SENATE FILE NO. SF0024

Health care reform demonstration project.

Sponsored by: Joint Labor, Health and Social Services Interim Committee

A BILL

for

AN ACT relating to health insurance; creating a health care reform demonstration project using the board and administrative structure of the Wyoming health insurance pool as specified; providing for a benefit design committee; authorizing payment of committee members' expenses as specified; providing for the design of the benefits package and plan of operation of the project; providing for eligibility; providing definitions; providing for evaluation of the project; providing for a repeal date; requiring reports; providing appropriations; and providing for an effective date.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 26-43-201 through 26-43-207 are created to read:

ARTICLE 2

HEALTH CARE REFORM DEMONSTRATION PROJECT

26-43-201. Health care reform demonstration project created.

The health care reform demonstration project is hereby created. The health care programs and services offered to people participating in the demonstration project shall be referred to as healthy frontiers.

26-43-202. Definitions.

(a) The definitions provided in W.S. 26-43-101 shall apply to this article except to the extent they are specifically inconsistent with subsection (b) of this section.

(b) As used in this article:

(i) "Administrator" means as defined in W.S. 26-43-101 unless a different individual or entity is selected pursuant to W.S. 26-43-203(d);

(ii) "Benefit design" means the schedule of health care benefits and other related services available to participants under this article. The benefit design may also include other features authorized for inclusion in the benefit design by this article;

(iii) "Clinical prevention services" means personal health support services provided by health care providers and other individuals including advanced practice nurses and clinical pharmacists or members of similar health care organizations as set forth in the benefit design and approved by the board. The clinical prevention services shall be designed to provide information, education and decision support for individuals who have specified diseases, or who are at risk for serious disease conditions or complications, and who meet other criteria which indicate a need for clinical management or prevention support;

(iv) "Contributions" means the amounts permitted or required to be paid into a personal health account by participants, the state or both;

(v) "Demonstration project" or "the project" means the health care reform project created pursuant to this article;

(vi) "Medical home" means a service provided by a physician, advanced practice registered nurse or physician assistant serving as the principal provider of primary care and the initial point of contact with the medical system for the patient. The medical home shall seek to strengthen the provider-patient relationship by replacing episodic care based on illnesses and patient complaints with a broad array of prevention, screening exams, advice on avoiding illness and, as needed, urgent care with referral to specialists as indicated. When appropriate, the medical home shall involve a plan of care for each individual and include teaching the individual to assist in the management of his health. Reimbursement for medical home services shall include reimbursement to the health care professional for patient care management;

(vii) "Participant" means an eligible individual enrolled in the project. No person shall be a participant who does not elect to be a participant;

(viii) "Personal health account" means an account provided in the benefit design and the plan of operations designed to pay qualified health expenses including deductibles and copayments as directed by the participant. The account may or may not be a health savings account or other federally tax advantaged account. The account may be portable to the individual;

(ix) "Plan of operation" means a plan governing the demonstration project to implement this article, including articles, bylaws and operating policies adopted pursuant to this article. The plan of operation includes the benefit design;

(x) "Premiums and copayments" means the amounts charged to participants including the portion of the premium to be paid by the participant and the portion to be paid by the state;

(xi) "Preventive services" means the schedule of services to prevent or detect illness available to participants and any other related benefit provisions specified in the benefit design to achieve the objective of this article;

(xii) "Primary care" means care provided by a family practice physician, pediatrician, internist, obstetrician or an advanced practice registered nurse or physician's assistant in a similar practice. Surgical and radiological procedures are not primary care. The benefit design may include similar services of a primarily consultative and advisory nature provided by other specialists or providers as primary care. Particular preventive services and invasive diagnostic procedures shall be considered primary care to the extent authorized in the benefit design;

(xiii) "Specialty care" means care not included in primary care. Specialty care is generally provided by specialists with training and expertise in a given system, organ or disease and is often related to a special technical skill.

26-43-203. Benefit design and operations.

(a) There is created a benefit design committee of at least three (3) and no more than seven (7) persons appointed by the governor. Members of the committee other

than state employees shall receive per diem and mileage allowance as allowed to state employees, when actually engaged in committee activities.

(b) The benefit design committee shall create and modify as necessary the benefit design which shall include the following elements:

(i) Preventive services funded by the state with no or nominal cost to the participant to promote better health and identify chronic disease at the earliest possible stage. Preventive services shall include cost effective, evidence based and clinically proven screening tests, age appropriate wellness exams and maintenance prescriptions as specified in the benefit design. The benefit design may provide that a participant meeting specified criteria shall be required to participate in specific preventive services as a condition of eligibility for all or part of the state contributions to the participant's personal health account;

(ii) The use of a medical home to the extent practical. Routine primary care and preventive services identified pursuant to paragraph (i) of this subsection

shall normally be provided by the participant's medical home. To the extent practical, other care shall be provided through the medical home. As needed to obtain adequate services, reimbursement for advice and consultative services shall be at a higher level than customarily provided through similar health care reimbursement schedules. Requirements of, and reimbursement for, the medical home provider shall be established in advance as part of the plan of operation;

(iii) Clinical prevention services. The design shall provide access to clinical prevention services to assist certain participants with chronic disease or complicated health conditions and to provide information and resources to the participant, the medical home provider and other relevant providers to better manage the participant's illness and to improve the participant's quality of life. The services shall be made available at little or no cost to the participant. In priority order, clinical prevention services shall be provided first to assist the participant in getting the care he needs, provided second to help the participant avoid care that may do more harm than good or is unlikely to be helpful and provided third to minimize the cost of the care;

(iv) A personal health account funded by contributions from the participant with a matching state contribution. Participant contributions may be determined on a sliding scale based on income and may be modified pursuant to paragraph (i) of this subsection. The benefit design for the personal health account:

(A) Shall provide that the individual may retain the balance in the account upon leaving the project for use as specified in the benefit design;

(B) May allow the use of the account for health care related needs when the account balance exceeds an amount set in the benefit design, when the account balance remains after a length of time set in the benefit design, or both. The account may be used under this subparagraph for medical copayments, deductibles or premiums for specified family members not otherwise enrolled in the demonstration project;

(C) May provide that the state retains an interest in the account as necessary to ensure that any state-funded balance in an account reverts to the state:

(I) Upon the death of the participant, to pay any outstanding health care expenses of the participant or any enrolled member of the participant's household; and

(II) Following the expiration of a time specified in the benefit design, not to exceed ten (10) years, after a participant leaves the project.

(D) May provide that the participant may, under conditions specified in the benefit design, roll the balance in the account into a health savings account or similar federally tax advantaged account after leaving the project;

(E) May include any provisions needed to avoid or minimize any adverse federal tax consequences for the participant.

(v) A high deductible insurance plan, the coverage package of which qualifies as creditable coverage under the federal Health Insurance Portability and Accountability Act, 42 U.S.C. 1320d et seq., or subsequent

similar federal enactment. The high deductible insurance plan shall provide for premium cost share based on income as determined in the benefit design. The participant may pay premiums directly from the participant's personal health account. Deductibles and copayments may be paid from the personal health account at the discretion of the participant. For health care services not included in the prevention package, a system of copayments shall be required and shall be lower for primary care and higher for specialty care unless referred by a primary care physician. The benefit design committee in devising the sliding scale shall seek to create an incentive to join the project and leave Medicaid or other government programs. The benefit design shall seek to create an incentive to obtain a job that includes eligibility for employer provided health coverage. The high deductible insurance plan shall be limited in coverage and designed to work in conjunction with the design provisions identified in this section. The insurance plan may be provided directly by the project, may be purchased from the private sector or may be provided through the pool which is hereby authorized to provide this plan.

(c) The benefit design shall be recommended by the benefit design committee to the board. Upon approval by the board, the benefit design shall be forwarded to the governor as part of the plan of operation for the governor's final approval. Amendments to the benefit design shall be approved in the same manner except that the governor may delegate his final approval authority, in whole or in part, to the board.

(d) The administrator shall serve as the administrator of the project provided that financial arrangements satisfactory to the board and the commissioner can be agreed to with the administrator. If the financial arrangements cannot be made, the commissioner, with the advice and consent of the board, shall contract with a different administrator to administer this act.

(e) It shall be the duty of the board to manage the project so that the expenses of the project do not exceed the available appropriations plus premiums received. The board shall have the power to limit enrollment in the project to avoid overspending the appropriation. Except as provided in subsections (b) and (f) of this section and except for shared administrative expenses, the resources of

the Wyoming health insurance pool created by W.S. 26-43-102 shall not be used for the expenses of the project.

(f) The administrator, with the approval of the board, may purchase insurance or reinsurance for expenses in excess of an amount determined by the administrator with the advice and consent of the board or in the plan of operations. The insurance or reinsurance may be purchased from commercial sources or may be purchased from the pool which is hereby authorized to sell insurance or reinsurance to the demonstration project.

(g) The plan of operation for the demonstration project shall:

(i) Establish procedures for handling, investing and accounting of assets and monies of the project;

(ii) Contain provisions useful in implementing the benefit design;

(iii) Develop and implement a program to publicize and to maintain public awareness of the existence

of the project, the eligibility requirements and procedures for enrollment;

(iv) Provide as necessary for audits of the project and the administration of the project;

(v) Include the benefit design approved by both the benefit design committee and the board;

(vi) Provide procedures for enrolling participants and their families consistent with the eligibility requirements of this article. Insurance agents licensed to sell insurance in Wyoming may be allowed to enroll participants in the project and be paid a commission or fee for their related services.

26-43-204. Eligibility.

(a) Participants at the time of enrollment shall have family income not exceeding two hundred percent (200%) of the federal poverty level and shall be working at least twenty (20) hours per week or the equivalent. Participants may lose eligibility for failure to continue to work as specified in the benefit design.

(b) Priority in enrollment of participants shall be given to the following:

(i) Individuals who have completed a vocational readiness or work preparation program through the department of workforce services, any other Wyoming state agency or a Wyoming community college;

(ii) Individuals who have been participants in the Medicaid program or other state assistance program and who have become ineligible for that program due to increased earnings;

(iii) Individuals whose children are enrolled in Medicaid or the state children's health insurance program.

(c) Participants enrolled pursuant to this section may elect family coverage, provided all individuals are eligible. Children of participants shall be referred to the state children's health insurance program or Medicaid and shall not be enrolled in the demonstration project if eligible for one of those programs.

(d) After the expanded enrollment pursuant to W.S. 26-43-205 has been occurring for at least three (3) months, the board may determine that the maximum enrollment authorized by W.S. 26-43-205 is not likely using the priority categories set forth in subsection (b) of this section and may authorize the enrollment of a limited number of individuals who are eligible under subsection (a) of this section but who are not in a priority category.

26-43-205. Structure and enrollment limits.

(a) The project shall be structured as follows:

(i) There shall be an initial enrollment of no more than five hundred (500) participants and their family members, as appropriate to test the feasibility of implementing the initial benefit design. Enrollment shall begin after approval of the plan of operation by the board and the governor. Enrollment may begin after July 1, 2009;

(ii) After July 1, 2010 and approval by the board and the governor of a revised benefit plan and plan of operations based on experience with the initial enrollment, the project may enroll an additional two

thousand five hundred (2,500) participants and their family members and such additional participants to maintain stable project enrollment of three thousand (3,000) participants until July 1, 2013. The board in accepting participants for the project shall seek to have at least five hundred (500) participants who use the federally designated community health centers as their medical home and at least five hundred (500) participants who use primary health care providers in private practice as their medical home. The board shall seek to have enrollees representing sufficient communities within the state to demonstrate the statewide feasibility of the project.

26-43-206. Evaluation.

(a) The department of health shall have the primary responsibility for the evaluation of the demonstration project and shall report its evaluation publicly to the governor and the joint labor, health and social services interim committee annually beginning October 1, 2009. The board shall also provide the governor and the joint labor, health and social services interim committee with its evaluation as appropriate.

(b) The department of health in its evaluation of the project shall consider:

(i) Whether the project provides participants with adequate health care;

(ii) The extent to which participant turnover interferes with management and evaluation of the project and obtaining the expected benefits of the project;

(iii) Whether the project provides health coverage at a cost which is less than could be provided by other means, both public and private. When comparing with other public programs, the cost of those public programs shall be adjusted to assume reimbursement rates comparable to private reimbursement rates;

(iv) The extent to which the project reduces the rate of increase in medical costs;

(v) The extent to which the health of participants and their enrolled family members is improved due to participation in the project.

(c) No later than July 1, 2009, the department of health, after consultation with the administrator, shall provide the commissioner a list of those data elements which the department determines necessary to evaluate the project as required by this section. Upon approval of the list by the commissioner and after consultation with the board, the department of health may award one (1) or more contracts to collect any listed data not routinely collected by the board or other state agencies and to integrate that data as appropriate with related data collected by the board and other state agencies.

(d) To assist in the evaluation of the demonstration project, the administrator shall make a projection of the project's itemized expenses and shall revise the projection after enrollment of an adequate proportion of the expected total enrollment. The projection shall assume all costs associated with the provisions of W.S. 26-43-203. At appropriate intervals, the project shall be compared to actual experience. Itemized expenses shall include:

(i) The cost of services and care for participants using as their medical homes federally designated community health centers;

(ii) The cost of services and care for participants using as their medical homes providers practicing in the traditional fee for service environment;

(iii) The costs of services and care for participants using other medical homes, including managed care, if any, and those without medical homes;

(iv) Any other categories necessary to effectively manage the demonstration project;

(v) Any other categories identified by the board or department of health as necessary to evaluate the demonstration project.

(e) In collecting, evaluating and using the data collected pursuant to subsection (d) of this section and any other management data, the administrator may use the services of outside consultants. In comparing project expectations and results, the administrator shall identify and consider any limitations on statistical significance of data due to small numbers of participants in any category.

(f) The department of health, in consultation with the board, shall consider the feasibility and ethics of using a control group to facilitate the evaluation of the program. The board and the department of health are authorized to construct and utilize a control group.

(g) The department of health shall provide to the joint labor, health and social services interim committee and the governor an interim evaluation report by October 1, 2011 and a final evaluation report by December 31, 2013. To improve the statistical validity of the report, no new enrollment in the project shall be permitted after July 1, 2013. The report shall include any recommendations on whether the demonstration project should be discontinued, expanded to a larger population, expanded to obtain more statistically valid results or continued for a longer time with a stable enrollment to obtain more valid results. Unless the report recommends abandonment of the project, it shall include any recommendations on program alterations needed to achieve the objectives of the demonstration project as expressed in the evaluation criteria of subsection (b) of this section.

26-43-207. Sunset.

W.S. 26-43-201 through 26-43-206 are repealed effective December 31, 2014 and all participants shall be disenrolled effective July 1, 2014. The board shall use the period from April 1, 2014 to December 31, 2014 to fully discharge the affairs of the demonstration project.

Section 2. W.S. 26-43-102(d) by creating a new paragraph (vii) and (f) by creating a new paragraph (v) is amended to read:

26-43-102. Operation of the pool; board membership; board powers and duties.

(d) The board shall:

(vii) Manage the demonstration project pursuant to article 2 of this chapter.

(f) The board may:

(v) Provide a high deductible insurance plan or reinsurance to the demonstration project authorized by article 2 of this chapter.

Section 3.

(a) There is appropriated fifty thousand dollars ($50,000.00) from the general fund to the department of health. This appropriation shall be for the period beginning with the effective date of this act and ending June 30, 2010. This appropriation shall only be expended for the purpose of collecting and evaluating data related to the health care reform demonstration project. Notwithstanding any other provision of law, this appropriation shall not be transferred or expended for any other purpose and any unexpended, unobligated funds remaining from this appropriation shall revert as provided by law on June 30, 2010. This appropriation shall not be included in the department's 2011-2012 standard biennial budget request.

(b) There is appropriated five million one hundred thousand dollars ($5,100,000.00) from the general fund to the insurance department. This appropriation shall be for the period beginning with the effective date of this act and ending June 30, 2010. This appropriation shall only be expended for the purpose of contracting with the board of

directors of the Wyoming health insurance pool to implement the health care reform demonstration project. Notwithstanding any other provision of law, this appropriation shall not be transferred or expended for any other purpose and any unexpended, unobligated funds remaining from this appropriation shall revert as provided by law on June 30, 2010. This appropriation shall not be included in the department's 2011-2012 standard biennial budget request.

(c) There is appropriated one hundred thousand dollars ($100,000.00) from the general fund to the department of health. This appropriation shall be for the period beginning July 1, 2010 and ending June 30, 2012. This appropriation shall only be expended for the purpose of collecting and evaluating data related to the health care reform demonstration project and providing the interim evaluation report required by W.S. 26-43-205(g). Notwithstanding any other provision of law, this appropriation shall not be transferred or expended for any other purpose and any unexpended, unobligated funds remaining from this appropriation shall revert as provided by law on June 30, 2012. This appropriation shall not be

included in the department's 2013-2014 standard biennial budget request.

Section 4. This act is effective immediately upon completion of all acts necessary for a bill to become law as provided by Article 4, Section 8 of the Wyoming Constitution.

(END)