

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 439. This bill would provide a mechanism to license "Medicare provider organizations" in Kansas.

BACKGROUND

The introduction of SB 439 is largely a result of congressional passage of the federal Balanced Budget Act of 1997. One part of the Balanced Budget Act involved the enactment of the *Medicare+Choice* program. Under this new program, Medicare beneficiaries would be able to choose to receive benefits throughout the original Medicare fee-for-service program or through *Medicare+Choice plans,* which include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Medical Savings Accounts, or Provider-Sponsored Organizations (PSO). The goal of the *Medicare+Choice* program was to give Medicare beneficiaries more choice of health plans, while moving the program toward a managed care model.

Obviously, the Balanced Budget Act establishes a substantial amount of new federal law relating to the Medicare program. In some circumstances, however, the intent is that the new federal law works in conjunction with state laws. For example, the law requires that in order for a PSO to participate in *the Medicare+Choice* program, it must first seek licensure by the state in which it intends to operate. In essence, SB 439 attempts to provide a process for such state licensure to take place.

A Provider-Sponsored Organization under the Balanced Budget Act and a Medicare Provider Organization under SB 439 is the same thing. The federal law defines a PSO as a public or private entity established by health care providers, which provide a substantial proportion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk. In other words, the health care providers are the plan.

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215 S.E. 8th • P.O. Box 2308 • Topeka, Kansas 66601-2308 • (785) 233-7436 • FAX (785) 233-6955

If a PSO wants to be a part of the *Medicare+Choice* program, it must first seek state licensure. In general, if state licensure requirements are inconsistent with the federal law governing this program, a PSO can seek a federal waiver to participate in *Medicare+Choice.* The Balanced Budget Act specifically directs the Secretary of the Department of Health and Human Services to develop regulations providing solvency standards for PSOs, with a target date of publication by April 1, 1998. By June 1, 1998, the Secretary must establish regulations regarding all other standards for *Medicare+Choice* organizations. These federal standards will preempt any inconsistent state law or regulation. As such, a state discussing the licensing of PSOs, or Medicare Provider Organizations, as SB 439 calls them, must be sensitive to the requirements contained in the federal law.

KHA PRINCIPLES

- The Kansas Hospital Association recognizes the direction of the federal Balanced Budget Act that states should develop a licensure process for *Medicare+Choice* PSOs or Medicare Provider Organizations.
- In developing such a process, the Legislature should make its first priority the protection of consumers in situations where a particular entity is accepting insurance risk. This is true whether that entity is a PSO, an HMO or a traditional insurer.
- At the same time, state legislatures should encourage the development of PSOs. These organizations are provider-driven, putting clinical decisions in the hands of those most capable of balancing efficiency and patient care.
- The State of Kansas should avoid creating an additional layer of regulation on Medicare Provider Organizations that is inconsistent with federal law and regulations. That potential exists with Senate Bill 439 because at this point it is unclear what those federal standards will ultimately include.
- KHA is supportive of the Insurance Commissioner's efforts to develop a comprehensive law regulating different kinds of risk-bearing entities, presumably to be presented to the Legislature next session. Such a statute will provide the Commissioner the flexibility she needs to regulate each type of organization.

CONCLUSION

The Secretary of HHS is supposed to develop regulations governing Medicare PSO solvency by April 1. Other non-solvency regulations are to be published by June 1. At this point in time, we do not know what those federal regulations will say. In order to avoid two sets of potentially conflicting standards, SB 439 should recognize the controlling authority of these undeveloped federal regulations.

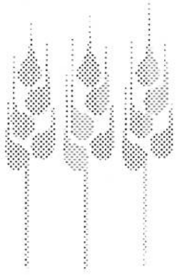
Thank you for your consideration of our comments.

Attachment

PSO TIMELINE AS OF DECEMBER 1, 1997

December, 1997	HCFA to publish Medicare+Choice/PSO timeline, including date after which it will no longer accept risk contract applications
January 1, 1998	The Negotiated Rulemaking Committee for PSO Insolvency Standards must report to HHS Secretary regarding its progress.
January 1, 1998	HCFA to require Medicare risk contractors to submit data regarding inpatient services for periods beginning on or after July 1, 1997.
January 1, 1998	HCFA begins assessment on all contractors of information user fee.
January – February, 1998	HCFA to issue interim final rule providing PSO definition. PSOs can apply for minimum enrollment waivers for 1998.
March, 1, 1998	The Negotiated Rulemaking Committee for PSO Insolvency Standards must issue its report.
March 1, 1998	JCFA to announce Medicare+Choice payment rates for 1999.
April 1, 1998	HCFA to publish PSO financial solvency standards.
May 1, 1998	All Medicare+Choice plans (including PSOs) must submit adjusted community rate ("ACR") proposals for basic and supplemental benefits, the plans premium, description of cost sharing, actuarial value of cost sharing, and description of any additional benefits.
June 1, 1998	HCFA to publish "Mega-Reg", which is all Medicare+Choice standards other than solvency.

Date of Publication of Mega-Reg	HCFA stops entering into new Medicare risk contracts.
November, 1998	HCFA signs all new Medicare+Choice contracts, including PSO contracts.
November, 1998	HHS conducts an educational and publicity campaign to inform beneficiaries about Medicare+Choice contracts, including PSOs.
January 1, 1999	Start date of Medicare+Choice contracts, including PSOs.
January 1, 1999	50/50 enrollment composition rule repealed.
January 1, 1999	Secretary has authority to grant 3 year waivers from minimum enrollment rules.



Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 439
February 18, 1998

The Kansas Association of Health Plans (KAHP) is a nonprofit corporation dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations, and others who support managed care. KAHP members serve over 200,000 Kansans.

The Kansas Association of Health Plans supports authorizing the Commissioner of Insurance to license Medicare provider-sponsored organizations (PSOs) pursuant to federal law. In addition, KAHP supports parallel federal and state solvency standards for Medicare PSOs.

KAHP also supports prohibiting Medicare PSOs from serving non-Medicare patients. Such appears to be the intent of SB 439 but if not KAHP would encourage that issue to be specifically addressed and clarified.

Respectfully,

Callie J Denton

Callie Jill Denton
Executive Director

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