Approved: _____
Date Apr 26

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Senator Don Steffes at 8:00 a.m. on April 5 , 2000 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Dr. William Wolff, Legislative Research
Ken Wilke, Office of Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Larrie Ann Lower, Kansas Association of Health Plans
Terry Bernatis, Health Benefits Administrator
Brad Smoot, Blue Cross Blue Shield
Howard Moses, Private Citizen

Others attending: (See Attached)

Chairman Steffes reported on the lack of compromise in recent conference committees with the House on **HB 2005** and **SB 574.** Chairman Tomlinson stated his reluctance to hearing any new bills at this late date. Senator Steffes presented a list of insurance bills introduced and worked in the Senate and those processed by the House (Attachment 1).

Continued hearings and action on:
SB 547–Insurance; providing coverage for certain mental health conditions
SB 663–Gynecological care under managed care system
Discussion on SB 160--Eliminating discrimination in the coverage of specific mental illnesses

SB 547 has been re-referred to the Committee for additional work. Senator Steffes explained the three options open to the Committee regarding passage of mental health parity:

- **SB 160**–Would mandate mental health parity in all private health care insurance policies as well as in the State Employees Health Care Plan.

- **SB 547**–Would allow test tracking mental health parity for employees not currently covered under the State Employees Health Plan and would apply to the private sector on January 1, 2002. The implementation would not require action by the Legislature at that time

- **SB 547– (with amendments from Kansas Association of Health Plans as presented on March 24, 2000)** Would allow test tracking mental health parity for employees not currently covered under the State Employees Health Plan for at least one year beginning January 1, 2001. The amendments as suggested by Ms. Lower in the first balloon would require that the HMO portion of the state employees health plan be restructured to match the mandated benefits in the bill. After March 1, 2002, the Legislature would review the cost and make its decision regarding continuation of the coverage for both state employees and the private sector or whether more data are required.

Senator Barone moved that the term "specific" be removed from obsessive compulsive disorders. Motion was seconded by Senator Praeger. Motion carried.

The Committee discussed the biologically based mental illnesses listed in **SB 547** and the lack of including schizophreniform which is a diagnosis often used prior to the diagnosis of schizophrenia. These illnesses would be recognized as physical ailments and treated with parity by health insurers–co-pays and deductibles.

Senator Barone moved to strip the list of biologically based mental illnesses from **SB 547** and insert the language on Page 2, Lines 21-30 of **SB 160.** Motion was seconded by Senator Biggs. Motion carried.

Terry Bernatis, State Employees Health Plan, reaffirmed to the Committee that the diseases listed in **SB 160** are currently those covered in the State Plan.

Senator Barone moved to pass out the version of **SB 547 (Alternative No. 2)** with the amendments. This would require test tracking in the Employees Health Plan beginning January 1, 2001 for one year, with no action being required by the Legislature at the end of that time period to mandate mental health parity. Action would be required by the Legislature to stop the automatic implementation of the mandate. The motion was seconded by Senator Biggs. Motion failed on a vote of four to five.

Senator Becker moved to report favorably **SB 547 (Alternative No. 3)** with the amendments. This would require test tracking by the State Employees Health Plan beginning, January 1, 2001, for one year, a report from the Health Commission by March 1, 2002, on the cost and utilization of the additional mental health coverage. Motion was seconded by Senator Biggs. Senator Becker then withdrew his original motion and moved to remove the language found in the original **SB 663 (direct access to OB/GYN in HMO)** from **SB 547** and to treat **SB 663** as a separate issue. Motion was seconded by Senator Brownlee. Motion failed by a vote of three to five.

The Committee discussed both bills' importance to the public and the political reality of their bracing each other up during floor debate. Commissioner Sebelius informed the Committee that although many HMO's currently allow one direct access visit to an OB/GYN per year, not all plans do. Larrie Ann Lower, Kansas Association of Health Plans said all of her 14 plans to allow one direct access visit per year.

1. Dr. Wolff presented a balloon amendment to **SB 547** which states that from and after January 1, 2001, the state health benefits program shall not be required to provide coverage under the provisions of K.S.A. 40-2,105, and amendments thereto, for any mental illness defined in section 1, and amendments thereto i.e. alcoholism, drug abuse, and nervous or mental conditions for the mental illnesses defined in this bill. (Attachment 2). Terry Bernatis said their concerns had been addressed in this amendment. Senator Barone requested a very comprehensive supplemental note be prepared by the Research Department for this all inclusive mental health parity bill.

Senator Feleciano moved to adopt the proposed amendment (Attachment 3). Motion was seconded by Senator Barone. Motion carried.

During Committee discussion on access to an in-network OB/GYN's without first seeing a primary care physician, Terry Bernatis stated that within their HMO's view this referral process as strictly paperwork. The one visit per year allowed is meant to be for one "well woman" checkup. The Committee questioned whether this should be limited to once a year. Senator Brownlee said her objection to the current language in the bill was because it was impractical and nearly impossible for an OB/GYN to continue treatment of a patient with the requirement of calling the primary care physician and reporting treatment procedures or requesting permission to continue treatment. This procedure requires the hiring of extra office help by primary care physicans and they become "paperwork docs."

Senator Brownlee moved for an amendment which would strike the language in **SB 547** on Page 2 after Line 40 and add "and up to three visits per year to complete medical treatment found to be necessary in the first visit." The intent is to remove barriers for the OB/GYN physicians in treatment of patients. Motion was seconded by Senator Clark. The motion failed by a vote of four to four.

The Committee continued their discussion of what is necessary paperwork for cost containment within HMO's and the necessity of the referral procedure. Is the current referral procedure regarding OB/GYN referral a necessary evil?

Senator Biggs moved to report favorably **SB 547** as amended with the inclusion of the direct access to OB/GYN component. Motion was seconded by Senator Barone. Senator Biggs withdrew his motion.

Senator Praeger moved to strike Section 2 on Page 3 from **SB 547** which would require the OB/GYN to communicate with such woman's primary care provider concerning any diagnosis or treatment rendered. Motion was seconded by Senator Brownlee. Motion carried.

Senator Brownlee commented that she found it interesting that Senator Barone was more knowledgeable of how OB/GYN's operated than she did. Senator Barone just smiled and did not verbally respond.

Senator Biggs moved to recommend for passage a **Substitute for SB 547** which contains all the passed amendments. Motion was seconded by Senator Praeger. Motion carried by a 5-2 vote. Opposed were Senators Brownlee and Clark.

Continued hearing and action on SB 668--Insurance; establishing the Kansas Business Health partnership

Senator Praeger explained the advantages of the Kansas Business Health Partnership as being a choice of plans, affordable rates for qualifying families, as well as an employer, employee and family friendly proposal (Attachment 4). The Governor is very supportive of this endeavor and views it as good for the people of Kansas. Senator Praeger then offered an amendment addressing eligibility of both employees and employers, authorization of the health committee, requirements for offering health benefit plans, continuing benefits for eligible children, and role of SRS in providing names of those eligible for participation (Attachment 5).

Terry Bernatis, Health Benefits Administrator, presented testimony which listed potential unintended consequences as a result of the language in Section 2 (h) (Attachment 6). Ms. Bernatis concluded that these concerns had been addressed by the amendment listed as Attachment 5.

Larrie Ann Lower, Executive Director of Kansas Association of Health Plans, said they were in agreement with the proposal as the amendment regarding Section 2 (h) in Attachment 5 addressed their concerns (Attachment 7).

Brad Smoot, Legislative Counsel for Blue Cross Blue Shield of Kansas, said they supported the concept of establishing a public/private partnership to expand opportunities for coverage of dependents of employees who currently cannot afford for the entire family to participate in the health insurance market (Attachment 8). Mr. Smoot offered amendments which would address the uninsured non-elderly without coverage who have no access to job-related insurance. He suggested a plan similar to the Oregon FHIAP which provides vouchers to persons in the group and the non-group market, thus addressing the bulk of the uninsured population (Attachment 9). Mr. Smoot said his company does not support HIPC's or purchasing cooperatives.

The question of what would happen to First Guard if many of its enrolled children transfer their coverage to a family plan under the proposed Partnership was discussed by the Committee and Mr. Smoot. There is the possibility of the plan eroding the base of First Guard unless First Guard starts offering a commercial product. Committee concerns included: how to allow more companies to provide insurance coverage through the Partnership; how to enroll more eligible children in the CHIP plan; the complexity of figuring eligibility e.g. through verifying incomes, companies who are eligible to participate; possible creation of a governmental bureaucracy; and is this actually limiting options of insurance coverage? Senator Praeger pointed out that this bill creates a task force and the private sector would work out the details rather than it being government-oriented. These plans would be free of state mandates in order to keep costs down.

Howard Moses presented testimony on behalf of those individuals with disabilities who are Medicaid and Medicare eligible as Supplemental Security Insurance (SSI) and Social Security Disability Insurance (SIDI) recipients (Attachment 10). The federal demonstration and health care subsidies to these individuals could be available to the Kansas Business health partnership, thus lowering premiums for plans developed by the Partnership.

Tom Bell, Kansas Hospital Association, presented written testimony in general support of the concept (Attachment 11).

Senator Praeger explained to the Committee that this was a prime time to begin the process as CHIP dollars are available due to reorganization by the federal government, HCFA is supportive of such partnerships, and SRS can be directed to apply for flexibility.

Senator Feleciano moved to amend Page 2 in the section regarding membership of the Kansas Business Health Policy Committee to include one member each to be appointed by the Minority Leader of the Senate and the Minority Leader of the House of Representatives. Also to be included should be three members from the private sector to be appointed by the Governor. Included in the motion was the request to add the balloon amendment offered by Senator Praeger in Attachment 5 and Section M of the balloon amendment offered by Blue Cross Blue Shield in Attachment 9. The motion was seconded by Senator Becker. Motion carried.

Committee members discussed their concern about the possibility of spending more than 10% of the CHIP money for administrative costs. Dissatisfaction with MAXIMUS' handling of the advertising and sign up of HealthWave was voiced.

Senator Praeger moved to report **SB 668** favorably as amended. The motion was seconded by Senator Feleciano. Motion carried by a vote of 5 to 2. Asking to be recorded as "nays0" were Senators Brownlee and Corbin.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: April 5, 2000

NAME	REPRESENTING
Rob Freeston	KAIFA
Kevin Brose	Hein West Chris.
Jim Schwartz	Alliance
Mary Becker	Kansans Respond
Robert Day	SRS
Howard Moses	self
Jay Burnett	Dof A
Jerry Slaughter	KMS
Chris Collins	KMS
[illegible]	D & A
Lisa Guthrie	Health Midwest
Bob Corkins	Ks. Public Policy Institute
MIKE LARKIN	KS EMPLOYER COALITION ON HEALTH
Larrie Ann Lower	KAHP
Holly Robertson	Student
Jennifer Ann	Federico Consulting
Gregory E. Rinkel	Washburn University - SW Policy
D. R. Snead	KSDAA

April 4, 2000

INSURANCE BILLS INTRODUCED AND PASSED BY SENATE 2000

SB 440	Insurance, risk-based capital requirements
SB 441	Health insurance; removing sunset on 1997 amendments required by HIPAA
SB 443	Insurance; codification of standard accounting procedures
SB 444	Insurance; mortgage guaranty insurance companies, concerning real estate security
SB 458	Insurance; licensing requirements for insurance agents; hearings
SB 574	Insurance; prohibition against health related cash discount cards
Sub SB 600	Insurance; prompt payment requirements for insurance companies
SB 619	Insurance; health maintenance organization insolvency
SB 651	Insurance, reciprocal insurance companies

BANKING BILLS INTRODUCED AND PASSED BY SENATE 2000

SB 412	Bank Commissioner, rules and regulations, correction of statutory references
SB 445	Uniform consumer credit code; concerning appraised value and appraisals
SB 457	Banks and trust companies; inactive companies or departments
SB 459	Mortgages; mortgage business and mortgage loans
SB 487	State moneys law, daily cash sheet
SB 498	Banks, providing for limitations on special orders issued by bank commissioner
SB 503	Enacting the Kansas uniform prudent investor act
SB 549	Cities; deposits of public moneys

INSURANCE BILLS UNDER CONSIDERATION

SB 547	Insurance; providing coverage for certain mental health conditions
SB 663	Gynecological care under managed care system
SB 668	Insurance; establishing the Kansas Business Health Partnership

INSURANCE BILLS INTRODUCED AND PASSED BY HOUSE

HB 2561	Motor vehicle certificates of title
HB 2648	Unclaimed property, canceled state warrants
HB 2652	Insurance; life insurance company investments; financial futures contracts

(Corrected)

As Amended by Senate Committee

Session of 2000

SENATE BILL No. 547

By Committee on Financial Institutions and Insurance

2-2

AN ACT concerning insurance; providing coverage for certain mental health conditions~~; amending K.S.A. 1999 Supp. 40-2,103 and repealing the existing section~~ ***authorizing gynecological care under certain circumstances without visiting a primary care provider.***

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

New Section 1. (a) From and after January 1, 2001, the state health benefits program established by K.S.A. 75-6101 *et seq.*, and amendments thereto, shall provide a program of insurance which provides coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.

(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, ~~specific~~ obsessive compulsive disorder and panic disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.

~~New Sec. 2. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for mental health benefits and which is delivered, issued for delivery, amended or renewed on or after January 1, 2002, shall include coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.~~

~~(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.~~

(c) [The provisions of this section shall be applicable to health main-

Senate Financial Institutions & Insurance
Date 4/5/00
Attachment 2

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tenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated ***contracting with the state to provide health care benefits***.

(d)] ~~The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.~~

~~(e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.~~

~~(f) The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 1999 Supp. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.~~

~~(g)~~ From and after January 1, ~~2002~~ ***2001***, [the state health benefits program shall not be required to provide coverage under] the provisions of K.S.A. 40-2,105, and amendments thereto, [shall not apply to mental illnesses as defined in this act] [for any mental illness defined in section 1, and amendments thereto].

~~New Sec. 3. The~~ ***Sec. 2. Except as provided in section 3, and amendments thereto, the*** provisions of this act shall be implemented as required by K.S.A. 1999 Supp. 40-2249a.

~~Sec. 4. K.S.A. 1999 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1999 Supp. 40-2,160 and 40-2,165 through 40-2,170~~ ~~***and section 2***~~~~, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.~~

~~Sec. 5. K.S.A. 1999 Supp. 40-2,103 is hereby repealed.~~

Sec. 3. (a) Each health insurer shall permit a woman insured by the health insurer to visit an in-network obstetrician or gynecologist for routine gynecological care from an in-network obstetrician or gynecologist at least one time each calendar year without requiring such woman to first visit a primary care provider, so long as:

(1) The care is medically necessary, including, but not limited to, care that is routine;

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(2) following each visit for gynecological care, the obstetrician or gynecologist communicates with such woman's primary care provider concerning any diagnosis or treatment rendered; and

(3) the obstetrician or gynecologist confers with such woman's primary care provider before performing any diagnostic procedure that is not routine gynecological care rendered during any such visit.

(b) This section shall be part of and supplemental to the patient protection act, cited at K.S.A. 1999 Supp. 40-4601 et seq., and amendments thereto.

(c) The provisions of K.S.A. 1999 Supp. 40-2249a and amendments thereto shall not apply to the provisions of this section.

Sec. ~~6.~~ *4.* This act shall take effect and be in force from and after its publication in the statute book.

2-4

(Corrected)

As Amended by Senate Committee

Session of 2000

SENATE BILL No. 547

By Committee on Financial Institutions and Insurance

2-2

AN ACT concerning insurance; providing coverage for certain mental health conditions~~; amending K.S.A. 1999 Supp. 40-2,103 and repealing the existing section~~ ***authorizing gynecological care under certain circumstances without visiting a primary care provider.***

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

New Section 1. (a) From and after January 1, 2001, the state health benefits program established by K.S.A. 75-6101 *et seq.*, and amendments thereto, shall provide a program of insurance which provides coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.

(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, ~~specific~~ obsessive compulsive disorder and panic disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.

~~New Sec. 2. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for mental health benefits and which is delivered, issued for delivery, amended or renewed on or after January 1, 2002, shall include coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.~~

~~(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.~~

(c) The provisions of this section shall be applicable to health main-

Senate Financial Institutions & Insurance
Date 4/5/00
Attachment 3

tenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated ***contracting with the state to provide health care benefits***.

(d) ~~The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.~~

~~(e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.~~

~~(f) The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 1999 Supp. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.~~

~~(g)~~ From and after January 1, ~~2002~~ ***2001***, the provisions of K.S.A. 40-2,105, and amendments thereto, shall not apply to mental illnesses as defined in this act.

~~New Sec. 3. The~~ ***Sec. 2. Except as provided in section 3, and amendments thereto, the*** provisions of this act shall be implemented as required by K.S.A. 1999 Supp. 40-2249a.

~~Sec. 4. K.S.A. 1999 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1999 Supp. 40-2,160 and 40-2,165 through 40-2,170 *and section* 2, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.~~

~~Sec. 5. K.S.A. 1999 Supp. 40-2,103 is hereby repealed.~~

Sec. 3. (a) Each health insurer shall permit a woman insured by the health insurer to visit an in-network obstetrician or gynecologist for routine gynecological care from an in-network obstetrician or gynecologist at least one time each calendar year without requiring such woman to first visit a primary care provider ~~, so long as:~~ + up to 3 visits per years to complete medical

(1) The care is medically necessary, including, but not limited ~~to, care that is routine;~~ treatment found to be necessary in the first visit

3-2

~~*(2) following each visit for gynecological care, the obstetrician or gynecologist communicates with such woman's primary care provider concerning any diagnosis or treatment rendered; and*~~

(3) the obstetrician or gynecologist confers with such woman's primary care provider before performing any diagnostic procedure that is not routine gynecological care rendered during any such visit.

(b) This section shall be part of and supplemental to the patient protection act, cited at K.S.A. 1999 Supp. 40-4601 et seq., and amendments thereto.

(c) The provisions of K.S.A. 1999 Supp. 40-2249a and amendments thereto shall not apply to the provisions of this section.

Sec. ~~6.~~ *4.* This act shall take effect and be in force from and after its publication in the statute book.

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STATE OF KANSAS

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TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: PUBLIC HEALTH AND WELFARE
HEALTH CARE REFORM LEGISLATIVE OVERSIGHT COMMITTEE
JOINT COMMITTEE ON CHILDREN AND FAMILIES
VICE CHAIR: FINANCIAL INSTITUTIONS AND INSURANCE
MEMBER: ASSESSMENT AND TAXATION
ELECTIONS AND LOCAL GOVERNMENT
SRS TRANSITION OVERSIGHT COMMITTEE

KEY ELEMENTS OF SENATE BILL 668

"KANSAS BUSINESS HEALTH PARTNERSHIP"

CHOICE:

This legislation creates the Kansas Business Health Partnership. The Partnership provides the opportunity for small businesses to pool their employees with other small businesses to offer - not just health insurance - but a choice of health plans to their employees. It will also allow for risk-sharing among the larger group of employees from all of the companies participating in the Partnership. This doesn't just "level the playing field" for these companies; it lets them on the "playing field".

The Partnership will perform the following organizational functions:

1. Contract with two or more health plans to provide choice
2. Establish several benefit options
3. Receive subsidies from the state and link those funds with eligible families
4. Receive premiums from employer and employee, making this administratively simple for the participating employers

AFFORDABILITY

The Partnership provides a mechanism for subsidies to assist families in purchasing health insurance through their employer. The subsidy comes from the Children's Health Insurance Program. The subsidy, along with the pooling of employees, creates the opportunity for small companies with low-wage workers to offer insurance. At some point in the future money from the tobacco settlement could also be used to subsidize the employees' share of the premium. This would, of course, need to be recommended by the Children's Cabinet and approved by the Governor and the Legislature.

EMPLOYER, EMPLOYEE AND FAMILY FRIENDLY

Instead of using the government-run program for the children, where they are insured separate from their parents, the family that qualifies can be covered by the same health plan offered through their place of employment. The employer that has not been able to afford to provide coverage for his/her employees may be motivated to do so with the availability of the subsidy. In this tight labor market, employers are increasingly looking for ways to attract and retain workers. This program can provide that incentive.

This approach builds on the concept of employer-based insurance coverage that, along with the government programs of Medicaid and Medicare, provides insurance for 85% of Americans. We could expand Medicaid (especially when one considers that our current eligibility level for non-pregnant adults is 43% of the federal poverty level); but instead, this is a private sector program that is both employee and employer friendly.

This Partnership also addresses the concern that the state is not enrolling enough children in the CHIP program (HealthWave). It creates another opportunity for outreach to get children enrolled while at the same time expanding coverage for their parents.

SENATE BILL No. 668

By Committee on Ways and Means

3-21

AN ACT concerning the establishment of the Kansas business health partnership

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

Section 1. As used in this act:

(a) "Carrier" means any insurance company, nonprofit medical and hospital service corporation, nonprofit optometric, dental, or pharmacy service corporation, municipal group-funded pool, fraternal benefit society or health maintenance organization, as these terms are defined by chapter 40 of the Kansas Statutes Annotated, and amendments thereto, that offers health benefit plans covering eligible employees of one or more small employers in the state.

(b) "Health committee" means the Kansas business health policy committee as specified in section 2, and amendments thereto.

(c) "Dependent" means the spouse or any child of an eligible employee.

(d) "Eligible employee" shall have the meaning ascribed to it in K.S.A. 40-2209d and amendments thereto.

(e) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical services corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by any employer or any certificate issued under any such policy, contract or plan.

(f) "Kansas business health partnership" or "health partnership" means a nonrisk bearing nonprofit corporation that has responded to a request for a proposal by the health committee and has been selected by the health committee to provide health insurance through multiple unaffiliated participating carriers to small employers and their employees.

(g) ["Low-and-modest wage employee" means any employee whose gross wage does not exceed 200% of the poverty level.] "Low wage or modest family income"

(h) "Small employer" shall have the meaning ascribed to it in K.S.A. 40-2209d and amendments thereto.

Sec. 2. (a) The governor of the state of Kansas shall appoint a cabinet level committee which shall be known as the Kansas business health pol-

(b) The Kansas business health policy committee, hereinafter referred to as the health committee, shall consist of:

(1) The secretary of the department of commerce [and housing] or the secretary's designee;

(2) the secretary of the department of social and [rehabilitative] services [rehabilitation] or the secretary's designee;

(3) the commissioner of insurance or the commissioner's designee;

(4) one member appointed by the president of the senate; and

(5) one member appointed by the speaker of the house of representatives.

~~Not more than one member appointed pursuant to paragraphs (4) and (5) of this subsection shall belong to the same political party~~. The secretary of each state agency represented on this committee shall provide such staff and other resources as the health committee may require.

(c) (1) The initial meeting of the health committee shall be convened within 60 days after the effective date of this act by the governor at a time and place designated by the governor.

(2) Meetings of the health committee subsequent to its initial meeting shall be held and conducted in accordance with policies and procedures established by the health committee.

(3) Commencing at the time of the initial meeting of the health committee, the powers, authorities, duties and responsibilities conferred and imposed upon the health committee by this act shall be operative and effective.

(d) The health committee shall develop and approve a request for proposals for a qualified entity to serve as the Kansas business health partnership, hereinafter referred to as health partnership, which shall provide a mechanism to combine federal and state subsidies with contributions from employers and employees to purchase health insurance [~~for low-and-modest wage employees~~] in accordance with guidelines developed by the health committee.

(e) The health committee shall evaluate responses to the request for proposals and select the qualified entity to serve as the health partnership.

(f) The health committee shall:

(1) Develop and approve subsidy eligibility criteria provided that:

(A) [Only low-and-modest wage employees of small employers that have low-and-modest wage employees shall be eligible for subsidies; and]

(A) Low wage and modest wage employees of small employers shall be eligible for subsidies if:
(1) the small employer has not previously offered health insurance coverage; or
(2) the small employer has previously offered health insurance coverage and a majority of such small employer's employees are low wage or modest wage employees as defined in section 1;

(B) any small employer's employee with a child who is eligible for coverage under the state childrens' health insurance program established by K.S.A. 1999 Supp. 38-2001 *et seq.*, and amendments thereto, [and the health insurance premium payment program] in the state medical assistance program shall be eligible automatically for a subsidy and shall be [or]

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low-and-modest wage employees; and

(2) determine and arrange for eligibility determination for subsidies of low-and-modest wage employees.

(g) The health committee shall oversee and monitor the ongoing operation of any subsidy program and the financial accountability of all subsidy funds.

(h) In the event that the health partnership established under this act is unable to obtain good faith bids from an adequate number of carriers, the health committee can require the development of good faith bids from and the participation in the health partnership by any carrier that contracts with either the department of administration or the department of social and rehabilitation services to provide fully-insured health coverage as required to implement the objectives of this act.

(i) The health committee is hereby authorized to accept funds from the federal government, or its agencies, or any other source whatsoever for research studies, investigation, planning and other purposes related to implementation of the objectives of this act. Any funds so received shall be deposited in the state treasury and shall be credited to a special revenue fund which is hereby created and shall be known as the health committee insurance fund and used in accordance with or direction of the contributing federal agencies. Expenditures from such fund may be made for any purpose in keeping with the responsibilities, functions and authority of the department. Warrants on such fund shall be drawn in the same manner as required of other state agencies upon vouchers signed by the secretary of the department of social and rehabilitation services upon receiving prior approval of the health committee.

(j) The health committee is authorized to develop policies for the use of additional federal or private funds to subsidize health insurance coverage for low-and-modest wage employees of predominantly low-wage small employers.

Sec. 3. (a) The health partnership selected by the health committee shall:

(1) Be a domestic not-for-profit corporation; and

(2) have a board of directors which includes among its members at least one director who is a small employer and at least one director who is an employee.

(3) No director shall have any interest in any business which sells health insurance or which provides or delivers any health care services.

(b) Operate the Kansas business health partnership.

Sec. 4. The health partnership shall develop and offer two or more health benefit plans to small employers. In any health benefit plan developed under this act, any carrier may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise re-

(C) At least 70 % of the small employer's employees are insured through the partnership; and

low wage or modest wage employees ; and
(3) develop subsidy schedules based upon employee wage levels

5-3

(i)

(j) The health committee is hereby authorized to organize, or cause to be organized, one or more advisory committees. No member of any advisory committee established under this subsection shall receive any payment or other compensation from the health partnership. The membership of each advisory committee established under this subsection shall contain at least one representative who is a small employer and one representative who is an eligible employee as defined in section 1and one representative of the insurance industry.

quired by state law. The provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2114 and subsection (D) of 40-2209 and 40-2229 and 40-2230, and K.S.A. 1999 Supp. 40-2,163, 40-2,164, 40-2,165 and 40-2,166, and amendments thereto, shall not be mandatory with respect to any health benefit plan developed under this act. In performing these duties, the health partnership shall:

(a) Develop and offer two or more lower-cost benefit plans such that:

(1) Each health benefit plan is consistent with any criteria established by the health partnership;

(2) each health benefit plan shall be offered by all participating carriers;

(3) no participating carrier shall offer any health benefit plan developed under this act to any small employer unless such small employer is covered through the health partnership; and

(4) a supplemental benefit plan or other benefit option shall be developed and made available so that the total package of benefits available to eligible children meet federal and state childrens' health insurance program standards established by K.S.A. 1999 Supp. 38-2001 *et seq.*, and amendments thereto, and the health insurance premium payment program in the state medical assistance program as implemented by the department of social and rehabilitation services;

(b) Offer coverage to any qualifying small employer.

(c) Offer employees of participating small employers a choice of participating carriers.

(d)(1) Include centralized and consolidated enrollment, billing and customer service functions;

(2) use one standard enrollment form for all participating carriers; and

(3) submit one consolidated bill to the small employer.

(e) Issue a request for proposals and selectively contract with carriers.

(f) Establish conditions of participation for small employers that conform with K.S.A. 40-2209b *et seq.*, and amendments thereto, and the health insurance portability and accountability act of 1996 (Public Law 104-191).

(g) Enroll small employers and their eligible employees and dependents in health benefit plans developed under this act.

(h) Bill and collect premiums from participating small employers including any share of the premium paid by such small employer's enrolled employees.

(i) Remit funds collected under subsection (h) to the appropriate contracted carriers.

(j) Provide that each eligible low-or-modest wage employee shall be permitted to enroll in such employee's choice of participating carrier.

(i) Except for preventative and health screening services, the

except that no participating carrier shall be required to offer any health benefit plan, or portion thereof, which such participating carrier is not licensed or authorized to offer in this state

(b) develop and make available one or more supplemental health benefit plans or one or more other benefit options so that the total package of health benefits available to all eligible children who receive health benefits through the health partnership meets, at a minimum, standards established by the federal health insurance program.

(f) issue or cause to be issued a request for proposals and contract with a qualified vendor for any administrative or other service not performed by the health committee or provided to the health committee under subsection (b) of section 2.

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(m) [(k)] Develop premium rating policies for small employers.

(m) [(l)] Be authorized to contract for additional group vision, dental and life insurance plans, and other limited insurance products.

Sec. 5. [The department of social and rehabilitation services shall develop and seek federal approval of a family waiver for the state childrens' health insurance program established by K.S.A. 1999 Supp. 38-2001 *et seq.*, and amendments thereto, and the health insurance premium payment program in the state medical assistance program for purposes of coverage through the health partnership.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

(1) In consultation with the health committee, the health partnership shall ensure, to the maximum extent possible, that the combined effect of the premium rating and subsidy policies is that subsidized workers and the dependents of such subsidized workers can afford coverage.

(2) Any rating policy developed under this subsection may vary with respect to subsidy status of workers and the dependents of such workers.

(o) Take whatever action is necessary to assure that any adult or child who receives health benefit coverage through the health benefit partnership and who is eligible for the state medical assistance program shall remain eligible to participate in the state health insurance premium payment program.

(p) Coordinate with the department of social and rehabilitation services to assure that any funds available for the coverage of infants and pregnant women under the state medical assistance program are also available for the benefit of eligible infants and pregnant women who receive health benefit coverage through the health partnership.

The department of social and rehabilitation services shall investigate and pursue all possible policy options to bring into this partnership to title XIX and title XXI eligible families of any employees employed by a small employer. Further, the department of social and rehabilitation services shall develop and seek federal approval of any appropriate variance or state plan amendment for the state children's health insurance program established by K.S.A. 1999 Supp.38-2001 et seq., and amendments thereto, and the state medical assistance program required to accomplish the purposes of this act.

Testimony to the
Senate Financial Institutions and Insurance Committee
By
Terry D. Bernatis, Health Benefits Administrator

SB 668 – Establishment of the Kansas Business Health Partnership

Thank you Mr. Chairman. I am Terry Bernatis, Health Benefits Administrator for the state of Kansas Health Benefits Plan. Thank you for an opportunity to testify concerning the establishment of the Kansas Business Health Partnership.

My goal is to briefly explain some potential unintended consequences as a result of the language in Section 2 (h). That language would require contractors with the Department of Administration to provide a good faith bid to the health partnership if it does not receive an adequate number of good faith bids on its own.

Except for the HMO's the state's employee health benefit plan is self insured. Carriers that bid on our business agree to adjudicate claims for a monthly administrative fee (ASO). They are known as "third party administrators." The state is assuming the risk of the claims costs not an insurance company. Many bid on our business because we represent their market niche. For example, Advanced Paradigm, Inc., the state's prescription drug benefit manager only bids on large groups and only with ASO's contracts.

The state's group health insurance plan is an employer provided benefit. Vendors bidding on the business know exactly who the covered population is and what the utilization of benefits is. Their bids are based on that knowledge. We believe that some carriers will decide not to bid on the state's employee plan. They will not want to assume the potential risk of bidding on a group that they don't know either the population covered or the potential claims risk on a fully insured basis since they will assume the risk. This will have a negative impact on the Commission's strategy to foster competitive bids.

The ones that make the decision to continue to bid on the business may make the decision to return to a fully insured contract. This means that the state and the state employees will be paying retention that is currently not being paid. There is every possibility that the vendors will "load" the retention for the unknown cost and risk associated for a plan they may or may not have to bid on and provide coverage. If you would like specific costs, we can provide them to you for your consideration.

Thank you for allowing me to talk about the state plan and potential unintended consequences.

Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 668
March 28, 2000

Good morning Chairman Steffes and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association 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 entities that support managed care. Members of the KAHP serve many of the Kansans who are insured by an HMO.

The KAHP would first like to commend Sen. Praeger for her work on this legislation and her vision and goal of creating an opportunity for more Kansans to obtain health insurance coverage. We would also like to commend the Committee for your interest and desire to address this issue. KAHP and the member health plans share that same desire and interest in somehow finding a way to decrease the number of Kansans who are uninsured. However, we have questions and concerns about the specifics of what is proposed in SB 668.

One of our principal concerns is on page 3, section (h). This section seems to require health plans who contract with department of administration or SRS to submit good faith bids in the event the "health partnership" is unable to obtain good faith bids from an adequate number of carriers. To do so could actually produce an unintended consequence of forcing competition out of the state plans. Some health plans that contract with the state have previously decided that they do not have the expertise to write small group coverage or simply do not desire to proceed into this type of coverage. This bill seems to require those plans who desire to continue to contract with the state would be required to write small group policies even if they are not in that field of business. This bill contemplates the partnership receiving federal dollars, health plans believe they may be required to build an infrastructure in order to comply with the federal requirements of the Health Care Financing Administration. Apparently, those requirements are extensive. Again, several health plans are not equipped to comply with the federal requirements

of HCFA. We encourage you to look at the plans' ability to participate in such a program as described in this legislation.

In addition, the partnership created to administer the program, page 4, line 25, duplicates services currently provided by health plans, i.e. enrollment, billing. It may not be cost efficient to provide those services through a new entity. The possibility of an additional administrative fee may result, in order to cover the cost of administering the program, and this could ultimately raise the cost of the coverage.

Some additional concerns we would like to raise include:

Page 3, line 23: It is unclear to us which department has authority over expenditures from the health committee insurance fund the Kansas Insurance Department, the Department of Commerce or SRS? They issue warrants. Commission has authority.

Page 3, lines 40-41: and Page 4, lines 7-9, it is unclear whether two plans or four plans are required to be offered. Also, the phrase "lower cost" creates confusion.

Page 4, lines 12-14: It also appears that health plans selected to participate in the partnership may not offer this coverage to small groups outside of the program.

Page 5, line 1: We are unclear on the meaning of the term "premium rating policies." clarified in balloon.

The KAHP would consider supporting the establishment of the cabinet level committee but would suggest that a representative from the insurance industry and a representative of employer/employee interest be included in the makeup of the committee.

In summary, the KAHP agrees that the uninsured population is a problem that deserves an answer. Again, we commend Sen. Praeger for her dedication and all of the Committee for your interest and desire in determining a solution. We would recommend that this issue not be forgotten but continue to work on it with Sen. Praeger and Committee members. I'll be happy to answer any questions the Committee may have.

BRAD SMOOT

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Statement of Brad Smoot
Legislative Counsel
Blue Cross Blue Shield of Kansas
Senate Financial Institutions & Insurance Committee
Senate Bill 668
March 28, 2000

Blue Cross Blue Shield of Kansas is a non-profit mutual insurance company providing coverage for more than 700,000 Kansans in 103 counties. In this capacity, we serve small employer groups and individuals needing health insurance. We are pleased to support the concept of SB 668, establishing a public/private partnership to expand opportunities for coverage of dependents of employees who currently cannot afford for the entire family to participate in the health insurance market.

Our research (1998) indicates that 90.8% of non-elderly Kansans had some health insurance coverage from either private or public sources. The percentage was even higher for children (92.9%), and should be even higher now that the Children's Health Insurance Program is in operation. Yet, that leaves 9.2% of adults and 7.1% of children without valuable insurance protection. And of these uninsureds, our research indicates that 82% are members of a family with at least one member who is employed. We have noticed over the years that as insurance premiums rise, employers pay a smaller portion of employee coverage and even less, if any, of the family coverage, thus, reducing the number of dependants covered.

SB 668 is a thoughtful and helpful response to the issue of affordability of coverage. In many ways it is similar to Oregon's Family Health Insurance Assistance Program. The Oregon program provides public funds to subsidize persons who purchase coverage individually or as part of an employer group. A description of Oregon's FHIAP is attached for your review and consideration.

With some amendment, SB 668 could accomplish many of its objectives more efficiently and serve a larger population. As drafted, SB 668 would provide assistance only to those few persons who acquire coverage from an employer group and purchase such coverage through the purchasing cooperative (HIPC). A 1999 study by the Commonwealth Fund indicates that 88% of those non-elderly without coverage have no access to job-related insurance. Our own surveys indicate that of 23% of Kansans employers do not offer coverage. Clearly, if one is to address the uninsured, one must look beyond those employers currently offering coverage. By contrast, the Oregon FHIAP, provides vouchers to persons in the group and the non-group market, thus, addressing the bulk of the uninsured population.

In addition, many of those who might benefit from the Kansas Business Health Partnership are already employed by businesses which offer some employee health insurance. In order to participate under SB 668, the employer would be forced to drop his or her current coverage and purchase new coverage through the HIPC. Again, the Oregon program avoids this problem by providing vouchers to individuals rather than relying upon an exclusive HIPC.

As you can tell, we at BCBSKS are skeptical of HIPC's. The Alliance for Employee Health Access (a purchasing coop) operating in Wichita utilizes only one carrier. Other carriers do not participate since there is no reason to compete with themselves while adding additional administrative costs. And while the Alliance and other HIPC's provide choice among forms of coverage (indemnity, PPO's and HMO's), others in the marketplace (including BCBSKS) provide similar options for employees in the small group market already. Consequently, we see the HIPC (as structured in SB 668) as an unnecessary cost which adds little choice beyond what is currently available and which operates to disrupt current insurance relationships while serving only a small portion of those uninsureds in need of assistance.

Attached, are proposed amendments to SB 668 to allow the Kansas Business Health Partnership to operate more simply along the lines of the Oregon program.

In summary, we support the effort to assist working Kansans in the purchase of group and non-group insurance coverage. SB 668 is a valuable start and with some modification could serve Kansas families who have heretofore been unable to purchase coverage.

Thank you for consideration of our views.

Section Contents

Family Health Insurance Assistance Program's Mission:

- To remove economic barriers to health insurance coverage for uninsured Oregonians.
- To build on the private sector and encourage self-reliance through participation in and access to the health benefit system.

Program Principles

In designing the concept for FHIAP, the Legislature wanted to develop a model program that not only protects the well-being of economically disadvantaged Oregonians, but helps them to become self-reliant. Toward that goal, the program is designed based on the following principles:

- **Fosters independence and self-reliance** — The subsidy amount will decrease as family income increases, so the affordability of health coverage will not end when families work their way off of welfare or increase their income through job advancement.

- **Encourages comparison shopping and consumer choice** — Eligible families without employer-sponsored coverage may apply the subsidy to their choice from among a variety of health benefit plans.

- **Respects confidentiality and maintains personal dignity** — Oregonians using the subsidy are not stigmatized in any way.

- **Assures administrative simplicity and efficiency** — Program administration will not require the development of a new government agency and the program design encourages participation and is easily accessible to the customer.

- **Not an entitlement** — Program expenditures are limited to the funding allocated and the expenditures authorized by the Legislature. Being eligible for the program doesn't guarantee that a person or family will receive the subsidy.

- **Responds to "real life" issues of maintaining a household budget on a modest income** — Subsidies will be adequate to make health insurance more affordable, as well as recognize a family's cash flow needs.

- **Builds on strengths of the current system** — Encourages and builds upon employer-based coverage, and recognizes that providing access to health care to all Oregonians requires collaboration between the private and public sectors.

- **Extends health coverage to the uninsured** — The goal of the program is to remove economic barriers and increase the number of Oregonians with access to health care.

- **Emphasizes health insurance for children** — Adults are eligible for the subsidy only if all children in the family are covered by a health benefit plan.

- **Promotes equity in health care financing** — The program targets those working Oregonians who through their tax dollars help pay for both Medicaid and Medicare, yet cannot afford health coverage themselves.

FHIAP Income Guidelines & Subsidy Levels

Income Guidelines — based on 1999 Federal Poverty Levels

Family Size	Column A*	Column B	Column C
1	$687-$864	$865-$1,036	$1,037-$1,167
2	$922-$1,160	$1,161-$1,391	$1,392-$1,567
3	$1,157-$1,456	$1,457-$1,746	$1,747-$1,966
4	$1,392-$1,752	$1,753-$2,100	$2,101-$2,366
5	$1,627-$2,049	$2,050-$2,455	$2,456-$2,765
6	$1,862-$2,345	$2,346-$2,810	$2,811-$3,165
7	$2,097-$2,641	$2,642-$3,165	$3,166-$3,564
8	$2,332-$2,937	$2,938-$3,520	$3,521-$3,964
For each additional family member add:	$235-$295	$296-$354	$355-$399
FHIAP will pay:	**95%**	**90%**	**70%**

**People earning less than the lowest amount in Column A may be eligible for FHIAP at the 95 percent subsidy rate.*

Subsidy Levels

- Subsidy levels will be based on a family's average monthly gross income and are a percentage of the premium cost.
  - Less than 126% of FPL — 95% subsidy
  - 126% up to 151% of FPL — 90% subsidy
  - 151% up to 170% of FPL — 70% subsidy
- Subsidies are high enough to encourage selection of a plan with comprehensive benefits and low deductibles.

IPGB

FHIAP Eligibility Requirements

Eligibility

- Must reside in Oregon.
  - There is no time requirement to be considered a resident. However, applicants must live in Oregon with an intent to stay.

- **Must be a U.S. citizen or a legal non-citizen.**
  - Must have Immigration and Naturalization Services (INS) verification that applicant is in the United States legally.

- **Must have been without health insurance for the previous six months.**
  - This does not apply to those leaving Medicaid.
  - If Medicaid recipients had private health insurance and were receiving a Health Insurance Premium (HIP) reimbursement payment, they will also be considered uninsured for up to 60 days after leaving Medicaid.
  - People can get health insurance while on the reservation list, but must have been uninsured for prior six months.

- **Must have investments and savings less than $10,000.**
  - Investments and savings are the same for FHIAP as they are for OHP Medicaid. This includes cash on hand, checking and savings accounts, and stocks and bonds.
  - Homes, cars, tools of trade, qualified retirement funds, etc., are NOT counted.

- **All children in the family must have health insurance before adults can use the subsidy.**
  - Children who are covered under Medicaid or CHIP will be considered to be covered by health insurance.

- **People eligible for or receiving Medicare cannot use the subsidy.**

What Health Insurance FHIAP Subsidizes

Group Market

- If employer OFFERS health benefits and PAYS any portion of the premium, the employee *must* take that coverage.
- If employer OFFERS health benefits to dependents and PAYS any portion of the premium, the dependents *must* take that coverage, unless they are enrolled in another plan such as OHP Medicaid or CHIP.
- FHIAP will subsidize any health benefit plan an employer offers.
  - If dental coverage is part of employee benefit package, FHIAP will subsidize it.
- Individual market is available to those missing open enrollment periods.
- Many group carriers indicate they can conduct special open enrollment periods.

Individual Market

- If the employer does not offer or does not pay any portion of group health insurance, individuals and families may purchase health insurance from FHIAP-certified carriers.
- The following are certified carriers for FHIAP:
  - CareOregon
  - Kaiser Foundation Health Plan of the Northwest
  - ODS Health Plan
  - PacifiCare of Oregon
  - QualMed Oregon Health Plan
  - Regence Blue Cross Blue Shield of Oregon
  - Regence HMO Oregon
  - Oregon Medical Insurance Pool (OMIP)

Implementation History

July 1997	◆ Passed by 1997 Legislature (HB 2894)
Aug.-Sept. 1997	◆ Assembled Implementation Team
Feb. 1998	◆ Selection of Third Party Administrator
April-June 1998	◆ Community partners and health insurance agent training
July 1998	◆ First enrollments in FHIAP
May 1998 -Jan.1999	◆ Over 49,000 inquires and requests for information
Dec. 1998	◆ Waiting list established for applications
Jan. 1999	◆ First 3,000 enrollments (subsidy & insured)
June 1999	◆ Over 6,100 enrollments (subsidy & insured); more than 14,000 people joined the waiting list since February
July 1999	◆ FHIAP budget passed by Legislature with $3 million reduction
Nov. 1999	◆ Public forums held in Portland, Eugene, Medford, Pendleton, and Bend to gather input on how to implement budget reduction
Jan. 2000	◆ Over 6,200 enrollments (subsidy & insured); more than 76,000 inquires and requests for information

Explanation of Balloon for SB 668

The attached balloon amendments for SB 668 do not call for employers acquiring coverage through a mechanism that involves multiple carriers offering coverage in each employer group.

Instead, it anticipates coverage continuing to exist as it does in general today.

At the same time, however, *it broadens the reach of SB 668 to encompass* not only low and moderate wage employees of small employers, but *low-income individuals regardless of their employment status.*

It calls for the health partnership to receive grants from the state and administer those in the form of subsidies for the purchase of health insurance by low-income Kansans. *It relies on insurance mechanisms already in place in the market.* If the person is employed where coverage is offered by an employer, the person must acquire coverage there (at least, at the first open enrollment). Otherwise, coverage can be acquired on a nongroup basis from any carrier, including (if the person were to be otherwise uninsurable) the Kansas Health Insurance Association (high risk pool). *Because in many low-wage firms employers do not offer coverage, access to nongroup coverage is important and tying subsidies to employers who offer coverage may miss as many as 80% of the persons who lack coverage.*

It anticipates providing the subsidies on a sliding scale.

If dependent coverage is available within an employer group, *an applicant receiving a subsidy must acquire coverage for dependents* – i.e., could not acquire coverage only for the employee or individual, leaving children without coverage.

The subsidies would be distributed on a first-come, first-served basis. Since there is no absolute right to the subsidy, *it cannot be characterized as an entitlement pro*gram, and *the cost exposure is limited* to the appropriations the state seeks to make, plus whatever grants the health partnership might secure.

Because it would be available to any low-income employee, the references to small employers are eliminated. This is done because the wage basis in many large industries can be as low as in small employers.

Because it anticipates coverage being acquired through carriers currently serving existing groups (i.e., an employer might be offering coverage but not paying the full employee cost, so that the low-income employee is not taking the coverage, or not taking the coverage for dependents, and would do so with the subsidies), the elimination of mandated benefits in group coverage would not make sense – doing so for the entire group when only one or two low-wage employees are receiving the subsidy would not seem appropriate, and insurers would not be able to separately rate or administer coverage lacking the mandates if they were eliminated for one or two employees. *Mandates are eliminated for persons acquiring coverage in the nongroup market.*

This draft anticipates a program similar to Oregon's Family Health Insurance Assistance Program. It would permit the health partnership to establish limits on the subsidies to wean recipients away, if appropriate.

Session of 2000

SENATE BILL No. 668

By Committee on Ways and Means

3-21

AN ACT concerning the establishment of the Kansas business health partnership

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

Section 1. As used in this act:

(a) "Carrier" means any insurance company, nonprofit medical and hospital service corporation, ~~nonprofit optometric, dental, or pharmacy~~ service corporation, municipal group-funded pool, fraternal benefit society or health maintenance organization, as these terms are defined by chapter 40 of the Kansas Statutes Annotated, and amendments thereto, that offers health benefit plans covering eligible employees of one or more small employers in the state.

(b) "Health committee" means the Kansas ~~business~~ health policy committee as specified in section 2, and amendments thereto.

(c) "Dependent" means the spouse or any child of an eligible employee.

(d) "Eligible employee" shall have the meaning ascribed to it in K.S.A. 40-2209d and amendments thereto.

(~~e~~) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical services corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by any employer or any certificate issued under any such policy, contract or plan.

(f) "Kansas ~~business~~ health partnership" or "health partnership" means a nonrisk bearing nonprofit corporation that has responded to a request for a proposal by the health committee and has been selected by the health committee to ~~provide~~ health insurance ~~through multiple unaffiliated participating carriers to small employers and their employees.~~

(g) "Low-and-modest wage employee" means any employee whose gross wage does not exceed 200% of the poverty level.

(h) ~~"Small employer" shall have the meaning ascribed to it in K.S.A. 40-2209d and amendments thereto.~~

Sec. 2. (a) The governor of the state of Kansas shall appoint a cabinet level committee which shall be known as the Kansas ~~business~~ health policy committee.

, the Kansas health insurance association,

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or of an eligible individual.

(e) "Eligible individual" shall mean an individual or head of household in a family, the gross earnings of which do not exceed 200% of the federal poverty level.

facilitate the acquisition of

by low-and-modest wage employees, eligible individuals, and/or their dependents.

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(b) The Kansas ~~business~~ health policy committee, hereinafter referred to as the health committee, shall consist of:

(1) The secretary of the department of commerce or the secretary's designee;

(2) the secretary of the department of social and rehabilitative services or the secretary's designee;

(3) the commissioner of insurance or the commissioner's designee;

(4) one member appointed by the president of the senate; and

(5) one member appointed by the speaker of the house of representatives.

Not more than one member appointed pursuant to paragraphs (4) and (5) of this subsection shall belong to the same political party. The secretary of each state agency represented on this committee shall provide such staff and other resources as the health committee may require.

(c) (1) The initial meeting of the health committee shall be convened within 60 days after the effective date of this act by the governor at a time and place designated by the governor.

(2) Meetings of the health committee subsequent to its initial meeting shall be held and conducted in accordance with policies and procedures established by the health committee.

(3) Commencing at the time of the initial meeting of the health committee, the powers, authorities, duties and responsibilities conferred and imposed upon the health committee by this act shall be operative and effective.

(d) The health committee shall develop and approve a request for proposals for a qualified entity to serve as the Kansas ~~business~~ health partnership, hereinafter referred to as health partnership, which shall provide a mechanism to combine federal and state subsidies with contributions from employers ~~and~~ employees, to purchase health insurance for low-and-modest wage employees, in accordance with guidelines developed by the health committee.

(e) The health committee shall evaluate responses to the request for proposals and select the qualified entity to serve as the health partnership.

(f) The health committee shall:

(1) Develop and approve subsidy eligibility criteria provided that:

(A) Only low-and-modest wage employees of ~~small~~ employers that have low-and-modest wage employees shall be eligible for subsidies; and

(B) any ~~small~~ employer's employee with a child who is eligible for coverage under the state childrens' health insurance program established by K.S.A. 1999 Supp. 38-2001 *et seq.*, and amendments thereto, and the health insurance premium payment program in the state medical assistance program shall be eligible automatically for a subsidy and shall be included in the determination of eligibility for the ~~small~~ employer and its

, and eligible individuals

and eligible individuals

(f) within the budget provided therefore, the health committee shall award to the health partnership grants to be administered in trust to provide subsidies called for by this act.

(g) Subject to approval by majority vote of the

the health partnership

and eligible individuals and/or their dependents

and any eligible individual

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low-and-modest wage employees; and

(2) determine and arrange for eligibility determination for subsidies of low-and-modest wage employees.

and eligible individuals and/or their dependents.

(g) The health committee shall oversee and monitor the ongoing operation of any subsidy program and the financial accountability of all subsidy funds.

(3) Establish minimum benefit requirements for individual health benefit plans subject to subsidy, including but not limited to the types of services covered and the amount of cost sharing to be allowed.

(4) Administer grants awarded to the health partnership for the operation of the health partnership and provision of subsidies to enrollees accepted by the health partnership.

~~(h) In the event that the health partnership established under this act is unable to obtain good faith bids from an adequate number of carriers, the health committee can require the development of good faith bids from and the participation in the health partnership by any carrier that contracts with either the department of administration or the department of social and rehabilitation services to provide fully-insured health coverage as required to implement the objectives of this act.~~

~~(i)~~ (h) The health committee is hereby authorized to accept funds from the federal government, or its agencies, or any other source whatsoever for research studies, investigation, planning and other purposes related to implementation of the objectives of this act. Any funds so received shall be deposited in the state treasury and shall be credited to a special revenue fund which is hereby created and shall be known as the health committee insurance fund and used in accordance with or direction of the contributing federal agencies. Expenditures from such fund may be made for any purpose in keeping with the responsibilities, functions and authority of the department. Warrants on such fund shall be drawn in the same manner as required of other state agencies upon vouchers signed by the secretary of the department of social and rehabilitation services upon receiving prior approval of the health committee.

(j) The health committee is authorized to develop policies for the use of additional federal or private funds to subsidize health insurance coverage for low-and-modest wage employees ~~of predominantly low-wage small employers~~ and of eligible individuals and/or their dependents

Sec. 3. (a) The health partnership selected by the health committee shall:

(1) Be a domestic not-for-profit corporation; and

(2) have a board of directors which includes among its members at least one director who is a small employer and at least one director who is an employee.

(3) No director shall have any interest in any business which sells health insurance or which provides or delivers any health care services.

(b) Operate the Kansas business health partnership.

Sec. 4. ~~The health partnership shall develop and offer two or~~ more health benefit plans to small employers. ~~In any health benefit plan developed under this act, any carrier may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise re-~~

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~~quired by state law~~. The provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2114 ~~and subsection (D) of 40-2209~~ and 40-2229 and 40-2230, and K.S.A. 1999 Supp. 40-2,163, 40-2,164, 40-2,165 and 40-2,166, and amendments thereto, shall not be mandatory with respect to any health benefit plan developed under this act. ~~In performing these duties, the health partnership shall:~~

~~(a) Develop and offer two or more lower-cost benefit plans such that:~~

~~(1) Each health benefit plan is consistent with any criteria established by the health partnership;~~

~~(2) each health benefit plan shall be offered by all participating carriers;~~

~~(3) no participating carrier shall offer any health benefit plan developed under this act to any small employer unless such small employer is covered through the health partnership; and~~

~~(4)~~ a supplemental benefit plan or other benefit option shall be developed and made available so that the total package of benefits available to eligible children meet federal and state childrens' health insurance program standards established by K.S.A. 1999 Supp. 38-2001 *et seq.*, and amendments thereto, and the health insurance premium payment program in the state medical assistance program as implemented by the department of social and rehabilitation services.

~~(b) Offer coverage to any qualifying small employer.~~

~~(c) Offer employees of participating small employers a choice of participating carriers.~~

~~(d) (1) Include centralized and consolidated enrollment, billing and customer service functions;~~

~~(2) use one standard enrollment form for all participating carriers; and~~

~~(3) submit one consolidated bill to the small employer.~~

~~(e) Issue a request for proposals and selectively contract with carriers.~~

~~(f) Establish conditions of participation for small employers that conform with K.S.A. 40-2209b *et seq.*, and amendments thereto, and the health insurance portability and accountability act of 1996 (Public Law 104-191).~~

~~(g) Enroll small employers and their eligible employees and dependents in health benefit plans developed under this act.~~

~~(h) Bill and collect premiums from participating small employers including any share of the premium paid by such small employer's enrolled employees.~~

~~(i) Remit funds collected under subsection (h) to the appropriate contracted carriers.~~

~~(j) Provide that each eligible low-or-modest-wage employee shall be permitted to enroll in such employee's choice of participating carrier.~~

for eligible individuals and their dependents under a policy not issued to a group.

Section 5. A

Any carrier receiving the benefit of subsidies under this act shall be required to provide such supplemental benefits to enrollees.

4-8-14

SENATE BILL No. 668

By Committee on Ways and Means

3-21

AN ACT concerning the establishment of the Kansas business health partnership

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

Section 1. As used in this act:

(a) "Carrier" means any insurance company, nonprofit medical and hospital service corporation, nonprofit optometric, dental, or pharmacy service corporation, municipal group-funded pool, fraternal benefit society or health maintenance organization, as these terms are defined by chapter 40 of the Kansas Statutes Annotated, and amendments thereto, that offers health benefit plans covering eligible employees of one or more small employers in the state.

(b) "Health committee" means the Kansas business health policy committee as specified in section 2, and amendments thereto.

(c) "Dependent" means the spouse or any child of an eligible employee.

(d) "Eligible employee" shall have the meaning ascribed to it in K.S.A. 40-2209d and amendments thereto.

(e) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical services corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by any employer or any certificate issued under any such policy, contract or plan.

(f) "Kansas business health partnership" or "health partnership" means a nonrisk bearing nonprofit corporation that has responded to a request for a proposal by the health committee and has been selected by the health committee to provide health insurance through multiple unaffiliated participating carriers to small employers and their employees.

(g) "Low-and-modest wage employee" means any employee whose gross wage does not exceed 200% of the poverty level.

(h) "Small employer" shall have the meaning ascribed to it in K.S.A. 40-2209d and amendments thereto.

Sec. 2. (a) The governor of the state of Kansas shall appoint a cabinet level committee which shall be known as the Kansas business health policy committee.

(b) The Kansas business health policy committee, hereinafter referred to as the health committee, shall consist of:

(1) The secretary of the department of commerce or the secretary's designee;

(2) the secretary of the department of social and rehabilitative services or the secretary's designee;

(3) the commissioner of insurance or the commissioner's designee;

(4) one member appointed by the president of the senate; and

(5) one member appointed by the speaker of the house of representatives.

Not more than one member appointed pursuant to paragraphs (4) and (5) of this subsection shall belong to the same political party. The secretary of each state agency represented on this committee shall provide such staff and other resources as the health committee may require.

(c) (1) The initial meeting of the health committee shall be convened within 60 days after the effective date of this act by the governor at a time and place designated by the governor.

(2) Meetings of the health committee subsequent to its initial meeting shall be held and conducted in accordance with policies and procedures established by the health committee.

(3) Commencing at the time of the initial meeting of the health committee, the powers, authorities, duties and responsibilities conferred and imposed upon the health committee by this act shall be operative and effective.

(d) The health committee shall develop and approve a request for proposals for a qualified entity to serve as the Kansas business health partnership, hereinafter referred to as health partnership, which shall provide a mechanism to combine federal and state subsidies with contributions from employers and employees to purchase health insurance for low-and-modest wage employees in accordance with guidelines developed by the health committee.

(e) The health committee shall evaluate responses to the request for proposals and select the qualified entity to serve as the health partnership.

(f) The health committee shall:

(1) Develop and approve subsidy eligibility criteria provided that:

(A) Only low-and-modest wage employees of small employers that have low-and-modest wage employees shall be eligible for subsidies; and

(B) any ~~small employer's~~ employee with a child who is eligible for coverage under the state childrens' health insurance program established by K.S.A. 1999 Supp. 38-2001 *et seq.*, and amendments thereto, and the health insurance premium payment program in the state medical assistance program shall be eligible automatically for a subsidy and shall be included in the determination of eligibility for the small employer and its employed by an employer determined by the health committee to be eligible for coverage under this act

9-2

low-and-modest wage employees; and

(2) determine and arrange for eligibility determination for subsidies of low-and-modest wage employees.

(g) The health committee shall oversee and monitor the ongoing operation of any subsidy program and the financial accountability of all subsidy funds.

~~(h) In the event that the health partnership established under this act is unable to obtain good faith bids from an adequate number of carriers, the health committee can require the development of good faith bids from and the participation in the health partnership by any carrier that contracts with either the department of administration or the department of social and rehabilitation services to provide fully insured health coverage as required to implement the objectives of this act.~~

(h) The health committee is hereby authorized to accept funds from the federal government, or its agencies, or any other source whatsoever for research studies, investigation, planning and other purposes related to implementation of the objectives of this act. Any funds so received shall be deposited in the state treasury and shall be credited to a special revenue fund which is hereby created and shall be known as the health committee insurance fund and used in accordance with or direction of the contributing federal agencies. Expenditures from such fund may be made for any purpose in keeping with the responsibilities, functions and authority of the department. Warrants on such fund shall be drawn in the same manner as required of other state agencies upon vouchers signed by the secretary of the department of social and rehabilitation services upon receiving prior approval of the health committee.

(i) The health committee is authorized to develop policies for the use of additional federal or private funds to subsidize health insurance coverage for low-and-modest wage employees of predominantly low-wage small employers.

Sec. 3. (a) The health partnership selected by the health committee shall:

(1) Be a domestic not-for-profit corporation; and

(2) have a board of directors which includes among its members at least one director who is a small employer and at least one director who is an employee.

(3) No director shall have any interest in any business which sells health insurance or which provides or delivers any health care services.

(b) Operate the Kansas business health partnership.

Sec. 4. ~~The~~ health partnership shall develop and offer two or more health benefit plans to small employers. In any health benefit plan developed under this act, any carrier may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise re-

Except as provided in subsection (m) of this section, the

2-3

quired by state law. The provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2114 and subsection (D) of 40-2209 and 40-2229 and 40-2230, and K.S.A. 1999 Supp. 40-2,163, 40-2,164, 40-2,165 and 40-2,166, and amendments thereto, shall not be mandatory with respect to any health benefit plan developed under this act. In performing these duties, the health partnership ~~shall:~~ may

(a) Develop and offer two or more lower-cost benefit plans such that:

(1) Each health benefit plan is consistent with any criteria established by the health partnership;

(2) each health benefit plan shall be offered by all participating carriers;

(3) no participating carrier shall offer any health benefit plan developed under this act to any small employer unless such small employer is covered through the health partnership; and

(4) a supplemental benefit plan or other benefit option shall be developed and made available so that the total package of benefits available to eligible children meet federal and state childrens' health insurance program standards established by K.S.A. 1999 Supp. 38-2001 *et seq.*, and amendments thereto, and the health insurance premium payment program in the state medical assistance program as implemented by the department of social and rehabilitation services.

(b) Offer coverage to any qualifying small employer.

(c) Offer employees of participating small employers a choice of participating carriers.

(d) (1) Include centralized and consolidated enrollment, billing and customer service functions;

(2) use one standard enrollment form for all participating carriers; and

(3) submit one consolidated bill to the small employer.

(e) Issue a request for proposals and selectively contract with carriers.

(f) Establish conditions of participation for small employers that conform with K.S.A. 40-2209b *et seq.*, and amendments thereto, and the health insurance portability and accountability act of 1996 (Public Law 104-191).

(g) Enroll small employers and their eligible employees and dependents in health benefit plans developed under this act.

(h) Bill and collect premiums from participating small employers including any share of the premium paid by such small employer's enrolled employees.

(i) Remit funds collected under subsection (h) to the appropriate contracted carriers.

(j) Provide that each eligible low-or-modest wage employee shall be permitted to enroll in such employee's choice of participating carrier.

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(k) Develop premium rating policies for small employers;

(l) Be authorized to contract for additional group vision, dental and life insurance plans, and other limited insurance products.

Sec. 5. The department of social and rehabilitation services shall develop and seek federal approval of a family waiver for the state childrens' health insurance program established by K.S.A. 1999 Supp. 38-2001 *et seq.*, and amendments thereto, and the health insurance premium payment program in the state medical assistance program for purposes of coverage through the health partnership.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

subject to the limitations on carries set forth in K.S.A. 40-2209d, 40-2209g, and 40-2209h.

(m) Provide a mechanism for direct subsidies to low and modest wage employees of employers acquiring coverage through a direct contract with a carrier rather than through the health partnership, and for provision to such employees of a supplemental benefit plan as described in Section 4(a)(u) of this act.

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April 3, 2000

The Honorable Don Steffes
128–E
State Capitol

RE: Senate Bill 668, establishing the Kansas Business Health Partnership

Dear Senator Steffes,

I commend the actions by the Senate Financial Institutions and Insurance Committee to establish affordable health insurance for small employers and taking advantage of the federal parent coverage option through Senate Bill 668. The public-private partnership approach of the Kansas Business Health Partnership provides affordable insurance to employees of small businesses and provides small businesses with the ability to attract and retain a stable workforce in an expansive economy.

Another population of qualified workers that could benefit from this partnership approach is individuals with disabilities who are Medicaid and Medicare eligible as Supplemental Security Insurance (SSI) and Social Security Disability Insurance (SSDI) recipients. Many of these individuals, with skills and talents sought by small businesses, wish to return to work but fear the loss of health coverage and other services.

The recent passage of The Ticket to Work and Work Incentives Improvement Act (Public Law 106-170), as well as provisions of the Balanced Budget Act of 1997 (Section 4733, Public Law 105-33), have expanded health care services under Medicare and state-option Medicaid programs for persons with disabilities who want to work but fear losing their health care. A description of these health care provisions is attached.

The federal demonstration and health care subsidies to these individuals could be available to the Kansas Business Health Partnership, thus lowering premiums for plans developed by the Partnership. Nearly one-half of the individuals with disabilities being targeted are Medicare eligible, thus limiting the direct State Medicaid contributions.

My career includes a presidential appointment as Deputy Assistant Secretary of the Office of Special Education and Rehabilitative Services, US Department of Education. I believe the availability of affordable health care and an alliance with small businesses pose the greatest opportunity to reduce the 74% unemployment rate among adults with disabilities. The Kansas Association of Centers for Independent Living, the Statewide Independent Living Council of Kansas and other organizations initiating action on Public Law 106-170 encourage the Committee to consider including these federal health care subsidies as within the range of options available to the Kansas Business Health Partnership.

Questions or inquiries could be directed to Shannon Jones at 785-234-6990 or Howard Moses at 785-266-7292.

Sincerely,

Howard Moses

Note: The provisions of P.L. 106-170 most relevant to the work of the proposed Kansas Business Health Partnership include:

1. **Section 201, Expanding State Options Under the Medicaid Program for Workers with Disabilities – Options 1 and 2;**
2. **Section 203, Grants to Develop and Establish State Infrastructures to Support Working Individuals with Disabilities; and**
3. **Section 204, Demonstration of Coverage under the Medicaid Program of Workers with Potentially Severe Disabilities.**

Overview of the Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170)

During the period of 1997 to 1999, Congress passed and the President signed two Acts that include provisions:

- Improving work incentives under the Social Security Disability Insurance Program (SSDI) and the Supplemental Security Income Program (SSI) and
- Expanding health care services under Medicare and Medicaid programs for persons with disabilities who are working or who want to work but fear losing their health care.

Those laws include the Balanced Budget Act of 1997 (Public Law 105-33) and the Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170). For purposes of this White Paper, our focus will be on the provisions expanding health care services under Medicare and Medicaid programs for persons with disabilities. An explanation of improvements in SSDI and SSI work incentives can be provided upon request.

The Balanced Budget Act of 1997 (Public Law 105-33) adds a new provision in the Medicaid program [Section 1902(a)(10)((A)(ii)(XIII) of the Social Security Act] that allows states to elect to provide Medicaid coverage to persons with disabilities who are working and who otherwise meet SSI eligibility criteria but have net income up to 250% of the Federal poverty guidelines. Beneficiaries under the more liberal income limit may "buy into" Medicaid by paying premium costs. Premiums are set on a sliding scale based on an individual's income, as established by the state. Medicaid law allows states to utilize more generous eligibility criteria than SSI rules related to unearned income and resources to provide Medicaid eligibility under this new option.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) (TWWIIA) has four purposes [Section 2(b) of the Act]:

- To provide health care and employment preparation and placement services to individuals with disabilities that will enable those individuals to reduce their dependency on cash benefit programs.

would continue to flow from continuing eligibility for Part A, but the Part B premium would apply as usual. A Medicare Buy In program is already available under current law which allows disabled workers to obtain Medicare. The result would be that after the 8 1/2 years disabled workers could continue to be covered under Medicare if their disability continues and if they pay a required premium under Medicare Part A and Part B.

Demonstration of Coverage under the Medicaid Program of Workers with Potentially Severe Disabilities.

Under Sec. 204 of TWWIIA, a state may apply to the Secretary of HHS for approval of a demonstration project under which a specified maximum number of individuals who are workers with a potentially severe disability are provided medical assistance equal to that provided to workers with disabilities whose income does not exceed 250% of the Federal poverty level and who would be eligible for SSI, except for their earnings (the provision added by the Balanced Budget Act of 1997). In the case of a state that has not elected to provide medical assistance to these workers with disabilities, the state's demonstration project must provide such medical assistance as the Secretary determines is an appropriate equivalent to the medical assistance provided under such option.

A "worker with a potentially severe disability" is an individual (aged 16-64) who is employed and has a specific physical or mental impairment that, as defined by the state, is reasonably expected, but for the receipt of medical assistance, to become blind or disabled as defined under the Social Security Act for purposes of the SSI program. In accordance with the conference report, the States' definitions of workers with potentially severe disabilities can include individuals with a potentially severe disability that can be traced to congenital birth defects as well as diseases or injuries developed or incurred through illness or accident in childhood or adulthood.

Subject to the amount of funds appropriated for this demonstration, the Secretary must approve applications if the state demonstrates that it is maintaining fiscal effort and the state provides for an independent evaluation. The Secretary may allow for sub-state demonstrations (thereby waiving the statewide provision in the Medicaid legislation).

Congress must appropriate $42 million for each of the fiscal years 2001-2004 and $41 million for each of the fiscal years 2005-2006. In no case may payments made to the states by the Secretary exceed $250 million in the aggregate. In addition, in no case may the payments made by the Secretary to the states for administrative expenses relating to annual reports exceed $2 million. A state with an approved demonstration project must submit an annual report to the Secretary.

New Grant Programs

Grants to Develop and Establish State Infrastructures to Support Working Individuals with Disabilities.

The Secretary of HHS must award grants to states to support the design, establishment, and operation of state infrastructures that provide items and services to support working individuals with disabilities. The Secretary must also award grants to states to conduct outreach campaigns regarding the existence of such infrastructures. [Section 203 of the Act]

Expanding State Options Under the Medicaid Program for Workers with Disabilities.

Under Sec. 201 of TWWIIA, effective October 1, 2000, states may establish one or two new optional Medicaid eligibility categories.

New Option 1.

States would have the option to cover individuals with disabilities (aged 16-64) who, except for earnings, would be eligible for SSI. In other words, states would be allowed to permit working individuals with disabilities with incomes above 250% of the Federal poverty level to buy-into the Medicaid program by paying premiums and other cost-sharing charges on a sliding-fee scale based on income.

New Option 2.

If and only if a state provides Medicaid coverage to individuals described in Option 1, the state would also have the option of providing coverage to employed persons with disabilities (aged 16-64) whose medical condition has improved (and as a result are no longer eligible for SSDI or SSI and therefore are no longer eligible for Medicaid) but who continue to have a severe medically determinable impairment as defined in regulations issued by the Secretary of HHS.

Under both of these options, states could establish uniform limits on assets, resources, and earned or unearned income (or both) for this group that differ from the Federal SSI requirements. The state would be required to make premiums or other cost-sharing charges the same for both these two new eligibility groups. States may require individuals with incomes above 250% of the Federal poverty level to pay the full premium cost. In the case of individuals with incomes between 250 percent and 450 percent of the poverty level, premiums may not exceed 7.5 percent of income. States must require individuals with adjusted gross incomes above $75,000 per year (subject to annual adjustments after FY 2000) to pay all the premium costs. States may choose to subsidize premium costs for such individuals, but they may not use Federal matching funds to do so.

For the purposes of Option 2, individuals would be considered "employed" if they earn at least the Federal minimum wage and work at least 40 hours per month or are engaged in work that meets criteria for work, hours, or other measures established by the state and approved by the Secretary of HHS.

The Act requires that in order to receive Federal Medicaid funds, states must maintain the level of expenditures they expended in the most recent fiscal year prior to enactment of this provision to enable working individuals with disabilities to work.

Extending Medicare for SSDI Beneficiaries.

Prior to the passage of TWWIIA, SSDI beneficiaries are allowed to test their ability to work for at least nine months without affecting their SSDI (and therefore their Medicare) status. SSDI payments stop after a three-month grace period when a beneficiary has monthly earnings at or above substantial gainful employment after the nine-month period. If the beneficiary remains disabled but continues working, Medicare can continue for an additional 39 months (for a total of 48 months). Effective October 1, 2000, the Act provides for continued Medicare Part A coverage for 4 1/2 additional years (for a total of 8 1/2 years) without the payment of premiums. Part B of Medicare benefits

- To encourage states to adopt the option of allowing individuals with disabilities to purchase Medicaid coverage that is necessary to enable such individuals to maintain employment.
- To provide individuals with disabilities the option of maintaining Medicare coverage while working.
- To establish a return to work ticket program that will allow individuals with disabilities to seek the services necessary to obtain and retain employment and reduce their dependency on cash benefit programs.

Our discussion here will be limited to expanded availability of health care services.

In order to be eligible for a state infrastructure grant, a state must demonstrate that it makes personal assistance services available under its Medicaid plan to the extent necessary to enable individuals with disabilities to remain employed, including working individuals with disabilities with incomes up to 250% of poverty buying into Medicaid under the provision added by the Balanced Budget Act of 1997. The term "personal assistance services" means a range of services provided by one or more persons, designed to assist an individual with a disability to perform daily activities on and off the job that the individual would typically perform if the individual did not have a disability. Such services shall be designed to increase the individual's control in life and ability to perform every day activities on or off the job. HCFA has indicated that a waiver program of personal assistance services may serve as a proxy for the first year of the state infrastructure change grant.

With respect to the amount of a state's infrastructure grant, the Act directs the Secretary of HHS to reward states that adopt the state Medicaid buy-in option for working individuals with disabilities with incomes up to 250% of poverty (as added by the Balanced Budget Act of 1997). States that choose not to adopt this option would be subject to a maximum grant award established by a methodology developed by the Secretary, consistent with the limit applied to states that take up the option.

States are required to submit an annual report to the Secretary on the use of grant funds. In addition, the report must indicate the percent increase in the number of SSDI and SSI beneficiaries who return to work.

The Act specifies that Congress must appropriate $20 million for fiscal year 2001, $25 million for fiscal year 2002, $30 million for fiscal year 2003, $35 million for fiscal year 2004, $40 million for fiscal year 2005, and for each of the fiscal years 2006-2011 an amount appropriated for the preceding fiscal year increased by the Consumer Price Index.

Other grant authorities under TWWIIA benefiting community based organizations and other entities in Kansas include:

Work Incentives Outreach Program.

Under the Act, the Social Security Administration is required to establish a community-based work incentives planning and assistance program for the purpose of disseminating accurate information to individuals on work incentives. Under the program, the Commissioner is required to:

- Establish a program of grants, cooperative agreements, or contracts to provide benefits planning and assistance (including information on the availability of protection and advocacy services) to individuals with disabilities and outreach to individuals with disabilities who are potentially eligible for work incentive programs; and
- Establish a corps of work incentive specialists located within the Social Security Administration.

The Commissioner is required to determine the qualifications of agencies eligible for grants, cooperative agreements, and contracts. Eligible organizations may include Centers for Independent Living, protection and advocacy organizations, AIDS service organizations, client assistance programs, state Developmental Disabilities Councils, and state welfare agencies. State Medicaid agencies and Social Security field offices are

ineligible. Under the Act, Congress may appropriate $23 million for each of the fiscal years 2000-2004.

State Grants for Work Incentives Assistance to Disabled Beneficiaries.

The Commissioner of the Social Security Administration is authorized to make grants to existing protection and advocacy systems established under the Developmental Disabilities Assistance and Bill of Rights Act to provide information and advice about obtaining vocational rehabilitation, employment services, advocacy, and other services a SSDI or SSI beneficiary may need to secure or regain gainful employment, including applying for and receiving work incentives. Under the Act, Congress may appropriate $7 million for each of the fiscal years 2000-2004.

KANSAS HOSPITAL
KHA
ASSOCIATION

Donald A. Wilson
President

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kansas Hospital Association Tom Bell

RE: Senate Bill 668

DATE: April 5, 2000

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 668. This legislation creates the Kansas Business Health Partnership to allow for pooling of employees in small companies. It strengthens the practice of job based insurance by encouraging this type of coverage for low wage workers. It also provides insurance subsidies for certain low wage earners working for small group employers. We are in general support because of the objective SB 668 is attempting to achieve.

In 1998, 18.4% of the under 65 population was uninsured, compared with 14.8% in 1987. The erosion of employment based health benefits is responsible for a substantial portion of this increase. Currently, the vast majority of the uninsured have some connection to the workplace, with over 83% living in families headed by workers. Nearly 60% of uninsured workers are either self-employed or working in firms with fewer than 100 employees, while 41% are living in families with annual incomes of under $20,000.

The point here is that the increasing number of uninsured Americans is a significant and growing problem. While Senate Bill 668 may not be perfect, it is a legitimate and good faith attempt to begin the process of solving part of the problem in Kansas. The Kansas Hospital Association is encouraged that the Kansas Legislature is interested in this important issue and we look forward to assisting in future legislative discussions. Thank you for your consideration of our comments.

Senate Financial Institutions & Insurance
Date 4/5/00

Attachment 11

Kansas Hospital Association
215 SE 8th Ave. • P.O. Box 2308 • Topeka, KS • 66601 • 785/233-7436 • Fax: 785/233-6955 • www.kha-net.org