

**Report of the  
Senate Select Committee on  
Healthcare Access  
to the  
2019 Special Committee on  
Medicaid Expansion**

**CHAIRPERSON:** Senator Gene Suellentrop

**VICE-CHAIRPERSON:** Senator Ed Berger

**OTHER MEMBERS:** Senators Molly Baumgardner, Rick Billinger, Jim Denning, Bud Estes, Anthony Hensley, Dan Kerschen, Ty Masterson, Pat Pettey, Mary Pilcher-Cook, and Mary Jo Taylor

**STUDY TOPIC**

- Consider solutions to improve access to healthcare in Kansas and report the information to the Special Committee on Medicaid Expansion.

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# Senate Select Committee on Healthcare Access

## **Summary of Conclusions:**

The Senate Select Committee on Healthcare Access proposes bill draft 20rs1873 be revised to clarify the premium charged to covered individuals whose income is greater than 100 percent of the federal poverty level would be equal to 5.0 percent of modified adjusted gross income assessed on an individual basis, but the aggregate share cannot exceed 5.0 percent of the modified adjusted gross income of the household, and the revised bill be provided to the members of the Senate Select Committee on Healthcare Access and the Special Committee on Medicaid Expansion.

The Select Committee requests the Office of Revisor of Statutes prepare two memorandums to be delivered to the Special Committee on Medicaid Expansion that compare bill draft 20rs1873, as revised, to pending legislation specified in this report.

To the extent possible under the law, the Select Committee requests and encourages the Kansas Insurance Department to begin work on a Section 1332 waiver.

If the Select Committee is authorized to continue working on 20rs1873, as revised, it is recommended the bill be introduced on the first day possible and referred to the Senate Select Committee on Healthcare Access, and if the Select Committee is not authorized to continue, then the revised bill draft be introduced on the first day possible and referred to the Senate Committee on Public Health and Welfare.

The Select Committee requests the Kansas Department for Aging and Disability Services provide testimony to the committee that hears bill draft 20rs1873, as revised, and to apply for a waiver *via* statute on the Institutions for Mental Disease (IMD) exclusion recommended by the Task Force on Mental Health and also use the guidelines the Centers for Medicare and Medicaid Services (CMS) published in their November 1, 2017, letter to state Medicaid directors on that subject that integrated crisis stabilization centers into the IMD exclusion.

The Select Committee requests the Kansas Hospital Association (KHA) develop transparency plans as specified in this report.

The Select Committee requests the Kansas Department of Commerce to initiate a rural health care task force as outlined in this report.

The Select Committee requests KHA work with the University of Kansas Health System to evaluate applying to CMS for a demonstration project for a modified rural health delivery system.

The Select Committee recommends the Kansas Congressional delegation be asked to improve the fiscal health and modify the delivery system of rural hospitals and providers.

***Proposed Legislation:*** Bill draft 20rs1873, as revised.

## BACKGROUND

On May 29, 2019, the Senate President announced the creation of the Senate Select Committee on Healthcare Access (Select Committee), charging it to consider solutions to improve access to healthcare in Kansas and report the information to the Special Committee on Medicaid Expansion. The Select Committee was authorized two meeting days.

## COMMITTEE ACTIVITIES

The Select Committee met on October 22 and 23, 2019.

### **Overview of Current Medicaid Program, Populations Covered, Numbers Served, and Expenditures, including Inmate Coverage Both during and after Incarceration**

The State Medicaid Director, Kansas Department of Health and Environment (KDHE), provided an overview of the current Medicaid program, financial estimates on expansion, and waivers.

KDHE maintains the State Plan and has accountability for the Section 1115 waiver. Within federal guidelines and as authorized by state law, KDHE sets the guidelines and eligibility policy for people to apply for Medicaid. KDHE contracts for the Medicaid Management Information System and the Kansas Eligibility and Enforcement System. Three managed care organizations (MCOs) oversee the delivery and payment of healthcare services. KDHE is the primary contact with the federal Centers for Medicare and Medicaid Services (CMS).

Generally, a Medicaid application must be filed, an applicant must be able to act on his or her own behalf (at least 18 years old or a guardian and/or conservator has to apply), either a U.S. citizen or eligible non-citizen, and a resident of Kansas. The applicant must provide all needed information and cooperate with the application process. All persons residing in the household must be included on the application. Financial requirements may vary, depending on which population category one is classified. If the

information has not been received within the statutory guideline of generally 45 days, the process starts over; however, the statutory guideline may be paused under specific circumstances. Requiring the application process to start over is the exception and not the rule because KDHE reaches out to applicants to complete the missing information.

A state's Medicaid expansion plan must include coverage for ambulatory patient services, emergency services, hospitalization, pregnancy, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive services, and pediatric services.

In Kansas, the applicant must be a resident of the state. Kansas does not provide a Medicaid option for childless adults, regardless of income. Non-pregnant parents and caretakers are eligible for KanCare (the Medicaid managed care program in Kansas) when their income is at or below 38 percent of the federal poverty level (FPL). Since the Federal Health Insurance Exchange does not provide subsidies until one is at 100 percent of FPL, there is a coverage gap in Kansas for those between 38 percent and 100 percent of FPL. Eligibility is granted on an annual basis.

The State Medicaid Director reviewed the process for covering inmates both during and after release. This included releases from prisons, state hospitals, and county jails and discharges from mental health institutions.

**Fiscal assumptions.** The fiscal impact of one Medicaid expansion bill (2019 HB 2066) assumes:

- 150,000 newly eligible members would equate to a 36 percent increase in the total population, which would be in line with the national average (35 percent) but more than states that have most recently expanded (22 percent). KDHE estimates approximately 80,000 potential members;
- \$625 per member per month (PMPM) capitation payment;

- Offsets, including privilege fees and incremental drug rebates, to reduce the total cost. Also, the Department of Corrections (DOC) would be able to access additional federal funds for the expansion population, resulting in savings; and
- Straight Medicaid expansion, with no additional layers placed on top of the program.

The initial cost for expansion would be approximately \$1.1 billion. After all offsets, the net cost to the State would be approximately \$34.0 million to \$35.0 million. The estimate does not account for savings that could be realized by DOC. Since July 1, 2012, KDHE and DOC have used Medicaid funding to pay for inpatient services when an inmate is in a hospital for more than 24 hours. The inmate must meet all required eligibility criteria and have a qualifying event. Many cases today require presumptive disability determination, but that need would diminish under expansion. Both agencies have dedicated staff to work on these cases.

There is no estimate for secondary economic benefits. If premiums are assessed to the expansion population, states are required to transfer 90 percent of the premiums to the federal government.

The State Medicaid Director also provided a list of guardrails from CMS on proposals that would not be approved based on policy or legal grounds. A financial estimate of “partial” Medicaid expansion was also provided.

### **Medicaid Waivers: Types, Populations and Services Covered, Submission and Approval Process, and Length of Time to Institute**

The State Medicaid Director, KDHE, and a representative from the Kansas Health Institute reviewed Medicaid and other waivers:

- Section 1115 waivers must demonstrate budget neutrality—federal spending cannot exceed what would have been spent in the absence of the waiver. In

KanCare, the waiver is used to mandate most populations enroll in a managed care plan;

- Section 1915(c) or HCBS (Home Community Based Services) waivers must be cost neutral—per capita costs do not exceed average cost of institutional settings. The waivers are used to target services to specific populations; and
- Section 1332 waivers are not considered Medicaid waivers, as they are in a different section of the Affordable Care Act, and have different approval/authority paths than Medicaid waivers. This section of the Affordable Care Act grants no authority to waive anything in Title XIX (Medicaid).

KanCare operates under a comprehensive Section 1115 waiver, which is approved through December 31, 2023. Each of the Section 1915(c) waivers is under the Section 1115 umbrella. These are the HCBS waivers administered by the Kansas Department for Aging and Disability Services (KDADS). Most beneficiaries are required under the waiver to receive all their services through managed care plans. MCOs manage HCBS waiver services along with physical and behavioral health services. More than 100 special terms and conditions (STCs) must be monitored, and quarterly reporting for financial performance and other measures is required.

Straight expansion could be implemented under an amendment to the State’s current waiver, which would include the expansion population and updated calculations showing budget neutrality. Additional layers added to the expansion plan would be handled one of two ways, with the path to approval ultimately determined by CMS. Amendment to the current waiver, including updating budget neutrality, does not require the assistance of a consultant, other than KDHE’s current actuarial vendor. If CMS deems changes to be substantial, they could deem this a new demonstration, which would require a new waiver application and the assistance of a consultant, as well as adding time to the process.

A Medicaid Section 1115 waiver application or amendment cannot assume any potential impact from a Section 1332 waiver submission.

#### **Approval timeline for Section 1115 waivers.**

A State intending to amend the provisions of a current waiver must give 120 days' notice to CMS. If a waiver is amended, a State would likely not be required to hold multiple public meetings, though the waiver and corresponding State Plan Amendment would be posted for public comment. The current actuarial vendor for KDHE would recalculate budget neutrality, incorporating new eligibility groups.

New waiver applications have additional CMS requirements, which would likely involve hiring a consultant to assist with the process. For reference, the current KanCare waiver renewal application took approximately 22 months to complete.

#### **State Innovation (Section 1332) Waivers**

According to the State Medicaid Director, most states have used 1332 waivers for reinsurance on the insurance exchange. Nearly every state grants authority to a state insurance agency to file and administer the waiver. Generally when granted, this waiver leverages federal savings, which are then passed through to fund program. There are four guardrails to be met in order for the waiver to be deemed complete. Coverage must be as comprehensive as coverage would be absent the waiver. Coverage must be affordable. The scope of coverage must be provided to a comparable number of residents, and there cannot be an increase in the federal deficit.

When calculating budget neutrality for either waiver, the assumptions of the base and waiver must be separate and distinct.

A representative of the Kansas Health Institute provided an overview of State Innovation (Section 1332) waivers. Section 1332 of the Patient Protection and Affordable Care Act (ACA) allows states to apply to the Secretary of the U.S. Department of Health and Human Services (HHS) for a waiver to develop and implement state-specific approaches and strategies to health reform and coverage to provide citizens with access to affordable health care. States can either use

existing statutory authority to enforce the ACA and issue a regulation or executive order or enact a new state law to apply for and implement a waiver. However, states can simultaneously pursue legislative authority to pursue a waiver while developing and drafting a waiver application and actuarial analysis. Section 1332 waivers, once approved, may remain in effect for five years and can be extended. States that receive waivers may become eligible for federal pass-through funding to help implement waiver plans.

A state's application must demonstrate its proposed waiver plan will:

- Provide comprehensive coverage that is comparable to the coverage offered through the ACA;
- Ensure affordability by providing coverage and cost-sharing protection against excessive out-of-pocket spending;
- Provide coverage to at least a comparable number of residents as the ACA; and
- Ensure the waiver plan will not increase the federal deficit.

Through a waiver, certain provisions of the ACA and the Internal Revenue Code can be waived, such as establishing qualified health plans (QHPs), consumer choices and insurance competition through health insurance, premium tax credits and cost-sharing reductions for QHPs offered within the marketplace, and employer shared responsibility. Other provisions such as pre-existing condition protections, allowable premium rating factors, including age bands; guaranteed availability and renewability of health coverage; risk adjustment; and eligibility determinations under certain premium tax credits, cost sharing reductions, Medicaid, and the Children's Health Insurance Plan (CHIP) cannot be waived.

Concerning federal guidance to states, in March 2017, HHS issued a letter to all governors encouraging them to submit Section 1332 waiver applications to address cost and coverage issues in their individual health insurance markets. HHS

specifically encouraged states to consider implementing a high-risk pool or state-operated reinsurance program to lower marketplace premiums. In October and November 2018, HHS issued new guidance to states designed to give more flexibility in the design of Section 1332 waivers and now refers to them as State Relief and Empowerment waivers. States are encouraged to reach out to HHS for assistance in formulating an approach that meets the requirements of Section 1332. HHS also identified five principals for a high-performing health care system that will be considered when reviewing waiver applications and expressed that states should aim to provide increased access to affordable private market coverage, encourage sustainable spending growth, foster state innovation, support and empower those in need, and promote consumer-driven health care.

States can direct public subsidies into a defined-contribution, consumer-directed account that individuals may use to pay health insurance premiums or other health care expenses. States can create a new, state-administered subsidy program to meet the needs of its population. States could provide financial assistance for different types of health insurance plans, including non-QHPs, to potentially increase consumer choice of more affordable options. To give more flexibility to implement reinsurance or high-risk pool programs, states may waive the single-risk pool requirement.

If a state's waiver is approved and results in savings to the federal government for advance premium tax credits (APTCs) or small business tax credits, the state can receive those savings as pass-through funding and use them to help fund the cost of implementing the state waiver program.

APTCs are refundable tax credits designed to help eligible individuals and families with annual household incomes of at least 100 percent—but no more than 400 percent—of FPL (\$25,100 to \$100,400 for a family of four in 2019) to purchase insurance through health insurance marketplaces created under the ACA. When individuals and families enroll through the marketplace, they can choose to have the marketplace compute the estimated APTC that is paid to the insurance company to lower their monthly premiums. The amount of the APTC is generally equal to the premium for the second-lowest cost silver plan available through the marketplace that applies to

individuals enrolled in the plan, minus a certain percentage of their household income.

Federal regulations also authorize states to submit a single “coordinated waiver application” to the Secretary of HHS for a waiver under Section 1332 and under other existing waiver processes (e.g., Section 1115), which will be evaluated independently according to the applicable federal law.

To date, HHS has approved Section 1332 waivers for 13 states. Of the approved waivers, 12 were to establish state-based reinsurance programs. States that will be implementing reinsurance programs for plan year 2020 include Colorado, Delaware, Montana, North Dakota, and Rhode Island. States with approved waivers projected reductions in premiums ranging from 5.9 percent to 30.0 percent.

### **Individual Health Insurance Marketplace**

The Director of the Health and Life Division (Director), Kansas Insurance Department (KID), provided an overview of the individual health insurance marketplace in Kansas, covering the demographics and statistics of the insured and uninsured. The Director described the several ways persons can apply through the federally facilitated marketplace (FFM). In 2020, consumers shopping on the FFM in Kansas will have the opportunity to choose from 82 individual policies offered by five health insurance companies depending upon where they live. This is an increase of 59 plans over the 2019 number. Concerning categories of insurance plans, catastrophic plans must have actuarial values below 60 percent, meaning the plans will cover less than 60 percent of the expected cost. Bronze plans and expanded bronze plans have actuarial values of at least 60 percent. Silver plans have an actuarial value of at least 70 percent. Gold plans have an actuarial value of at least 80 percent, and platinum plans have an actuarial value of at least 90 percent.

The Director explained the APTCs, which is the tax credit based on the household information and income estimate included in a FFM application. The premium tax credit is only available through the FFM. If income or

household information changes, the premium tax credit will likely change as well. Of the 89,993 individuals who made plan selections as most recently reported, the average premium is \$661, and the average premium after the APTC is \$149. Of the 77,446 individuals receiving the APTC, the average credit received is \$596, and the average premium among consumers after the APTC is \$76.

The Cost Sharing Reduction (CSR), the Director explained, is a discount that lowers what an enrollee pays for their deductibles, coinsurance, and co-payments. The enrollee must purchase a Silver plan to receive the extra savings. Eligibility is determined during completion of a Marketplace application. If the enrollee qualifies for CSR, they also have a lower out-of-pocket maximum. People with incomes between 100 and 150 percent of FPL can enroll in a plan where the actuarial value is increased to 94 percent. People with incomes between 150 and 200 percent FPL can enroll in a plan where the actuarial value is increased to 87 percent. People with incomes between 200 and 250 percent FPL can enroll in a plan where the actuarial value is increased to 73 percent. A fourth variant is a zero cost-sharing plan that is available to certain Native Americans.

Open enrollment for plan year 2020 begins November 1, 2019, and ends December 15, 2019. Kansans may enroll in coverage, stay on their current policy (if available), or enroll in a different policy from the same company or a different company. Consumers currently enrolled in a QHP through the FFM may be eligible for automatic re-enrollment. Anyone wishing to have coverage effective January 1, 2020, must complete the application process by December 15, 2019. After December 15, 2019, the only way to obtain coverage is *via* a special enrollment period due to a qualifying event.

### **Medicaid Expansion Experience in Other States**

A representative of AdventHealth Mid-America Region reviewed Medicaid expansion experience in other states. The conferee reviewed data from Colorado, Illinois, and Kentucky showing the number of people covered by Medicaid or CHIP as of July 2018, the increase in the number of people covered by Medicaid or CHIP from Fall 2013 to July 2018, and the

reduction in the uninsured rate from 2013 to 2017. These three states have accepted federal Medicaid expansion.

### **Rural Hospitals**

Representatives of the University of Kansas Health Systems (UKHS) Care Collaborative provided testimony concerning rural hospitals, which included data on rural quality performance measures, chronic care management, and the impact on total cost of care. Access to health care is defined as having timely use of personal health services to achieve the best possible health outcome. Measuring access is a complex task when trying to include dimensions besides availability of services, such as quality, effectiveness, and efficiency.

Persons in Kansas who need care generally have lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists and sub-specialists, and limited job opportunities.

Rural health issues, which started in the 1990s, include an increase in age-adjusted mortality, disability, and chronic diseases. This is due to several causes, including obesity, cancer, heart disease, diabetes, injury-related deaths, and chronic conditions.

Studies demonstrate that insurance coverage impacts health and mortality outcomes, as well as reducing disparities. Providers need to consider “upstream” issues, such as reducing risk factors that lead to illness and chronic conditions and include social determinants of health. The “downstream” consequences of the lack of access can lead to more advanced stages of cancer, renal disease, or diabetes at the time of diagnosis, thus increasing costs and decreasing outcomes.

There are more than 170 rural health clinics, 100 safety net clinics, and 57 federally qualified health centers, that are required to provide care regardless of insurance coverage or ability to pay. Like critical access hospitals, the reimbursement models for some are cost-based. Additional payments are possible based on modeling that includes utilizing sliding-fee scales; certain services required, which are not likely to offset



reduced payments from volume; and rural population characteristics.

A representative of HaysMed discussed how Medicaid expansion would impact rural Kansas. While not the single solution to all the challenges that health care faces today, the representative stated it is one of the short-term solutions to be implemented as longer-term options are developed. More than 130,000 Kansans would benefit.

A representative from the Neosho Memorial Regional Medical Center shared comments concerning what it is like to live in Southeast Kansas where many of the residents work multiple part-time jobs and do not have access to affordable health insurance. The financial margins in rural hospitals in Kansas are thin. Additional funding would allow the Neosho facility to increase staff wages, purchase needed equipment to improve services, and address public health issues.

A representative from the Kansas Hospital Association indicated Kansas has the highest number of at-risk hospitals in the country. There is discussion about the possible creation of another model that will allow some flexibility for these challenged facilities, requiring Congress to change Medicare law. From the Legislature, support would be needed with rules and regulations concerning the definition of what it means to be a hospital. The conferee stated a literature review conducted by the Kaiser Family Foundation indicated Medicaid expansions result in reductions in uncompensated care costs for hospitals and clinics. A growing number of studies show an association between expansion and gains in employment as well as growth in the labor market (with a minority of studies showing neutral effects in this area). Most analyses that looked at rural and urban coverage changes find that Medicaid expansion has had a particularly large impact in rural areas. Research shows that Medicaid expansions result in reductions in uninsured medical visits and uncompensated care costs. Studies demonstrate that Medicaid expansion has significantly improved hospital operating margins and financial performance.

A representative of Navigant, a healthcare consultant firm, suggested a multi-step approach

to assess community health needs, strategic, and operational transformation opportunities in rural health. The factors that contribute to rural hospital success encompass more than just clinical services and reimbursement. Community-specific issues, such as out-migration, workforce availability, and employment, are critical to identifying effective approaches. The conferee shared information concerning the firm's work in Tennessee to assist with its Rural Hospital Transformation Program.

### **Health Insurance Exchange Experience, Lock-out Period, Social Determinants of Health, and Medicaid Plan Tiers**

A representative of Centene provided testimony on state innovation and Medicaid expansion as experienced by that company. Experience in other states suggests the expansion population may have different healthcare needs than traditional Medicaid population (*e.g.*, behavioral health needs) and unique opportunities for support through addressing social determinants of health (SDoH). Research shows enrollees may have complex needs, such as homelessness, mental illness, and substance abuse. Enrollees reported improved health, ability to work, and job seeking after receiving coverage. However, some enrollees faced persistent barriers to employment, such as poor health, disability, caregiving responsibilities, and older age. There is often "pent-up" demand in the first year of expansion with an increase in hospitalizations, which return to comparable rates of utilization as non-expanded states in the second year. There may be an opportunity to increase supply for primary care to improve access. Additionally, federally qualified health centers have greater financial stability in expansion states and could be used to promote access. The four areas of consideration with Medicaid expansion are eligibility, delivery system, program design, and implementation.

### **Workforce Development System**

The Director of Workforce Development, Kansas Department of Commerce, provided an overview of 11 various workforce services available in the state. Under the KANSASWORKS umbrella, businesses, job candidates, and educational institutions are linked to ensure employers can find skilled workers.

Employment services are provided to employers and job candidates through the state's 27 workforce centers, online or virtual services, and the mobile workforce center. The federally funded workforce development programs are delivered, in part, through local workforce centers. These employer-driven services include recruiting skilled workers, screening and assessing job candidates, and identifying individuals needing skill enhancement.

Universal access is granted to all employers and Kansans for labor exchange, labor recruitment, assessment, testing, and screening services. Qualified access to intensive training and related services is provided to eligible Kansans under the guidance and direction of a Local Workforce Development Board (LWDB). Specialized placement and job location assistance is available to targeted populations, such as veterans, those displaced from work because of foreign competition, and migrant and seasonal farm workers.

#### **Status and Stability of Tobacco Tax Collection, Impact of Increase in Tobacco Tax**

The Director of Research and Analysis, Kansas Department of Revenue (KDOR), provided testimony concerning the status and stability of tobacco tax collection and the impact of an increase in the tobacco tax. Kansas has three different excise taxes on tobacco or smoking products: cigarettes, other tobacco products, and consumable materials. The tax on cigarettes was enacted in 1927 and was last increased in 2015. As of July 1, 2015, the tax on cigarettes is \$1.29 for a pack of 20 cigarettes and \$1.61 for a pack of 25 cigarettes. The tax on the privilege of selling tobacco products was enacted in 1972 and is 10 percent of the wholesale price of the product. Tobacco products are generally defined as a variety of smoking and chewing tobaccos but exclude cigarettes. The tax on the privilege of selling electronic cigarettes was enacted in 2015 with the tax of \$0.05 per milliliter of consumable material imposed on July 1, 2017. Consumable material is defined to mean any liquid solution or other material that is depleted as an electronic cigarette is used.

KDOR estimated that if the price of a 20-pack of cigarettes increased by \$0.50, \$1.00, or \$1.50,

the additional revenue would be \$31.3 million, \$53.14 million, or \$66.66 million, respectively, in FY 2021. Assuming the tax on a 20-pack of cigarettes stayed at the current \$1.29, and the tax on milliliters (mls) increased to \$0.43/ml, \$0.65/ml, or \$1.29/ml, then the additional revenue from e-cigarettes would be \$7.9 million, \$12.42 million, or \$25.34 million, respectively, in FY 2021. Assuming the tax on a 20-pack of cigarettes increased by \$1.00 to \$2.29, and the ml tax increased to \$0.76/ml, \$1.15/ml, or \$2.29/ml, then the additional revenue from e-cigarettes would be \$14.67 million, \$22.55 million, or \$44.84 million, respectively, in FY 2021. The e-cigarette tax revenue would be estimated to increase in subsequent fiscal years while the revenues on cigarettes would be estimated to decrease.

#### **COMMITTEE RECOMMENDATIONS**

The Select Committee proposes bill draft 20rs1873 be revised to clarify the premium charged to covered individuals whose income is greater than 100 percent of the federal poverty level would be equal to 5 percent of modified adjusted gross income assessed on an individual basis, but the aggregate share cannot exceed 5 percent of the modified adjusted gross income of the household, and the revised bill draft reflecting the clarification be provided to the members of the Senate Select Committee on Healthcare Access.

The Select Committee recommends a copy of 20rs1873, as revised, be delivered to the Special Committee on Medicaid Expansion.

The Select Committee requests the Office of Revisor of Statutes to prepare two memorandums to be delivered to the Special Committee on Medicaid Expansion by comparing bill draft 20rs1873, as revised, to:

- 2019 HB 2066, as amended by the House Committee of the Whole, with clarification the 5.0 percent premium charge in the revised bill draft would not address the same group of persons as those who would be assessed the \$25 monthly fee in 2019 HB 2066; and
- 2019 SB 54.

To the extent possible under the law, the Select Committee requests and encourages the Kansas Insurance Department to begin work on a Section 1332 waiver and contract with an actuarial expert on Section 1332 waivers, without requiring approval from the Kansas Department of Administration to enter into a contract for such actuarial services, as timing is of the essence.

If the Select Committee is authorized to continue working on 20rs1873, as revised, it is recommended the bill be introduced on the first day possible and referred to the Senate Select Committee on Healthcare Access, and if the Select Committee is not authorized to continue, then the revised bill draft be introduced on the first day possible and referred to the Senate Committee on Public Health and Welfare.

The Select Committee requests the Kansas Department for Aging and Disability Services provide testimony to the committee that hears 20rs1873, as revised, and apply for a waiver *via* statute on the Institutions for Mental Disease (IMD) exclusion recommended by the Task Force on Mental Health and also use the guidelines CMS published in their November 1, 2017, letter to state Medicaid directors on that subject that integrated crisis stabilization centers into the IMD exclusion.

The Select Committee requests the Kansas Hospital Association (KHA) develop a transparency plan to analyze any current cost shifting to commercial insurance plans and a transparency plan to measure in detail uncompensated care (*e.g.*, charity, bad debt, in-kind donations) on an allowable, not a gross charge, perspective net of disproportionate share hospital (DSH) payments.

The Select Committee requests the Kansas Department of Commerce initiate a rural health care task force, in the vein of the model established in Tennessee, to investigate the health care issues in rural Kansas.

The Select Committee requests KHA work with the University of Kansas Health System to evaluate applying to CMS for a demonstration project for a modified rural health delivery system.

Pending the appropriate approval as per Legislative Leadership Council policy, a letter be sent from the Senate Select Committee on Healthcare Access to the Kansas Congressional delegation asking for their support of the efforts and help in the passage of legislation to improve the fiscal health and modify the delivery system of rural hospitals and providers.

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## Minority Report

As members of the Select Senate Committee on Healthcare Access, we are encouraged by the initial discussions about Medicaid expansion going into the 2020 session of the Kansas Legislature. However, we have concerns about many of the provisions in the *20rs1873* bill draft that was recommended by majority party members of the Committee.

We believe a Medicaid expansion bill must be simple and cost effective. The Committee bill is anything but that. It is significantly more complicated, more expensive, and needlessly adds more bureaucratic red tape than the plans offered by Governor Kelly or approved with bipartisan support in the Kansas House of Representatives.

The bill sets up a three-step process for submitting 1115 and 1332 waivers to the Centers for Medicare and Medicaid Services (CMS) for approval. The first two steps have been denied in other states by CMS this year. Specifically, after spending significant time and taxpayer money, both the Utah and Idaho waivers were rejected by CMS. After that rejection, those two states proceeded with full, straightforward Medicaid expansion. Kansas should follow their example.

Submitting waivers that we know CMS will deny creates a delay of implementation of the third step in the Committee bill – allowing for straightforward Medicaid expansion which we know CMS will approve. In addition, we are concerned that the Committee bill does not establish “a time certain” for the submission of a 1115 waiver to CMS.

The Committee bill provides, “*The insurance commissioner shall design the reinsurance program in coordination with the secretary of health and environment to offset any cost of the 1115 waiver...*” (New Sec. 2 (B), page 2). Both the 1115 waiver and 1332 waiver are required to be cost neutral on their own under federal law. We believe CMS will not permit us to co-mingle these waivers.

Reinsurance has nothing to do with Medicaid expansion and should not be included in any bill to expand Medicaid. This idea has never been considered previously by the Legislature in the six years Medicaid expansion has been discussed.

Establishing a reinsurance program is a costly, multi-year process.

In Colorado, for example, a reinsurance program *via* a 1332 waiver was discussed for three years after stakeholder meetings, actuarial analyses and certifications, economic analyses through the Insurance Department, time to draft a waiver and engage with CMS, a public comment period, time to engage their federal delegation, in addition to the 180-day application process itself. It is unrealistic to assume a reinsurance program can be successfully implemented in Kansas in less than a year.

<https://www.colorado.gov/pacific/dora/cms-approves-colorados-1332-waiver-reinsurance-program>

The first step for implementing a reinsurance program should be separate legislation to instruct the Kansas Insurance Department to conduct a feasibility study to determine if reinsurance would be cost effective for the Kansas insurance marketplace.

Establishing a reinsurance program will require a tax increase, which will be very controversial in an election year. We oppose including a tax increase in a Medicaid expansion bill when both the Governor and Kansas House of Representatives have offered proposals to expand Medicaid to 150,000 Kansans **without** a tax increase.

The Committee bill provides, *“The secretary of commerce shall coordinate with secretary of health and environment to certify to the secretary of health and environment each covered individual’s compliance with this section.”* (New Sec. 3a, page 4) Also: *“Such evaluation shall be a prerequisite for coverage under the act.”* (New Sec. 3b, page 5)

While we were led to believe the Committee bill has no work requirement, we believe this provision will create harmful barriers to healthcare access, similarly to an actual work requirement. Instead of simply utilizing the current KANSASWORKS program, it requires a verification process as a condition of eligibility. So, while the beneficiary may not be denied coverage if they cannot find work, the reporting/verification is what created problems in states like Kentucky and Arkansas. The Department of Commerce is very worried about the vague language and what will be required to “track” outcomes.

Another concern we have is the bill adds co-pays for non-urgent care. *“The secretary of health and environment shall submit...waiver or other approval request to assess each covered individual a copayment for each instance of non-urgent emergency care in an amount determined by the secretary of health and environment.”* (New Sec. 4b, page 6)

The burden for collecting copayments falls onto providers. Also, KDHE does not have a definition for “non-urgent emergency care.”

We believe the penalties for nonpayment of premiums are extremely punitive. They are among the highest and harshest in the nation (New Sec. 4c, page 6). Individuals become ineligible when: First coverage premium payment is not made; Delinquent in making payment by 60 days or more; Delinquent by more than 60 days triggers a 6-month lockout. The KDHE Secretary is given no discretion, so this may put sick people in jeopardy of losing their insurance when they need it the most.

Lockouts result in Kansans “flip-flopping” between being insured and not being insured. This has a negative impact on continuity of care and is detrimental to improving access to healthcare and health insurance. This makes it harder for managed care organizations (MCOs) to effectively manage and coordinate care and harder to measure the quality of care beneficiaries receive.

Multiple studies have found that regular and ongoing access to healthcare reduced preventable hospitalizations for individuals with chronic diseases. In addition, lockouts interfere with treatment for people with mental health and substance use disorders, where continuity of care is extremely important.

The Committee bill provides, *“In awarding any contract for an entity to administer state Medicaid services using a managed care delivery system, the secretary of health and environment shall: require that any entity administering state Medicaid services provide tiered benefit plans with enhanced benefits for individuals who demonstrate healthy behaviors as determined by the secretary of health and environment .”* (New Sec. 6b,3, pages 7-8)

Only Indiana and Nebraska have pursued tiered plans. This will be an expensive, complicated undertaking for the agency and especially for providers. It introduces implementation and on-going operational complexity, which results in additional administrative costs. The implementation costs related to system changes would require around 1,300 hours and cost about \$156,000 for the state system. Similar costs will also be incurred by each MCO. This is estimated to be around \$468,000. The ongoing administrative costs for this are unknown.

Tiered benefit plans could also be detrimental to the Medicaid network, as providers would likely begin denying Medicaid patients. There is no way for a provider to track a beneficiary’s plan.

The Committee bill includes a severability clause should the federal match fall below 90%. (New Sec. 7, page 8) It requires that coverage terminates beginning the first day that the FMAP falls below 90%, resulting in immediate loss of coverage. This is more punitive than the House legislation.

Our last concern is that the Committee bill provides, *“The secretary of corrections shall coordinate with county sheriffs to facilitate Medicaid coverage for any inmate incarcerated in a Kansas jail during any time period that the inmate is eligible for coverage.”* (New Sec. 12, page 11) It is unclear whether the Secretary even has jurisdiction to do this.

As evidenced by the experiences of those states who have already expanded Medicaid in a straightforward manner, we conclude that the Legislature, working together with Governor Kelly, should keep the Kansas plan to expand Medicaid simple and cost effective. That means removing the complicated, unnecessary, and proven unsuccessful provisions from the bill draft recommended by the Select Senate Committee on Healthcare Access. We believe doing so is the best way to ensure fiscal responsibility while also providing thousands of Kansans much needed access to affordable healthcare in a timely manner.

Senator Barbara Bollier  
Senator Anthony Hensley  
Senator Pat Pettey