INTERIM STUDY PROPOSAL 2009-236

State of Arkansas
88th General Assembly
Regular Session, 2011

A Bill

MGF/CDS
HOUSE BILL

By: Representative King

Filed with: Arkansas Legislative Council
pursuant to A.C.A. §10-3-217.

For An Act To Be Entitled

AN ACT TO CONVERT MEDICAID AND ARKIDS FIRST TO PREMIUM ASSISTANCE PROGRAMS TO ALLOW LOW-INCOME FAMILIES TO PARTICIPATE IN PRIVATE SECTOR HEALTH INSURANCE PLANS; TO PROVIDE FOR AN AMENDED STATE PLAN FOR MEDICAID AND ARKIDS FIRST; TO PROVIDE FOR PREMIUM ASSISTANCE; TO PROVIDE FOR PREMIUMS AND COST SHARING; TO PROVIDE FOR AN INDIVIDUAL INCENTIVE PROGRAM; TO PROVIDE FOR EMPLOYER AND GROUP HEALTH PLAN REQUIREMENTS; AND FOR OTHER PURPOSES.

Subtitle

TO CONVERT MEDICAID AND ARKIDS FIRST TO PREMIUM ASSISTANCE PROGRAMS TO ALLOW LOW-INCOME FAMILIES TO PARTICIPATE IN PRIVATE SECTOR HEALTH INSURANCE PLANS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

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

Subchapter 20. Market-based Premium Assistance Program

20-77-2001. Definitions.

As used in this subchapter:

(1) "ARKids First Program" means the state plan under § 20-77-1101 et seq;

(2) "Cost effective" means that the cost of qualified group coverage under this subchapter meets the cost-effectiveness test requirements allowable under federal requirements under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., as it existed on January 1, 2011;

(3) "Full benefit eligible individual" means an individual who meets the criteria established in Section 1937(a)(2)(C)(i) of the Social Security Act;

(4) "Insurer" means any person or organization subject to the authority of the Insurance Commissioner that offers or issues one (1) or more health benefit plans or insurance in this state, including without limitation:

(A) An insurance company;

(B) A hospital and medical services corporation;

(C) A fraternal benefit society;

(D) A health maintenance organization; and

(E) A multiple employer welfare arrangement;

(5) "Premium assistance subsidy" means payments on behalf of individuals under Title XIX or XXI of the Social Security Act consistent with federal requirements for the purchase of qualified group coverage;

(6)(A) "Qualified health benefit plan" means a group health plan that conforms with the requirements under federal law for the purposes of matching requirements under Title XIX or XXI of the Social Security Act.

(B) "Qualified health benefit plan" includes health insurance coverage offered through an employer;

(7) "Self-funded health benefit plan" means a health benefit plan that is:

(A) Not subject to regulation by this state or any state; and

(B) Paid in whole or in part by the employer from its own assets or from a funded welfare benefit plan, if the plan does not shift any risk or liability for benefit payments to an insurer other than through reinsurance or stop-loss coverage; and

(8) "Targeted low-income child" means a child:

(A) Whose family income is the greater of the following:

(i) Above the Medicaid eligibility level and below two hundred percent (200%) of the federal poverty level; or

(ii) Fifty percentage points above the state's Medicaid eligibility level; and

(B) Is either:

(i) Ineligible for Medicaid; or

(ii) Not covered under any form of health insurance.

20-77-2002. Premium assistance subsidy program.

(a) The Division of Medical Services of the Department of Human Services shall apply to the Centers for Medicare & Medicaid Services for approval to amend the Medicaid state plan:

(1) To establish a premium assistance subsidy program to provide the state with the maximum flexibility allowable to purchase qualified health benefit plans that the division determines is cost effective under Title XIX, of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2011 including without limitation, Sections 1906, 1906A, and 1925;

(2) To adopt each of the benchmark benefit plans permitted under Section 1937(b)(1) of the Social Security Act;

(3) To adopt the benchmark equivalent benefit plan permitted under Section 1937(b)(2) of the Social Security Act; and

(4) To provide that in calculating the actuarial value of any benchmark equivalent plan, in accordance with Section 1937(b)(3) of the Social Security Act, the actuary shall apply the maximum cost sharing allowable under Sections 1916 and 1916A of the Social Security Act.

(b) The division shall apply to the Centers for Medicare & Medicaid Services for approval to amend the ARKids First Program:

(1) To establish a premium assistance subsidy program to provide the state with the maximum flexibility allowable under Title XXI of the Social Security Act to purchase qualified health benefit plans that the division determines is cost effective;

(2) To adopt each of the benchmark benefit plans permitted under Section 2103(a)(2) of the Social Security Act;

(3) To adopt the benchmark equivalent benefit permitted under

Section 2103(a)(1) of the Social Security Act; and

(4) To provide that in calculating the actuarial value of any benchmark equivalent plan, in accordance with Section 1937(b)(3) of the Social Security Act, the actuary shall apply the maximum cost sharing allowable under Section 1916 and Section 1916A of the Social Security Act.

20-77-2003. Targeted low-income child.

(a)(1) The Division of Medical Services of the Department of Human Services shall provide supplemental coverage for each targeted low-income child enrolled in a cost-effective qualified health benefit plan.

(2) The supplemental coverage required under subsection (a)(1) of this section shall consist of:

(A) Items or services that are not covered or are only partially covered under the qualified health benefit plan offered through an employer; and

(B) Cost-sharing protection.

(b) The division may directly pay out-of-pocket expenditures for cost sharing imposed under the qualified health benefit plan offered through an employer and collect or not collect all or any portion of the expenditures from the parent of the child.

(c) If a group health plan or health insurance coverage offered through an employer is certified by an actuary as providing health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit plan described in § 20-77-2002 or benchmark equivalent coverage that meets the requirements of § 20-77-2002, the division may provide premium assistance subsidies for enrollment of a targeted low-income child in the group health plan or health insurance coverage in the same manner as the subsidies are provided under this subsection for enrollment in a qualified health benefit plan offered through an employer but without regard to the requirement for supplemental coverage for benefits and cost-sharing protection under subsection (a) of this section.

(d) For all the health benefit plans offered or issued in this state by insurers, the division, in consultation with the Insurance Commissioner, shall determine those plans which meet the criteria of being either a benchmark benefit plan or a benchmark equivalent benefit plan.

(e) If one (1) or more eligible individuals also are eligible to

enroll in a self-funded health benefit plan, the division shall establish procedures for determining whether the plan meets the criteria of being either a benchmark benefit plan or a benchmark equivalent benefit plan.

20-77-2004. Maximum premium assistance — Opt-out option.

(a) The Division of Medical Services of the Department of Human Services shall use premium assistance to the maximum extent allowable to the state under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2011, including without limitation, the authorities under Section 1906, Section 1906A, and Section 1925 of the Social Security Act and under Title XXI of the Social Security Act.

(b) If possible, in the case of a household or family in which more than one (1) individual is eligible for benefits under either Medicaid or the ARKids First Program, the division shall enroll all full benefit eligible individuals in the family or household in the same qualified health benefit plan.

(c) Individuals who are exempt from mandatory enrollment under Section 1937(a)(2)(C)(ii) of the Social Security Act may elect to opt out of enrollment in a qualified health benefit plan in accordance with federal law.

20-77-2005. Premium payments.

(a) On behalf of eligible individuals, the Division of Medical Services of the Department of Human Services shall pay the applicable individual or family premiums to entities that provide or sponsor qualified health benefit plans, including without limitation plans that are:

(1) Commercial health plans;

(2) Managed care organizations; or

(3) Qualified health benefit plan offered through an employer.

(b) For reasons of administrative ease and program integrity, the division may direct that premium assistance payments be made to one (1) or more of the following:

(1) Full benefit eligible individuals;

(2) Insurers that issue qualified health benefit plans;

(3) Plan administrators of self-funded health benefit plans; and

(4) One (1) or more administrative agents designated by the division.

20-77-2006. Maximum allowable cost sharing.

(a) The Division of Medical Services of the Department of Human Services shall calculate the maximum allowable cost sharing for a full benefit eligible individual based on the individual's family or household gross income, including all earned and unearned income.

(b) Income and expense disregards applied in determining program eligibility shall not be applied in determining the maximum allowable cost sharing under subsection (a) of this section.

(c) If a full benefit eligible individual enrolled in a qualified health benefit plan incurs cost sharing during a plan year in excess of the maximum allowable cost sharing, the division shall pay to the plan or plan sponsor, on behalf of the full benefit eligible individual, any cost sharing incurred by the individual under the terms of the plan that is in excess of the maximum allowable amount.

20-77-2007. Incentive program.

(a) The Division of Medical Services of the Department of Human Services shall establish an incentive program in which cost-sharing obligations may be reduced for individuals who participate in initiatives to improve health outcomes and lower health care costs.

(b) Incentive program activities may include, but are not limited to, appropriate immunizations, appropriate and cost-effective prescription drug utilization, self-management of chronic health conditions, and participation in quality improvement initiatives.

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