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KANSAS: BASELINE REPORT

State-Level Field Network Study
of the Implementation of the
Affordable Care Act

December 2014

Rockefeller Institute of Government
State University of New York

The Brookings Institution

Fels Institute of Government
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KANSAS

BASELINE REPORT

State-Level Field Network Study of the Implementation of the Affordable Care Act

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KANSAS: BASELINE REPORT

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1. Decisions to Date

Overview

At this time, Kansas has a federally facilitated exchange (FFE) and has not expanded its Medicaid program as called for in the Affordable Care Act (ACA). The Kansas Insurance Department (KID) is assisting the FFE with plan management functions, but it is not an official state partnership exchange.

The primary players in decisions about the exchange and Medicaid include Governor Sam Brownback, Insurance Commissioner Sandy Praeger, and the Republican-controlled Kansas legislature. Although both the governor and the insurance commissioner are Republicans, they frequently have opposing views on the ACA. Brownback has been an opponent of the ACA since before its passage, voting against it as a U.S. senator, and has continued in his opposition after being elected Kansas governor in 2010. Praeger is a moderate Republican who worked collaboratively with then-Kansas Governor Kathleen Sebelius (Democrat) on various health reform issues, and has encouraged implementation of the ACA.^{1,2} It is important to note that in the state of Kansas, the insurance commissioner is an independently elected official and is not appointed by the governor.

Exchange Decision Process

The Kansas Insurance Department applied for and was awarded a \$1 million federal exchange planning grant in September 2010. The planning grant provided seed money for KID to

establish eight exchange planning workgroups, which began meeting in January 2011.³ Each workgroup was assigned a specific portion of exchange planning, such as the agent/broker/navigator workgroup and the funding/financial workgroup. Each workgroup was chaired by a Kansan experienced in the workgroup's jurisdiction, such as a former attorney general, a former state budget director, the highest ranking official from the state Medicaid agency, and the chief counsel of the state's largest insurer.⁴ The workgroups established an aggressive schedule with the intent of making the necessary key decisions to build a framework for the intended July 2011 release of a request for proposal (RFP) for a vendor to build a state-based exchange.⁵

With the required letter of support from Democratic Governor Mark Parkinson (who replaced Sebelius after she was confirmed as secretary of the U.S. Department of Health and Human Services), KID applied for an early innovator grant in fall 2010. The 2010 election resulted in another change in governorship. In February 2011, the \$31.5 million grant was awarded to the state, but only after the Department of Health and Human Services (HHS) requested and received a letter from Brownback, the newly elected governor, indicating his support for KID's administration of the grant.⁶ Importantly, acceptance of the early innovator grant signaled Kansas's intent to establish a state exchange and combine the technical architecture of the state exchange with the state's Medicaid eligibility determination system.⁷ An upgrade of the state Medicaid eligibility system had been underway for a number of years.

For several months, each of the eight exchange planning workgroups met frequently, compiling recommendations that were passed to a committee composed of the workgroup chairs and other key representatives. These recommendations were intended to shape the content of the RFP for the development of the state exchange.

However, in May 2011, after mounting political pressure and facing a legislature that had become considerably more conservative as a result of the 2010 elections, the Brownback administration requested a delay in the release of the RFP. The release was postponed from the planned release in July of that year, until after the issue could be considered during the 2012 legislative session (January–May 2012). This change resulted in fewer meetings by the planning workgroups.⁸

Eventually, in August 2011, the Brownback administration announced it was returning the early innovator grant to HHS, citing concerns with the federal government's ability to meet future funding obligations.⁹ This announcement changed the game for implementation of a state-based exchange in Kansas, which would now need the support of the Kansas legislature, and an increasingly tight timeline for completion.

Praeger continued to speak in support of a state exchange over the next several months. A legislative interim committee

recommended in November 2011 that the recommendations of the exchange planning workgroups be reviewed and considered by the health, budget, and insurance committees during the 2012 legislative session.¹⁰ However, the Republican-controlled House and Senate showed little support for establishment of a state exchange during the 2012 session. The only ACA-related bill that was seriously debated was the “Health Care Freedom Act,” a proposed amendment to the Kansas constitution that would have stated that no rule or law could force a Kansas individual or employer to buy insurance. The proposal passed in the house but failed by one vote in the Senate to reach the two-thirds majority required to place the proposed constitutional amendment on a statewide ballot.¹¹ When the 2012 legislature adjourned without passing legislation to authorize a state-run exchange, it was clear Kansas would default to a federally facilitated model, as the deadline for conditional approval of a state exchange was January 1, 2013, before the next legislative session.

Consideration of a federal-state partnership exchange was declined by Brownback in November 2012.¹² Currently, the state has a federally facilitated exchange, although KID received authorization from HHS in March 2013 to perform plan management functions for the Kansas FFE.¹³

Medicaid Expansion Decision Process

In 2011, Kansas was among the last of twenty-six states to join the multistate lawsuit challenging the constitutionality of the ACA.¹⁴ After the July 2012 Supreme Court ruling, which made Medicaid expansion essentially optional for states, Brownback did not officially support Medicaid expansion, but did not explicitly state that Kansas would opt out of expansion, as some conservative Republican governors had done.¹⁵

During the 2013 Kansas legislative session, the governor was quoted as saying he had “active conversations with people” about the potential benefits and risks of expanding the state’s Medicaid program, but “expansion would have to be addressed by the legislature.”¹⁶ Little legislative support existed for expansion, although some legislators — including the Senate president — expressed a willingness to remain flexible, and a bill to expand Medicaid eligibility was introduced.^{17,18} However, the bill to expand eligibility did not get a hearing. The House subsequently passed a resolution opposing Medicaid expansion, which was added as a budget proviso in the Senate. The proviso bars any expenditure for Medicaid expansion for fiscal years 2013, 2014, and 2015, unless first approved by the legislature.¹⁹

Whether Kansas will expand Medicaid in the future is unclear. In fall 2013, three national organizations tracking state ACA activity published updates of state Medicaid expansion decisions. All three organizations categorized Kansas as “not expanding Medicaid,” with only one, the Kaiser Family Foundation, stating that the Kansas governor is still “weighing options.”^{20,21,22}

In February 2013, the state's Medicaid agency released a report analyzing the costs of expanding the Medicaid program, which could be interpreted as a sign that the state was gathering information to inform a decision on expansion.²³ However, in September 2013, a spokesperson for the Brownback administration said KanCare (the state's recently launched Medicaid managed care program), was "the best path forward" for the state. He said, "Though HHS keeps continued interest in the innovative and forward-thinking measures taking place with KanCare, the state is not currently having discussions with HHS about expansion."²⁴ In addition, in testimony to a congressional committee, Kansas Lieutenant Governor Jeff Colyer referenced the Kansas position on Medicaid expansion, saying, "Kansans have chosen not to expand Medicaid."²⁵

In 2013, about thirty advocacy and industry groups formed the Kansas Medicaid Access Coalition and provided a petition to the governor with 2,700 signatures supporting expansion.^{26,27} The Kansas Hospital Association (KHA) released [an analysis](#) of the proposed Medicaid expansion, predicting minimal cost to the state and a positive impact on economic and employment growth.²⁸ KHA, and individual hospital chief executive officers (CEOs), have actively supported Medicaid expansion, as has the Kansas insurance commissioner.^{29,30,31} In December 2013, KHA announced it had hired Mike Leavitt (former HHS secretary under George W. Bush and former Republican governor of Utah) to help craft a Medicaid expansion plan for Kansas. KHA's president said he hopes Leavitt can help design a framework that Kansas Republican policymakers may support, [similar to plans developed in Arkansas and Iowa](#), which utilize premium assistance to purchase private insurance.³²

Vocal opposition to expansion has come from the state's chapter of Americans for Prosperity³³ and the conservative-leaning think tank, the Kansas Policy Institute.³⁴ In September 2013, the Kansas Republican Party adopted a resolution explicitly denouncing Medicaid expansion.³⁵ Since that time, several newspapers, including the *Kansas City Star*, *Wichita Eagle*, and *Winfield Daily Courier*, published editorials in favor of Medicaid expansion.^{36,37,38}

Key decision points in Kansas:

- September 2010: Award of \$1 million federal exchange planning grant to KID
- February 2011: Award of \$31.5 million early innovator grant to KID
- August 2011: *Return* of the \$31.5 million early innovator grant by the governor
- January-May 2012: 2012 Kansas legislative session
- June 2012: Supreme Court ruling on ACA constitutionality
- January-May 2013: 2013 Kansas legislative session

1.2. Goal Alignment

As outlined in Section 1.1, Kansas initially took an affirming response to the federal policy goals encompassed in the ACA. The state's early innovator grant application and award clearly signaled the state's intent to not only establish a state exchange, but also a willingness to share the architecture Kansas created with other states to facilitate establishment of their state exchanges.³⁹ However, even as the grant was being awarded, Kansas's position on a state exchange model became less clear when statewide elections replaced Democratic Governor Parkinson and Attorney General Steve Six with two conservative Republicans — Brownback and Derek Schmidt, respectively — in January 2011. In his first month in office, Schmidt joined the lawsuit challenging the constitutionality of the ACA.⁴⁰ By August 2011, when Brownback returned the early innovator grant, Kansas could no longer be classified as affirming federal policy goals.

For the last two years, Kansas could have been described as taking a wait and see response. The two key policy questions — establishment of a state exchange and expansion of Medicaid — have not been embraced by the governor, but also have not been overtly opposed. The governor declined the opportunity to establish a state exchange or a federal-state partnership exchange, but the state has not passed legislation prohibiting the implementation of the ACA, as some other states have done.⁴¹ The governor has not supported Medicaid expansion, but was quoted saying he has had “active conversations with people” about the potential benefits and risks of expanding the state's Medicaid program.⁴² State lawmakers have been more oppositional, passing a resolution opposing expansion in the House and adding similar language as a budget proviso in the Senate.⁴³

The state has taken advantage of other opportunities created by the ACA. For example, the state's Medicaid and social service agencies are receiving an enhanced federal match (i.e., ninety-ten funding) to upgrade the state's Medicaid eligibility determination system and are implementing a Health Homes initiative authorized by the ACA.^{44,45,46} The Kansas Department of Health and Environment has received more than \$10 million in grants for a maternal, infant, and early childhood visitation program since enactment of the ACA, and the Kansas Insurance Department has received more than \$4 million in rate review grants.^{47,48}

Overall, a wait and see response is the best description of Kansas's response to federal policy goals in the ACA.

Part 2 — Implementation Tasks

2.1. Exchange Priorities

As a state with a federally run exchange, Kansas has had little role in the prioritization of major implementation tasks — namely website development, information systems capability, program articulation, outreach, and navigational activities. Prioritization

falls under the discretion of the federal agencies in charge of the exchange. According to interviewees, implementation tasks for the Kansas exchange were largely the role of HHS, with assistance from other federal agencies that have authority under the ACA. State officials have had little influence, if any, over determining which of the implementation tasks are more important than others.

Prioritization of some implementation tasks for the Kansas exchange can be inferred from funding decisions made at the federal level. In August 2013, \$67 million in navigator grants were awarded to public and private consumer groups in the thirty-four states – including Kansas – that have federally run exchanges.⁴⁹ HHS prioritized states with the most uninsured legal residents younger than sixty-five years of age by providing those states with more funding for navigator assistance.⁵⁰ Kansas received \$886,085, while other states with larger uninsured populations received larger amounts of money. For example, Texas and Florida received \$10.9 million and \$7.9 million, respectively.⁵¹

A total of \$150 million was provided to health center programs in all fifty states to help enroll uninsured Americans in the exchanges. States with a higher proportion of uninsured legal residents received more grant funding for education and outreach activities through these programs funded under the Public Health Service Act.⁵² Out of the \$150 million, \$1,633,928, or approximately 1.1 percent, was awarded to Kansas health centers.⁵³

In addition to providing funding to the states, the federal government is doing some outreach in Kansas. Interviewees reported that HHS is focusing its outreach efforts in larger cities with the most uninsured – Wichita and Kansas City – rather than on the whole state.

Although federal officials hold the primary responsibility for prioritization, the Kansas Insurance Department has played a role in developing certain aspects of the federal exchange. Interviewees specifically cited plan management functions and consumer assistance as areas where KID influenced federal officials' conceptualization of states' roles in the operation of the federal exchange.

2.2. Leadership – Who Governs?

Interviewees reported that management of the Kansas FFE and other federally administered exchanges does not reside with one, or even several, individuals. Direction about the Kansas exchange came from a team, or multiple, topic-specific user groups of federal officials, with the composition of the team depending on the question or issue at hand. For example, different teams existed for plan management, risk adjustment, rate review, consumer assistance and outreach, etc. Team members were primarily within HHS, with some limited interactions with the Departments of Treasury and Labor, and most were located in Washington D.C. Although the Region Seven Center for Medicare & Medicaid Services (CMS) office is located in Kansas City, MO,

relatively close to the state's capital, officials in the regional office were not involved in providing input or guidance to Kansas about the exchange.

Correspondence between state officials and federal teams occurred primarily via conference calls and email. Interviewees reported that it was difficult to determine who on a federal team held leadership positions. This sometimes created uncertainty about whether a response was an official response; however, this uncertainty was alleviated by the inclusion of the entire membership of the applicable federal team on all email correspondence, assuring that everyone involved was on the same page. Interviewees stated that while this approach initially may have seemed inefficient, it quickly became clear that a team-based system was the optimal approach. Assigning responsibility to one or even a small group of individuals was not possible due to the complexity and time frame of the project.

In addition to interacting with federal teams, interviewees reported that Kansas also has a designated state officer through CMS/Center for Consumer Information and Insurance Oversight (CCIIO) for exchange operations. State officers serve as a liaison between state and federal officials, assisting with many aspects related to exchange operations. The individual assigned to Kansas has responsibility for multiple states, though interviewees were unsure which other states the officer managed. State assignments were not regional in nature and were not handled out of the CMS regional office. Interviewees reported that at the time of interviews, Kansas was on its sixth state officer since March 2010. The relatively high turnover was attributed to a number of factors, such as changing needs of Kansas or other states and reassignment of state officers to other or additional responsibilities.

In March 2013, KID received approval from CCIIO to operate as a marketplace plan management (MPM) state.⁵⁴ As an MPM, KID manages the certification of qualified health plans and collects and analyzes information on plans and rates, covered benefits and cost sharing requirements for the Kansas exchange. KID is also responsible for ensuring ongoing plan compliance, addressing consumer complaints, providing technical assistance when needed, and decertifying issuers.^{55,56}

2.3. Staffing

There are no exchange employees located within Kansas. Navigators and other assistance are discussed below.

2.4. Outreach and Consumer Education

Statewide, outreach and education efforts are largely uncoordinated. Some limited coordination exists through KID and the Kansas Marketplace Consortium, a partnership of statewide provider and nonprofit organizations involved in the federal navigator grant program (see more detail in the navigator assistance section). Although its main focus is navigator assistance, the

consortium does provide an avenue for communication among multiple partner organizations that are involved in assistance, outreach and educational efforts.

Because there is no central coordinating body for outreach and educational activities, it is difficult to describe all the activities in the state. Most of the outreach and consumer education activities occur through educational meetings targeted to both consumers and policy audiences. Some outreach is also taking place through websites devoted to the ACA; limited mass marketing; and a small amount of direct, person-to-person outreach.

The key entities involved in providing education meetings are KID, Blue Cross Blue Shield of Kansas, the Health Reform Resource Project, K-State Research and Extension, and several regionally based initiatives in the state's metro areas and in southeast Kansas.^{57,58} KID is the primary state entity involved in education and outreach activities, specifically related to the state's insurance market and insurance coverage in general. As the state's insurance regulator and consumer protection agency, KID already provides information and education to the public about insurance, regulations, and plans in the Kansas market. The insurance commissioner and staff have been active in presenting educational information about the ACA at meetings and events across the state. Blue Cross Blue Shield of Kansas organized a series of more than fifteen educational meetings across the state throughout October, November, and December. The Health Reform Resource Project, K-State Research and Extension, and regional initiatives were all active in making ACA-related presentations throughout 2013. In addition to providing educational sessions, KID staff created a website, www.insureKS.org, to inform consumers about basic insurance facts, the exchange in general, and rates and plans available on the exchange. The website, which interviewees stated has received positive feedback from other states, also includes an interactive web-based assistance tool called "Alex" that allows users to enter information and learn more about plan and pricing options that might be available to them through the exchange. The website also includes a searchable list of navigators and insurance agents and brokers by city or ZIP code, as well as a calendar of navigator assistance events throughout the state. The website integrates a variety of communication tools, such as social media, videos, interactive tools, and printable publications. In addition to the KID website, each of the insurers offering coverage in the Kansas exchange has either a stand-alone website dedicated to health care reform, or a resource page embedded in their company site.

Insurance companies have utilized some mass marketing, such as television, direct mail, and radio ads, for outreach. The insurance commissioner recorded a public service announcement for radio and television, and KID staff created brochures for members of the Kansas Marketplace Consortium, its navigators, and others to distribute. Some federal outreach resources have been

targeted to mass marketing in the state's two large metro areas but, overall, mass marketing has been limited. At this point, very little direct, person-to-person outreach has occurred outside of the navigator assistance described below.

K-State Research and Extension has developed ACA-related educational materials and has distributed them at approximately forty county fairs. Several research and extension faculty members are also completing certified application counselor (CAC) training as part of a grant through the U.S. Department of Agriculture. Some local chapters of national organizations such as the National Alliance on Mental Illness (NAMI), Planned Parenthood Federation of America, and the American Association of Retired People (AARP) are providing materials or are hosting educational sessions with support from their national organizations. Some local nonprofit organizations are also playing limited roles in the education of and outreach to their members. In various communities, local libraries have also been involved, posting materials or holding navigator assistance events with computer access.

According to interviewees, few federal outreach or resources have been targeted to Kansas, with virtually no activity outside of the state's two largest metro areas. Staff from the federal CMS regional office (located in Kansas City) have participated in some educational meetings or forums, but most of these activities have been organized by state-level entities. While some marketing materials are available from the federal government (and some Spanish-speaking materials have been helpful), several interviewees stressed that they felt in order to reach their audience, they needed Kansas-specific materials that could be seen as independent from the federal government or "Obamacare."

Currently, there are no outreach and education activities funded solely by state resources. Most activities are funded through federal or local foundation grants. Some state employees are participating in educational activities as part of, or in addition to, their existing responsibilities.

Kansas foundations have played an active role in supporting education and outreach efforts for the ACA. Multiple private health care foundations in Kansas collaborated to create the Health Reform Resource Project in the spring of 2011, which provided a pool of grant funding for community-based organizations interested in working on ACA implementation. The project is staffed by an individual active in other outreach activities as well. Private foundations have also contributed to local initiatives in Wyandotte County and southeast Kansas. Several entities that received federal funding to employ navigators also reported outreach and education activities related to navigator assistance. Insurance companies in Kansas paid for brochures that serve as the primary educational tool used by KID and the consortium. Other outreach and education is happening largely without new funding.

Local media has had both a positive and a negative role in outreach and education in Kansas. Respondents mainly reported positive or neutral experiences with the media, giving examples of coverage of educational or outreach events. Several respondents also cited examples in which media reported incorrect or misleading information about the ACA.

2.5. Navigational Assistance

The major navigator assistance activities in Kansas are being implemented by the Kansas Marketplace Consortium, a collaborative group of six statewide nonprofit organizations funded through the federal navigator grant program. The Kansas Association for the Medically Underserved (KAMU) serves as the lead agency for the consortium, which also includes the:

- Kansas Hospital Association's Kansas Hospital Education and Research Foundation
- Kansas Insurance Department
- Kansas Association of Local Health Departments
- Association of Community Mental Health Centers of Kansas
- Kansas Association of Area Agencies on Aging and Disabilities⁵⁹

The consortium received the largest federal navigator grant in Kansas, more than \$500,000. The consortium is focused on the entire state, with the goal of recruiting and training 250 navigators. The six partner organizations represent a community of entities, including safety net clinics, health departments, hospitals, community mental health centers, and area agencies on aging, in 427 locations in Kansas. The staff from the partner organizations serve on the consortium's advisory committee, which meets weekly to oversee the progress of recruiting, training, and securing office space for navigators. The partner organizations are responsible for encouraging their members (i.e., local health departments, hospitals, health centers, etc.) to participate by hosting volunteer navigators or using staff to become navigators.

The consortium's goal is to certify 250 navigators to assist approximately 48,000 Kansans. The group proactively planned its strategy for navigator assistance prior to the official posting of the federal funding opportunity, anticipating the limited time frame to design and implement the navigator program post-award. According to the consortium, more than 200 navigator candidates as of October 2013 were in various stages of screening, training, and certification at the time of interviews. As of December 2013, KID listed forty-eight available navigators on insureKS.org.⁶⁰

The consortium modeled its navigator program after the Senior Health Insurance Counseling for Kansas (SHICK) program, which relies heavily on volunteers to serve as assistants. Three regionally based navigator coordinators were hired to manage the network of navigators, with one statewide director overseeing the

program and the federal requirements. While some federal and private foundation funding has allowed for the hiring of several additional navigators and one additional coordinator, most navigators and certified application counselors (CACs) in Kansas are existing employees of organizations (clinics, hospitals, health departments, etc.) and are taking on navigator/assistor work in addition to current responsibilities. Some navigators are providing their services on a strictly volunteer basis. Unlike some other states that used navigator grant funds to hire and pay navigators, Kansas's grant funds were used to pay coordinators, and the consortium relies on volunteers to fulfill the navigator function. Kansas interviewees reported that this volunteer-based model allows them to expand capacity and utilize existing resources of partner organizations. All navigators affiliated with the consortium, whether an employee of an organization or a volunteer from the community, must go through a screening process that includes a background check and certification through the federal navigator training process.

Two other organizations received smaller federal navigator grants, and their efforts are more narrowly targeted than those of the consortium. Ascension Health, which is partnering with Wichita-based Via Christi Health System, and Advanced Patient Advocacy, LLC, which is partnering with three hospitals in the suburban Kansas City area, each received less than \$200,000 in funding and report focusing on specific counties and populations.⁶¹ Ascension Health has used its grant funds to hire two full-time and one part-time navigator. They are focused in the Sedgwick County area. Advanced Patient Advocacy, LLC, also hired three navigators with their grant funds. They are focused on four Kansas counties – Douglas, Johnson, Labette, and Wyandotte.

InsureKS.org lists seventy-four CACs across the state, although nearly half are located in the state's two main urban areas.⁶² Most CACs in Kansas are based in clinics, hospitals, or other social service agencies. There is no entity that oversees or coordinates CACs, and interviewees report that there is no federal financial support for this type of oversight or coordination. Kansas's federally qualified health clinics have also received additional federal funding to hire navigators or CACs and to support the efforts of these in-person assistors. It is unclear how many of Kansas's seventy-four CACs were hired with federal funding and how many are existing employees. InsureKS.org also lists 702 insurance agents who are available to help with enrollment through the exchange.⁶³ No collaboration was reported between agents and the other navigator assistance efforts in Kansas.

The main entities involved in navigator assistance are somewhat involved in outreach and consumer education activities, particularly in person-to-person outreach, such as navigator events or educational meetings. Much of the outreach and education in Kansas is being done by KID, which is a partner of the consortium

and maintains a list of navigators and calendar of navigator events on its website. Through the consortium, navigators and navigator coordinators are responsible for outreach in their respective communities. At the time of interviews, much of the navigators' time was being spent helping individuals who presented at the health clinic, hospital, or other location of the navigator; less time was being spent on outreach and education by the individual navigators or their partner organizations.

It is too early to assess the capability of the navigator assistance in Kansas to meet anticipated need. Although the consortium was ready to implement the navigator program shortly after the grant award was announced (August 15, 2013), the timeline to hire staff, recruit navigators, train navigators, and begin helping consumers was still short (by October 1, 2013). The model of utilizing volunteers and existing staff considerably increases the capacity of the navigators to meet the needs for assistance. However, there are nearly 200,000 uninsured Kansans eligible for tax credits through the exchange, as well as additional uninsured and insured Kansans who may seek assistance.⁶⁴ Even if the consortium meets its goal of assisting 48,000 Kansans, and the other two navigator grantees also meet their goals, there will likely still be Kansans who need assistance.

As an FFE state, Kansas navigators must be certified using the federal navigator training. While interviewees reported helpful aspects of the training, they also noted that the program was not tailored with state-specific information. For example, the federal training assumes that states expand Medicaid, and for states that don't expand Medicaid, information about tax credits and eligibility is incorrect. Therefore, a navigator trainee would have to answer a question about Medicaid expansion incorrectly in a nonexpanding state in order to provide the "correct" response for the training's test. In addition, interviewees said they felt that the federal training did not provide sufficient reference material. As a result, the consortium developed "quick guides" as reference materials for navigators and conducted additional training and technical assistance calls for navigators, so that they could adequately meet the needs for assistance and accurately answer questions of consumers.

At the time of data collection, local media outlets had published negative articles about the reputations and qualifications of individual navigators in Kansas.^{65,66,67} Interviewees noted that the negative media attention on the navigator program may adversely impact their efforts to recruit volunteers. As a result of the negative media attention, the chair of the state's Senate Public Health and Welfare Committee reported that she planned to propose legislation to regulate and license navigators and other assistants.⁶⁸ If passed, Kansas navigators would go through a screening process, which includes a background check and federal certification. This additional regulation or licensing could impact

the ability of the consortium to meet its goal of recruiting 250 navigators.

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. Agency officials stated that since opting to be a federally facilitated exchange, there has been little interaction between state agencies. Interviewees reported that during the roughly six months of work on the state's innovator grant (which called for integration of a state-based exchange with Medicaid infrastructure), interactions between the state insurance department and state Medicaid agency were frequent and productive. These interactions halted when it became clear that the state would have a federally facilitated exchange. Relationships were described as still being positive, even though interactions are not frequent.

2.6(b) Intergovernmental Relations. As described above, Kansas officials reported interacting with teams of federal officials on matters related to the exchange. Contacts are primarily housed within the HHS and HHS subagencies, CMS and the Center for Consumer Information and Insurance Oversight. Additional interactions occur with officials from the Departments of Labor and Treasury, though generally with assistance from an HHS intermediary. Interviewees noted that having direct contacts with the Labor and Treasury Departments would have been helpful, as they handle key parts of ACA implementation — tax credits and employer guidance.

Interviewees described the interactions between state and federal officials as positive. One interviewee expressed great respect for federal officials working to implement the ACA, citing how hard they have worked and their efforts to be as transparent and inclusive of state regulators as possible, even though they were “building it while flying it.”

Interviewees noted the level of effort required to stay current on the many aspects of exchange implementation. Kansas officials reported wanting to have as much input as possible on the exchange that would ultimately operate in the state, and consequently made continual efforts to interact with, and build strong working relationships with, each federal team and state officer.

According to interviewees, KID was one of a few proactive state regulatory agencies across the nation that provided feedback and guidance to HHS on several aspects of exchange operations. For example, KID officials, along with other state members of the National Association of Insurance Commissioners (NAIC), educated federal officials about the value of adopting the System for Electronic Rate and Form Filing (SERFF), used by most states to manage insurance plans. Interviewees also reported multiple conversations between federal and state officials about which entity would have responsibility for specific issues related to consumer assistance. These efforts allowed them to influence these aspects of exchange operations, and were attributed largely to the Kansas insurance

commissioner's role in the NAIC. Praeger, the insurance commissioner, is a past president of NAIC (2008) and is the current chair of the Health Insurance and Managed Care Committee.⁶⁹ Additionally, unlike most other state insurance commissioners, the Kansas insurance commissioner is an elected office, rather than a gubernatorial appointment. This uncommon structure allowed Praeger to act independently from other state officials (i.e., governor and legislators) on some matters related to the exchange.

Kansas Medicaid officials reported working primarily with federal officials at CMS, and described those working relationships as positive. Because federal and state governments have a long history of collaborating on Medicaid operations, new relationships did not have to be built in regards to the Medicaid changes with the exchange. Interviewees did not describe differences in their working relationships for exchange operations than for other Medicaid operations, though noted that they do have a designated primary contact for work related to the eligibility system upgrade and a different primary contact for exchange operational issues.

In Kansas, administration of Medicaid and Children's Health Insurance Program (CHIP) are state agency functions and do not involve local governments. As such, local governments do not interact with the exchange.

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). There are four companies offering plans in the Kansas FFE: Blue Cross Blue Shield (BCBS) of Kansas, BCBS of Kansas City, Coventry Health Care of Kansas, and Coventry Health and Life Insurance. Three of the four companies (BCBS of Kansas, BCBS of Kansas City, and Coventry Health and Life Insurance) held more than 75 percent of the state's individual market in calendar year 2012.⁷⁰

There are a total of sixty-five plans being offered in the individual and family exchange by Kansas insurers: sixteen bronze, twenty-four silver, fifteen gold, two platinum, and eight catastrophic plans. Kansas's 105 counties are divided into seven rating areas, and consumers in these areas have between seventeen and forty-two plans to choose from. The vast majority of plans offered in Kansas are Preferred Provider Organization (PPOs) plans. A limited number of Point of Service (POS) plans are available, all offered by Coventry Health Care of Kansas. One notable aspect of the insurance offerings is the decision by the two insurers (BCBS of Kansas City and Coventry Health and Life) offering coverage in Johnson and Wyandotte counties — which contain the state's second largest metropolitan area and the county (Johnson) with the highest per capita income in the state — to not offer any platinum plans. Consumers in these two counties also have the smallest number of plans to choose from (seventeen), and are the only consumers in the state who do not have a platinum plan offering.

Nationwide, use of narrow provider networks to control prices has been noted with concern by consumer advocates and health care providers.⁷¹ The *Kansas City Star* newspaper reported that in the Johnson and Wyandotte county area, BCBS of Kansas City is offering several plans with narrow provider networks — including just seven of the area hospitals in their networks, rather than the nineteen area hospitals typically covered by this insurer. Coventry Health and Life was reported to have a much broader network, though it did exclude one major hospital in the area.⁷²

The state's largest insurer, BCBS of Kansas, is not offering any plans with narrow networks. In a recorded interview with the KHI News Service and Kansas Public Radio, a company spokeswoman stated that BCBS of Kansas plans have "100 percent of the hospitals in our service area and 97 percent of all other providers in all of our plans on and off the exchange."⁷³

In twenty-three Kansas counties, Coventry Health Care of Kansas is offering POS plans, which generally have more restrictive provider networks than PPO plans. In the counties where they are offered, these plans have the lowest premiums of all available plans.

2.7(c) Program Articulation. Kansas has elected to maintain determination authority, rather than allowing the exchange to make a full Medicaid determination on behalf of the state. From October 1 through November 30, 2013, the federal exchange assessed 2,353 Kansans to be eligible for Medicaid or CHIP.⁷⁴ It is unclear how many of these people will ultimately be determined eligible by the state.

Kansas began an eligibility system upgrade in 2009, before passage of the ACA. This upgrade potentially would allow for a simple electronic interface between the federal exchange and the state system. However, Kansas Medicaid, like all other state Medicaid programs, was not sending or receiving eligibility files from the federal exchange at the time of interviews in October 2013. The state Medicaid agency was receiving "flat files" from the exchange. The flat files did not contain all the information necessary to make a Medicaid determination, but were intended to help states anticipate individual workload and customer service needs. Interviewees reported that it was too early to assess the quality of data on flat file. Some quality concerns existed based on preliminary reviews, however. But without more complete data, interviewees were not able to fully evaluate how accurately the exchange was able to apply Kansas Medicaid eligibility rules to individuals applying for coverage. On December 17, 2013, CMS began sending account transfer files to ten states whose eligibility systems were expected to process the information better than others. Kansas was not among the ten states.⁷⁵

On November 29, 2013, CMS released new guidance, providing an opportunity to request waiver authority to enroll individuals in Medicaid based on the information in an "enhanced flat file," in advance of full account transfers.⁷⁶

Whether Kansas will pursue this waiver authority is unknown as of this writing.

2.7(d) States That Did Not Expand Medicaid. Current Medicaid eligibility levels in Kansas are among the lowest in the nation. Childless adults who are not disabled cannot qualify no matter how poor they are. Parents and other caregivers can qualify only if their income is below 33 percent of the federal poverty level (\$7,770 annual income for a family of four). According to Kansas Health Institute estimates, approximately 182,000 Kansans fall into the eligibility gap between Medicaid and premium tax credit eligibility, of which approximately 78,400 do not have health insurance.

The rocky rollout of HealthCare.gov, the federal government shutdown for the first three weeks of October, and the threat of cancellation of many individually purchased health insurance policies occupied the majority of news cycles and policymakers' attention for quite some time. As such, less focus has been directed towards the eligibility gap in states that did not expand Medicaid than probably would have been otherwise. Very little news coverage in Kansas has focused exclusively on the eligibility gap, generally focusing instead on problems with obtaining coverage through HealthCare.gov.^{77,78,79,80,81,82,83,84}

The Kansas Health Consumer Coalition (KHCC) convened a Kansas Medicaid Access Coalition to lobby for expansion of Medicaid. The coalition includes more than fifty organizations, and they began lobbying efforts during the 2013 legislative session and plan to continue in 2014.^{85,86}

The Kansas Hospital Association has also been a vocal proponent of Medicaid expansion in Kansas. It released a study in February 2013 that quantified the economic impact of Medicaid expansion and estimated the creation of 4,000 new jobs and infusion of \$3 billion into the state's economy by 2020.⁸⁷ In November 2013, KHA ran a series of ads supporting Medicaid expansion.⁸⁸ In December 2013, KHA announced it had hired Mike Leavitt, the former HHS secretary, to help craft a plan [similar to those developed in Arkansas and Iowa](#), which expand Medicaid through the use of private insurance.⁸⁹

In February 2013, the state's Medicaid agency released an analysis of the cost of expanding Medicaid. It estimated a ten year cost to the state of \$1.1 billion for expansion. However, the report also described an estimated cost of \$513 million to the state for the program, even if the state chose NOT to expand, a likely result of increased enrollment of already-eligible individuals who became cognizant of Medicaid due to heightened awareness, called the "woodwork effect."

Two other cost estimates were released in the spring of 2013 – one from the Cato Institute and another from the Kansas Health Institute. Cato estimated \$4.7 billion in state cost over ten years; KHI provided a range of estimates, from \$221 to \$912 million in state cost over seven years.⁹⁰ A panel discussion (February

2013) featuring representatives of each of the organizations that created cost estimates was well attended by policymakers.⁹¹

2.8. Data Systems and Reporting

In September 2009, Kansas received a grant from the Health Resources and Services Administration (HRSA) to upgrade its Medicaid eligibility system. Work on this system upgrade continued throughout the debate and passage of the ACA and, as outlined in this report's first section, was to serve as the technological backbone for a state-based health insurance exchange.

When the state's early innovator grant was returned to the federal government in August 2011, there was a brief period of uncertainty about whether the system upgrade would continue since the original grant funding from HRSA had been discontinued by that time. However, the state applied for and received approval for enhanced (ninety-ten) funding through the ACA to continue the eligibility system upgrade. The system's online application portal was launched in September 2012.⁹² Capability to perform Medicaid eligibility determination was targeted for October 2013, but was delayed.⁹³ Use of the system to perform eligibility determinations for other benefits — i.e., the Supplemental Nutrition Assistance Program (SNAP) — is targeted for May 2014.⁹⁴

Aside from the Medicaid eligibility system upgrade, with its ability to integrate with the federal exchange as required by the ACA, interviewees reported no use of data systems or reporting to facilitate ACA exchange enrollment or monitoring. Interviewees involved in navigator functions were still in the process of recruiting navigators at the time of interviews and had not yet begun to use data to inform their outreach strategies. Other interviewees were awaiting release of enrollment data from the federal exchange and anticipated that the information may be used to determine what areas of the state were in need of additional outreach activities.

Part 3 — Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

As with other FFE states, the Small Business Health Options Program (SHOP) and individual exchanges are not combined in Kansas. There are seven plans offered on the SHOP market — two bronze, three silver, and two gold. No platinum plans are offered. Similar to the individual market, Johnson and Wyandotte counties have fewer choices than other parts of the state. Only two plans — one silver and one gold — are offered in the SHOP exchange in each of these counties. In all other areas of the state, employers have five plans to choose from.

Interviewees reported little outreach activity specific to employers and the SHOP exchange. The Kansas Insurance Department has resources geared specifically to employers, but noted

that the need for employer education is broader – both small and large employers need information about what the ACA requires of them. Overall, SHOP has been a low priority with little activity at the state level and a federal yearlong delay in the ability for small businesses to enroll online in the exchanges.

Part 4 – Summary Analysis

4.1 Policy Implications

It is difficult to assess at this point what groups will gain or lose influence as implementation of health reform goes forward. In November 2014, Kansas voters will be electing the governor and state insurance commissioner for the next four years, as well as several members of the congressional delegation. If Brownback is reelected, it is likely the approach to implementation of the ACA will continue as it has over the last four years. In addition, since Praeger is not running for reelection, a new insurance commissioner will be in office beginning in 2015, and he or she may or may not share Praeger's approach to implementation. Several members of the Kansas legislature are also up for reelection, but there is no expectation that there will be a significant change in the overall make-up of that body.

If Brownback remains in office and a more conservative insurance commissioner is elected, it seems likely that conservative legislators, and perhaps some employer groups that have been opposed to the ACA, will gain or maintain their current levels of influence toward ACA implementation. Under this scenario, insurers, hospitals, health care providers, and consumer advocates may ultimately lose some influence. In addition, even if the Democratic candidates for governor and insurance commissioner are elected, the generally conservative Kansas legislature will likely limit any significant change in the state's approach to ACA implementation.

The Kansas Hospital Association and health care foundations and advocacy groups in the state have expressed their support for Medicaid expansion to counteract changes in Medicare and Disproportionate Share Hospital payments and to reduce the number of uninsured Kansans. Going forward, whether the conservative governor and legislative majorities decide to expand Medicaid will be a key measure of the influence of these groups.

September 2014 Update

Medicaid Expansion

It is unlikely that Kansas will expand Medicaid in 2015. On April 18, 2014, Brownback signed into law House Bill 2552, which states there will be no expansion of Medicaid unless the Kansas legislature expressly consents to and approves of the expansion. The legislature completed its 2014 session in May and will not return until January 2015. On August 18, 2014, Brownback also

stated that if reelected, he would continue to fight against implementation of the Affordable Care Act and specifically stated that “we don’t need to see [Medicaid] expansion taking place in the state of Kansas.”

Navigator Assistance

In February 2014, a bill was introduced in the Kansas legislature to regulate health insurance navigators. Senate Bill 362 would have imposed a number of requirements and limitations on navigators operating in Kansas, similar to those included in a navigator law enacted in Missouri that was blocked from enforcement by the U.S. District Court for the Western District of Missouri. Ultimately, SB 362 failed to pass out of the House Committee on Health and Human Services at the end of May.

In April 2014, the Kansas Marketplace Consortium, the group that received the largest federal navigator grant for the state, reported that it had trained and certified 163 navigators in fifty-one of the 103 counties in Kansas. The consortium and its navigators conducted numerous outreach and enrollment activities during the open enrollment period, which were attended by more than 24,000 Kansans and provided direct enrollment assistance to 15,756 individuals.

2013-14 Marketplace Enrollment

For the first official open enrollment period ending March 31, 2014, 57,013 Kansans enrolled in qualified health plans through the Kansas federally facilitated marketplace. Seventy-nine percent of those individuals obtained coverage with tax credits or cost-sharing subsidies and 38 percent were age thirty-four or younger.

Data Systems

The Kansas Department of Health and Environment reported in July 2014 that there would be further delays in the enhanced functionality of the Kansas Eligibility and Enforcement System, known as KEES. Once KEES is fully operational, it will be able to process online applications for various social service programs, including Medicaid, and will also be able to exchange Medicaid eligibility information with the federally facilitated marketplace.

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