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LEGISLATURE OF NEBRASKA

ONE HUNDRED FOURTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 1032

Introduced by McCollister, 20; Baker, 30; Bolz, 29; Campbell, 25; Chambers, 11; Cook, 13; Crawford, 45; Haar, 21; Hansen, 26; Howard, 9; Kolowski, 31; Mello, 5; Morfeld, 46; Pansing Brooks, 28; Schumacher, 22; Sullivan, 41.

Read first time January 19, 2016

Committee: Health and Human Services

A BILL FOR AN ACT relating to medical care; to adopt the Transitional Health Insurance Program Act; to provide severability; and to declare an emergency.

Be it enacted by the people of the State of Nebraska,

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Section 1. Sections 1 to 11 of this act shall be known and may be cited as the Transitional Health Insurance Program Act.

Sec. 2. The Legislature finds:

(1) It is necessary to improve the health of and health care coverage for uninsured individuals in Nebraska in a manner that utilizes the private health insurance market, emphasizes personal responsibility, leverages insurance offered by employers and private insurance companies, and strengthens Nebraska's health care system as a whole;

(2) Access to coverage under the medical assistance program should lead to improved health outcomes, long-term employment, a strong workforce, and transition from the program to private health insurance coverage;

(3) Increased access to health insurance should be monitored and assessed to ensure that it has a positive impact on employment and wages and a decreased reliance on public assistance programs;

(4) Health benefits for the newly eligible population under the federal Patient Protection and Affordable Care Act, Public Law 111-148, should be provided in a manner that encourages personal responsibility and supports increasing economic stability for low-wage workers;

(5) Health care coverage for newly eligible low-income Nebraskans must be delivered in a way that incorporates innovative models of care, care coordination, and the promotion of a patient-centered, integrated health care system; and

(6) Extension of coverage for individuals who are newly eligible for medical assistance must be accomplished in a fiscally sustainable and responsible manner that safeguards the interests of Nebraska taxpayers and provides accountability and oversight.

Sec. 3. For purposes of the Transitional Health Insurance Program Act:

(1) Cost-effective employer-sponsored insurance means group health care coverage (a) that is offered by a public or private employer to its

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employees, (b) that meets the definition of minimum essential coverage under 26 U.S.C. 5000A(f), as such section existed on January 1, 2016, and (c) for which the employer pays no less than fifty percent of the total cost of the employee's coverage;

(2) Department means the Department of Health and Human Services of the State of Nebraska;

(3) Federal poverty level means the most recently revised poverty income guidelines published by the United States Department of Health and Human Services;

(4) Health benefit exchange or marketplace means an American Health Benefit Exchange established by the state under 42 U.S.C. 18031, as such section existed on January 1, 2016;

(5) Medicaid means the medical assistance program established pursuant to the Medical Assistance Act and the program paying all or part of the costs of care and services provided to an individual pursuant to Title XIX of the federal Social Security Act;

(6) Medically frail or exceptional medical condition means a disabling mental disorder, a serious and complex medical condition, and physical or mental disabilities that significantly impair an individual's ability to perform one or more activities of daily living, as described in 42 C.F.R. section 440.315(f), as such section existed on January 1, 2016. Medically frail or exceptional medical condition includes at least two chronic conditions, or one chronic condition and the risk of a second chronic condition, or a serious and persistent mental health condition. For purposes of this subdivision, chronic condition includes, but is not limited to, a mental health condition, a substance use disorder, asthma, diabetes, heart disease, or obesity;

(7) Newly eligible or newly eligible individual means an individual who:

(a) Is defined under section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act, 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), as such section

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existed on January 1, 2016, for whom increased federal funding is provided for under section 1905(y)(2)(A) of the federal Social Security Act, 42 U.S.C. 1396d(y)(2)(A), as such section existed on January 1, 2016;

(b) Is a resident of Nebraska;

(c) Is nineteen years of age or older and under sixty-five years of age; and

(d) Satisfies all applicable federal income, citizenship, and immigration requirements;

(8) Patient-centered medical home means a health care delivery system pursuant to which the patient establishes an ongoing relationship with a primary care provider team to provide comprehensive, accessible, and continuous evidence-based primary and preventive care and to coordinate the patient's health care needs across the health care system to improve quality, safety, access, and health outcomes in a cost-effective manner;

(9) Qualified health plan means a health insurance plan as defined in 42 U.S.C. 18021, as such section existed on January 1, 2016, that is available for purchase on a health benefit exchange; and

(10) Wrap-around benefits means benefits that are required to be provided by medicaid pursuant to the terms of a state plan amendment or waiver but are not covered by a qualified health plan or employer-sponsored insurance.

Sec. 4. (1) The department shall submit to the Centers for Medicare and Medicaid Services any waivers or state plan amendments necessary to do the following:

(a) Establish and implement a premium assistance program, to be known as the Transitional Health Insurance Premium Assistance Program, to allow health insurance coverage for all newly eligible individuals (i) who do not have access to cost-effective employer-sponsored insurance, (ii) who are not determined by the department to be medically frail, and

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(iii) who are not otherwise exempt under federal law from enrolling in a qualified health plan on the health benefit exchange;

(b) Establish and implement an employer-sponsored insurance premium program, to be known as the Employee Health Insurance Program, for all newly eligible individuals who have access to cost-effective employer-sponsored insurance; and

(c) Establish and implement a health insurance program, to be known as the Innovation Health Improvement Program, under medicaid, for newly eligible individuals who are medically frail or otherwise exempt from Transitional Health Insurance Premium Assistance Program coverage.

(2)(a) Newly-eligible individuals described in subdivision (1)(a) of this section shall have access to and enroll in a high-value, one hundred percent actuarial value, silver-level qualified health plan offered on the health benefit exchange. For such newly eligible individuals participating in the program described in such subdivision, the department shall pay the full cost of the qualified health plan's premiums and any required copayments, coinsurance, and deductibles directly to the qualified health plan issuer.

(b) Coverage for such individuals shall be effective the first day of the month following the month of application for enrollment. If the individual is eligible, the department shall provide fee-for-service coverage under medicaid from the date an individual applies until enrollment in the qualified health plan becomes effective. The department shall provide wrap-around benefits that are not covered by the qualified health plan.

(3) Newly eligible individuals who have access to cost-effective employer-sponsored insurance, either directly as an employee or through another individual such as a spouse, dependent, or parent who is eligible, shall be eligible for the Employee Health Insurance Program established under subdivision (1)(b) of this section. The department shall determine whether the employer-sponsored insurance is cost-

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effective employer-sponsored insurance in each individual circumstance. Payments shall be made by the department for the purchase of cost-effective employer-sponsored insurance through the employer, including the employee's share of an employer-sponsored insurance premium plus any required copayments, coinsurance, and deductibles. For Employee Health Insurance Program participants, the department shall provide for wrap-around benefits that are not covered in the employer-sponsored coverage.

(4)(a) Newly eligible individuals who are medically frail or who are otherwise exempt from the Transitional Health Insurance Premium Assistance Program shall be enrolled in the Innovation Health Improvement Program established pursuant to subdivision (1)(c) of this section under medicaid which shall provide coverage of a benchmark benefit package as defined in section 1937(b)(1)(D) of the federal Social Security Act, 42 U.S.C. 1396u-7(b)(1)(D), as such section existed on January 1, 2016.

(b) Treatment and services under the Innovation Health Improvement Program shall include (i) all mandatory and optional coverage under section 68-911 for health care and related services in the amount, duration, and scope in effect on January 1, 2016, and (ii) any additional wrap-around benefits required by the federal Patient Protection and Affordable Care Act, Public Law 111-148, as such act existed on January 1, 2016, which are not included in section 68-911. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-5, as such act existed on January 1, 2016, shall apply to Transitional Health Insurance Program coverage.

(5) Following initial enrollment, an enrollee covered under this section is eligible for covered benefits for twelve months and the department shall review each enrollee's eligibility annually.

(6) Provider networks for the newly eligible population shall include, but not be limited to, the carrier's current provider networks, federally qualified health centers, and rural health clinics.

Sec. 5. (1)(a) The waiver required pursuant to section 4 of this

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act shall include provisions to ensure personal responsibility, the development of cost-conscious consumer behavior, and the use of preventive care services. Beginning the first month of eligibility, each newly eligible individual enrolled in the programs established pursuant to such section whose income is above fifty percent of the federal poverty level shall contribute two percent of their monthly household income, as determined in accordance with 42 U.S.C. 1396a(e)(14), as such section existed on January 1, 2016, to the department or the department's designee. Pursuant to federal law, contributions for all newly eligible enrollees in an enrollee's household cannot exceed five percent of family income per calendar quarter.

(b) Failure to make monthly contributions as described in this section shall result solely in a debt to the State of Nebraska in the amount of the unpaid contributions which may be collected through garnishment, lien foreclosure, or recovery in a proper form of action in the name of the state.

(c) The waiver described in section 4 of this act shall require no additional premiums, copayments, or cost-sharing, except in the case of inappropriate utilization of a hospital emergency department which shall not exceed fifty dollars.

(d) The department or the department's designee shall remit contributions collected from participants pursuant to this section to the Transitional Health Insurance Program Fund to defray the state share of cost for the program.

(2) The department shall submit the waiver required under section 4 of this act to the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services not later than fourteen months after the effective date of this act. Coverage under the waiver shall begin within ninety days after the approval of the waiver by the Centers for Medicare and Medicaid Services. The Department of Health and Human Services of the State of Nebraska shall negotiate the waiver

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with the Centers for Medicare and Medicaid Services in good faith.

Sec. 6. (1) Any qualified health plan that provides benefits under subdivisions (1)(a) and (b) of section 4 of this act shall ensure that all newly eligible individuals enrolled in the plan have access to a qualified, licensed primary care provider and, where available, are enrolled in a patient-centered medical home. If patient-centered medical homes are not available for a significant number of newly eligible participants, the department shall develop plans for increasing the availability of patient-centered medical homes in Nebraska. Such plans shall be presented to the Health and Human Services Committee of the Legislature in the annual report required pursuant to section 8 of this act. All enrollees under such qualified health plans shall make an appointment with such primary care provider within sixty days after enrollment.

(2)(a) All newly eligible individuals who are enrolled in the Innovation Health Improvement Program described in subdivision (1)(c) of section 4 of this act shall have access to a qualified, licensed primary care provider and shall be enrolled in a health home. The health home shall provide intensive care management and patient navigation services by a multidisciplinary team of providers led by a dedicated care manager who ensures each newly eligible individual enrolled in the Innovation Health Improvement Program receives needed medical care, behavioral health care, and social services through a single integrated care agency. A personal provider shall be responsible for providing all of the patient’s health care and health-related needs or for arranging health care provided by other qualified providers at all stages of life, including provision of preventive care, acute care, chronic care, long-term care, transitional care between providers and settings, and end-of-life care.

(b) The delivery system for newly eligible individuals described in subsection (1) of section 4 of this act shall integrate providers,

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integrate clinical services and the nonclinical community and social support services, and incorporate safety net providers, including, but not limited to, federally qualified health centers, rural health clinics, community mental health centers, public hospitals, and other nonprofit and public health care providers that have extensive experience in providing health care to vulnerable individuals.

(3) The department shall develop measures to determine clinical outcomes to be attained by patient-centered medical homes, health homes, and quality health benchmarks that meet specified health improvement goals for newly eligible individuals.

Sec. 7. (1) The Transitional Health Insurance Employment Program is created. The program shall:

(a) Provide individuals receiving assistance pursuant to subsection (1) of section 4 of this act a referral to employment programs, adult basic education programs, or high school equivalency programs offered through the department, the Department of Labor, the State Department of Education, workforce development agencies, or other entities. The Department of Health and Human Services shall create information-sharing agreements with any such entity, as necessary, and such entities shall notify the department when a participant has received services; and

(b) For individuals who are unemployed, provide referral to the program described in subsection (2) of this section.

(2) The Transitional Health Insurance Employment Program shall provide education and skills training to individuals receiving assistance pursuant to subdivision (1)(a) or (c) of section 4 of this act who opt to participate in the program. Such program shall:

(a) Prioritize individuals who are unemployed for participation in the program;

(b) Provide English reading and writing and mathematics skills required to succeed in a postsecondary educational credentialing or degree program;

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(c) Be open only to participants who are co-enrolled in adult education, developmental education, or English as a second language classes;

(d) Target the specific workforce needs of an occupational sector within the state and provide services aimed at improving education, skills, and employment prospects for participants;

(e) Use educational best practices, including, but not limited to, contextualized instructional strategies, team teaching, modularized learning, or reduced student-teacher ratios; and

(f) Provide for supportive services needed for student educational and employment success, including, but not limited to, job coaching and support for personal needs.

(3)(a) To the greatest extent possible, the program described in this section shall be connected to or build upon similar or complementary programs funded by the federal Workforce Innovation and Opportunity Act, 29 U.S.C. 3101, as such act existed on January 1, 2016.

(b) It is the intent of the Legislature to appropriate five hundred thousand dollars each fiscal year to create, on a pilot-program basis, the program described in this section. The program shall be evaluated according to the terms established in subsection (1) of section 8 of this act and shall expire on June 30, 2020. Neither state nor federal medical assistance funds shall be utilized for the program.

(c) The department may contract with a nonprofit third-party entity to administer the program established under this section.

(d) To the extent funding has been expended or is unavailable for the program in any fiscal year, the program established pursuant to this section may be suspended by the department.

Sec. 8. (1) The department shall include in its application for waivers required by the Transitional Health Insurance Program Act a plan for the collection of data and creation of data-sharing agreements with the State Department of Education, Department of Labor, Department of

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Revenue, and Department of Insurance in order to collect and analyze whether the programs established under the act lead to the following for program participants:

(a) Increased transition from medicaid coverage to qualified health insurance coverage;

(b) Increased maintenance of continuous health coverage and access to qualified health plans;

(c) Increased full-time or part-time employment;

(d) Increased earnings;

(e) Increased educational attainment; or

(f) Decreased utilization of public assistance programs.

(2) The department shall also collect information and data necessary to analyze whether the programs established under the act lead to the following:

(a) Lower administrative costs attributable to medicaid for the newly eligible population compared to the cost of administering benefits for the traditional medicaid population;

(b) Improved health outcomes for the medically frail population;

(c) Lower costs in the health benefit exchange for qualified health plans due to more individuals participating in the health benefit exchange; or

(d) Decreased utilization of the emergency room for nonemergency needs due to the copayment requirement under the act.

(3) The department shall collect and analyze the information required by subsection (2) of this section and provide a report electronically on December 1, 2017, and each December 1 thereafter to the Health and Human Services Committee of the Legislature.

Sec. 9. (1) The Transitional Health Insurance Program Fund is created. The fund shall be used to support medicaid, including paying for the state’s share of cost for the newly eligible participants pursuant to the Transitional Health Insurance Program Act. Interest and income earned

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by the fund shall be credited to the fund. The Legislature may utilize money from the Health Care Cash Fund for purposes of the Transitional Health Insurance Program.

(2) Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act. Any unexpended balance remaining in the fund at the close of the biennium shall be appropriated for the succeeding biennium.

(3) The department shall use the Transitional Health Insurance Program Fund for the purposes described in the Transitional Health Insurance Program Act.

Sec. 10. If the rate of federal funding for newly eligible enrollees, as established in 42 U.S.C. 1396d(y)(1), as such section existed on January 1, 2016, falls below ninety percent, coverage for newly eligible enrollees shall automatically terminate as of the date such federal funding falls below such level.

Sec. 11. The department shall adopt and promulgate rules and regulations to carry out the Transitional Health Insurance Program Act.

Sec. 12. If any section in this act or any part of any section is declared invalid or unconstitutional, the declaration shall not affect the validity or constitutionality of the remaining portions.

Sec. 13. Since an emergency exists, this act takes effect when passed and approved according to law.