Session of 2022

HOUSE BILL No. 2459

By Representative Coleman

12-15

AN ACT concerning insurance; relating to health insurance; enacting the Kansas health act; creating a universal single-payer guaranteed healthcare coverage program; pertaining to eligibility and enrollment, benefits, board of trustees, healthcare providers, care coordination, program standards, rules and regulations, retraining of impacted employees, advisory council and revenue proposal; establishing the Kansas health trust fund.

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

Section 1. (a) The provisions of sections 1 through 21, and amendments thereto, shall be known and may be cited as the Kansas health act.

(b) (1) The legislature finds and declares that all residents of the state have the right to healthcare. While the affordable care act brought many improvements in healthcare and healthcare coverage, it still leaves many Kansans without coverage or with inadequate coverage.

(2) Thousands of Kansans either do not get the healthcare they need or face financial obstacles and hardships to get it. Neither is acceptable. There is no plan other than the Kansas health act that will enable Kansans to meet their healthcare needs. Kansans, as individuals, employers and taxpayers, have experienced a rise in the cost of healthcare and healthcare coverage in recent years, including premiums, deductibles and copayments, costs arising from having restricted provider networks and already high out-of-network charges. Many Kansans live without healthcare because they cannot afford it or suffer financial hardship to get it.

(3) Businesses have also experienced increases in the costs of healthcare benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(4) Older adults and individuals with disabilities often cannot receive the services necessary to stay in the community or other long-term services and supports. Even when older adults and individuals with disabilities receive long-term services and supports, especially services in the community, it is often at the cost of unreasonable demands on unpaid family caregivers, depleting their own or family resources, or

impoverishing themselves to qualify for public coverage. Including long-term services and supports in Kansas health is a major step forward for older adults, individuals with disabilities and their families.

(5) Healthcare providers are also affected by inadequate health coverage in Kansas. A large number of hospitals, health centers and other providers now experience substantial losses due to the provision of care that is uncompensated. Individuals often find that they are deprived of affordable care and choice because of decisions by health plans guided by the plan's economic interests rather than the individual's healthcare needs.

(6) To address the fiscal crisis facing the healthcare system and the state and to ensure that Kansans can exercise their right to healthcare, affordable and comprehensive healthcare coverage must be provided. This legislation is an enactment of utmost state interest for the purpose of establishing a comprehensive universal guaranteed healthcare coverage program and a healthcare cost control system for the benefit of all residents of the state of Kansas.

(c) It is the intent of the legislature to create the Kansas health program, which shall provide a universal single-payer health plan for every Kansan, funded by broad-based revenue based on one's ability to pay. While the legislature intends that federal waivers and approvals be sought where they will improve the administration of the Kansas health program, the legislature intends that the program be implemented even in the absence of such waivers or approvals. The state shall work to obtain waivers and other approvals relating to medicaid, the children's health insurance program, medicare, the affordable care act and any other appropriate federal programs, under which federal funds and other subsidies that would otherwise be paid to the state of Kansas, Kansans and healthcare providers for healthcare coverage that will be equaled or exceeded by the Kansas health program will be paid by the federal government to the state and deposited in the Kansas health trust fund or paid to healthcare providers and individuals in combination with Kansas health trust fund payments, and for other program modifications, including elimination of cost sharing and insurance premiums. Under such waivers and approvals and to the maximum extent possible, healthcare coverage under such programs shall be replaced and merged into the Kansas health program, which shall operate as a true single-payer program.

(d) If any necessary waiver or approval is not obtained, the state shall use state plan amendments and seek waivers and approvals to maximize and make as seamless as possible the use of federally matched public health programs and federal health programs in the Kansas health program. Thus, although other programs such as medicaid or medicare may contribute to paying for care, it is the goal of this legislation that healthcare coverage be delivered by Kansas health and, as much as

possible, multiple sources of funding be pooled with other Kansas health funds.

(e) This program will promote movement away from fee-for-service payment, which tends to reward quantity and requires excessive administrative expense, and toward alternate payment methodologies, such as global or capitated payments to providers or healthcare organizations, that promote quality, efficiency, investment in primary and preventive care and innovation and integration in the organization of healthcare.

(f) The program shall promote the use of clinical data to improve the quality of healthcare and public health, consistent with the protection of patient confidentiality. The program shall maximize patient autonomy in choice of healthcare providers and healthcare decision making. Care coordination within the program shall ensure management and coordination among a patient's healthcare services, consistent with patient autonomy and person-centered service planning, rather than acting as a gatekeeper to needed services.

(g) This act shall not be construed to create any employment benefit, nor does it require, prohibit or limit the providing of any employment benefit.

(h) In order to promote improved quality of and access to healthcare services and promote improved clinical outcomes, it is the policy of the state to encourage cooperative, collaborative and integrative arrangements among healthcare providers who might otherwise be competitors, under the active supervision of the secretary of health and environment. It is the intent of the state to supplant competition with such arrangements and regulation only to the extent necessary to accomplish the purposes of this act and to provide state action immunity under the state and federal antitrust laws to healthcare providers, particularly with respect to their relations with the single-payer Kansas health plan created by this act.

(i) There have been numerous professional economic analyses of state and national single-payer health proposals by noted consulting firms and academic economists. They have almost all come to similar conclusions of net savings in the cost of health coverage and healthcare. These savings are driven by:

(1) Eliminating the administrative bureaucracy costs, marketing and profit of multiple health plans and replacing that with the dramatically lower costs of running a single-payer system;

(2) substantially reducing the administrative costs borne by healthcare providers dealing with those health plans; and

(3) using the negotiating power of over 2,000,000 consumers to achieve lower drug prices. These savings will more than offset costs primarily from:

(A) Relieving patients of deductibles, copayments and out-of-

network charges;

(B) covering the uninsured;

(C) increasing provider payment rates above medicare and medicaid rates; and

(D) replacing uncompensated home healthcare with paid care.

(j) Unlike premiums and out-of-pocket spending, the Kansas health act tax will be progressively graduated based on an individual's ability to pay. The vast majority of Kansans today spend dramatically more in premiums, deductibles and other out-of-pocket costs than they will in Kansas health act taxes. They will have broader coverage, including long-term care, no restricted provider networks or out-of-network charges and no deductibles or copayments.

Sec. 2. As used in the Kansas health act:

(a) "Act" means the Kansas health act;

(b) "affordable care act" means the federal patient protection and affordable care act, public law 111-148, and the health care and education reconciliation act of 2010, public law 111-152, as in effect on July 1, 2022;

(c) "board" means the board of trustees of the Kansas health program created by section 4, and amendments thereto;

(d) "care coordination" means, but is not limited to, managing, referring, locating, coordinating and monitoring healthcare services for the member to ensure that all medically necessary healthcare services are made available to and are effectively used by the member in a timely manner, consistent with patient autonomy. "Care coordination" does not include a requirement for prior authorization for healthcare services or for a referral for a member to receive healthcare services;

(e) "care coordinator" means an individual or entity approved to provide care coordination under section 8, and amendments thereto;

(f) "department" means the department of health and environment;

(g) "federally matched public health program" means medicaid and the state children's health insurance program, K.S.A. 38-2001 et seq., and amendments thereto;

(h) "healthcare organization" means an entity that is approved by the secretary under section 12, and amendments thereto;

(i) "healthcare provider" means any individual or entity legally authorized to provide healthcare services under medicaid, medicare or chapter 65 of the Kansas Statutes Annotated, and amendments thereto;

(j) "implementation period" means the period under section 3, and amendments thereto, during which the program is subject to special eligibility and financing provisions until the program is fully implemented pursuant to section 3, and amendments thereto;

(k) "Kansas health," "Kansas health program" and "program" mean the Kansas health program created by this act;

(l) "medicaid" means the Kansas medical assistance program established in accordance with title XIX of the federal social security act, 42 U.S.C. § 1396 et seq., and chapter 39 of the Kansas Statutes Annotated, and amendments thereto, including any medicaid waiver programs granted under section 1915 of the federal social security act;

(m) "medicare" means title XVIII of the federal social security act;

(n) "member" means an individual who is enrolled in the program;

(o) "non-payroll tax" means the tax on taxable income, including, but not limited to, interest, dividends and capital gains, not subject to the payroll tax;

(p) (1) "out-of-state healthcare service" means a healthcare service provided to a member while the member is temporarily out of the state and is:

(A) Medically necessary that such healthcare service be provided while the member is out of the state; or

(B) clinically appropriate that such healthcare service be provided by a particular healthcare provider located out of the state rather than in the state.

(2) "Out-of-state healthcare service" does not include any healthcare service provided to a Kansas health member by a healthcare provider qualified under section 7, and amendments thereto, that is located outside the state. Such healthcare service shall be covered as otherwise provided by this act;

(q) "participating provider" means any individual or entity that is a healthcare provider qualified under section 7, and amendments thereto, and that provides healthcare services to members under the program or a healthcare organization;

(r) "payroll tax" means the tax on payroll income and self-employed income subject to the medicare part A tax;

(s) "person" means any individual or natural person, trust, partnership, association, unincorporated association, corporation, company, limited liability company, proprietorship, joint venture, firm, joint stock association, department, agency, authority or other legal entity, whether for-profit, nonprofit or governmental;

(t) "resident" means an individual whose primary place of abode is in Kansas, who is employed or self-employed full time in Kansas, without regard to such individual's immigration status, as determined according to rules and regulations adopted by the secretary;

(u) "revenue proposal" means the revenue plan and legislative bills, as proposed and enacted under section 19, and amendments thereto, to provide the revenue necessary to finance the Kansas health program;

(v) "secretary" means the secretary of health and environment; and

(w) "tax" means the payroll tax or nonpayroll tax to be enacted under

the revenue proposal.

Sec. 3. (a) The Kansas health program is hereby created in the department. The secretary shall establish and implement the program pursuant to this act. The program shall provide comprehensive health coverage to every Kansas resident who enrolls in the program.

(b) To the maximum extent possible, the secretary shall organize, administer and market the program and services as a single program under the name "Kansas health" or such other name as the secretary shall determine, regardless of which law or source the definition of a benefit is found, including, on a voluntary basis, retiree health benefits. In implementing this act, the secretary shall avoid jeopardizing federal financial participation in such program and shall take care in promoting public understanding and awareness of available benefits and programs.

(c) The secretary shall determine when individuals may begin enrolling in the program. There shall be an implementation period beginning on the date that individuals may begin enrolling in the program and ending as determined by the secretary. Individuals shall not enroll in the Kansas health program until the legislature enacts the revenue proposal in section 19, and amendments thereto, and as the legislature shall further provide.

(d) (1) An insurer authorized to provide coverage pursuant to chapter 40 of the Kansas Statutes Annotated, and amendments thereto, may offer benefits that do not cover any service for which coverage is offered to individuals under the program, but shall not offer benefits that cover any service for which coverage is offered to individuals under the program.

(2) In accordance with paragraph (1), this subsection shall not prohibit the offering of:

(A) Any benefits to or for individuals, including such individual's family, who are employed or self-employed in the state but who are not residents of the state;

(B) benefits during the implementation period to individuals who enrolled or may enroll as members of the program; or

(C) retiree health benefits.

(e) A postsecondary educational institution, as defined in K.S.A. 74-3201b, and amendments thereto, may purchase coverage under the program for any student or student's dependent who is not a resident of this state.

(f) To the extent that any provision of chapters 38, 39, 40 and 65 of the Kansas Statutes Annotated, and amendments thereto, is inconsistent with any provision of this act, the provisions of this act shall control except where explicitly provided otherwise by this act or explicitly required by federal law or rules and regulations.

(g) (1) The provisions of K.S.A. 40-22a13 through 40-22a16, and

amendments thereto, shall not apply to the program, and the provisions of this section shall control.

(2) An external appeal shall not require utilization review or an adverse determination. When the program makes an adverse determination, an external appeal shall be automatic unless specifically waived or withdrawn by the member or the member's designee. Services, including services provided for a chronic condition, shall continue unchanged until the outcome of the external appeal decision is issued. When an external appeal is initiated or pursued by the member's healthcare provider, such provider shall notify the member or the member's designee, and such appeal shall be subject to the member's or member's designee's right to waive or withdraw. No fee shall be required to be paid by any party to an external appeal, including the member's healthcare provider.

(3) When an external appeal is denied, the external appeal agent shall notify the member or the member's designee and, where appropriate, the member's healthcare provider within two business days of the determination. The notice shall include a statement that the member, member's designee or healthcare provider has the right to appeal the determination to a fair hearing under this subsection and to seek judicial review.

(4) A member may designate a person or entity to serve as the member's designee for purposes of this subsection if the person or entity agrees to be such designee. The designee may include, but not be limited to, a member's family member, care coordinator, healthcare organization providing the service under review or appeal or a labor union or entity affiliated with and designated by a labor union of which the member or member's family member is a member.

(h) The secretary shall adopt rules and regulations as necessary to implement the provisions of this section, including rules and regulations to establish a process for fair hearings under this section. At a minimum, the process shall conform to the standards for fair hearings under the Kansas administrative procedure act.

(i) Nothing in this act shall preclude the use of a medicare managed care entity or other entity created by or under the direction of the program when reasonably necessary to maximize federal financial participation or other federal financial support under any federally matched public health program, medicare or the affordable care act. To the maximum extent feasible, any entity under this subsection shall operate in the background without burden on or interference with the member and the healthcare provider and shall not deprive the member or healthcare provider of any right or benefit under the program and otherwise consistent with this act.

Sec. 4. (a) There is hereby established the Kansas health board of trustees in the department. At the request of the secretary, the board of

trustees shall consider any matter to effectuate the provisions of this act and may advise the secretary thereon. From time to time, the board of trustees may submit to the secretary any recommendations to effectuate the provisions of this act.

(b) The secretary shall submit all proposed rules and regulations under this act for consideration by the board. The board shall either approve, amend and approve or reject such proposed rules and regulations. The secretary shall adopt such rules and regulations so approved or amended and approved by the board.

(c) The board shall be composed of:

(1) The secretary or the secretary's designee, as an ex officio member;

(2) the director of the budget or the director's designee, as an ex officio member; and

(3) 29 trustees appointed by the governor as follows:

(A) Six members who are representatives of healthcare consumer advocacy organizations that have a statewide or regional constituency and are involved in issues of interest to low-income and moderate-income individuals, older adults and individuals with disabilities, at least three of whom shall be representatives of organizations led by consumers in such groups;

(B) three members who are representatives of professional organizations representing physicians;

(C) three members who are representatives of professional organizations representing licensed or registered healthcare professionals other than physicians;

(D) three members who are representatives of general hospitals, one of whom shall be a representative of public general hospitals;

(E) one member representing community health centers;

(F) two members representing rehabilitation or home care providers;

(G) two members representing behavioral, mental health or disability service providers;

(H) two members representing healthcare organizations;

(I) three members representing organized labor; and

(J) two members who shall be employers or representatives of employers required to pay the payroll tax under this act or, prior to the tax becoming effective, will pay the tax;

(4) six members appointed by the speaker of the house of representatives;

(5) six members appointed by the president of the senate;

(6) two members appointed by the minority leader of the house of representatives; and

(7) two members appointed by the minority leader of the senate.

(c) After the end of the implementation period, no individual shall

serve as a trustee unless such individual is a member of the program.

(d) Each trustee shall serve at the pleasure of the appointing authority, except the trustees serving as ex officio trustees.

(e) The chairperson of the board shall be appointed by the governor from among the trustees and may be removed as chairperson by the governor.

(f) The board shall meet at least four times each calendar year. Meetings shall be held upon the call of the chairperson and as provided by the board. A majority of the appointed trustees shall be a quorum of the board. The affirmative vote of a majority of the trustees voting, but not fewer than 12, shall be necessary for any action taken by the board.

(g) The board may establish an executive committee to exercise any powers or duties of the board as the board may provide and other committees to assist the board or the executive committee. The chairperson of the board shall be the chairperson of the executive committee and shall appoint the chairperson and members of all other committees. The board may appoint one or more advisory committees. Members of such advisory committees need not be members of the board of trustees.

(h) Trustees shall serve without compensation, except that trustees shall be paid for such trustees' mileage and actual and necessary expenses incurred while performing the duties of the board as provided in K.S.A. 75-3223, and amendments thereto.

(i) Notwithstanding any provision of law to the contrary, no officer or employee of the state or any local government shall forfeit such officer's or employee's office or employment by reason of serving as a trustee.

(j) The board and the board's committees or advisory committees may request and receive the assistance of the department and any other state or local governmental entity in exercising the powers and duties of the board or any committee of the board.

(k) Not later than July 1, 2024, the board shall develop and present to the governor and the legislature proposals for:

(1) Incorporating retiree health benefits into Kansas health;

(2) accommodating employer retiree health benefits for individuals who have been members of Kansas health but live as retirees outside of the state;

(3) accommodating employer retiree health benefits for individuals who earned or accrued such benefits while residing in the state prior to the implementation of Kansas health and live as retirees outside of the state;

(4) Kansas health coverage of healthcare services covered under the workers compensation act, including whether and how to continue funding for such services under the workers compensation act and incorporate an element of experience rating;

(5) Kansas health coverage of healthcare services covered under personal injury protection benefits under the Kansas automobile reparations act, including whether and how to continue funding for such services; and

(6) integrating of United States department of veterans affairs health programs with Kansas health coverage of healthcare services, except that enrollment in or eligibility for United States department of veterans affairs health programs shall not affect an individual's eligibility for Kansas health coverage.

Sec. 5. (a) Every resident of this state shall be eligible and entitled to enroll as a member of the program.

(b) No individual shall be required to pay any premium or other charge for enrolling or being a member under the program.

(c) A newborn child shall be enrolled effective on the date of such child's birth if enrollment is done prior to such child's birth or within 60 days after such child's birth.

Sec. 6. (a) The program shall provide comprehensive health coverage to every member. Such comprehensive health coverage shall include all healthcare services required to be covered under any of the following, without regard to whether the member would otherwise be eligible for or covered by the program or source referred to:

(1) The state children's health insurance program, K.S.A. 38-2001 et seq., and amendments thereto;

(2) medicaid, including, but not limited to, services provided under medicaid waiver programs under section 1915 of the federal social security act;

(3) medicare;

(4) chapter 40 of the Kansas Statutes Annotated, and amendments thereto; and

(5) any additional healthcare service authorized to be added to the program's benefits by the program.

(b) No member shall be required to pay any premium, deductible, copayment or coinsurance under the program.

(c) The program shall provide for the payment for:

(1) Emergency and temporary healthcare services provided to a member or individual entitled to become a member who has not had a reasonable opportunity to become a member or to enroll with a care coordinator; and

(2) healthcare services provided in an emergency to an individual who is entitled to become a member or enrolled with a care coordinator, regardless of such individual having had an opportunity to do so.

Sec. 7. (a) Any healthcare provider qualified to participate under this section may provide healthcare services if the healthcare provider is

otherwise legally authorized to perform healthcare services for the individual under the circumstances involved.

(b) A member may choose to receive healthcare services under the program from any participating provider, consistent with the provisions of this act relating to care coordination and healthcare organizations. Such member choice shall be subject to the provisions of this act relating to discrimination, appropriate clinically relevant circumstances and the willingness or availability of the provider.

Sec. 8. (a) A care coordinator may be an individual or entity approved by the program that is:

(1) A healthcare provider who is:

(A) The member's primary care practitioner;

(B) the member's provider of primary gynecological care at the option of a female member; or

(C) a specialist healthcare provider who regularly and continually provides treatment to the member at the option of a member who has a chronic condition that requires specialty care;

(2) an entity licensed under chapter 65 of the Kansas Statutes Annotated, and amendments thereto, or other entity approved by the secretary;

(3) a healthcare organization;

(4) a labor union or an entity affiliated with and designated by a labor union of which the enrollee or enrollee's family member is a member, except that this provision shall not preclude such an entity from becoming a care coordinator under paragraph (5) or a healthcare organization under section 12, and amendments thereto; or

(5) any not-for-profit or governmental entity approved by the program.

(b) (1) Every member shall enroll with a care coordinator that agrees to provide care coordination to the member prior to receiving healthcare services to be paid under the program. Healthcare services provided to a member shall not be subject to payment under the program unless the member is enrolled with a care coordinator at the time the healthcare service is provided.

(2) This subsection shall not apply to emergency or temporary healthcare services provided under section 6, and amendments thereto.

(3) The member shall remain enrolled with such care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. A member has the right to change such member's care coordinator.

(c) The care coordinator shall provide care coordination to the member. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the

member, consistent with rules and regulations adopted by the secretary.

(d) A healthcare organization may establish rules relating to care coordination for members in such healthcare organization different from this section but otherwise consistent with this act and other applicable law.

(e) (1) The secretary shall adopt rules and regulations for an individual or entity to be approved as a care coordinator in the program, including, but not limited to, the revocation, suspension, limitation or annulment of approval when:

(A) The secretary determines that the individual or entity is not qualified or competent to be a care coordinator;

(B) the care coordinator exhibits a course of conduct that is inconsistent with such rules and regulations;

(C) the care coordinator exhibits an unwillingness to meet such rules and regulations; or

(D) the care coordinator is a potential threat to the public health or safety.

(2) Such rules and regulations shall not limit approval to be a care coordinator in the program for criteria other than those under this section and shall be consistent with good professional practice.

(3) In adopting such rules and regulations, the secretary shall:

(A) Consider existing standards developed by national accrediting and professional organizations; and

(B) consult with national and local organizations working on care coordination or similar models, including healthcare providers, hospitals, clinics and consumers and such consumers' representatives.

(4) When adopting rules and regulations for approval of care coordinators for individuals receiving chronic mental healthcare services, the secretary shall consult with the behavioral sciences regulatory board.

(f) To maintain approval under the program, a care coordinator shall:

(1) Renew the care coordinator's status at a frequency determined by the secretary; and

(2) provide data to the department as required by the secretary to enable the secretary to evaluate the impact of care coordinators on quality, outcomes, cost and patient and provider satisfaction.

Sec. 9. (a) (1) The secretary shall adopt rules and regulations for healthcare providers to be qualified to participate in the program, including, but not limited to, the revocation, suspension, limitation or annulment of qualification to participate when:

(A) The secretary determines that the healthcare provider is not qualified or competent to be a provider of specific healthcare services;

(B) the healthcare provider exhibits a course of conduct that is inconsistent with program rules and regulations;

(C) the healthcare provider exhibits an unwillingness to meet such

rules and regulations; or

(D) the healthcare provider is a potential threat to the public health or safety.

(2) Such rules and regulations may be different for different types of healthcare providers and healthcare professionals. The secretary may require that such healthcare providers and healthcare professionals participate in medicaid, the state children's health insurance program as provided in K.S.A. 38-2001 et seq., and amendments thereto, or medicare to qualify to participate in the program. Any healthcare provider that is qualified to participate under medicaid, the state children's health insurance program as provided in K.S.A. 38-2001 et seq., and amendments thereto, or medicare shall be qualified to participate in the program. Any healthcare provider's revocation, suspension, limitation or annulment of qualification to participate in any such programs shall apply to the healthcare provider's qualification to participate in the program unless such healthcare provider follows the procedures to become qualified under the program by the end of the implementation period.

(b) The secretary shall adopt rules and regulations for recognizing healthcare providers located outside the state for purposes of providing coverage under the program for out-of-state healthcare services.

(c) Rules and regulations adopted under this section shall include provisions for expedited temporary qualification to participate in the program for healthcare providers who are:

(1) Temporarily authorized to practice in the state; or

(2) recently arrived in the state or recently authorized to practice in the state.

Sec. 10. (a) (1) The secretary shall adopt rules and regulations for payment methodologies for healthcare services and care coordination provided to members under the program by participating providers, care coordinators and healthcare organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis.

(2) All payment methodologies and rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the healthcare service and assuring an adequate and accessible supply of the healthcare service.

(3) In determining such payment methodologies and rates, the secretary shall consider factors including the:

(A) Usual customary rates immediately prior to the implementation of the program, reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner of insurance;

(B) level of training, education and experience of the healthcare provider or providers involved; and

(C) scope of services, complexity and circumstances of care including geographic factors.

(4) Until other applicable payment methodologies are established, healthcare services provided to members under the program shall be paid on fee-for-service basis, except for care coordination.

(b) The program shall engage in good faith negotiations with healthcare providers' representatives, including, but not limited to, negotiations in relation to rates of payment and payment methodologies.

(c) (1) Except as provided by this subsection, prescription drugs eligible for reimbursement under this act and dispensed by a pharmacy shall be provided and paid for in the same manner as under the Kansas medical assistance program.

(2) When the member is enrolled in a managed care provider and a prescription for such member is made under section 340B of the federal public health service act and under a memorandum of understanding relating to the 340B program between the Kansas health program and the relevant 340B program covered entity, the managed care provider shall purchase, pay for and provide for the drugs under the 340B program.

(3) The Kansas health program shall enter into and maintain a memorandum of understanding relating to the 340B program with each 340B program covered entity in the state that agrees to enter into such memorandum of understanding.

(4) When prescription drugs are not dispensed through a pharmacy, payment shall be made as otherwise provided in this act, including use of the 340B program as appropriate.

(d) Payment for healthcare services established under this act shall be considered payment in full. A participating provider shall neither charge any rate in excess of the payment established under this act for any healthcare service provided under the program nor solicit or accept payment from any member or third party for any such service except as provided under section 14, and amendments thereto. This subsection shall not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payor when permitted under section 14, and amendments thereto.

(e) The program may provide payment methodologies for payment for capital-related expenses for specifically identified capital expenditures incurred by nonprofit or governmental entities pursuant to this act.

(f) The secretary shall adopt rules and regulations for payment methodologies and procedures for paying for out-of-state healthcare services.

Sec. 11. The program shall not require prior authorization for any healthcare service that is in any manner more restrictive in terms of access to or payment for such service than that which would be required for such

service under medicare part A or part B. Prior authorization for prescription drugs provided by pharmacies under the program shall be in accordance with K.S.A. 39-7,120, and amendments thereto.

Sec. 12. (a) A member may choose to enroll and receive healthcare services under the program from a healthcare organization.

(b) A healthcare organization shall be a nonprofit or governmental entity that is:

(1) Approved by the secretary; or

(2) a labor union or an entity affiliated with and designated by a labor union of which the enrollee or the enrollee's family member is a member and if allowed by applicable law and approved by the secretary for other members of the program.

(c) A healthcare organization may be responsible for providing all or a part of the healthcare services to which the healthcare organization's members are entitled under the program, consistent with the terms of such healthcare organization's approval by the secretary.

(d) (1) The secretary shall adopt rules and regulations for an entity to be approved as a healthcare organization in the program, including, but not limited to, rules and regulations relating to the revocation, suspension, limitation or annulment of approval when:

(A) The secretary determines that the entity is not competent to be a healthcare organization;

(B) the healthcare organization exhibits a course of conduct that is inconsistent with rules and regulations;

(C) the healthcare organization exhibits an unwillingness to meet such rules and regulations; or

(D) the healthcare organization is a potential threat to the public health or safety.

(2) Such rules and regulations shall not limit approval to be a healthcare organization in the program for criteria other than those under this section and shall be consistent with good professional practice.

(3) In adopting such rules and regulations, the secretary shall:

(A) Consider existing standards developed by national accrediting and professional organizations; and

(B) consult with national and local organizations working in the field of healthcare organizations, including healthcare providers, hospitals, clinics, long-term supports and service providers, consumers, consumer representatives and labor organizations representing healthcare workers.

(4) When developing and implementing standards of approval of healthcare organizations, the secretary shall consult with the secretary for aging and disability services.

(5) To maintain approval under the program, a healthcare organization shall:

(A) Renew such healthcare organization's status at a frequency determined by the secretary; and

(B) provide data to the department as required by the secretary to enable the secretary to evaluate the healthcare organization in relation to the quality of healthcare services, healthcare outcomes, cost and patient and provider satisfaction.

(e) The secretary shall adopt rules and regulations relating to healthcare organizations consistent with and to ensure compliance with this act.

Sec. 13. (a) The secretary shall adopt rules and regulations for the program and for healthcare organizations, care coordinators and healthcare providers, consistent with this act, including rules and regulations for:

(1) The scope, quality and accessibility of healthcare services;

(2) relations between healthcare organizations; and

(3) relations between healthcare organizations and healthcare providers, including:

(A) Credentialing and participation in the healthcare organization; and

(B) terms, methods and rates of payment.

(b) Rules and regulations under the program shall include, but not be limited to, provisions to promote the following:

(1) Simplification, transparency, uniformity and fairness in healthcare provider networks, referrals, payment procedures and rates, claims processing and approval of healthcare services;

(2) primary and preventive care, care coordination, efficient and effective healthcare services, quality assurance, coordination and integration of healthcare services, including use of appropriate technology and promotion of public, environmental and occupational health;

(3) elimination of healthcare disparities;

(4) nondiscrimination with respect to members and healthcare providers on the basis of race, ethnicity, national origin, religion, disability, age, sex, sexual orientation, gender identity or expression or economic circumstances. Healthcare services provided under the program shall be appropriate to the member's clinically relevant circumstances;

(5) accessibility of care coordinators, healthcare organization services and healthcare services, including accessibility for individuals with disabilities and individuals with limited ability to speak or understand English, and the provision of care coordination, healthcare organization services and healthcare services in a culturally competent manner; and

(6) the maximization and prioritization of the most integrated community-based supports and services in relation to long-term supports and services.

(c) Any participating provider or care coordinator that is organized as

a for-profit entity, other than a professional practice of one or more healthcare providers, shall be required to meet the same rules and regulations as entities organized as nonprofit entities, and payments under the program paid to such entities shall not be calculated to accommodate the generation of profit or revenue for dividends or other return on investment or the payment of taxes that would not be paid by a nonprofit entity.

(d) Every participating provider shall permit examination of such provider's records by the program and furnish to the program such information as may be reasonably required for purposes of reviewing accessibility and utilization of healthcare services, quality assurance, promoting improved patient outcomes, cost containment, the making of payments and statistical or other studies of the operation of the program or for protection and promotion of public, environmental and occupational health.

(e) The secretary shall consult with representatives of members, healthcare providers, care coordinators, healthcare organization employers, organized labor, including representatives of healthcare workers, and other interested parties in adopting rules and regulations and making other policy determinations under this act.

(f) The program shall maintain the security and confidentiality of all data and other information collected under the program when such data would be considered confidential patient data. Aggregate data of the program that is derived from confidential data but does not violate patient confidentiality shall be public information, including for purposes of the open records act.

Sec. 14. (a) Consistent with this act and to the maximum extent possible, the secretary shall seek all federal waivers and other federal approvals and arrangements to submit state plan amendments necessary to operate the program. No provision of this act and no action under the program shall diminish any right or benefit the member would otherwise have under any federally matched public health program or medicare.

(b) (1) The secretary shall apply to the United States secretary of health and human services or any other appropriate federal official for all waivers of requirements and shall make other arrangements under medicare, any federally matched public health program, the affordable care act and any other federal programs that provide federal moneys for payment for healthcare services, that are necessary to enable all Kansas health members to receive all benefits under the program to enable the state to implement this act.

(2) The secretary shall receive and deposit all federal payments under such programs in the state, including moneys that may be provided in lieu of premium tax credits, cost-sharing subsidies and small business

tax credits, to the credit of the Kansas health trust fund and use such moneys for the Kansas health program and other provisions under this act.

(3) To the maximum extent possible, the secretary shall negotiate arrangements with the federal government for bulk or lump-sum federal payments to be paid to Kansas health in place of federal spending or tax benefits for federally matched health programs or federal health programs. The secretary shall take all actions under section 3, and amendments thereto, as are reasonably necessary.

(4) The secretary may require members or applicants to become members to provide information necessary for the program to comply with any waiver or arrangement under this section.

(c) The secretary may take actions consistent with this act to enable Kansas health to administer medicare in Kansas, to create a medicare managed care plan that would operate consistent with this act and to be a provider of prescription drug coverage under medicare part D for eligible members of Kansas health.

(d) The secretary may waive or modify the applicability of the provisions of this section relating to any federally matched public health program or medicare as necessary to implement any waiver or arrangement under this section or to maximize the benefit to the Kansas health program under this section, if the secretary, in consultation with the director of the budget, determines that such waiver or modification is in the best interests of both the members affected by the action and the state. No action under this subsection shall diminish any right or benefit the member would otherwise have under the program, any federally matched public health program or medicare.

(e) The secretary may apply for coverage under any federally matched public health program or medicare on behalf of any member and enroll the member in such federally matched public health program or medicare if such member is eligible. Enrollment in a federally matched public health program or medicare shall not cause any member to lose any healthcare service provided by the Kansas health program or diminish any right or benefit such member would otherwise have under the Kansas health program.

(f) Notwithstanding the provisions of K.S.A. 39-709, and amendments thereto, or any other statute, the commissioner shall adopt rules and regulations to increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, increase the benefits for any federally matched public health program and for any such program to reduce or eliminate an individual's coinsurance, cost-sharing or premium obligations or increase an individual's eligibility for any federal financial support related to medicare or the affordable care act. Under this

subsection, the secretary may act upon a finding approved by the director of the budget that:

(1) Will help increase the number of members who are eligible for and enrolled in federally matched public health programs or any program that will reduce or eliminate an individual's coinsurance, cost-sharing or premium obligation or increase an individual's eligibility for any federal financial support related to medicare or the affordable care act;

(2) will not diminish any individual's access to any healthcare service, benefit or right the individual would otherwise have;

(3) is in the best economic interests of the Kansas health program; and

(4) does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(g) To enable the secretary to apply for coverage or financial support under any federally matched public health program, the affordable care act or medicare on behalf of any member and enroll the member in any such program, the secretary may require that every member or applicant to become a member shall provide information to enable the secretary to determine whether the member or applicant is eligible for any such program. The Kansas health program shall make a reasonable effort to notify the member of such member's obligations under this subsection. After a reasonable effort has been made to contact the member, the member shall be notified in writing that such member has 60 days to provide such required information. If such information is not provided within the 60-day period, the member's coverage under the program may be terminated.

(h) To the extent necessary for purposes of this section, as a condition of continued eligibility for healthcare services under the program, a member who is eligible for benefits under medicare shall enroll in medicare, including parts A, B and D.

(i) (1) Except as provided in paragraph (2), the program shall provide premium assistance for all members enrolling in medicare part D drug coverage under section 1860D of title XVIII of the federal social security act, limited to the low-income benchmark premium amount established by the federal centers for medicare and medicaid services and any other amount that the federal centers for medicare and medicaid services establishes under such agency's de minimis premium policy.

(2) Payments made on behalf of members enrolled in a medicare advantage plan may exceed the low-income benchmark premium amount if the secretary determines such action to be cost effective to the program.

Sec. 15. (a) The secretary shall contract with nonprofit organizations to provide:

(1) Consumer assistance to individuals with respect to selection and

changing selection of a care coordinator or healthcare organization, enrolling, obtaining healthcare services and other matters relating to the program;

(2) healthcare provider assistance to healthcare providers providing or considering whether to provide healthcare services under the program, with respect to participating in a healthcare organization; and

(3) care coordination assistance to individuals and entities providing and seeking or considering whether to provide care coordination to members.

(b) The secretary shall, directly and through grants to nonprofit organizations, conduct programs using data collected through the Kansas health program to promote and protect the quality of healthcare services, patient outcomes and public, environmental and occupational health, including cooperation with other data collection and research programs of the department. No individually identifiable patient information or data shall be used or disclosed under this subsection. The secretary shall provide for the security and confidentiality of any individually identifiable patient information or data in accordance with applicable state and federal law.

Sec. 16. (a) As used in this section:

(1) "Third-party payor" means any entity that provides or arranges reimbursement in whole or in part for the purchase of healthcare services;

(2) "healthcare provider administrative employee" means an employee of a healthcare provider primarily engaged in relations or dealings with third-party payors or seeking payment or reimbursement for healthcare services from third-party payors; and

(3) "impacted employee" means an individual who, at any time from July 1, 2022, until two years after the end of the implementation period, is employed by a third-party payor or is a healthcare provider administrative employee and whose employment ends or is reasonably anticipated to end as a result of the implementation of the Kansas health program.

(b) On or before October 1, 2022, the secretary of labor shall convene a retraining and reemployment task force including, but not limited to:

(1) Representatives of potential impacted employees;

(2) individuals with experience and expertise in healthcare providers;

(3) individuals with experience and expertise in retraining and reemployment programs relevant to the circumstances of impacted employees; and

(4) representatives of the department of labor.

(c) The secretary of labor and the task force shall review and provide:

(1) Analysis of potential impacted employees by job title and geography;

(2) competency mapping and labor market analysis of impacted

employee occupations with job openings; and

(3) establishment of regional retraining and reemployment systems, including, but not limited to, job boards, outplacement services, job search services, career advisement services and retraining advisement, to be coordinated with the Kansas health advisory council established under section 18, and amendments thereto.

(d) (1) Three or more impacted employees, a recognized union of workers including impacted employees or an employer of impacted employees may file a petition with the secretary of labor to certify such employees as impacted employees.

(2) Impacted employees shall be eligible for up to two years of:

(A) Retraining at any training provider approved by the secretary of labor; and

(B) unemployment benefits, if the impacted employee is enrolled in a training program approved by the secretary of labor, is actively seeking employment and is not currently employed full time. An impacted employee may maintain unemployment benefits for up to two years even if such impacted employee does not meet the criteria of this subsection but is 63 years of age or older at the time of loss of employment as an impacted employee.

(e) The secretary shall provide moneys from the Kansas health trust fund to the secretary of labor for retraining and reemployment program for impacted employees under this section.

(f) The secretary of labor shall adopt rules and regulations and take other actions reasonably necessary to implement the provisions of this section.

Sec. 17. When any settlement, judgment or order in the course of litigation, or any contract or agreement made as an alternative to litigation, provides that one party shall pay for healthcare coverage for another party who is entitled to enroll in the program, any party to the settlement, judgment, order, contract or agreement may apply to the court for modification of such settlement, judgment, order, contract or agreement. The modification may provide that the paying party shall pay all or a part of the Kansas health tax that is owed by the other party. As used in this section, "Kansas health tax" means the tax or taxes enacted by the legislature as part of the revenue proposal in section 19, and amendments thereto, to fund the program.

Sec. 18. (a) The Kansas health advisory council is hereby created in the department.

(b) The Kansas health advisory council shall be composed of 13 members, appointed as follows:

(1) One member appointed by the governor to represent organized labor;

(2) one member appointed by the governor to represent mental health and behavioral health providers;

(3) one member appointed by the governor to represent professional organizations for physicians;

(4) one member appointed by the governor to represent adult care facilities;

(5) one member appointed by the speaker of the house of representatives to represent community health centers;

(6) one member appointed by the speaker of the house of representatives to represent organizations advocating for older adults;

(7) one member appointed by the speaker of the house of representatives to represent healthcare professions other than physicians;

(8) one member appointed by the minority leader of the house of representatives to represent employers;

(9) one member appointed by the president of the senate to represent hospitals;

(10) one member appointed by the president of the senate to represent counties and local municipalities;

(11) one member appointed by the president of the senate to represent healthcare workers;

(12) one member appointed by the minority leader of the senate to represent women's health service providers; and

(13) the secretary or the secretary's designee.

(c) Members of the council shall be appointed for terms of three years. Vacancies shall be filled in the same manner as the original appointment for the remainder of any unexpired term. No person shall be a member of the council for more than six years in any period of 12 consecutive years.

(d) Members of the council shall serve without compensation but shall be reimbursed for such member's necessary and actual expenses incurred while engaged in the business of the council as provided in K.S.A. 75-3223, and amendments thereto. The program shall provide financial support for such expenses and other expenses of the council.

(e) The council shall meet at least quarterly. The council may form committees to assist the council in the council's work. Members of any such committee need not be members of the council.

(f) The council shall advise the secretary, the governor and the legislature on all matters relating to the development and implementation of the Kansas health program.

(g) The council shall adopt, and from time to time revise, a community health improvement plan for the state for the purposes of:

(1) Promoting the delivery of healthcare services in the state and improving the quality and accessibility of care, including cultural

competency, clinical integration of care between service providers, including, but not limited to, physical, mental and behavioral health, physical and development disability services and long-term supports and services;

(2) planning facilities and health services in the state;

(3) identifying gaps in regional healthcare services;

(4) promoting increased public knowledge and responsibility regarding the availability and appropriate utilization of healthcare services;

(5) identifying needs in professional and service personnel required to deliver healthcare services; and

(6) coordinating regional implementation of retraining and reemployment programs for impacted employees under section 16, and amendments thereto.

(h) The council shall hold at least four public hearings annually on matters relating to the Kansas health program and the development and implementation of the community health improvement plan.

(i) The council shall publish an annual report to the secretary and the board on the progress of the community heath improvement plan. Such report shall be posted on the department's website.

(j) All meetings of the council and committees thereof shall be subject to the open meetings act.

Sec. 19. (a) The governor shall submit to the legislature a revenue proposal. Such revenue proposal shall be submitted to the legislature as part of the governor's budget report pursuant to K.S.A. 75-3721, and amendments thereto, for the fiscal year ending June 30, 2024. In developing the revenue proposal, the governor shall consult with the appropriate officials of the executive branch, the president of the senate, the speaker of the house of representatives, the chairpersons of the appropriations and health and human services committees of the house of representatives and the ways and means and public health and welfare committees of the senate and representatives of business, labor, consumers and local government.

(b) The basic structure of the revenue proposal shall be a progressively graduated tax on:

(1) All payroll and self-employed income, paid by employers, employees and self-employed individuals; and

(2) taxable income, including, but not limited to, interest, dividends and capital gains, not subject to the payroll tax.

(c) Income below $25,000 per year shall be exempt from such taxes, except that for individuals enrolled in medicare, any income below $50,000 per year shall be exempt from such taxes. Higher brackets of income subject to such taxes shall be assessed at a higher marginal rate than lower brackets. The taxes shall be set at levels anticipated to produce

sufficient revenue to finance the program, to be increased as enrollment grows, taking into consideration anticipated federal revenue available for the program. Provisions shall be included for state residents who are employed out of state and nonresidents who are employed in the state, including those employed less than full time.

(d) All income subject to the medicare part A tax shall be subject to the payroll tax. Such payroll tax shall be set at a percentage of such income and shall be progressively graduated so that the percentage is greater on higher brackets of income. For employed individuals, the employer shall pay 80% of the payroll tax and the employee shall pay 20% of such tax, except that an employer may agree to pay all or a part of the employee's share. A self-employed individual shall pay the full amount of the payroll tax.

(e) There shall be a tax on income that is subject to the personal income tax under article 32 of chapter 79 of the Kansas Statutes Annotated, and amendments thereto, and is not subject to the payroll tax of this section. Such tax shall be set at a percentage of such income and shall be progressively graduated so that the percentage is greater on higher brackets of income.

(f) The amount of the taxes shall be set at an appropriate level to cover the actual cost of the program and shall be changed as anticipated enrollment grows. The revenue proposal shall include a mechanism for determining the rate of such taxes.

(g) (1) If an individual is employed out of state by an employer that is subject to Kansas law, the employer and employee shall be required to pay the payroll tax as if the employment were in the state. If an individual is employed out of state by an employer that is not subject to Kansas law, either:

(A) The employer and employee shall voluntarily comply with the tax; or

(B) the employee shall pay the tax as if such employee were self-employed.

(2) (A) The payroll tax shall apply to any out-of-state resident who is employed or self-employed in the state. Such individual and individual's employer shall be allowed to take a credit against such payroll tax each would otherwise pay for amounts they spend respectively on health benefits for:

(i) The individual, if the individual is not eligible to be a member of the program; and

(ii) any member of the individual's immediate family.

(B) For the employer, such credit shall be available regardless of the form of the health benefit to ensure that the revenue proposal does not relate to employment benefits in violation of federal law. For non-

employment-based spending by the individual, such credit shall be available for and limited to spending for health coverage and not for out-of-pocket health spending. Such credit shall be available without regard to how little is spent or how sparse the benefit. The credit may only be taken against the payroll tax. Any excess amount may not be applied to any other tax liability.

(h) The taxes under this section shall not supplant state revenue to pay for the medicaid program as such program exists on the effective date of the revenue proposal, unless the revenue proposal as enacted provides otherwise.

(i) The director of taxation shall remit the entire amount collected under the revenue proposal to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the Kansas health trust fund.

Sec. 20. (a) There is hereby established in the state treasury the Kansas health trust fund to be administered by the secretary of health and environment. All expenditures from the Kansas health trust fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary of health and environment or the secretary's designee.

(b) The Kansas health trust fund shall consist of:

(1) All moneys obtained from taxes pursuant to legislation enacted as proposed under section 19, and amendments thereto;

(2) federal payments received as a result of any waiver or other arrangements agreed to by the United States department of health and human services or other appropriate federal departments or agencies for healthcare programs established under medicare, any federally matched public health program or the affordable care act;

(3) the amounts paid by the department that are equivalent to the amounts paid on behalf of residents of this state under medicare, any federally matched public health program or the affordable care act for health benefits that are equivalent to health benefits covered under Kansas health;

(4) federal and state moneys for purposes of the provision of services authorized under title XX of the federal social security act that would otherwise be covered under the Kansas health act; and

(5) state moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality or institution that provides health services that are covered under Kansas health. Payments to the fund pursuant to this paragraph shall be in an amount equal to the money appropriated for such purposes for the fiscal year ending on June 30, 2022.

(c) Moneys in the Kansas health trust fund shall be used only for purposes established under the Kansas health act, including, but not limited to, the establishment of an appropriate reserve account, and for no other governmental purpose. It is the intent of the legislature that the moneys deposited in this fund shall remain intact and inviolate for the purposes set forth in this section.

Sec. 21. If any provision of this act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to this end, the provisions of this act are severable.

Sec. 22. This act shall take effect and be in force from and after its publication in the statute book.