MODEL FOR A BEHAVIORAL HEALTHCARE FUNDING ACT

Model statute designed to fit here:
State Statutes
Chapter XX. Health and Safety
Article XX.
Would cite as XXXX § XX–XX.

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§ XX–XX–1. **Short Title.**

Chapter XX, Article XX may be cited as the "Healthcare Funding Act of 20__" or "HFA20__."

§ XX–XX–2. **Definitions**

A. "adult" means (i) all [state] residents who are over age 18 and under age 65 and (ii) all other persons over age 18 and under age 65 who receive healthcare services in the state.

B. "assessed entity" means any health carrier or other entity that contracts or offers to insure, provide, deliver, arrange, pay for, administer any claims for or reimburse or facilitate the sharing of any of the costs of healthcare services for any person residing in or receiving healthcare services in the state, including, without limitation, the following:

   (1) Any writer of individual, group, or stop loss insurance;

   (2) Health Maintenance Organization;

   (3) Third Party Administrator;

   (4) Preferred Provider Agreement;

   (5) Fraternal Benefit Society;

   (6) Administrative services organization and any other organization managing claims on behalf of a self-insured entity;

   (7) Any self-insurer or other entity that provides an employee or group benefit plan and does not utilize an external claims management service;

   (8) Any governmental entity that provides an employee or group benefit plan and does not utilize an external claims management service; or

   (9) Any entity, administrator or sponsor of any healthcare cost sharing program.

C. "assessment" means the association member liability with respect to costs determined in accordance with this chapter.

D. "association" means the Healthcare Information Line Association created by this chapter.

E. "board" means the board of directors of the association.

F. "child" or "children" means (i) all [state] residents who are under age 19 and (ii) all other persons under age 19 who receive healthcare services in [state].

G. "covered lives" means all individuals who reside or receive health care in the state and who are:

   (1) Covered under an individual health insurance policy issued or delivered in the state;

   (2) Covered under a group health insurance policy that is issued or delivered in the state;

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(3) Covered under a group health insurance policy evidenced by a certificate of insurance that is issued or delivered to an individual who resides in the state;

(4) Protected, in part, by a group excess loss insurance policy where the policy or certificate of coverage has been issued or delivered in the state; or

(5) Protected, in part, by an employee benefit plan of a self-insured entity or a government plan for any employer or government entity which (i) has an office or other worksite located in the state or (ii) has 50 or more employees in the state, or

(6) Participants or beneficiaries of a health cost sharing program.

H. “director” means a director of the association.

I. “executive director” means the executive director of the association.

J. "health carrier" or "carrier" means an entity subject to the insurance laws and rules of the state, or subject to the jurisdiction of the superintendent of insurance, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

K. “health cost sharing program” means any cost sharing or similar program which seeks to share or coordinate the sharing of the costs of healthcare services and which in the preceding twelve (12) months either has (a) coordinated payment for or reimbursed over $10,000 of costs for health services delivered in [state] or (b) communicated by mail or electronic media to residents of [state] concerning their potential participation.

L. “healthcare information line” or “HIL” means any information line or referral service, including the PediPRN and MomsPRN, which is available to providers in the state, and which is funded pursuant to the association’s plan of operation. ***[Adjust for correct names for any existing referral lines to be funded.]***

M. "provider" means a person licensed by the state to provide healthcare services or a partnership or corporation or other entity made up of those persons.

N. “secretary of health” means the secretary of the [state] Department of Health. ***[Adjust for correct state names.]***

O. “senior” means (i) all [state] residents who are over age 64 and (ii) all other persons over age 64 who receive healthcare services in [state].

P. “state” means the state of [state].

Q. “superintendent of insurance” means the superintendent of the [state] Office of Superintendent of Insurance. ***[Adjust for correct state names.]***

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§ XX–XX–3. **Association and HIL Fund Created**

A. There is hereby created the [state] Healthcare Information Line Association or "HILA" for the primary purpose of equitably determining and collecting assessments for the cost of HILs in the state which are not covered by other federal or state funding.

B. The association shall be comprised of all assessed entities, as defined in this chapter,

C. A HIL fund "HIL Fund" shall be maintained in the custody of the state treasurer. Receipts from public and private sources for funding HILs may be deposited into the account in the manner and method specified in the association's plan of operation. Expenditures from the account must be used exclusively for the costs of operating any HILs funded by the association, at no cost to providers. Only the secretary of health or such secretary's designee may authorize expenditures from the account.

§ XX–XX–4. **Powers and Duties**

A. The association shall be a not-for-profit, voluntary corporation and shall possess all general powers as derive from that status under state law and such additional powers and duties as are specified in this section.

B. The directors' terms and method of appointments shall be specified in the plan of operation. The board of directors shall include:

   (1) The secretary of health or the secretary's designee. ***[Adjust for correct state names.]***

   (2) The superintendent of insurance or the superintendent's designee. ***[Adjust for correct state names.]***

   (3) Three health carrier representatives.

   (4) Two provider representatives, one of whom serves primarily children and one of whom serves primarily adults.

   (5) One representative from a third-party administrator which is not a health carrier.

   (6) The board may include up to three additional members as specified in the association's plan of operation.

C. Any director may designate a personal representative to act for the director at a meeting or on a committee. A personal representative shall notify the meeting's presiding officer of such designation. A director may revoke any such designation at any time.

D. The board shall have the following duties:

   (1) Prepare and adopt articles of association and bylaws.

   (2) Prepare and adopt a plan of operation.

   (3) Submit the plan of operation to the secretary of health for approval following opportunity for comment by the superintendent of insurance.

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(4) Conduct all activities in accordance with the approved plan of operation.

(5) Undertake reasonable steps to minimize (i) duplicate counting of covered lives or (ii) duplicate assessments.

(6) Pay the association's operating costs.

(7) Remit collected assessments, after costs and reserves, to the state treasurer for credit to the HIL Fund.

(8) Submit to the secretary of health, no later than 120 days after the close of the association's fiscal year, a financial report in a form acceptable to the secretary of health.

(9) Submit a periodic noncompliance report to the secretary of health and the superintendent of insurance listing any assessed entities that failed to either (i) remit assessments in accordance with the plan of operation or (ii) after notice from the association, comply with any reporting or auditing requirement of this chapter or the plan of operation.

E. The board shall have the following powers:

(1) Enter into contracts, including one or more contracts for executive director and administrative services to administer the association.

(2) Sue or be sued, including taking any legal action for the recovery of any assessment or interest or other cost reimbursement due to the association. Reasonable legal fees and costs for any amounts determined to be due to the association shall also be awarded to the association.

(3) Appoint, from among its directors, committees to provide technical assistance and to supplement those committees with non-board members.

(4) Engage professionals including auditors, attorneys, and independent consultants.

(5) Borrow and repay working capital, reserve, or other funds and grant security interests in assets and future assessments as may be helpful or necessary for such purposes.

(6) Maintain one or more bank accounts for collection of assessments, refund overpayments, and pay the association's costs of operation.

(7) Invest reserves as the board determines to be appropriate from time to time.

(8) Provide member and public information about its operations.

(9) Enter into one or more agreements with other state or federal authorities, including similar funding associations in other states, to assure equitable allocation of funding responsibility with respect to individuals who may reside in one state but receive healthcare services in another. Any amounts owed under any such agreements shall be included in the estimated costs for assessment rate setting purposes.

(10) Enter into one or more agreements with assessed entities for one or more alternative payment methodologies for the respective assessed entity's covered lives.

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(11) Assist the secretary of health in qualification for grant and other resources from the federal government and adjust its procedures as may be needed from time to time so that appropriate adjustments are made to any assessment liability with respect to any person who is eligible for federally funded services.

(12) Perform any other functions the board determines to be helpful or necessary to carry out the plan of operation or the purposes of this chapter.

§ XX–XX–5. **Assessments**

A. Assessment rates shall be determined as follows:

(1) The secretary of health shall provide estimated HIL operation costs, not covered by any other state or federal funds, for the succeeding year no later than 120 days prior to the commencement of each year and shall update such estimate at such times as reasonably may be requested by the association.

(2) Add estimates to cover the association's operating costs, including any interest payable, for the upcoming year.

(3) Add a reserve of up to 10% of the sum of the preceding (1) and (2) for unanticipated costs.

(4) Add a working capital reserve in such amount as may be reasonably determined by the board from time to time.

(5) Subtract the amount of any unexpended fund balance, including any net investment income earned, as of the end of the preceding year.

(6) Calculate a per child covered life per month and per adult covered life per month and a per senior covered life per month amount to be self-reported and paid by all assessed entities by dividing the annual amount determined in accordance with the above subparagraphs (1) through (5) by the number of covered lives in each age band, respectively, projected to be covered by the assessed entities during the succeeding program year, divided by 12. At the option of the association, the assessment may, instead, be calculated (i) as a single per covered life assessment, not segregated for child and adult and senior covered lives or (ii) as separate child and adult covered lives assessment with the senior covered lives included with the adult covered lives.

B. Within 45 days of the close of each calendar quarter, an assessed entity must pay a quarterly assessment equal to assessment rates multiplied by the applicable number of covered life months covered by the assessed entity in the preceding calendar quarter. Unless otherwise determined by the board, the assessed entity which would have been responsible for payment or coordination of payment or reimbursement of any primary care provider healthcare services for any individual shall be the entity responsible for reporting the respective covered lives and for payment of the corresponding assessment.

C. At any time after one full year of operation under paragraphs A and B above, the association, upon two-thirds (2/3) vote of its board and the approval of the secretary of health, may:

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(1) Make changes to the assessment collection mechanism outlined in those subsections; or

(2) Add any healthcare information line or other services for which the board determines funding pursuant to this Healthcare Funding Act is desirable to those services funded by this act. Any such changes shall be reflected in an updated plan of operation available to the public.

D. If an assessed entity has not paid in accordance with this section, interest accrues at 1% per month, compounded monthly on or after the due date.

E. The board may determine an interim assessment for new programs covered or to cover any unanticipated funding shortfall. The board shall calculate a supplemental interim assessment using the methodology for regular assessments, but payable over the remaining fiscal year, and such interim assessment shall be payable together with the regular assessment commencing the calendar quarter that begins no less than 30 days following the establishment of the interim assessment. The board may not impose more than one interim assessment per year, except in the case of a public health emergency declared in accordance with state or federal law.

F. For purposes of rate setting, medical loss ratio calculations, and reimbursement by plan sponsors, all association assessments are considered medical benefit costs and not regulatory or administrative costs.

G. In the event of any insolvency or similar proceedings affecting any payer, assessments shall be included in the highest priority of obligations to be paid by or on behalf of such payer.

H. **[Alternative A – Annual Accounting]** The state treasurer shall supply funds as needed for HIL operations throughout the state's fiscal year. No later than 45 days following the close of the state's fiscal year, the state treasurer shall provide an accounting of HIL operating costs not covered by any other state or federal program and advise the association of the final amount needed to cover the prior fiscal year. The association shall reimburse such amount within 45 days of receiving the accounting, provided, however, that with respect to all or any part of any amount due which exceeds 105% of the amount which had been projected by the secretary of health to be needed for such fiscal year, the association may defer such payment and the state treasurer shall include such deferral in the subsequent year's accounting. In the event of such deferral, any such remaining unreimbursed amount shall be included in the assessment calculation by the association for the funds to be raised by the association in the subsequent year.

[Alternative B – Just in Time Funding] The secretary of health's designee shall advise the association not later than 5 business days in advance of the association's share of funding for each HIL program expense payment. Not later than 2 business days prior to the payment due date, the association shall transfer by automated clearinghouse transaction or wire or otherwise deposit such share into the HIL Fund.

I. If the association discontinues operation for any reason, any unexpended assessments, including unexpended funds from prior assessments in the HIL Fund, after the association's wind down expenses, shall be refunded to payees in proportion to the respective assessment

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payments by payees over the most recent eight quarters prior to discontinuation of association operations.

§ XX–XX–6. **Reports and Audits**

A. Each assessed entity is required to report its respective numbers of covered lives in a timely fashion as prescribed in this chapter and respond to any audit requests by the association related to covered lives or assessments due to the association. Upon failure of any assessed entity to respond to an audit request within 10 days of the receipt of notification of said audit request by the association, the assessed entity shall be responsible for prompt payment of the fees of any outside auditor engaged by the association to determine such information and shall make all books and records requested by said auditors available for inspection and copying at such location within the state as may be specified by such auditor.

B. Failure to cure non-compliance with any reporting, auditing, or assessment obligation to the association within 30 days from the postmarked date of written notice of noncompliance shall subject the assessed entity to all the fines and penalties, including suspension or loss of license, allowable under any provision of any other state statute. Any monetary fine or penalty shall be remitted to the HIL Fund and, thereby, reduce future obligations of the association for HIL funding. The assessed entity also shall pay for reasonable attorneys' fees and any other costs of enforcement under this section.

§ XX–XX–7. **Immunity**

Apart from liabilities of assessed entities expressly stated in this chapter or the plan of operation, there shall be no liability on the part of and no cause of action of any nature shall arise against (i) any association member or a member's agents, independent contractors, or employees, (ii) the association or its agents, contractors, or employees, (iii) members of the board of directors, (iv) the secretary of health or the representatives thereof, or (v) the superintendent of insurance or the representatives thereof, for any action or omission by any of them related to activities under this chapter.

§ XX–XX–8. **Tax Exempt Status**

The association is expressly granted exemption from all taxes levied either by the state or any governmental entity located therein.

§ XX–XX–9. **Severability**

If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

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§ XX–XX–10. **Rulemaking**

The secretary of health and the superintendent of insurance may adopt rules to carry out the purposes of this chapter.

§ XX–XX–11. **Administrative Allowance to Department of Health**

Within forty-five days following the close of each calendar quarter, the association shall transfer from assessments raised a sum equal to _____________ percent (___%) of the costs funded by the association to the [state] Department of Health's ________ account in recognition of the support from the department and its staff in enabling association members to meet their obligations for funding healthcare services at lower cost.

§ XX–XX–12. **Transitional Matters**

To generate sufficient start-up funding, the association may accept prepayment from member assessed entities, subject to offset of future amounts otherwise owing or other repayment method as determined by the board.

This act shall take effect upon passage. However, no assessment shall become effective before January 1, ____.

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It is the mission of KV Foundation to reduce barriers that limit healthcare services for individuals, no matter their medical insurance coverage. KV Foundation encourages best practices in the funding of healthcare but is not itself a policy maker.

The draft is offered as an uncompensated service to local policy officials or industry organizations with the understanding that it would be reviewed by appropriate legislative services staff in the respective state prior to being made part of any bill. In particular, the titles of all state officials should be conformed to state practice.

KV Foundation is pleased to assist states, state agencies, and state-chartered not-for-profit organizations prior to state policy being set by the respective state legislature. Ideally, this occurs after consultation and consensus building involving appropriate health and health insurance agencies along with key private stakeholders, including, at a minimum, key organizations concerned with medical care and health insurance operations in the state.

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