Hall of the House of Representatives

89th General Assembly - Regular Session, 2013

Amendment Form

Subtitle of House Bill No. 1965

TO REFORM THE STATE MEDICAID PROGRAM.

Amendment No. 1 to House Bill No. 1965

Amend House Bill No. 1965 as originally introduced:

Page 1, lines 9 and 10, delete the title in its entirety and substitute the following:
"AN ACT CONCERNING HEALTH INSURANCE FOR CITIZENS OF THE STATE OF ARKANSAS; TO CREATE THE HEALTHCARE REFORM ACT OF 2013; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES."

AND

Page 1, line 14, delete the subtitle in its entirety and substitute the following:
"TO CREATE THE HEALTHCARE REFORM ACT OF 2013; AND TO DECLARE AN EMERGENCY."

AND

Delete everything after the enacting clause and substitute the following:

"SECTION 1. Arkansas Code Title 20, Chapter 77, is amended to add an additional subchapter to read as follows:

Subchapter 21 — Healthcare Reform Act of 2013

20-77-2101. Title.

This act shall be known and may be cited as the "Healthcare Reform Act of 2013".

20-77-2102. Legislative intent.

(a) The Department of Human Services shall explore design options that reform the Medicaid program utilizing the Healthcare Reform 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 and transparency that will deliver value to the taxpayers.

(b)(1)(A) It is the intent of the General Assembly that the State of Arkansas through the Department of Human Services shall utilize a private insurance plan with an independence account for all "low-risk" participants.

(B) The private plan is for all "low-risk" participants who may be eligible for traditional Medicaid.

(2) The Healthcare Reform Act of 2013 shall ensure that:

(A) Private healthcare plans increase and government-operated programs such as Medicaid decrease;

(B) Decisions about the design, operation, and implementation of the private plan, including cost, remain within the purview of the State of Arkansas and not with Washington, D.C.; and

(C) Shall be for citizens of the United States who have resided in Arkansas for a minimum of five (5) years.

(c) It is the intent of the General Assembly that:

(1) The State of Arkansas furnish services to help families and individuals attain or retain capability for independence or self-care; and

(2) Public assistance, the Healthcare Reform Program, and the Medicaid Program shall be sustainable, accountable, cost-effective, person-centered and opportunity-driven programs utilizing competitive and value-based purchasing and private healthcare plans to maximize available services and encourage complete independence from public assistance and services.

(d) It is the intent of the General Assembly to redesign the Healthcare and Medicaid Programs utilizing private sector healthcare plans in order to achieve a person-centered, accountable, and opportunity-driven program.

(e) It is the intent of the General Assembly that the Healthcare and Medical Assistance Programs be a results-oriented system of coordinated care that focuses on independence, freedom, and choice that maximizes the available service options; promotes accountability and transparency; encourages and rewards healthy outcomes, personal responsibility, and responsible choices; drives employment first; and mandates efficiencies and program integrity.

(f) To achieve these goals, the Department of Human Services shall apply for any necessary waivers, state plan amendments, or both from the Secretary of the United States Department of Health and Human Services, including without limitation a waiver of the appropriate sections of Title XIX, 42 U.S.C. § 1396 et. seq.

(g) The application for and the provisions of a waiver, state plan amendment, or both under subsection (f) of this section shall be implemented to ensure that upon the enactment of the federal waiver, the Department of Human Services shall adopt rules approved by the General Assembly in order to implement the federal waiver, state plan amendment, or both to create a private-sector-type plan that is free from burdensome federal regulations.

20-77-2103. 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;

(11) Reduce waste, fraud, and abuse; and

(12) Increase transparency.

(b)(1) The State of Arkansas shall take an integrated and market-based approach to covering low-income Arkansans by offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program.

(2) The market-based approach shall:

(A) Maximize the available service options;

(B) Promote accountability, personal responsibility, independence, self-care, and transparency;

(C) Encourage and reward healthy outcomes and responsible choices; and

(D) Promote efficiencies that will deliver value to the participants, the state, and the federal government.

20-77-2104. 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 individual" means an individual who is an adult 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 an individual who:

(A) Would not be eligible for Medicaid under laws and rules in effect on January 1, 2013;

(B) Has 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; and

(C) Is not determined to be more effectively covered through the standard Medicaid program, such as an individual who is medically frail or other individual with exceptional medical needs for whom coverage through the Health Insurance Marketplace is determined to be impractical or overly complex, or that 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 Arkansas 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)(A) "Low risk" means Medicaid-eligible citizens who are not aged, blind, or disabled as defined by the Department of Human Services on January 1, 2013.

(B) "Low risk" includes children eligible for Medicaid and for the ARKids First Program Act, § 20-77- 1101 et seq., commonly known as the "ARKids B program" as defined by the Department of Human Services on January 1, 2013;

(7) "Premium" means a charge that must be paid as a condition of enrolling in healthcare coverage;

(8) "Program" means the Healthcare Reform Program established by this subchapter;

(9) "Qualified Health Plan" means a State Insurance Department certified individual health insurance plan offered by a carrier through the Health Insurance Marketplace; and

(10) Independence Account means a flexible personalized account for the recipient that can be used for medical expenses, employment training, and costs of education.

20-77-2105. Public-sector-type plans.

(a) The Department of Human Services shall design public-sector-type plans that reform the Medicaid program so that it is a person-centered, financially sustainable, accountable, cost-effective, transparent, and opportunity-driven program with choices that:

(1) Utilizes private-sector modeled, competitive, and value-based purchasing to maximize the available service options, promote accountability and transparency, encourage and reward healthy outcomes, independence, upward mobility, employment-first, and responsible choices;

(2) Promotes efficiencies and the coordination of services across all populations;

(3) Ensures that recipients pay fair share and that program integrity resounds throughout the program; and

(4) Ensures the state will have a fiscally sound source of publicly financed healthcare for the most needy Arkansans.

(b) In developing and implementing this system of reform, the Department of Human Services shall pursue the following principles and goals:

(1) Allow recipients to make reasoned and cost-effective choices about their health by providing them with the information and array of service options they need and offering rewards for healthy decisions, employment and training, and personal accountability and cost effectiveness;

(2) Encourage personal responsibility by deploying cost sharing, encouraging shopping for healthcare services and assuring the information available to beneficiaries is easy to understand and accurate, providing an intermediary if necessary, and providing adequate access to needed services;

(3) Enable consumers to receive individualized health care that is outcome-oriented, focused on prevention and wellness, disease management, recovery, and maintaining full independence;

(4) Enable consumers to become engaged in their healthcare by

establishing Independence accounts that drive personal responsibility and incentivize and reward health behaviors, employment, and outcomes;

(5) Promote private-sector-type competition between healthcare providers to ensure best-value purchasing and the best price possible to leverage resources and to create opportunities for improving service quality and performance;

(6) Redesign purchasing and payment methods to assure fiscal accountability;

(7) Encourage and reward service quality and cost effectiveness by tying reimbursements to evidence-based performance measures and standards, including those related to patient satisfaction;

(8) Ensure that all beneficiaries have a primary care medical home or care management that drives wellness, prevention, and coordinated care that provides quality and is cost-effective for the taxpayer;

(9)(A) Continually improve technology to be fully transparent on cost and price, including designing and deploying a transparency tool so that recipients can shop and be rewarded for cost-effective, quality-driven choices and take advantage of recent innovations and advances that help decision makers, consumers, and providers to make informed and cost-effective decisions regarding health care.

(B) The technology under subdivision (b)(9)(A) of this section may engage the consumers, case managers, and clinicians in tracking health outcomes and improving health; and

(10)(A) Design an enterprise-wide program integrity plan to promote and enforce program integrity through continual audits to ensure that waste and fraud are eradicated.

(B) The department may choose any method for achieving and implementing the principles enumerated in this act that provides program flexibility in exchange for federal budgetary certainty and under which Arkansas will operate all facets of the state's Medicaid program free from federal rules and regulations;

(c) The department shall submit a report to the Governor and the General Assembly by December 1, 2013, and annually thereafter describing the status of the administration and implementation of the private-sector-type plan.

20-77-2106. Administration of the Healthcare Reform Program.

(a) The Department of Human Services shall:

(1) Create and administer the Healthcare Reform 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 free from burdensome federal rules.

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

(d)(1) Where appropriate, the Department of Human Services may pay premiums and supplemental cost-sharing subsidies directly to the Qualified Health Plans for enrolled eligible individuals.

(2) The intent of the payments under subdivision (d)(1) of this section is to increase participation and competition in the Health Insurance

Marketplace, intensify price pressures, and reduce costs for both publicly and privately funded health care and deliver value to the taxpayers.

(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, § 20-77-1101 et seq., commonly known as the "ARKids B program"; and

(2) The Department of Human Services shall develop 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 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 healthcare purchasing decisions.

(g) The program used shall be the most cost effective program available on the market to deliver value to the taxpayers.

(h)(1) The State Insurance Department and Department of Human Services shall administer and promulgate rules to administer the program approved by the General Assembly authorized under this subchapter.

(2) 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.

(i) 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.

(j) 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; and

(2) The program is subject to cancellation upon appropriate notice, and waiting lists may be implemented; and

(k) This program shall not take effect until the federal government approves 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 waiting lists may be implemented; and

(3) The program is not an entitlement program.

20-77-2107. Independence Account for recipients.

(a)(1) As part of the private plan, the Department of Human Services shall design an Independence Account for all recipients in the private plan that will be the focus of driving personal responsibility, independence, healthy living, and upward mobility.

(2) The recipient may be incentivized without limitation to achieve a healthier life style, better health, employment, or education.

(b)(1) The Independence Account shall be used without limitation to ensure that funds deposited by the state to be used for:

(A) Healthcare-related expenses;

(B) Employment training and costs associated with employment; and

(C) Education, training, and educational expenses for their children.

(2) Funds may be rolled over from year to year so that the account grows to help the recipient to achieve a better lifestyle.

(c) The goal of this account is to drive personal responsibility and upward mobility so that the recipient can live free from government subsidy.

(d)(1) The department shall establish and oversee an assessment and coordination process to assure proper decision making and program planning for recipients occur in addition to financial eligibility.

(2) The assessment and coordination process shall determine healthcare status, track utilization, assist with employment and monitor outcomes.

(3) The department may also choose to establish an administrative services organization as a means to manage populations across human services programs.

(e)(1) The department shall also design and implement either internally or through the health carrier, a transparency tool to enable recipients to be able to shop for cost-effective and quality-based care.

(2) The transparency tool shall engage the recipients in the cost and quality of their health care.

(3) If a recipient chooses cost-effective and quality-based providers, he or she shall be rewarded through his or her Independence Account.

(f) The department shall adopt rules to govern the Independence Account to be approved by the General Assembly.

20-77-2108. Waiver and state plan amendment.

(a)(1) The Department of Human Services shall apply for and obtain a waiver, a state plan amendment, or both that provide full program flexibility in exchange for federal budgetary certainty under which Arkansas will operate all facets of the state's Medicaid program.

(2) The waiver, state plan amendment, or both, and flexibility sought shall provide that this subchapter shall not be effective until the United States Government waives the following federal provisions or mandates:

(A) Actuarial Soundness under 42 C.F.R. 438.6(c) or all actuarial soundness rules;

(B) Equal Access to Care under 42 USC § 1396a(a)30, or all equal-access-to-care rules;

(C) Section 1902(a)(23) of Title XIX of the Social Security Act or a state or federal law that is commonly known as the "any willing provider" or a "free choice of provider" provision, 42 U.S.C. Section 1902(a)(10)(B), Section 1902(a)(17), or any references to free choice of providers;

(D) Amount, duration, and scope of services;

(E) Comparability of eligibility standards;

(F) Cost sharing under Section 1902(a)(14) insofar as it incorporates section 1916;

(G) Cost sharing under Section 1902(a)(14), 1916(e) and(f), and 42 C.F.R. 447.51, 447.53(e) and 447.56;

(H) Freedom of choice under Section 1902(a)(23) and all references to freedom of choice;

(I) Statewideness under Section 1902(a)(1) and all references to statewideness;

(J) Statewideness/Uniformity under Section 1902(a)(1)and all references to statewideness;

(K) Reasonable promptness under Section 1902(a)(8)and all references to reasonable promptness;

(L) Section 1902(a)(10)(C)(i) to allow Health Savings Accounts or Independence Accounts;

(M) Income and Resource Rules under Section 1902(a)(10)(C)(i);

(N) Payment for self-directed Care under Section 1902(a)(32), or both;

(O) Mandatory and optional services under 42 C.F.R. 440 or any references to mandatory and/or optional services; and

(P) Mandatory health benefits regulations under 45 C.F.R. Parts 147, 155, and 156 benchmark and benchmark-equivalent under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148; and

(3) This subchapter shall not be effective until the United States Government allows:

(A) The state to create resource tests or asset tests;

(B) The state to time limit able-bodied recipients and hold able-bodied recipients to strict work requirements;

(C) Health savings accounts or Independence Accounts;

(D) A program or option that is for citizens only;

(E) The state to create waiting lists for all Medicaid services under State wideness/Uniformity Section 1902(a)(1) and Reasonable Promptness § 1902(a)(8);

(F) The state to eliminate wrap-around services for all "low-risk" participants on Medicaid or Medicaid expansion or on the private plan; and

(G) The State of Arkansas to gradually implement the private plan.

(b) By December 1, 2013, the Department of Human Services shall provide proof to the cochairs of the Legislative Council that the private plan created under this subchapter is ready to be implemented and that all systems are in place and all healthcare networks are established in each county of this state.

(c)(1) A participant in the private plan created under this subchapter is eligible for only those benefits provided by a Health Plan or other appropriate care-management entity.

(2) Wrap-around services are not included and are not available to participants in this private plan created under this subchapter.

(3) The program shall not be effective until the state receives a formal commitment from the United States Government that wrap-around services are not part of the program.

(d) The Department of Human Services shall develop a model and seek to:

(1) Waive provisions of Title XIX of the Social Security Act, 42

U.S.C. § 1396 et. seq., requiring:

(A) State-wideness to allow for the provision of different services in different areas/regions of the state;

(B) Comparability of services to allow for the provision of different services to members of the same or different coverage groups;

(C) Prohibitions restricting the amount, duration, and scope of services included in the Medicaid state plan;

(D) Prohibitions limiting freedom of choice; and

(E) Retroactive payment for medical assistance, at the state's discretion.

(2) Waive the applicable provisions of Title XIX of the Social Security Act, 42 U.S.C. § 1396 et. seq., required to:

(A) Expand cost-sharing requirements above the five per cent (5%) of income threshold for beneficiaries in certain populations; and

(B) Establish Independence Accounts that encourage personal responsibility and reward beneficiaries who reach certain prevention and wellness targets or employment, or educational goals;

(3) Establish waiting lists if necessary for Medicaid services;

(4) Expand disease management and wellness programs for all Medicaid beneficiaries;

(5) Empower and mandate able-bodied Medicaid beneficiaries to work whenever possible and mandate all able-bodied Medicaid beneficiaries who are not working to search for work;

(6) Drive competition into the Medicaid program and ensure best prices.

(e)(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.

(f) The Department of Human Services shall track the Hospital Assessment Fee as defined in § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.

(g) 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.

20-77-2109. Standards of healthcare coverage through the Health Insurance Marketplace.

(a) Healthcare coverage shall be achieved through a health plan or other appropriate quality-based plan.

(b) All participating carriers in the Health Insurance Marketplace shall offer quality approved health care.

(c) To assure price competitive choice among healthcare coverage options, the State Insurance Department shall assure that at least two (2)

Qualified Health Plans or appropriate care alternatives 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 initiative 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.

20-77-2110. 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 Healthcare Reform Program.

20-77-2111 Effective date.

This subchapter shall be in effect until June 30, 2017, unless amended or extended by the General Assembly.

SECTION 2. Arkansas Code Title 19, Chapter 5, Subchapter 11, is amended to add an additional section to read as follows:

19-5-1140. Healthcare Reform Program Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "Healthcare Reform Program Trust Fund".

(b)(1) The Healthcare Reform Program Trust Fund shall consist of moneys saved and accrued under the Healthcare Reform Act of 2013, § 20-77-2101 et seq.

(2) The fund shall also consist of other revenues and funds authorized by law.

(c) The fund may be used by the Department of Human Services to pay for future obligations under the Healthcare Reform Program created by the Healthcare Reform Act of 2013, § 20-77-2101 et seq.

SECTION 3. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the Healthcare Reform Program requires private insurance companies to create, present to the Department of Human Services for approval, implement, and market a new kind of insurance policy; and that the private insurance companies need certainty about the law creating the Healthcare Reform Program before fully investing time, funds, personnel, and other resources to the development of the new insurance policies. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the

bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

The Amendment was read _____

By: Representative Westerman

MGF/NJR - 04-10-2013 12:41:49 _____

MGF629 **Chief Clerk**