

Stricken language would be deleted from and underlined language would be added to present law.

State of Arkansas
90th General Assembly
Regular Session, 2015

A Bill

HOUSE BILL 1262

By: Representatives Miller, Ballinger, Bentley, M. Gray, Ladyman, Payton, B. Smith, Sorvillo, Speaks,
Tosh, Wallace, Womack

By: Senator B. King

For An Act To Be Entitled

AN ACT TO TERMINATE THE MEDICAID EXPANSION PROGRAM OR THE HEALTH CARE INDEPENDENCE PROGRAM, COMMONLY KNOWN AS THE "PRIVATE OPTION"; TO CREATE THE ARKANSAS HEALTH REFORM LEGISLATIVE TASK FORCE; TO TERMINATE ARKANSAS'S PARTICIPATION IN MEDICAID EXPANSION; TO REPEAL THE HEALTH CARE INDEPENDENCE ACT OF 2013; AND FOR OTHER PURPOSES.

Subtitle

TO TERMINATE THE MEDICAID EXPANSION PROGRAM COMMONLY KNOWN AS THE "PRIVATE OPTION"; TO TERMINATE ARKANSAS'S PARTICIPATION IN MEDICAID EXPANSION; AND TO REPEAL THE HEALTH CARE INDEPENDENCE ACT OF 2013.

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

SECTION 1. DO NOT CODIFY. Termination of Medicaid expansion in Arkansas.

(a) Arkansas's participation in Medicaid expansion established under the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, is terminated effective on and after June 30, 2016.

(b)(1) The Health Care Independence Program, commonly known as the "Private Option", established by the Health Care Independence Act of 2013, §



20-77-2401 et seq., shall terminate on and after June 30, 2016.

(2) Subdivision (b)(1) of this section does not prohibit federal funding for the payment of expenses incurred before December 31, 2015, by persons participating in the Health Care Independence Program who were determined as more effectively covered through the traditional Arkansas Medicaid Program.

SECTION 2. DO NOT CODIFY. Health Care Independence Program.

(a) The Department of Human Services shall:

(1) Amend the state Medicaid plan, consistent with this act, to reflect Arkansas's withdrawal from the Medicaid expansion program and to eliminate eligibility for the population enrolled in the Health Care Independence Program, commonly known as the "Private Option", to be effective on or before June 30, 2016;

(2) Notify all persons enrolled in the Health Care Independence Program, commonly known as the "Private Option", that the Health Care Independence Program and Arkansas's participation in Medicaid expansion under the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, ends on June 30, 2016; and

(3) Inform any new person who enrolls in the Health Care Independence Program, commonly known as the "Private Option", that the Health Care Independence Program and Arkansas's participation in Medicaid expansion under the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, ends on June 30, 2016.

(b) The department may prohibit new enrollees in the Health Care Independence Program to begin the transition period before the termination date of June 30, 2016.

SECTION 3. TEMPORARY LANGUAGE. DO NOT CODIFY. Arkansas Health Reform Legislative Task Force – Creation – Membership – Duties.

(a) There is created the Arkansas Health Reform Legislative Task Force.

(b)(1) The task force shall consist of the following sixteen (16) members of the General Assembly:

(A) The President Pro Tempore of the Senate, or his or her designee who is a member of the Senate;

(B) Five (5) members of the Senate appointed by the President Pro Tempore of the Senate;

(C) The Senate Majority Leader, or his or her designee who is a member of the Senate;

(D) The Senate Minority Leader, or his or her designee who is a member of the Senate;

(E) The Speaker of the House of Representatives, or his or her designee who is a member of the House of Representatives;

(F) Five (5) members of House of Representatives appointed by the Speaker of the House of Representatives;

(G) The House Majority Leader, or his or her designee who is a member of the House of Representatives; and

(H) The House Minority Leader, or his or her designee who is a member of the House of Representatives.

(2) The Surgeon General shall serve as a nonvoting member of the task force.

(3) If a vacancy occurs on the task force, the vacancy shall be filled by the same process as the original appointment.

(4) Legislative members of the task force shall be paid per diem and mileage as authorized by law for attendance at meetings of interim committees of the General Assembly.

(c)(1) The President Pro Tempore of the Senate shall designate one (1) member of the task force to call the first meeting of the task force within thirty (30) days of the effective date of this act and serve as chair of the task force at the first meeting.

(2) At the first meeting of the task force, the members of the task force shall elect from its membership a chair and other officers as needed for the transaction of its business.

(3)(A) The task force shall conduct its meetings at the State Capitol or another site with teleconferencing capabilities.

(B) Meetings of the task force shall be held at least one (1) time every two (2) months but may occur more often at the call of the chair.

(4) The task force shall establish rules and procedures for conducting its business.

(5)(A) A majority of the voting members of the task force shall

constitute a quorum for transacting business of the task force.

(B) An affirmative vote of a majority of a quorum present shall be required for the passage of a motion or other task force action.

(6) The Bureau of Legislative Research shall provide staff for the task force.

(d)(1) The purpose of the task force is to:

(A) Recommend an alternative healthcare coverage model and legislative framework to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq., upon program termination; and

(B) Explore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled.

(2) To achieve this purpose, the task force shall:

(A) Identify resources and funding necessary to ensure an effective and efficient transition from the Health Care Independence Program, while minimizing or eliminating any need for the General Assembly to raise additional state general revenue;

(B) Identify the populations eligible for and participating in the Health Care Independence Program, including both:

(i) Individuals newly eligible for health coverage under the program; and

(ii) Individuals previously eligible for Medicaid before the effective date of the program, whether under a Medicaid waiver or some other eligibility criteria;

(C) Study the healthcare needs and other relevant characteristics of those populations served by the Health Care Independence Program;

(D) Recommend measures and options to preserve access to quality health care for those populations served by the Health Care Independence Program;

(E) Structure any recommended measures and options in a manner that achieves the following:

(i) Protection of Arkansas workers and employers from federal mandates and regulations by limiting the role of the federal government in defining the healthcare choices and coverage available in the

Arkansas health insurance market;

(ii) Maximum flexibility for the state and limitations on federal restrictions on the state's ability to efficiently and effectively manage the Arkansas Medicaid Program;

(iii) Opportunities to limit the size of the traditional Medicaid program by serving healthier beneficiaries in the private market;

(iv) Strengthening of the employer-sponsored health insurance market;

(v) Increased employment of able-bodied recipients of taxpayer-funded healthcare services;

(vi) Healthier behaviors, increased accountability, and personal responsibility for beneficiaries;

(vii) Enlistment of enough providers so that care and services are available at least to the extent that such care and services are available under the Health Care Independence Program;

(viii) Access to health services in rural areas of the state;

(ix) Continuity of coverage for eligible individuals as their income or life circumstances change; and

(x)(a) Continued payment innovation, delivery system reform, and market driven improvement, including without limitation the Arkansas Health Care Payment Improvement Initiative, for which current federal grant support will expire on or before December 31, 2016.

(b) The task force shall review the Arkansas Health Care Payment Improvement Initiative and recommend continuation, suspension, termination, or other actions the task force deems appropriate to the Governor.

(F) Estimate the impact of the Health Care Independence Program and of its termination on the state's economy as a whole and on the state's general revenue budget;

(G) Recommend procedures to optimize and streamline the legislative review and approval process for state plan amendments and other Medicaid rules, so as to promote efficiency, ensure agency responsiveness to changing market conditions, encourage transparency, and protect against undue influence by special interests; and

(H) If the task force determines necessary, contract with the consultants to assist the task force with the study.

(3)(A) On or before December 31, 2015, the task force shall file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate a written report of the task force's activities, findings, and recommendations.

(B) The task force may file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate a final written report on or before December 30, 2016.

(e) The task force expires December 31, 2016.

SECTION 4. Effective on and after June 30, 2016, Arkansas Code Title 20, Chapter 77, Subchapter 24, is repealed.

~~Subchapter 24 — Health Care Independence Act of 2013~~

~~20-77-2401. — Title.~~

~~This act shall be known and may be cited as the "Health Care Independence Act of 2013".~~

~~20-77-2402. — 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 this subchapter 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 utilize a private insurance option for "low-risk" adults.~~

~~(2) This subchapter shall ensure that:~~

~~(A) Private healthcare 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.~~

~~20-77-2403. 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 of Arkansas 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.~~

~~20-77-2404. Definitions.~~

~~As used in this subchapter:~~

- ~~(1) "Carrier" means a private entity certified by the State Insurance Department and offering plans through the Arkansas 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 United States citizens or documented qualified aliens according to the 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 Arkansas Health Insurance Marketplace is determined to be impractical or 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) "Arkansas 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 Plans based upon price, benefits, services, and quality, regardless of the governance structure of the marketplace;~~

~~(6) "Independence accounts" means individual financing structures that operate similar to a health savings account or a medical savings account;~~

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

~~(8) "Program" means the Health Care Independence Program established by this subchapter; and~~

~~(9) "Qualified Health Plan" means a State Insurance Department-certified individual health insurance plan offered by a carrier through the Arkansas Health Insurance Marketplace.~~

~~20-77-2405. Administration of Health Care Independence Program.~~

~~(a) The Department of Human Services shall:~~

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

~~(2)(A) Submit and apply for any:~~

~~(i) Federal waivers necessary to implement the program in a manner consistent with this subchapter, including without limitation approval for a comprehensive waiver under section 1115 of the Social Security Act, 42 U.S.C. § 1315; and~~

~~(ii)(a) Medicaid State Plan Amendments necessary to implement the program in a manner consistent with this subchapter.~~

~~(b) The Department of Human Services shall submit only those Medicaid State Plan Amendments under subdivision (a)(2)(A)(ii)(a) of this section that are optional and therefore may be revoked by the state at its discretion.~~

~~(B)(i) As part of its actions under subdivision (a)(2)(A) of this section, the Department of Human Services shall confirm that employers shall not be subject to the penalties, including without limitation an assessable payment, under section 1513 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as existing on January 1, 2013, concerning shared responsibility, for employees who are eligible individuals if the employees:~~

~~(a) Are enrolled in the program; and~~

~~(b) Enroll in a Qualified Health Plan through the Arkansas Health Insurance Marketplace.~~

~~(ii) If the Department of Human Services is unable to confirm provisions under subdivision (a)(2)(B)(i) of this section, the program shall not be implemented.~~

~~(b)(1) Implementation of the program is conditioned upon the receipt of necessary federal approvals.~~

~~(2) 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 Arkansas Health Insurance Marketplace.~~

~~(d)(1) The Department of Human Services is specifically authorized to pay premiums and supplemental cost-sharing subsidies directly to the Qualified Health Plan 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.~~

~~(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";~~

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

~~(A) Children eligible for the ARKids First Program Act, § 20-77-1101 et seq.; and~~

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

~~(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 Arkansas 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 healthcare purchasing decisions.~~

~~(g)(1) The State Insurance Department and the Department of Human Services shall administer and promulgate rules to administer the program authorized under this subchapter.~~

~~(2) No less than thirty (30) days before the State Insurance Department and the 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 from the Centers for Medicare and Medicaid Services all necessary waivers and approvals to allow non-aged, non-disabled program-eligible participants to enroll in a program that will create and utilize independence accounts that operate similarly to a health savings account or medical savings account during the calendar year 2015.~~

~~(2) The independence accounts shall:~~

~~(A) Allow a participant to purchase cost-effective high-deductible health insurance; and~~

~~(B) Promote independence and self-sufficiency.~~

~~(3) The state shall implement cost sharing and copays and, as a condition of participation, earnings shall exceed fifty percent (50%) of the federal poverty level.~~

~~(4) Participants may receive rewards based on healthy living and self-sufficiency.~~

~~(5)(A) At the end of each fiscal year, if there are funds remaining in the account, a majority of the state's contribution will remain in the participant's control as a positive incentive for the responsible use of the healthcare system and personal responsibility of health maintenance.~~

~~(B) Uses of the funds may include without limitation rolling the funds into a private sector health savings account for the participant according to rules promulgated by the Department of Human Services.~~

~~(6) The Department of Human Services shall promulgate rules to implement this subsection.~~

~~(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.~~

~~(1) The Department of Human Services shall track the hospital assessment under § 20-77-1902 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.~~

~~20-77-2406. Standards of healthcare coverage through Arkansas 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)(1) All participating carriers in the Arkansas Health Insurance Marketplace shall offer healthcare coverage conforming to the requirements of this subchapter.~~

~~(2) A participating carrier in the Arkansas Health Insurance Marketplace shall maintain a medical loss ratio of at least eighty percent (80%) for an individual and small group market policy and at least eighty-five percent (85%) for a large group market policy as required under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as existing on January 1, 2013.~~

~~(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 healthcare coverage for program-eligible individuals shall participate in the Health Care 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 or rules, or both, the applicable provisions of this subchapter.~~

~~20-77-2407. Enrollment.~~

~~(a) The General Assembly shall assure that a mechanism within the Arkansas 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.~~

~~20-77-2408. Effective date.~~

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