State of Kansas

Jim Denning
Senate Majority Leader

January 23, 2020

Re: Proponent on SB252

Dear Chairman Suellentrop, Vice Chairman Berger, and Committee members:

Thank you for allowing me to testify in support of SB252. Twenty-two (22) Senators are sponsors on this bipartisan bill.

SB252 is known as the Kansas Innovative Solutions for Affordable Healthcare Act. SB252 is mostly the work product of the Special Senate Select Committee on Health Care Access. The Select Committee met on October 22 and 23, 2019 to begin establishing a transparent Senate position to provide health care for as many Kansans as possible.

In bipartisan fashion, negotiations with the Governor, using the Senate language contained in 20rs1873, and the documented recommendations from Special Senate Select Committee on Health Care Access, the compromise SB252 was agreed to by a Senate majority and is now before this committee for consideration.

Section 2 – Expansion and Re-Insurance

SB252 expands Medicaid coverage up to 138% of the federal poverty level (FPL) with a Federal Medical Assistance Percentage (FMAP) of 90/10. This first stage of health care coverage will be implemented by January 1, 2021.

The next stage will be the implementation of Reinsurance by January 1, 2022. This is a multipart waiver request to implement reinsurance and request, if budget neutral to the federal deficit, transition 100-138% of FPL back to the private market on the exchange. If the request to transition 100-138% back to the private market is declined, reinsurance will still go forward with a January 1, 2022 implementation date.

Reinsurance should reduce premiums by at least 20% and provide younger and healthy Kansans, as well as Kansans with pre-existing conditions, to have access to affordable health insurance. Premiums have more than doubled and out of pocket expenses have increased 30%. We need state-based solutions because the expected federal based solutions have not materialized.

Section 3 - Pathway to Employment

Took Senate 20rs1873 language.

A pathway to employment approach was chosen over a hard count work requirement. Providing a pathway to work was seen as the best approach at this time. The federal ACA law prohibits any work requirement protocol that can impact enrollment up to 138% of the federal poverty level. That is to say, it is illegal to modify enrollment to exclude any U.S citizen between the ages of 19-64 with income up to 138% of FPL. It is known that many states are proposing a work requirement to be eligible for Medicaid. At this point in time not a single state has a functioning work requirement for Medicaid eligibility. Either the work requirement has been denied by CMS, struck down by the courts, and/or has been deemed too expensive by states to implement. Having a hard count work requirement in the bill will be complete waste of money and resources. KDHE and the MCO's will have to build a program to implement only to have it quickly stuck down by the courts. The MCO's and KDHE are not going to build the implementation program for free. As a result, work requirement language will actually increase the pmpm charge from MCO's. See the waiver tracker attached. Here is the dynamic link to follow work requirement waivers. https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

How the Pathway to Employment is structured

Integrate a work assessment questionnaire as part of Medicaid application and eligibility process. The assessment must be completed to be eligible for Medicaid. Lee Norman, M.D. Secretary of KDHE has given written assurance that the following questions will be added to the Medicaid eligibility application for coverage.

Pathway to Work – Work Assessment Questionnaire

What best describes your current employment situation?

(If you select option 5, go to the next question. Otherwise skip the next question)

1. I have a job (jobs) and work 20 or more hours a week
2. I have a job (jobs) and work less than 20 hours a week
3. I recently lost my job and am looking for another
4. I recently lost my job and am not currently looking for another
5. My current situation does not let me have a job (go to next question if you select this answer)

What about your current situation does not let you have a job?

1. I don't have a high school diploma or G.E.D.
2. I don't have transportation to get to a job
3. I need to care for older people in my home

4. I need to care for young children in my home
5. I need to care for someone with a disability in my home
6. I do not feel that I am healthy enough to work
7. I am a full-time student

Integrate with KansasWorks program

1. Administered by the Department of Commerce
    a. The secretary of Commerce shall maintain a unique identifier for KansasWorks participants
    b. Provide connections with employers
    c. Provide annual outcomes report to the legislature

Section 4 – Monthly Premiums

Monthly premiums will apply to the new expanded population within 100-138% of FPL not to exceed $25 monthly for an individual, not to exceed $100 per family.

Garnishment will happen if an individual gets more than 60 days past due on making monthly premiums. Garnish tax return refunds, lottery winnings, wages, etc. KDHE shall utilize the debt collection procedures authorized by K.S.A. 75-6201 et seq., and amendments thereto.

Section 5 - Premium assistance program

Took Senate 20RS1873 language.

Section 6 – Use MCO delivery system and implement Tiered benefits

Took Senate 20RS1873 language.

No discrimination between profit and not for profit MCO's allowed when evaluating RFP's for participation in Kancare.

Incentive given to MCO's when Kancare contracts are renewed to sell insurance plans on the Exchange.

Tiered benefits implemented by 7-1-22

Section 7 & 8 - Poison pill

Took Senate 20RS1873 language.

If the FMAP drops below the 90% match the expansion plan terminates over a 12-month period. NO NEW enrollments will be accepted as of the date of the FMAP change.

This provision is non-severable.

Section 11 – Sheriff's local government jail language

Took Senate 20RS1873 language.

There are two programs the DOC will help local jails implement if the Sheriff's request assistance.

If an inmate has a medical procedure that requires an overnight stay at the hospital those claims will be submitted directly to Medicaid and get paid at the 90/10 match rate. The result of this policy will be that local jails will not pay for these procedures with property taxes. This section providers property tax relief to local governments.

The second program provides for Medicaid coverage the day an inmate is released from jail. This will result in less recidivism and lower bad debt to hospitals with this population having health care coverage upon release from jail.

DOC report to legislature beginning 2022 the savings to state from being able to provide Medicaid reimbursement for inmate inpatient hospitalization.

Section 13 - Economic impact on SGF

Took Senate 20RS1873 language.

LPA will perform the analysis.

Section 14 - Drug Rebate transparency (SB231)

Took Senate 20RS1873 language.

Effective 7-1-21 all drug rebates from the Medicaid program will be reported on the monthly state receipts report. This will result in more transparency and the legislature directly appropriating approximately $80M in drug rebates to caseload costs.

Section 15 - FMAP Stabilization Fund (SB2)

Took Senate 20RS1873 language.

Section 16 - Rural hospital transformation program

Took Senate Select Committee recommendation.

Section 17 – Kansas Insurance Department (KID) analyze any cost shifting from hospitals to commercial insurance companies.

Took Senate 20RS1873 language.

KID will report annually to the legislature with 2018 as the base year.

Section 18 - Kansas Insurance Department (KID) analyze cost benefits of converting from Federal facilitated exchange to a State based exchange.

Took Senate 20RS1873 language.

Analyze impacts to commercial rates, additional flexibility allowed in plan designs etc. The federal government charges 3% annual fee to individual plans to pay for the Federal facilitated exchange. This is approximately $18M annually. We can do for a lot less.

Section 19 - KDHE creates guidelines for Hospitals to report bad debt

Took Senate Select Committee recommendation.

Section 21 - Institutions for Mental Diseases (IMD) Exclusion Waiver submitted no later than 1-1-21

Took Senate Select Committee recommendation.

The IMD exclusion is a discriminatory federal rule that prohibits federal Medicaid reimbursement to states for adult patients receiving mental health or substance abuse care in a psychiatric or substance abuse treatment facility with more than 16 beds.

Section 23 - KanCare oversight gets extra day, per meeting, for 2 years to monitor Medicaid rollout.

Took Senate 20RS1873 language.

Section 25 through 32 - Hospital Surcharge

Expanded on Senate 20RS1873 language.

Hospitals will commit $35M annually as a pay for. This should make Medicaid expansion budget neutral to the state SGF. See Section 17 on monitoring any cost shifting.

Legislature will monitor any cost shifting to commercial insurance.

Discussion on possible amendments

With 22 sponsors on the bill I respectfully request that any committee amendments regarding policy be held off for floor debate with possible exception of amending abortion language contained in HB2066 in committee.

The Hyde Amendment was enacted by Congress and is current law, which restricts using federal funds for abortion. To insure that SB252 prohibits program coverage or reimbursement for any abortion services that amendment should be put on either in committee or on the floor. I am pro-life and going the extra mile to ensure that no funds can be used for abortion is always worthwhile.

I ask that no amendment be offered in Committee regarding religious freedom aka conscience objection. Such an amendment will be viewed as a type of discrimination. I will not be able to support such an amendment.

Adding a hard count work requirement will only delay the process and result in a waste of money on programming and attorney fees once the courts block it. Again, at this point in time not a single state has a functioning work requirement for Medicaid eligibility. Either the work requirement has been denied by CMS, struck down by the courts, and/or have been deemed too expensive by states to implement.

The Senate's pathway to employment policy will be much more effective in getting people the resources needed and matched up with employers needing employees. The foundation of the pathway to work has many of the elements of Nebraska's recently proposed work requirement. In order to make an informed decision on what is needed to find work for the unemployed receiving Medicaid benefits we need analytics to base our plan on. The work assessment questionnaire must be completed by everyone applying for coverage. The analytics produced from the work assessment questionnaire will give us the data that we need to make a more work ready population. Lastly, if outcomes data from the work assessment questionnaire shows that able bodied adults are avoiding employment opportunities, we can adjust our model and seek a strident work requirement with the outcomes data to back it up.

Thank you for your attention. I'm ready to take questions at the appropriate time.

Sincerely,

Senator Jim Denning
Senate Majority Leader

KANSAS OFFICE of
REVISOR of STATUTES
LEGISLATURE of THE STATE of KANSAS
Legislative Attorneys transforming ideas into legislation.

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MEMORANDUM

To:	Senator Jim Denning
From:	Scott Abbott, Assistant Revisor of Statutes
Date:	January 9, 2020
Re:	Comparison of 2020 Senate Bill No. 252 to 2019 House Bill No. 2066, as amended by the House Committee of the Whole

The table beginning on page 2 of this memorandum compares provisions in 2020 Senate Bill No. 252 to 2019 House Bill No. 2066, as amended by the House Committee of the Whole, on an issue-by-issue basis. The table is organized according to the structure of SB 252.

The following provisions exist in substantially the same form in both SB 252 and HB 2066:

- Authority for KDHE to submit to the federal government any approval request necessary to implement the respective program (section 2(a) of SB 252 and section 6 of HB 2066);

- Exclusion from the work referral for full-time students enrolled in a postsecondary educational institution or technical college (section 3(c) of each);

- Redirection of revenues from privilege fees assessed on health maintenance organizations associated with expansion beneficiaries to a new special revenue fund to be used for medical assistance payments for expansion beneficiaries (section 10 of SB 252 and section 8 of HB 2066), including technical conforming amendments to K.S.A. 40-3213; and

- Requirements imposed on KDHE and the secretary of corrections to make annual reports to the legislature identifying costs and cost savings (sections 10 through 12 of SB 252 and sections 9 through 11 of HB 2066).

Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State

Published: January 16, 2020 by the Kaiser Family Foundation (KFF)

SOURCE: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

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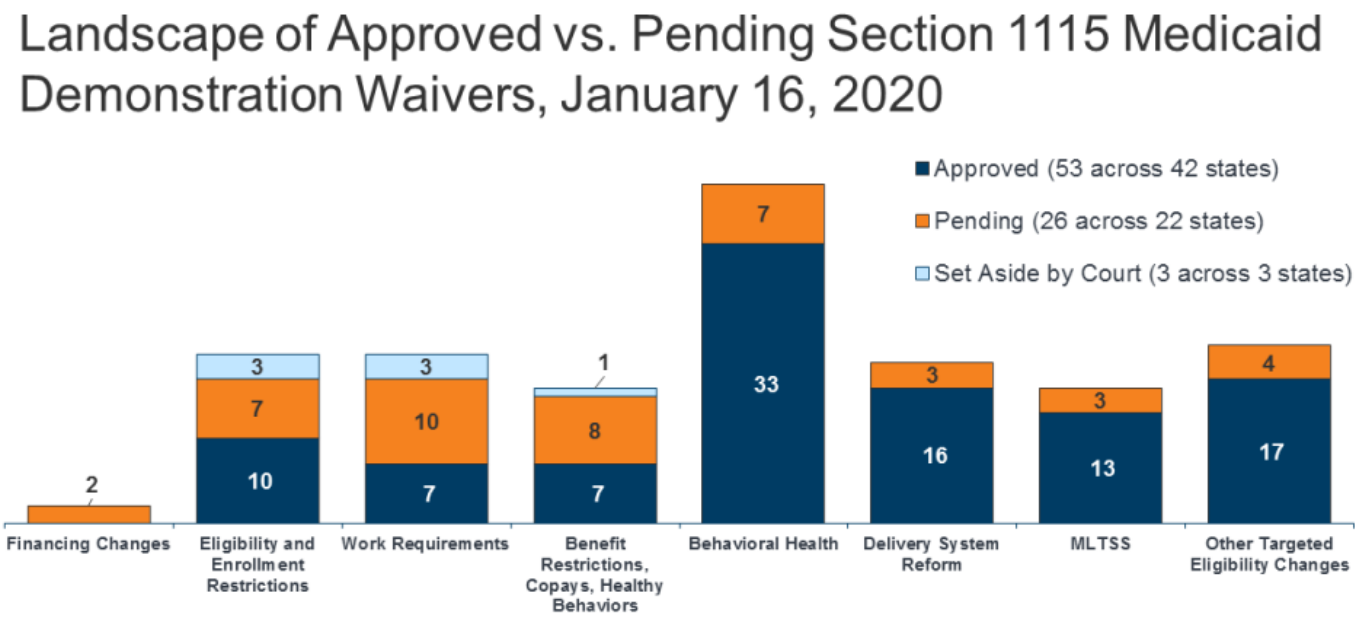

NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page.
"MLTSS" = Managed long-term services and supports.

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Senator Jim Denning, Majority Leader

Work Requirement Waivers: Approved and Pending as of January 16, 2020 (TABLE 1)

State	Waiver Status	Expansion Adults	Traditional Adults	Age Exemptions	Hours Required
AL	Pending		X (parents 0-18% FPL)	60+	35/week (or 20/week for parents or caretakers with a child under age 6)
AZ	Approved/Not Implemented [1]	X		50+	80/month
AR	Set Aside by Court [2]	X		50+	80/month
GA	Pending [3]		X (parents and childless adults 50-100% FPL)	65+	80/month
ID	Pending	X		60+	20/week average
IN	Approved/Implemented [4]	X	X	60+	Ramps up to 20/week
KY	Set Aside by Court [5]	X	X	65+	80/month
MI	Approved/Implemented [6]	X		63+	80/month
MS	Pending [7]		X (parents 0-27% FPL)	65+	20/week
MT	Pending	X		>55	80/month
NE	Pending [8]	X		60+	80/month
NH	Set Aside by Court [9]	X		65+	100/month
OH	Approved/Not Implemented	X		50+	80/month
OK	Pending		X (parents 0-45% FPL)	>50	Ramps up to 20/week
SC	Approved/Not Implemented [10]		X (parents 0-100% FPL and certain targeted adults)	65+	80/month (quarterly average)
SD	Pending [11]		X (parents 0-50% FPL, in Minnehaha or Pennington County)	60+	80/month or achieve monthly milestones in individualized plan
TN	Pending		X (parents 0-98% FPL)	65+	20/week average
UT	Approved/Not Implemented	X		60+	No ""hour"" requirement; specified job search/training activities required unless working 30/week
VA	Pending	X	X	65+	Ramps up to 80/month
WI	Approved/Not Implemented		X (childless adults 0-100% FPL)	50+	80/month

SOURCES: KFF analysis of approved and pending waiver applications posted on Medicaid.gov.

NOTES (TABLE 1)

- Populations, exemptions, penalties or consequences, and other details vary significantly by waiver.
- **ME:** On December 21, 2018, CMS approved a Section 1115 waiver for Maine that included a work requirement and other eligibility restrictions. On January 22, 2019, the new Gov Janet Mills informed CMS that the state is not accepting the terms of the approved waiver.
- For the Traditional Adults group, other groups such as Transitional Medical Assistance (TMA), family planning only, or former foster care youth, may be included in some states.

FOOTNOTES (TABLE 1)

1. Arizona requested an exemption from the work requirement for all American Indian/Alaska Native beneficiaries. CMS approved a narrower exemption for only beneficiaries who are members of federally recognized tribes. On October 17, 2019, Arizona announced its decision to postpone implementation of its work requirement until further notice, noting an evolving national landscape concerning Medicaid community engagement programs and ongoing litigation.

2. On March 27, 2019, the court set aside the Arkansas Works waiver amendment, approved by CMS March 5, 2018. Implementation of the work requirement and the reduction of retroactive eligibility from 3 months to 30 days prior to the date of application coverage is stopped unless and until HHS issues a new approval that passes legal muster or prevails on appeal.

3. GA's proposed work requirement applies to parent/caretaker relative (P/CR) and childless adult enrollees 50-100% FPL. Compliance with the work requirement must be established at the time of enrollment. Unlike other states with work requirements, Georgia is not offering exemptions to the requirement other than good cause exceptions.

4. While Indiana began implementation of the work requirement in 2019, no hours are required in the first 6 months. The phase-in of required hours begins in months 7-9 with a requirement of 5 hours per week. On July 25, 2019, IN submitted a request to amend its work requirement exemptions, adding an exemption for members of federally recognized tribes enrolled in managed care and changing the caretakers of dependent children exemption from those caring for dependents under age 7 to those caring for dependents under age 13. On October 31, 2019, the Indiana Family and Social Services Administration announced it will temporarily suspend the enforcement of its work requirement, which was scheduled to begin January 2019, due to a pending legal challenge. The state notes no benefits suspensions will be considered until after *Rose v. Azar* is decided.

5. On March 27, 2019, the court set aside the reapproved Kentucky HEALTH waiver. In its previous decision, the court had set aside the original waiver approval, and on November 20, 2018, CMS reapproved the Kentucky HEALTH waiver with minor technical changes. Unless and until HHS issues another approval that passes legal muster or prevails on appeal, the work requirement, monthly premiums up to 4% of income, coverage lockouts for failure to timely renew eligibility or timely report a change in circumstances, heightened cost-sharing for non-emergency ER use, and elimination of retroactive eligibility and non-emergency medical transportation will not be implemented. The separate "institution for mental disease" substance use disorder payment waiver was not set aside and was allowed to go into effect.

6. A lawsuit filed in federal court on November 22, 2019, challenges CMS approval of Michigan's waiver that authorizes the work requirement and other provisions, including coverage loss related to premium nonpayment and failure to complete healthy behaviors. While the work requirement is scheduled to take effect on January 1, 2020, Michigan's new Gov announced a delay in implementation of the new healthy behavior and premium requirements until October 1, 2020.

7. For non-exempt parents or caretakers whose incomes exceed the eligibility threshold as a result of meeting the work requirement, but who continue to fulfill the requirement, Mississippi would extend Medicaid coverage for a 12-month transitional medical assistance period. These beneficiaries would then qualify for an additional 12 months of coverage contingent upon continued work/community engagement participation.

8. NE is proposing to implement Medicaid expansion through a tiered benefit structure (with a "Basic" benefit package and a "Prime" package). To access "Prime" benefits (which would include "Basic" benefits plus vision, dental, and over-the-counter medication), expansion enrollees must meet certain wellness and “personal responsibility” requirements as well as work/community engagement requirements beginning in year 2 of the demonstration. Non-participation in these activities would not affect eligibility, only benefit tier.

9. On July 29, 2019, the court set aside the Granite Advantage Health Care Program demonstration, approved by CMS on Nov. 30, 2018. Implementation of the work requirement and the elimination of retroactive eligibility is stopped unless and until HHS issues a new approval that passes legal muster or prevails on appeal. Previously, on July 8, 2019, NH enacted legislation that allowed for the suspension of the work requirement’s implementation up to but not after July 1, 2021, and suspended the work requirement through Sept. 30, 2019.

10. SC's work requirement applies to traditional parent/caretaker relative (P/CR) enrollees up to 100% FPL, TMA enrollees, and a newly established Targeted Adult Group (See Aggregate Pending Table for more detail). For all groups, compliance with the work requirement must be established at the time of enrollment, barring exemption.

11. For non-exempt parents or caretakers whose incomes exceed the eligibility threshold as a result of meeting the work requirement, but who continue to fulfill the requirement, South Dakota would extend Medicaid coverage for a 12-month transitional medical benefits (TMB) period. These beneficiaries would then qualify for an additional 12 months of premium assistance (limited to no more than the previous year’s TMB per member per month amount) to pay for employer-sponsored insurance or qualified health plan premiums. Beneficiaries would be responsible for cost sharing and any premium costs exceeding the TMB amount during the premium assistance period.

Issue	**2020 SB 252**	**2019 HB 2066 HCoW**
Legislative notice	Sec. 2(a): At least 10 days prior to submission of any waiver request to the federal government, the Department of Health and Environment or the Insurance Department shall submit such waiver request to the State Finance Council.	No equivalent provisions.
Eligibility	Sec. 2(b) and (c): "Any adult under 65 years of age who is not pregnant and whose income meets the limitation…" with two scenarios: 1. Up to 138% of the federal poverty level beginning on 1-1-2021; and 2. up to 100% of the federal poverty level beginning on 1-1-2022, if the state finance council and the federal government approve implementation of a health insurance plan reinsurance program. If the reinsurance program is not approved, eligibility remains at 138%.	Sec. 2: "Any adult under 65 years of age who is not pregnant and whose income does not exceed 133% of the federal poverty level[.]"
Work referral	Sec. 3: The Department of Health and Environment (KDHE) refers all non-disabled adults in the program who are unemployed or working fewer than 20 hours per week to the Kansasworks program administered by the Department of Commerce. As a condition of coverage, KDHE evaluates each new applicant for education and employment status and factors impacting the applicant's employment status. The Department of Commerce maintains a unique identifier to monitor Medicaid expansion Kansasworks participants.	Sec. 3: As a condition of coverage, KDHE refers the same adults to the state's existing workforce programs, including, but not limited to, Kansasworks or K-GOAL administered by the Kansas Department for Children and Families.

Premiums or fees	Sec. 4: KDHE charges to each covered individual whose income is greater than 100% FPL a $25 monthly fee, up to $100 per family household. No fee is charged to a covered individual whose income is 100% FPL or less. Past due premiums are subject to setoff against state lottery or gaming winnings and tax refunds in accordance with current Kansas law. KDHE may require MCOs to collect the fee in lieu of KDHE. KDHE submits to the legislature an annual report in January detailing accounts receivable for fees collected in the prior calendar year.	Sec. 14: KDHE charges to each covered individual a $25 monthly fee, up to $100 per family household. An individual's coverage is suspended for three months following three consecutive months of nonpayment. An individual may apply for reinstatement once but shall be permanently suspended following an additional three months of nonpayment.
Premium assistance	Sec. 5: KDHE may establish a premium assistance program for individuals whose household income does not exceed 138% FPL and who are eligible for coverage through an employer but cannot afford premiums. Eligibility would be the same as for expanded Medicaid coverage. An individual's premiums would be capped at 2% of the individual's household income.	Sec. 4: Same, except that an individual qualifies if household income does not exceed 138% FPL **or** is eligible for coverage through an employer but cannot afford premiums.
Managed care	Sec. 6: Except as prohibited by federal law, requires that KDHE administer Medicaid using a managed care delivery system. Requires KDHE, when evaluating contract proposals to provide managed care services, to: 1) Not provide favorable or unfavorable treatment based on for-profit or not-for-profit status; 2) Give preference to an entity that provides health insurance plans on the marketplace; and 3) Require the entity to provide tiered benefit plans with enhanced benefits for beneficiaries who demonstrate healthy behaviors.	No equivalent provisions.

"Poison pill"	Sec. 7: Requires KDHE to terminate coverage under the program over 12 months if the federal medical assistance percentage (FMAP) becomes lower than 90%, as provided in current federal law. Specifies that there shall be no new enrollment following a decrease in FMAP.	Sec. 13: Same, except no specific mention of new enrollment following a decrease in FMAP.
Severability	Sec. 8: The "poison pill" provision is nonseverable from the remainder of the bill. All other provisions are severable.	Sec. 5: All provisions are severable.
Inmate coverage	Sec. 11(a): Requires the secretary of corrections to coordinate with county sheriffs to facilitate enrollment of an inmate incarcerated in a Kansas jail for state medicaid services during any time period that the inmate is eligible (offsite hospitalization for longer than 24 hours).	No equivalent provisions.
Audit	Sec. 13: Requires the legislative post audit committee to direct the legislative division of post audit to conduct an audit of the direct economic impact of the program on the state general fund during the first two fiscal years of the program, and requires LPA to submit the audit to the legislature.	No equivalent provisions.
Drug rebate revenue	Sec. 14: Requires KDHE to remit all Medicaid drug rebate revenue (including current Medicaid population) for deposit into the state general fund, and for such revenue to be included as a separate item on any monthly state general fund receipts report prepared by the Kansas Legislative Research Department or the Division of the Budget.	Sec. 7: Requires KDHE to remit all Medicaid expansion drug rebate revenue for deposit into a new special revenue fund administered by KDHE to be used for medical assistance payments for expansion beneficiaries.

FMAP stabilization fund	Sec. 15: Includes the provisions of 2019 Senate Bill No. 2. Creates the FMAP stabilization fund. Increases to state share of Medicaid costs, due to a year-to-year decreases in the FMAP, would be funded out of the FMAP stabilization fund. Decreases to state share of Medicaid costs, due to a year-to-year increase in the FMAP, would be deposited into the FMAP stabilization fund. Directs that any moneys recovered by the Attorney General in the case *Texas v. United States*, challenging the legal validity of the health insurance providers fee imposed under the federal Patient Protection and Affordable Care Act, be deposited into the FMAP stabilization fund.	No equivalent provisions.
Rural hospital transformation program	Sec. 16: Requires KDHE to establish an advisory committee comprised of public and private stakeholders for the purpose of developing and implementing transformation plans to improve the viability of eligible rural hospitals.	No equivalent provisions.
Report on cost shifting	Sec. 17: Requires the Kansas Insurance Department (KID) to analyze and prepare a report detailing any cost shifting from hospitals to commercial health insurance plans as a result of implementation of the act, and to submit the report annually to the House and Senate health committees.	No equivalent provisions.
Report on health exchange conversion	Secs. 18 and 20(a)(1) (appropriations): Requires KID to study and prepare a report on any risks and benefits associated with converting the health benefit exchange in Kansas from a federal facilitated health exchange to a state-based health benefit exchange, to procure a contractor to conduct the study, and to submit the report to the House and Senate health committees on or before January 11, 2021.	No equivalent provisions.

Report on uncompensated care	Sec. 19: Requires KDHE, in coordination with public and private stakeholders, to establish a task force for the purpose of developing a plan to measure and report uncompensated care provided by Kansas healthcare providers and hospitals, including historical data, and to submit such report annually to the House and Senate health committees.	No equivalent provisions.
Reinsurance program waiver	Sec. 20(a)(2): Requires KID to: 1. Prepare a waiver under section 1332 of the federal patient protection and affordable care act to implement a reinsurance program for health insurance plans; 2. procure the services of an experienced contractor to assist in developing such waiver; 3. develop the waiver in coordination with KDHE to offset potential costs associated with Medicaid expansion; 4. determine the extent to which a $35M annual appropriation for reinsurance would decrease health insurance premiums in Kansas; and 5. within 150 days, submit the waiver request and supporting actuarial analysis to the state finance council for approval.	No equivalent provisions.
"Institutions for mental disease exclusion"	Sec. 21: Requires KDHE to submit a waiver to CMS prior to 1-1-2021 to allow for medicaid reimbursement for inpatient psychiatric acute care and nullifies a previous budget proviso with a conflicting deadline.	No equivalent provisions.
State Finance Council involvement	Sec. 22: Appropriates $35M to the State Finance Council in fiscal year 2022 for the health insurance plan reinsurance program and directs the Council to approve or deny the proposed reinsurance program prior to submission of the associated waiver to CMS.	No equivalent provisions.
Bethell Joint Committee review	Sec. 23: During calendar years 2021 and 2022, adds one additional day to each quarterly meeting of the committee and directs the committee to monitor the implementation of the act.	No equivalent provisions.

Hospital surcharge	Secs. 25 through 32: Requires KDHE to impose a new surcharge on each hospital provider in an amount necessary to generate, in the aggregate, $35M per fiscal year. Surcharge revenues would be used to offset costs related to medicaid expansion beneficiaries.	No equivalent provisions.
Working group	No equivalent provisions.	Sec. 12: Establishes a working group to identify non-state general fund sources to fund any shortfall in the program, comprised of legislator members and members from various stakeholder organizations.
Abortion coverage	No equivalent provisions.	Sec. 15: Prohibits program coverage or reimbursement for any abortion services.