Approved: April 4, 2008
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 P.M. on March 10, 2008 in Room 136-N of the Capitol.

Committee members absent: Senator Mark Gilstrap- excused

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms. Renae Jefferies, Revisor of Statutes Office
Ms Margaret Cianciarulo, Committee Secretary

Conferees appearing before the Committee:

Others in attendance: Please see attached Guest List

Discussion and Final Action on SB541 - an act concerning the Kansas Health Policy Authority, relating to powers and duties thereof regarding a medical home and small business wellness grant programs; establishing the health reform fund.

Upon calling the meeting to order, the Chair stated that after the Committee hearing of March 4, 2008, Senator Journey requested some financial information on HealthWave in comparison to the Premium Assistance. She referred them to the yellow and blue sheets before them: the two yellow sheets reference the outlook on Premium Assistance and the three blue sheets reference the Kansas HealthWave Program. A copy of both are (Attachment 1) attached hereto and incorporated into the Minutes by reference. The Chair said what she is hoping to do today is discuss **SB541** and work it today.

She suggested they start by looking at the yellow sheets on Premium Assistance, sheet 2, showing projected costs as outlined in **SB11.** Then KHPA came back and, based on their proposals, added in expanding Premium Assistance to low income childless adults. She then referred the Committee to the last page of the blue sheets where the assumptions made on HealthWave are listed, but this packet would be to assume that we went to 250% of federal poverty level which has been proposed by Kansas Action for Children with all children eligible. She then stated that later in the meeting she would be giving the Committee a balloon that would be less costly because they would go to 225% the first year, 250% the second year and would have a crowd out provision. She added, some states put in the SCHIP laws as a requirement that you have to be without insurance for a certain number of months before you qualify for SCHIP and the reason they put that in the law is so people who have insurance do not drop it to enroll in SCHIP.

The Chair recognized Senator Schmidt who asked if this was the definition of crowd out? The Chair said that crowd out was when someone has an insurance policy and they drop it to go on SCHIP because it would be cheaper, because the state helps subsidize the plan. She went on to say that the proposal that was also before the Committee, also requires that families kick in a certain monthly payment in order to be on the plan.

The Chair recognized Senator Barnett who stated that he had looked at other states and many of them had a waiting period of up to a year but that does not necessarily eliminate crowd out. The Chair then called on Ms. Suzanne Wikle, Director of Health Policy, Kansas Action for Children, to address crowd out. Ms. Wikle agreed with Senator Barnett but said the overall value they would gain of opening this up would out weigh it.

The Chair then called on Ms. Emalene Correll, Kansas Legislative Research Department, who stated that the original law in 1999, had a provision that said that no child is eligible until such child as been uninsured for up to six months, if they had been covered by insurance and then the insurance had been dropped, however, this was taken out of the law three years ago.

The Chair then said she was going to pass out a balloon for purposes of discussion and let the Committee see what they think about this proposal, but first a discussion ensued with Dr. Marcie Nielsen, Executive Director, KHPA Dr. Andy Allison, Deputy Director, KHPA, and Mrs. Terri Weber, Kansas Legislative Research Department, with questions coming from Senators Barnett, Wagle, Schmidt, Brungardt including:

- Regarding Premium Assistance as a program, as you put it together would this be considered a legislative entitlement which means that if we enact the program we are obliged to pay for the program whether we have federal funds or not? And, regarding the federal poverty guidelines, what is 250% for a family of four and then for a family of two?

The Chair commented that the Committee is also looking at two different populations and asked them to look at the pink sheet (2008 Federal Poverty Guidelines) and stated:.

1. With Premium Assistance addressing adults who are 37 and 50% of poverty level and in looking at the pink sheet, the top end of that would be two individuals making $7,000.00 a year;

2. The HealthWave is to increase the benefits from 200% of federal poverty, which for two people would be $28,000.00, but to go to 250% which would be a mom and child at $35,000.00 and then there would also be a requirement for paying a part of their premium.

A copy of the 2008 Federal Poverty Guidelines is (Attachment 2) attached hereto and incorporated into the Minutes by reference.

- Was the monthly premium figured into this for 200% poverty level and at 250%?

- The Chair stated that she had visited with several oncologists regarding the Premium Assistance Program which would cover drugs at 75% with the first year of Premium Assistance to go for people are 37 to 50% of poverty level. So at the top of the income level you have two people living on $7,00.00/year and you are asking them to pay for 25% of their drug coverage. The oncologist said there was no way they could participate in a Premium Assistance Program because the cost of pharmaceuticals for an oncology patient would be thousands of dollars. The Chair said she is very concerned about people at this income with a chronic problem needing very expensive medication, but added that the oncologists would like to come up at interim, as would she, to discuss Premium Assistance and looking at who that person is at 37 to 50% of poverty level, what there needs are, and where are they living?

- Could you please clarify, what the Chair is saying is that the patient would have a 25% out of pocket expense for drugs, is this the way the Premium Assistance Program is designed?

- Could you clarify the Premium Assistance information passed out showing pharmaceuticals would be covered at 75%? And, what do you pay a month for adults on Medicaid?

- In your projection regarding the cost of Premium Assistance, about one fourth of this was going for administrative fees for the first year, so your cost for individuals is what?

- Regarding those oncology patients having to pay out of pocket, what are the circumstances of those patients right now, being uninsured and poor, having to pay 100% out of pocket, heading for bankruptcy or no treatment or diagnosis? (Having visited with those who represent hospitals and doctors (KMS and KHA) and they support Premium Assistance because it finally gets some insurance and coverage for these individuals that right now have nothing.)

- If the cost of Premium Assistance is going to be less than Medicaid or state health insurance and yet you are going to provide a least the same benefit as Medicaid?

- When other states have tried to go to a broader coverage, for instance Massachusetts, is this where the cost got away from them? Was Maine similar?

- Can you explain how the state could pay less for a policy than what we are paying for Medicaid and still have coverage at the provider level that is equal to or better? What do you think you will be leaving out that Medicaid pays? Did you really analyze the population of 37 to 50% of poverty level and what their medical needs are and what their ability is to pay on prescription drugs and outpatient needs?

- How would rebates work? Would rebates work for manufacturers? Would the insurance entities bidding on it be the ones that got the rebates or would it come back to the state, or how would that work

- If you take Medicaid does that automatically mean you are going to take Premium Assistance?

The Chair said that she was going to set before the Committee two proposals:

- one strikes Premium Assistance and sends it to a interim study committee

- the second, is an expansion of HealthWave which takes it to 225% next year of federal poverty level and in 2010 takes it to 250% and is dependent on federal funding coming in and has the crowd out provision.

A copy of these two proposals are (Attachment 3) attached hereto and incorporated into the Minutes by reference.

Senator Barnett made a motion to move the expansion of SCHIP as proposed in the amendment, which would be adding a new section to **SB541**, expanding SCHIP. It was seconded by Senator Schmidt.

Senator Haley asked for a discussion regarding concerns that the total Committee is not present. But does support this amendment. The Chair stated that this is a bill that is exempted and is dependent on the federal government authorizing the funds.

The Chair asked if there was any other discussion on amending this bill, seeing none, she asked for the will of the Committee and the motion carried.

The Chair recognized Senator Schmidt who stated in new Section 2A regarding medical home, there was some language that had been agreed to by the Kansas Medical Society, the Kansas Health Policy Authority, and the Kansas Academy of Family Practice and asked if the new language is available.

The Chair called on Mr. Dan Morin from KMS, who stated that the testimony they had passed out at the hearing on February 18, 2008, was a fairly lengthy amendment and with discussions with the KHPA and the KAFP, have trimmed it down and offered the definition from testimony that was submitted to a House Committee. As he had the only copy, the Chair asked him to read it to the Committee:

He stated, "Medical home" means a health care delivery model in which a patient establishes an on-going relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive accessible and continuous evidenced- based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner." He said this would just be new Section 2 a.

The Chair recognized Senator Haley who asked if this amendment speaks to prevention and efficiency?

As it does, the Chair said a motion was made by Senator Schmidt to adopt this language. It was seconded by Senator Barnett and the motion carried.

The Chair then stated that if the Committee had concerns regarding keeping Premium Assistance in statute until it is studied more thoroughly, we need to strike on page 4, Section 3 (f) and on page 5, down through line 11and asked what the will of the Committee was.

A discussion ensued with Senators Brungardt, Wagle, and Barnett regarding:

- finding a mechanism to keep Premium Assistance alive but not active and feels it is important that they are going to actually address medical costs and attempt to study and control it, we will have to find the will to pay for it and would like to keep it alive while they figure out what they are actually doing.

- will oppose if the Committee kills this proposal of Premium Assistance. (It is the first time in years that Kansas has taken the step to address those people who are in the greatest of needs and even if we do not have the money, as it is always subject to appropriations anyway, would rather keep it alive and keep debating it. And, in talking to people in the insurance industry, they really do not oppose it they just oppose not being able to be a player.

- Senator Barnett offered an amendment that speaks to the standard premium assistance as well that before the expansion occurs the KHPA will make recommendation regarding the proposed benefit design changes as the Chair has appropriately raised questions about, present it to the joint committee on health policy oversight by 2010 and in addition to the benefit design would also take into consideration what is available in the individual insurance market and also reinsurance options. (There is a mechanism of reinsurance that could probably help this whole situation but it has not been studied enough.) Basically, this amendment puts it all on the table, but it does not kill it. Senator Barnett made a motion to offer this amendment for **SB541.** A copy of his amendment is (Attachment 4) attached hereto and incorporated into the Minutes by reference.

The Chair asked if there were questions about this motion. Senator Haley asked why November of 2010?

The Chair stated that testimony has been offered from underwriters, questioning why we would start Premium Assistance at 37% of poverty when those people could easily be expanded on to Medicaid which would probably be more appropriate for someone at that low of income. And that yes, we do want to bring the private insurers, but they really are not interested until you reach 100% of poverty level. People who are under 100% have a very different set of needs. The first year we are looking at expanding to a group of very poor people. This is why it has been suggested that we send it to an interim committee. Strike it for now so the pressure is not on the legislature and there is not a misunderstanding that we fully approve of a program that takes people from 37 to 50% of poverty level and puts them into a premium assistance program when possibly the better avenue to go is Medicaid. So the Chair offered a substitute motion on top of Senator Barnett's amendment to strike Premium Assistance and send it to an interim committee.

The Chair recognized Senator Schmidt who asked if the interim committee could also study the possibility of doing a pilot program as we have two managed care organizations in our state now that could do a pilot program.

The Chair felt that this was a viable proposal and should be looked at and recognized Senator Barnett who stated that expanding Medicaid is pretty much status quo and cannot see us being satisfied with status quo and do not feel we can afford that any longer, but premium assistance will not only help these people, but small businesses who employ these people and offer insurance.

The Chair stated that leadership has made it very clear that when the Committee voted on this last year in **SB11**, no fiscal note was offered and we are hearing from providers that it is going to cost less than Medicaid and therefore, it might also pay providers less than Medicaid. She said she was going to have to call the question, as it is late.

Again, the Chair made a motion to strike Premium Assistance and put all issues in interim. Senator Schmidt seconded and the motion passed with a no vote from Senators Barnett and Haley.

Adjournment

As it was going on Senate session time and there was no further business, Chairperson Wagle adjourned the meeting with a possibility of a meeting at the rail later in the day. The time was 3:16 p.m.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Monday, March 10, 2008

NAME	REPRESENTING
Chad Austin	KS Hosp Association
Kerri Spielman	KAIA
Tom Bruno	EDS
Jarrod Forbes	UHG
Peggy Galvin	BCBSKC
Austin Hayden	Hein Law Firm
Reagan Cussimanio	KHPA
Corrie Edwards	KHCC
Steve Kearney	Kansas Action For Children
Sjanna Catsonadis	"
Stephanie Mullholland	"
Suzanne Wikle	"
Gary Brund	"
John Peterson	Capitol Strategies
Dan Morin	KS Medical Society
Marcy Nielsen	KHPA
Andy Allison	KHPA
Dan Murray	Federico Consulting

29 in att.

please continue to pass thank you - MLC

Premium Assistance Program

Description: Premium assistance, known as **Kansas Healthy Choices**, is a state program that uses public, employer, and potentially individual contributions to purchase private health insurance for Kansas families living in poverty who cannot otherwise afford coverage. As required by statute, it is to be designed as a phased-in plan to assist eligible low income Kansas residents with the purchase of private insurance or other benefits that are actuarially equivalent to the Kansas State Employee Health Plan. Subject to appropriation of funds and other eligibility requirements, in program years one and two, eligible participants shall consist of families at and under 50% of the federal poverty level; in program year three, eligible participants shall consist of families at and under 75% of the federal poverty level; in program year four, eligible participants shall consist of families at and under 100% of the federal poverty level. The Kansas Health Policy Authority is authorized to seek any approval from the Centers for Medicare and Medicaid Services necessary to accomplish the development or expansion of premium assistance programs for families.

Senate Health Care Strategies
Committee
Date: March 10, 2008
Attachment 1

Statutory Authority: KSA 75-7408(f)

Authorization Date: May 17, 2007

Type of Population Served: Low-income families.

Program Start Date: Up to 50% FPL - January 2009 (FY 2009)
Up to 75% FPL - July 2009 (FY 2010)
Up to 100% FPL - July 2010 (FY 2011)

Income Eligibility Levels: Using 2008 poverty level standards for a family of four: 50% FPL = $10,600
75% FPL = $15,900
100% FPL = $21,200

Funding Sources: 60% federal funds; 40% state general funds. State funds are subject to appropriation.

Number of Recipients Projected to be Served: 8,500 parents (FY 2009)
7,000 parents (FY 2010)
8,500 parents (FY 2011)
TOTAL 24,000 parents under %100 FPL

Projected Cost Per Member Per Month: $325 per month in FY 2009.

Projected Costs: See attached worksheet.

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Estimated Costs of SB 11 Premium Assistance (Kansas Healthy Choices) and Premium Assistance Expansion Program (Childless Adults)

	FY 2009		FY 2010		FY 2011		FY 2012		FY 2013	
	SGF	AF	SGF	AF	SGF	AF	SGF	AF	SGF	AF
SB 11 Premium Assistance										
Concept approved within SB 11 which requires appropriation to fund anticipated caseload costs.										
Program Cost	$ 3,700,000	$ 9,500,000	$ 14,000,000	$ 35,000,000	$ 31,000,000	$ 77,000,000	$ 41,000,000	$ 102,000,000	$ 45,000,000	$ 111,000,000
Administrative Cost	$ 1,200,000	$ 2,500,000	Unknown		Unknown		Unknown		Unknown	
SubTotal	$ 4,900,000	$ 12,000,000	$ 14,000,000	$ 35,000,000	$ 31,000,000	$ 77,000,000	$ 41,000,000	$ 102,000,000	$ 45,000,000	$ 111,000,000
SB 541 Expanding Insurance for Low-Income Kansans (Childless Adults)										
Program Cost	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,000,000	$ 64,000,000	$ 56,000,000	$ 140,000,000
Administrative Cost							Unknown		Unknown	
SubTotal							$ 26,000,000	$ 64,000,000	$ 56,000,000	$ 140,000,000
Grand Total	**$ 4,900,000**	**$ 12,000,000**	**$ 14,000,000**	**$ 35,000,000**	**$ 31,000,000**	**$ 77,000,000**	**$ 67,000,000**	**$ 166,000,000**	**$ 101,000,000**	**$ 251,000,000**

Assumptions

SB 11 Premium Assistance:

Projected cost increase of 3%.
18-month ramp up to full enrollment for each phase.
Three-year phase in plan.
70% of eligible families would be enrolled at the end of the 18 month ramp up.
Anticpated enrollment of 24,430 in FY 2011.

SB 541 Expanded Premium Assistance:

Projected cost increase of 3%.
18-month ramp up to full enrollment.
Target cost of $325 per member per month.
Anticipated enrollment of 36,600 childless adults.

Kansas HealthWave Program

Description: **HealthWave** is the State's combined Medicaid Capitated Managed Care Program (Title XIX) and State Children's Health Insurance Program (Title XXI) generally referred to as "SCHIP." HealthWave serves children and youth (under the age of 19) who enter the program either through eligibility for Medicaid or SCHIP and serves adults who are Medicaid eligible. The Medicaid component of HealthWave is an entitlement program, *i.e.*, any individual who meets the eligibility requirements set by the state and approved as part of the State Medicaid Plan must be covered by the program. The income eligibility requirements range up to 150% FPL. The SCHIP component of HealthWave provides health insurance coverage to children whose family income is too high to allow them to qualify for Medicaid-funded services. It is not an entitlement program. It is a capitated managed care plan with the matching federal SCHIP funds allocated annually to states according to a formula set out in federal law. The income eligibility requirement ranges from 150% FPL to 200% FPL. SCHIP provides continuous eligibility for 12 months once a formal determination is made that a child is eligible.

Statutory Authority: Medicaid Component - KSA 39-709(e)
SCHIP Component - KSA 38-2001

Start Date: Medicaid Component - 1960s
SCHIP Component - 1998
HealthWave Program - 2001

Type of Population Served: Medicaid Component - low income children and parents.
SCHIP Component - low income children.

Funding Sources: Medicaid Component - entitlement program; 60% federal funds; 40% state general funds.
SCHIP Component - 72.2% federal funds up to a maximum allotment; 27.8% state general funds; state dollars spent above federal maximum allotment must come from state general fund.

Number of Recipients Served: Medicaid Component - 122,110 average monthly enrollment (FY 2007)
SCHIP Component - 35,433 average monthly enrollment (FY 2007)

Cost Per Member Per Month: Medicaid Component - $258.10 per month (FY 2007)
SCHIP Component - $139.86 per month (FY 2007)

Premiums Paid Per Month: Medicaid Component - no premiums paid.
SCHIP Component - $20 per month for families at 151-175% FPL.
$30 per month for families at 176-200% FPL.

Costs: Medicaid Component - $239,435,218 (FY 2007)
SCHIP Component - $59,469,297 (FY 2007)

Total Federal SCHIP Allotments and Expenditures
(in billions)

FF Year	Total Allotments	Percent Change	Total Expenditures
1998	$ 4.295		$ 0.005
1999	4.275	(0.5) %	0.565
2000	4.275	-	1.220
2001	4.275	-	3.699
2002	3.150	(26.3)	3.682
2003	3.150	-	4.355
2004	3.150	-	4.607
2005	4.050	28.6	5.129
2006	4.050	-	5.451
2007	5.000	23.5	6.294
Ten Year Change	**$ 0.705**	**16.4 %**	

Kansas SCHIP Allotments and Expenditures
(in thousands)

SFY	Allotment	Percent Change	Expenditures	Percent Change
2003	23,827		34,512	
2004	23,767	(0.3) %	35,827	3.8 %
2005	27,245	14.6	40,247	12.3
2006	27,737	1.8	45,187	12.3
2007	36,542	31.7	42,942	(5.0)

Federal SCHIP funds are subject to a state-specific cap, or allotment.

Current Match Rate

Federal Match	72.2%
State Match	27.8

Factors included in the federal allotment formula

- Number of low income children under the age of 19 at or below 200 percent of federal poverty level
- Number of the above children without health insurance

Notations

State eligibility is continuous for twelve months after determination of eligibility. (KSA 38-2001)
HealthWave Premiums are $20 per month for families between 151-175 percent of FPL and $30 per month for families between 176-200 percent of FPL.
Healthwave is a capitated managed care plan covering children ages 0-19.

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Preliminary Estimate of Enrollment and Costs Associated with an Expansion of Kansas HealthWave from 200 Percent of Poverty to 250 Percent of Poverty

	FFY2008	FFY2009	FFY2010	FFY2011	FFY2012	5 YR Total
TOTAL Estimated New Enrollees	5,460	9,100	11,840	11,840	11,840	
Reduction in Uninsured	2,730	4,550	5,920	5,920	5,920	
Reduction in Privately Insured	2,730	4,550	5,920	5,920	5,920	
TOTAL Estimated Expenditures	$9,499,000	$16,829,000	$23,193,000	$24,653,000	$25,951,000	$100,125,000
Federal Expenditures	$6,801,000	$12,050,000	$16,606,000	$17,652,000	$18,581,000	$71,690,000
State Expenditures	$2,698,000	$4,779,000	$6,587,000	$7,001,000	$7,370,000	$28,435,000

Key Assumptions

1. When the expansion is fully implemented, 65 percent of uninsured children in the expansion income range are estimated to enroll. Full implementation is assumed roughly 18 months into the expansion.

2. Of those children enrolled in the expansion income range, 50 percent are assumed otherwise to have been enrolled in private coverage in the absence of the SCHIP expansion. This figure is adopted from Congressional Budget Office analysis. Note that the CBO includes among this "crowd-out" group those *uninsured* children whose parents would have enrolled them in private coverage in the absence of SCHIP.

3. A minor adjustment is made to the estimate of eligibles to account for those children likely ineligible due to citizenship status.

4. Presently, children enrolled in HealthWave are responsible for premiums roughly 1 percent of their family income. Premiums for the expansion population are assumed to be of this magnitude. If premiums are a more significant share of families' income, then enrollment will be less than estimated in this analysis.

5. Coverage expansions generally are considered a stimulus to enrollment among already eligible but unenrolled children. However, there are not good estimates of the magnitude of this impact. Thus, we are not able to estimate increased enrollment in HealthWave among those children below 200 percent of poverty.

6. Children at higher income levels are known to be in better health resulting in their insurance coverage costing less. However, there are not good estimates of the magnitude of this cost difference. Thus, we are not able to estimate the degree to which per capita costs for expansion children will be less than those for currently enrolled children.

Source

Estimates of likely eligibles are based on Center on Budget and Policy Priorities' analyses using Census Bureau data. Expenditure estimates incorporate per member per month costs in HealthWave in 2006 as reported by state officials updated by Congressional Budget Office inflation factors.

2008 Federal Poverty Guidelines*

Federal Poverty Percentage	Household Size 1	2	3	4	5
27.5%	$ 2,860	$ 3,850	$ 4,840	$ 5,830	$ 6,820
37%	3,848	5,180	6,512	7,844	9,176
50%	5,200	7,000	8,800	10,600	12,400
75%	9,750	13,125	16,500	19,875	23,250
100%	10,400	14,000	17,600	21,200	24,800
125%	13,000	17,500	22,000	26,500	31,000
133%	13,832	18,620	23,408	28,196	32,984
150%	15,600	21,000	26,400	31,800	37,200
185%	19,240	25,900	32,560	39,220	45,880
200%	20,800	28,000	35,200	42,400	49,600

For each additional person in the household add $3,600 for 100% of FPL.

* from U.S. Department of Health and Human Services (www.aspe.hhs.gov). Figures are for the 48 contiguous states and D.C..

Note: The HHS poverty guidelines, or percentage mulitples of them (such as 125 percent etc.) are used as an eligibility criterion by a number of federal programs including Head Start, Food Stamps, National School Lunch Program, Low-Income Home Energy Assistance, Children's Health Insurance Program and some parts of the Medicaid program. In general, cash public assistance programs do not use these poverty guidelines in determining elibility. A more detailed list of programs that use or do not use these guidelines can be found at www.aspe.hhs.gov.

Proposed Amendment to SB 541

Sec. 1. K.S.A. 38-2001 is hereby amended to read as follows: 38-2001. (a) The secretary of social and rehabilitation services shall develop and submit a plan consistent with federal guidelines established under section 4901 of public law 105-33 (42 U.S.C. 1397aa et seq.; title XXI).

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

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

(2) provides for presumptive eligibility for children where applicable;

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

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

(5) shall use the same prior authorization standards and requirements as used for health care services under medicaid to further the goal of seamlessness of coverage between the two programs; ~~and~~

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Attachment 3

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

(7) shall provide coverage, subject to appropriation of funds and other eligibility requirements, for children residing in a household having a gross household income (A) at or under 225% of the federal poverty income guidelines in 2009, and (B) at or under 250% of the federal poverty income guidelines in 2010 and subsequent years; the participants receiving coverage shall contribute to the payment for such coverage through a sliding-fee scale based upon ability to pay as established by rules and regulations of the secretary; and

(8) contains a provision which requires the newly enrolled participants with a family income over 200% of the federal poverty income guidelines to wait at least 8 months before participating in this program, if such participants previously had comprehensive health benefit coverage through an individual policy or a health benefit plan provided by any health insurer as defined in K.S.A. 40-4602, and amendments thereto. This waiting period provision shall not apply when the prior coverage ended due to loss of employment other than the voluntary termination, change to a new employer that does not provide an option for dependent coverage, discontinuation of health benefits to all employees, expiration of COBRA coverage period or any other situations where the prior coverage ended due to reasons unrelated to the availability of this program.

(c) The secretary is authorized to contract with entities authorized to transact health insurance business in this state to implement the health insurance coverage plan pursuant to subsection (a) providing for several plan options to enrollees which are coordinated with federal and state child health care programs, except that when contracting to provide managed mental health care services the secretary shall assure that contracted entities demonstrate the ability to provide a full array of mental health services in accordance with the early and periodic screening, diagnosis and treatment plan. The secretary shall not develop a request for proposal process which excludes community mental health centers from the opportunity to bid for managed mental health care services.

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

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

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

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

(4) shall provide for a simplified enrollment plan;

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

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

(7) may provide for payment of health insurance premiums, including contributions to a medical savings account if applicable, if it is determined cost effective, taking into account the number of children to be served and the benefits to be provided; and

(8) may provide that prescription drugs, transportation services and dental services are purchased outside of the capitated managed care plan to improve the efficiency, accessibility and effectiveness of the program.

(e) A child shall not be eligible for coverage and shall lose coverage under the plan developed under subsection (a) of K.S.A. 38-2001, and amendments thereto, if such child's family has not paid the enrollee's applicable share of any premium due.

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

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

make necessary adjustments to stay within the program's appropriations.

(g) Eligibility and benefits under the plan prescribed by this section are not and shall not be construed to be entitlements, are for legal residents of the state of Kansas and are subject to availability of state and federal funds and to any state and federal requirements and the provisions of appropriation acts. If the secretary determines that the available federal funds and the state funds appropriated are insufficient to provide coverage for the income eligibility levels prescribed by this section, a lower income level shall be adopted and implemented by the secretary, within the limits of appropriations available therefor, and all such changes shall be published by the secretary in the Kansas register.

(b) The Kansas health policy authority created under K.S.A. 2007 Supp. 75-7401, and amendments thereto, shall establish a small business wellness grant program. In implementing and administering the small business wellness grant program, the Kansas health policy authority shall:

(1) Develop a community grant program to provide technical assistance to small businesses to assist in the development of workplace wellness programs; and

(2) provide start-up funds to small businesses to assist in the development of workplace wellness programs.

(c) The provisions of this section shall expire and the small business wellness grant program shall be abolished December 30, 2016.

Sec. 4. K.S.A. 2007 Supp. 75-7408 is hereby amended to read as follows: 75-7408. (a) On and after July 1, 2006, the Kansas health policy authority shall coordinate health care planning, administration, and purchasing and analysis of health data for the state of Kansas with respect to the following health programs administered by the state of Kansas:

(1) Developing, implementing, and administering programs that provide medical assistance, health insurance programs, or waivers granted thereunder for persons who are needy, uninsured, or both, and that are financed by federal funds or state funds, or both, including the following:

(A) The Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. § 1396 et seq., and amendments thereto;

(B) the health benefits program for children established under K.S.A. 38-2001 et seq., and amendments thereto, and developed and submitted in accordance with federal guidelines established under title XXI of the federal social security act, section 4901 of public law 105-33, 42 U.S.C.§ 1397aa et seq., and amendments thereto;

(C) any program of medical assistance for needy persons financed by state funds only, to the extent appropriations are made for such a program;

(D) the working healthy portion of the ticket to work program under the federal work incentive improvement act and the medicaid infrastructure grants received for the working healthy portion of the ticket to work program; and

(E) the medicaid management information system (MMIS)~~; and~~

~~(F) a phased-in premium assistance plan to assist eligible low income Kansas residents with the purchase of private insurance or other benefits that are actuarially equivalent to the Kansas state employee health plan under a program authorized under subsection (a)(1). In program years one and two, subject to appropriation of funds and other eligibility requirements, eligible participants shall consist of families at and under 50% of the federal poverty level. Subject to appropriation of funds and~~

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~~other eligibility requirements, eligible participants in program year three shall consist of families at and under 75% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year four shall consist of families at and under 100% of the federal poverty level.~~ ~~*On July 1, 2011, subject to appropriation of funds and other eligibility requirements, eligible participants in the program shall also include childless adults age 19 and above at and under 100% of the federal poverty level.*~~ ~~The Kansas health policy authority is authorized to seek any approval from the centers for medicare and medicaid services necessary to accomplish the development or expansion of premium assistance programs for families~~ ~~*and childless adults*~~;

(2) the restrictive drug formulary, the drug utilization review program, including oversight of the medicaid drug utilization review board, and the electronic claims management system as provided in K.S.A. 39-7,116 through 39-7,121 and K.S.A. 2007 Supp. 39-7,121a through 39-7,121e, and amendments thereto; and

(3) administering any other health programs delegated to the Kansas health policy authority by the governor or by a contract with another state agency.

(b) Except to the extent required by its single state agency role as designated in K.S.A. 2007 Supp. 75-7409, and amendments thereto, or as otherwise provided pursuant to this act the Kansas health policy authority shall not be responsible for health care planning, administration, purchasing and data with respect to the following:

(1) The mental health reform act, K.S.A. 39-1601 et seq., and amendments thereto;

(2) the developmental disabilities reform act, K.S.A. 39-1801 et seq., and amendments thereto;

(3) the mental health program of the state of Kansas as prescribed under K.S.A. 75-3304a, and amendments thereto;

(4) the addiction and prevention services prescribed under K.S.A. 65-4001 et seq., and amendments thereto; or

(5) any institution, as defined in K.S.A. 76-12a01, and amendments thereto.

New Sec. 5. (a) There is hereby established in the state treasury the health reform fund which shall be administered by the Kansas health policy authority.

(b) All moneys credited to the health reform fund shall be expended for the purpose of funding the small business wellness grant program in section 3 and for funding other health reform options of the Kansas health policy authority. Moneys allocated or appropriated from the health reform fund shall not be used to replace or substitute for moneys appropriated from the state general fund in the immediate preceding fiscal

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(2) the restrictive drug formulary, the drug utilization review program, including oversight of the medicaid drug utilization review board, and the electronic claims management system as provided in K.S.A. 39-7,116 through 39-7,121 and K.S.A. 2007 Supp. 39-7,121a through 39-7,121e, and amendments thereto; and

(3) administering any other health programs delegated to the Kansas health policy authority by the governor or by a contract with another state agency.

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Prior to the expansion of this program to include childless adults age 19 and above as eligible participants, the Kansas health policy authority shall conduct an evaluation of the premium assistance program participation and cost effectiveness. The Kansas health policy authority shall make recommendations regarding proposed benefit design changes and present the findings to the joint committee on health policy oversight on or before November 1, 2010. The recommendations regarding benefit design changes shall include consideration of options available in the individual insurance market and available reinsurance options. In performing this evaluation, the Kansas health policy authority shall consult the insurance department as necessary.

Senate Health Care Strategies Committee
Date: March 10
Attachment 4