SENATE BILL REPORT
SB 5914

As of April 24, 2013

Title: An act relating to a medicaid waiver for premium assistance to purchase market-based exchange coverage for medicaid-eligible adults and children.

Brief Description: Concerning a waiver request to implement a premium assistance program to purchase market-based insurance for medicaid-eligible individuals.

Sponsors: Senator Parlette.

Brief History:
Committee Activity: Ways & Means: 4/23/13.

SENATE COMMITTEE ON WAYS & MEANS

Staff: Michael Bezanson (786-7449)

Background: Under the federal Affordable Care Act and subsequent US Supreme Court ruling, individuals and families with modified adjusted gross incomes between 138 and 400 percent of the federal poverty level will be required to have health insurance through a combination of public and private coverage expansions beginning January 1, 2014. Federal and state law created a state-based Health Benefit Exchange (Exchange) for these individuals and families to purchase insurance coverage with premium and cost-sharing credits, and created a separate exchange where small businesses may purchase insurance coverage.

As a state option under the federal Affordable Care Act, as per the Supreme Court decision, the state may expand Medicaid coverage to include all legal residents with modified adjusted gross family incomes below 138 percent of the federal poverty level beginning January 1, 2014.

In March 2013, the federal Centers for Medicare and Medicaid Services (CMS) issued formal guidance to states on Medicaid premium assistance or what is commonly referred to as the Arkansas Proposal. Medicaid premium assistance allows Medicaid beneficiaries to purchase health care coverage from Qualified Health Plans (QHP) through the Exchange. To implement a Medicaid premium assistance program, a state will be required to submit and obtain a Medicaid waiver.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

The CMS guidance for obtaining a waiver requires states to show how the premium assistance proposal will meet actuarial, economic, and budget neutrality tests. The waiver must include other provisions such as providing beneficiaries a choice of at least two QHPs, how the state will wrap-around QHP benefits and cost sharing, and a stop date where the demonstration should end no later than December 31, 2016. The State Innovation Waiver authority becomes effective in 2017 and will open a broader range of waiver proposals.

Summary of Bill: The Health Care Authority (HCA) must submit a waiver to implement a targeted Medicaid premium assistance program for:

- newly enrolling Medicaid expansion adults with incomes above 100 percent of the federal poverty level; and
- children covered in the Children's Health Insurance program with family incomes above 200 percent of the federal poverty level.

The waiver must include the possibility of applying premiums for individuals and cost sharing that may exceed 5 percent of the family income required under federal law.

HCA must submit a progress report to the Legislature and Governor by October 1, 2014, with a detailed project plan and timeline.

If cost effectiveness can be demonstrated, a formal waiver proposal must be submitted with the goal of implementation by January 1, 2016.

Appropriation: None.

Fiscal Note: Requested on April 23, 2013.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: CON: We support Medicaid expansion and are in support of the Exchange. Medicaid needs to be accessible, affordable, and understood. We have concerns with how this bill addresses churn. There need to be more specifics and the agency needs more time to develop such a complicated proposal. We have serious concerns with including children in the Children's Health Insurance Program (CHIP). CHIP covers many children that other states do not. CHIP provides affordable and comprehensive coverage. The Exchange is not as affordable as Medicaid or CHIP. This policy could represent barriers to administer and this will be more expensive for the state. We are not sure how this will meet the legal requirement to be cost effective. The federal government states that it costs $6,000 to support an enrollee in Medicaid and $9,000 to support an enrollee in the Exchange. It will be difficult to meet cost neutrality. The state still needs to implement Medicaid expansion and health reform. This is a complicated project on top of a complicated health reform.

OTHER: We have concerns over the cost-sharing components in this bill. Individuals with annual incomes below $15,000 have very little discretionary income. There are broad federal rules and hurdles to implement and administer cost sharing. We have programs in place

today and are supportive of these programs that use premium assistance as it relates to cost-effective employer coverage. We are appreciative of the timeline to allow for implementation.

Persons Testifying: CON: Mary Clogston, Assn. of American Retired Persons; Christina Peters, The Children's Alliance; Lonnie Johns-Brown, March of Dimes.

OTHER: Nathan Johnson, HCA.