HEALTH CARE

Medicaid Expansion / Health Insurance Exchange

This act expands Medicaid under the Affordable Care Act through the “private option” of policies offered on the state Health Insurance Exchange. The act allows low-income individuals to buy private insurance with Medicaid funding.

Submitted as:
Arkansas
HB 1219 (Section 21)
Status: Signed into law on April 23, 2013.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] Health Care Independence Act of 2013.

Section 2. [Legislative intent.]
(a) Notwithstanding any general or specific laws to the contrary, the Department of Human Services is to explore design options that reform the Medicaid Program utilizing the Health Care Independence Act of 2013 so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program utilizing competitive and value-based purchasing to:
(1) Maximize the available service options;
(2) Promote accountability, personal responsibility, and transparency;
(3) Encourage and reward healthy outcomes and responsible choices; and
(4) Promote efficiencies that will deliver value to the taxpayers.

(b) (1) It is the intent of the General Assembly that the State of Arkansas through the [Department of Human Services] shall utilize a private insurance option for low-risk adults.
(2) The Health Care Independence Act of 2013 shall ensure that:
(A) Private health care options increase and government-operated programs such as Medicaid decrease; and
(B) Decisions about the design, operation and implementation of this option, including cost, remain within the purview of the State of Arkansas and not with Washington, D.C.

Section 3. [Purpose.]
(a) The purpose of this subchapter is to:
(1) Improve access to quality health care;
(2) Attract insurance carriers and enhance competition in the Arkansas insurance marketplace;
(3) Promote individually-owned health insurance;
(4) Strengthen personal responsibility through cost-sharing;
(5) Improve continuity of coverage;
(6) Reduce the size of the state-administered Medicaid program;
(7) Encourage appropriate care, including early intervention, prevention, and wellness;
(8) Increase quality and delivery system efficiencies;
(9) Facilitate Arkansas's continued payment innovation, delivery system reform, and market-
driven improvements;
(10) Discourage over-utilization; and
(11) Reduce waste, fraud, and abuse.
(b) The [State] shall take an integrated and market-based approach to covering low-income
Arkansans through offering new coverage opportunities, stimulating market competition, and
offering alternatives to the existing Medicaid program.

Section 4. [Definitions.]
As used in this subchapter:
(1) “Carrier” means a private entity certified by the [State Insurance Department] and offering
plans through the Health Insurance Marketplace;
(2) “Cost sharing” means the portion of the cost of a covered medical service that must be paid
by or on behalf of eligible individuals, consisting of copayments or coinsurance but not
deductibles;
(3) “Eligible individuals” means individuals who:
(A) Are adults between nineteen (19) years of age and sixty-five (65) years of age with an
income that is equal to or less than one hundred thirty-eight percent (138%) of the federal
poverty level, including without limitation individuals who would not be eligible for
Medicaid under laws and rules in effect on January 1, 2013;
(B) Have been authenticated to be a United States citizen or documented qualified alien
according to the federal Personal Responsibility and Work Opportunity Reconciliation
Act of 1996, Pub. L. No. 104-193, as existing on January 1, 2013; and
(C) Are not determined to be more effectively covered through the standard Medicaid
program, such as an individual who is medically frail or other individuals with
exceptional medical needs for whom coverage through the Health Insurance Marketplace
is determined to be impractical, overly complex, or would undermine continuity or
effectiveness of care;
(4) “Healthcare coverage” means healthcare benefits as defined by certification or rules, or both,
promulgated by the [State Insurance Department for the Qualified Health Plans] or available
on the marketplace;
(5) “Health Insurance Marketplace” means the vehicle created to help individuals, families, and
small businesses in [State] shop for and select health insurance coverage in a way that
permits comparison of available Qualified Health Plan based upon price, benefits, services,
and quality, regardless of the governance structure of the marketplace;
(6) “Premium” means a charge that must be paid as a condition of enrolling in health care
coverage;
(7) “Program” means the Health Care Independence Program established by this subchapter; and
(8) “Qualified Health Plan” means a [State Insurance Department] certified individual health
insurance plan offered by a carrier through the Health Insurance Marketplace.
Section 5. [Administration of the Health Care Independence Program.]

(a) The [Department of Human Services] shall:

(1) Create and administer the Health Care Independence Program; and

(2) Submit Medicaid State Plan Amendments and apply for any federal waivers necessary to
    implement the program in a manner consistent with this subchapter.

(b) Implementation of the program is conditioned upon the receipt of necessary federal
    approvals.

(1) If the [Department of Human Services] does not receive the necessary federal approvals,
    the program shall not be implemented.

(c) The program shall include premium assistance for eligible individuals to enable their
    enrollment in a Qualified Health Plan through the Health Insurance Marketplace.

(d) The [Department of Human Services] is specifically authorized to pay premiums and
    supplemental cost-sharing subsidies directly to the Qualified Health Plans for enrolled
    eligible individuals.

(1) The intent of the payments under subdivision (d)(1) of this section is to increase
    participation and competition in the health insurance market, intensify price pressures,
    and reduce costs for both publicly and privately funded health care.

(e) To the extent allowable by law:

(1) The [Department of Human Services] shall pursue strategies that promote insurance
    coverage of children in their parents' or caregivers' plan, including children eligible for
    the [ARKids First Program Act], commonly known as the ["ARKids B program"]; and

(2) Upon the receipt of necessary federal approval, during calendar year [2015] the
    [Department of Human Services] shall include and transition to the Health Insurance
    Marketplace:

       (A) Children eligible for the[ ARKids First Program Act]; and

       (B) Populations under Medicaid from zero percent (0%) of the federal poverty level to
           seventeen percent (17%) of the federal poverty level.

(3) The [Department of Human Services] shall develop and implement a strategy to inform
    Medicaid recipient populations whose needs would be reduced or better served through
    participation in the Health Insurance Marketplace.

(f) The program shall include allowable cost sharing for eligible individuals that is comparable
    to that for individuals in the same income range in the private insurance market and is
    structured to enhance eligible individuals' investment in their health care purchasing
    decisions.

(g) The [State Insurance Department and Department of Human Services] shall administer
    and promulgate rules to administer the program authorized under this subchapter.

(1) No less than thirty (30) days before the [State Insurance Department and Department of
    Human Services] begin promulgating a rule under this subchapter, the proposed rule shall
    be presented to the [Legislative Council.]

(h) The program authorized under this subchapter shall terminate within one hundred twenty
    (120) days after a reduction in any of the following federal medical assistance percentages:

(1) One hundred percent (100%) in 2014, 2015, or 2016;

(2) Ninety-five percent (95%) in 2017;
(3) Ninety-four percent (94%) in 2018;
(4) Ninety-three percent (93%) in 2019; and
(5) Ninety percent (90%) in 2020 or any year after 2020.

(i) An eligible individual enrolled in the program shall affirmatively acknowledge that:
(1) The program is not a perpetual federal or state right or a guaranteed entitlement;
(2) The program is subject to cancellation upon appropriate notice; and
(3) The program is not an entitlement program.

(j)
(1) The [Department of Human Services] shall develop a model and seek approval from the Center for Medicare and Medicaid Services to allow a limited number of enrollees to participate in a pilot program testing the viability of a Health Savings Account or a Medical Savings Account.
(2) The pilot program shall be implemented during calendar year 2015.
(3) As soon as practicable, the [Department of Human Services] shall seek conditional federal approval to place Health Savings Accounts and Medical Savings Accounts on the Health Insurance Marketplace.

(k)
(1) State obligations for uncompensated care shall be projected, tracked, and reported to identify potential incremental future decreases.
(2) The [Department of Human Services] shall recommend appropriate adjustments to the General Assembly.
(3) Adjustments shall be made by the General Assembly as appropriate.

(l) The [Department of Human Services] shall track the Hospital Assessment Fee as [Insert citation] and report to the General Assembly subsequent decreases based upon reduced uncompensated care.

(m) On a quarterly basis, the [Department of Human Services and the State Insurance Department] shall report to the [Legislative Council] or to the [Joint Budget Committee] if the General Assembly is in session, available information regarding:
(1) Program enrollment;
(2) Patient experience;
(3) Economic impact including enrollment distribution;
(4) Carrier competition; and
(5) Avoided uncompensated care.

Section 6. [Standards of healthcare coverage through the Health Insurance Marketplace.]
(a) Healthcare coverage shall be achieved through a qualified health plan at the silver level as provided in 42 U.S.C. §§ 18022 and 18071, as existing on January 1, 2013, that restricts cost sharing to amounts that do not exceed Medicaid cost-sharing limitations.
(b) All participating carriers in the Health Insurance Marketplace shall offer healthcare coverage conforming to the requirements of this subchapter.
(c) To assure price competitive choice among healthcare coverage options, the [State Insurance Department] shall assure that at least two (2) qualified health plans are offered in each county in the state.
(d) Health insurance carriers offering health care coverage for program eligible individuals shall participate in Arkansas Payment Improvement Initiatives including:
(1) Assignment of primary care clinician;
(2) Support for patient-centered medical home; and
(3) Access of clinical performance data for providers.
(e) On or before July 1, 2013, the [State Insurance Department] shall implement through
certification requirements, rule, or both the applicable provisions of this subchapter.

Section 7. [Enrollment.]
(a) The General Assembly shall assure that a mechanism within the Health Insurance
Marketplace is established and operated to facilitate enrollment of eligible individuals.
(b) The enrollment mechanism shall include an automatic verification system to guard against
waste, fraud, and abuse in the program.

Section 8. [Severability.] Insert severability clause.
Section 9. [Repealer.] Insert repealer clause.
Section 10. [Effective Date.] Insert effective date.