

**Application Template for
Health Insurance Flexibility and Accountability (HIFA) §1115
Demonstration Proposal**

The State of Arkansas, Department of Human services, Division of Medical Services proposes a section 1115 demonstration entitled Arkansas Employer Sponsored Insurance Initiative, which will increase the number of individuals with health insurance coverage.

I. GENERAL DESCRIPTION OF PROGRAM

The Arkansas Employer Sponsored Insurance Initiative, which is scheduled to begin on July 1 2003, will provide health insurance coverage to an additional 55,000 residents of the State of Arkansas with incomes at or below 200% of the Federal poverty level. The increased coverage will be funded by State dollars (employer taxes), the SCHIP enhanced FMAP, and recipient cost sharing.

A. Overview

The State of Arkansas has a significant fiscal investment in the proposed expansions of health insurance coverage to uninsured Arkansans. This HIFA Employer Sponsored Insurance demonstration is one component of a broad initiative outlined in the Arkansas Health Insurance Strategic Plan.

Despite significant budget constraints, Arkansas has committed new state general revenue to 1) expand coverage for pregnant women to 200% FPL, 2) extend benefits for existing Medicaid beneficiaries, 3) expand coverage to children to 200% FPL (ARKids B 1115 demonstration), and 4) expand coverage for low income uninsured regardless of employment status (a Medicaid waiver).

Arkansas's commitment to reducing levels of uninsurance is further demonstrated by recently released US Census Bureau Current Population Survey (CPS) results. The majority of states reported increasing numbers of uninsured citizens from previous years. Arkansas was one of only a few states to report a decrease in the rate of uninsured. This decrease is a result of concerted efforts and several initiatives including utilization of tobacco settlement funds.

This proposed demonstration will continue Arkansas' expansion effort through the addition of coverage for uninsured employed individuals and their spouses. The Department of Human Services (DHS) proposes an Employer Sponsored Insurance (ESI) initiative under a Title XXI Health Insurance Flexibility and Accountability (HIFA) 1115 demonstration.

Recent findings in our state show that there are over 330,000 (20%) Arkansas adults (aged 19-64 years) who are without health insurance (many of whom are parents of children enrolled in the ARKids B¹ 1115 demonstration). In response

to those key findings, and based upon current private group health insurance and identified employer practices in Arkansas, the Arkansas Department of Human Services proposes to establish a new state-employer “safety net” benefits program to make health insurance available to uninsured Arkansans. Building upon recommendations of the Arkansas Health Insurance Expansion Initiative Roundtable², this proposal is intended to target and assist uninsured low-wage employees of small businesses in Arkansas.

Through this new state-employer sponsored group health insurance program targeting small employers, approximately 220,000 uninsured Arkansans could become newly insured. Of this group, 140,000 are adult residents of the State of Arkansas with incomes equal to or below 200% of the FPL and 80,000 are above 200% of the Federal Poverty Level (FPL).

The increased health insurance coverage will be funded by, state (employer taxes) and federal funds and by recipient cost-sharing.

The following briefly describes the highlights of the program:

1. The program will be employer driven; eligible employers will voluntarily determine their participation in the program. Employers will be eligible to participate in the program if they have not offered group health insurance for the prior 12 months.
2. Non-pregnant employees, aged 19 through 64, of participating employers, whose family income is equal to or less than 200% FPL will be eligible to participate in the demonstration; non-pregnant, uninsured spouses aged 19 through 64 will also be covered. Employees and spouses, aged 19 through 64, of participating employers whose family income is greater than 200% FPL will also be eligible for coverage, however, they will not be included in this demonstration and thus will not be SCHIP eligible.
3. Recipients in the program will receive a “safety-net” health insurance benefits package that preliminary actuarial analyses estimate will cover most basic health needs of the target population.
4. The state will receive and review employer group enrollment applications to determine the number of employees eligible for SCHIP match.
5. Employers will pay a tax to the state based on employer size.
6. Recipients will be required to cost share. Cost sharing will be in the form of deductibles, coinsurance and/or co-payments with an out of pocket maximum.
7. In the event that proposed Federal tax incentives become available, program officials would study the appropriateness of incorporating these provisions to enhance the program.

B. Application Processes

To enhance the strength of the state-employer partnership and to promote the stabilization of the health insurance marketplace, Arkansas proposes to employ an innovative enrollment strategy. Private health insurance agents across the state will recruit employers and collect group health insurance applications with specific information on each employee including family financial and insurance information. These group applications will be submitted to the DHS Division of County Operations (DCO), the DHS organizational entity that is responsible for establishing Medicaid and SCHIP eligibility. DCO will determine which employees meet the eligibility requirements for the demonstration.

Total quarterly taxes for the employer will be determined and a tax bill generated. Coverage will be initiated on the first day of the month following tax payments from the employer. Enabling legislation is being drafted for the 2003 legislative session; the legislation will provide a mechanism to collect the tax from employers, establish the program funding and appropriate the money to DHS.

Upon election to participate in the program, employers will be required to achieve 100% employee health insurance coverage regardless of family income. Participating employers will determine, in conjunction with employees, any employee cost sharing that is in addition to the cost sharing specified in Attachment E.

Program standardization and uniformity will be attained by making enrollment and disenrollment rules consistent across all enrollees and through utilization of private sector practices (e.g., full month enrollment based on payment).

C. Arkansas Demographics

Income Levels of Uninsured Arkansans			
<100% FPL	100-199%	200-399%	≥400%
27	45	21	8

Age of Uninsured Arkansans			
0-18	19-44	45-64	≥65
24%	51%	25%	1%

Employment Status of Uninsured Arkansans	
Employed	Unemployed
66%	34%

Target Groups by Age and Income		
	<100% FPL	100% - 200% FPL
19-64	26% of uninsured (~78,000)	42% of uninsured (~124,000)
0-18	27% of uninsured (~25,000)	54% of uninsured (~50,000)

NOTES:

¹ ARKids B is an 1115 demonstration which covers children, under 19, whose family income is equal to or less than 200% FPL. There is no resource limit. The coverage, though comprehensive, is less rich than traditional Medicaid. Cost sharing is required in the form of copayments and coinsurance. There are no premiums and no deductible.

² The Arkansas Health Insurance Expansion Initiative Roundtable is a consortium of Arkansas citizens who have undertaken the mission to study health insurance status in our state and provide recommendations to reduce the number of uninsured Arkansans and promote stability in the health insurance marketplace. The Initiative is funded by a grant from the US Department of Health and Human Services Health Resources Services Administration (HRSA) State Planning Grant (SPG) program and by a grant from the Robert Wood Johnson (RWJ) Foundation State Coverage Initiative (SCI) demonstration grant program.

Arkansas was one of the original eleven HRSA State Planning Grant recipients in 2000. In October 2001, Arkansas was one of four states selected to receive an RWJ SCI demonstration grant. This grant is intended to provide funds for a three-year period to enable the design and implementation of programs to reduce levels of uninsured.

II. DEFINITIONS

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes (such as Agent Orange payments.)

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

III. HIFA DEMONSTRATION STANDARD FEATURES

Please place a check mark beside each feature to acknowledge agreement with the standard features.

The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of its demonstration, additional STCs may apply.

Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort requirement will apply.

Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability or premium and cost sharing contributions made by or on behalf of program participants.

The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration.

IV. STATE SPECIFIC ELEMENTS

A. Upper income limit

The upper income limit for the eligibility expansion under the demonstration is 200 percent of the FPL.

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

B. Eligibility

Please indicate with check marks which populations you are proposing to include in your HIFA demonstration.

Mandatory Populations (as specified in Title XIX.)

- Section 1931 Families
- Blind and Disabled
- Aged
- Poverty-related Children and Pregnant Women

Optional Populations (included in the existing Medicaid State Plan)

Categorical

- Children and pregnant women covered in Medicaid above the mandatory level
- Parents covered under Medicaid
- Children covered under SCHIP
- Parents covered under SCHIP
- Other (please specify)

Medically Needy

- TANF Related
- Blind and Disabled
- Aged

Title XXI children (Separate SCHIP Program)

Title XXI parents (Separate SCHIP Program)

Additional Optional Populations (not included in the existing Medicaid or SCHIP State Plan.) If the demonstration includes optional populations not previously included in the State Plan, the optional eligibility expansion must be statewide in order for the State to include the cost of the expansion in determining the annual budget limit for the demonstration.)

Populations that can be covered under a Medicaid or SCHIP State Plan

- _____ Children above the income level specified in the State Plan
This category will include children from _____percent of the FPL through _____percent of the FPL.
- _____ Pregnant women above the income level specified in the State Plan
This category will include individuals from _____percent of the FPL through _____percent of the FPL.
- _____ Parents above the current level specified in the State Plan
This category will include individuals from _____percent of the FPL through _____percent of the FPL.

Existing Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, but are already receiving coverage in the State by virtue of an existing section 1115 demonstration.

- _____ Childless Adults (This category will include individuals from _____ percent of the FPL through _____percent of the FPL.)
- _____ Pregnant Women in SCHIP (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)
- _____ Other. Please specify:

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

New Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, and will be covered only as a result of the new HIFA demonstration.

- _____ Childless Adults (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)
- _____ Pregnant Women in SCHIP (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

X Other. Please specify:

The targeted individuals are non-pregnant, age 19 through 64 adults – employees and their spouses, who do not have access to employer sponsored insurance¹ and whose family income is not greater than 200% FPL. The children of the covered individuals will not be included in the Employer Sponsored Insurance demonstration; eligible children will be enrolled in regular Medicaid or in ARKids B, which covers children to 200% FPL. Pregnant women will not be covered in this demonstration since the State covers this group to 200% of FPL in its Medicaid program. See Attachment B.

¹ *If the employee's spouse has access to state health insurance, both the employee and the spouse will be excluded from this demonstration.*

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

C. Enrollment/Expenditure Cap

No

X Yes

(If Yes) Number of participants or dollar limit of demonstration (Express dollar limit in terms of total computable program costs.)

The Employer Sponsored Insurance demonstration will be capped at the State's SCHIP allotment remainder, after SCHIP ARKids B expenditures have been deducted.

D. Phase-in

Please indicate below whether the demonstration will be implemented at once or phased-in.

The HIFA demonstration will be implemented at once.

X The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline):

Arkansas proposes two phases in its demonstration proposal. Phase I will use unspent SCHIP funds to operate a pilot. In phase II, DHS intends to utilize unspent SCHIP funds to cover additional uninsured adult Arkansans below 200% of the FPL.

1. Phase I

a. Pilot Project Parameters

In Phase I of the requested 1115 demonstration waiver, Arkansas plans to establish a pilot project to operate for a period of 12 to 24 months. The primary target group for this project will be small employers who presently do not offer health insurance as a benefit to their employees. While small employers will serve as the core of the pilot, larger employer groupings will also be recruited so as to obtain demographically diverse information.

Employers will be eligible statewide on a first come, first serve basis within the following strata:

Size of employer (# employees)	Number of employer groups	Number of employees *(max)
2-5	50	250
6-10	75	750
11-100	40	4000
101-500	10	5000

** It is estimated that half of the employees will have a spouse who will be covered in this demonstration.*

Total enrollment for the pilot project will be capped at **15,000** individuals (approximately 10,000 employees and 5,000 spouses). This will include eligible employees (aged 19-64) and non-pregnant uninsured spouses who are aged 19-64.

b. Pilot Program Learning Objectives

Information obtained from the pilot project will be closely analyzed and will be utilized for optimal design and rollout of Phase II of the demonstration. Implementation of the pilot project will provide valuable programmatic information to State and Federal officials regarding the following:

- 1) Impact on existing state programs – Individuals eligible under the proposed demonstration waiver include non-pregnant employees, aged 19-64, and their uninsured, non-pregnant spouses, also aged 19-64. Arkansas provides Medicaid coverage to pregnant women and children with family incomes less than 200% FPL. The demonstration will also increase health insurance coverage in Arkansas by identifying family members who are eligible for Medicaid and ensuring their application for Medicaid.
- 2) Uptake rates – Analysis of data collected by the Arkansas Health Insurance Expansion Initiative Roundtable indicates that a majority of Arkansas employers and household members without health insurance would purchase coverage if an affordable alternative were

available. This finding is supported by reported Medical Expenditure Panel Survey (MEPS) data. Information collected through the pilot project would allow for an enhanced determination of uptake rates by employers and employees presented with the proposed safety net benefits plan.

- 3) Actuarial experience – The Roundtable used information obtained from commercial insured populations in Arkansas to conduct a “shadow utilization” study. The proposed safety net benefits package was developed by the Roundtable to provide coverage for the majority of services required by the population studied. Analysis of utilization by the enrollees in the pilot project will afford enhanced refinement of this actuarial analysis.
- 4) Employer / employee satisfaction – The Department of Human Services will conduct a survey of participating employers and enrollees to determine satisfaction levels within the pilot project. This information will be employed to optimize design and operation of Phase II of the demonstration project.
- 5) Impact on the uninsured – Perhaps most importantly, Arkansas will monitor changes in the rate of uninsured within the state. This monitoring will be conducted through the Census Bureau Current Population Survey (CPS) and by periodic deployment of the Arkansas Survey of Health Insurance Status. Current state efforts to expand health insurance coverage have yielded positive effects as demonstrated by CPS findings released in 2002 reporting a decrease in the percentage of uninsured Arkansans from previous years.
- 6) Demographic data – The State will collect demographic data relative to the newly insured individuals. The data will demonstrate the State’s ability to increase coverage through the demonstration and through increased enrollment in Medicaid.

2. Phase II

Based on the data gathered in Phase I, Arkansas DHS will determine whether to proceed to Phase II and whether the program will require modifications. In Phase II, DHS intends to utilize unspent SCHIP funds to expand coverage to up to 40,000 additional (plus the 15,000 from Phase I) uninsured adult Arkansans whose income is equal to or below 200% of the FPL. Enrollment limits in Phase II will be based upon available and unspent SCHIP funds.

E. Benefit Package

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

_____ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.

2. Optional populations included in the existing Medicaid State Plan

- _____ The same coverage provided under the State’s approved Medicaid State plan.
- _____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
- _____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- _____ A health benefits coverage plan that is offered and generally available to State employees
- _____ A benefit package that is actuarially equivalent to one of those listed above
- _____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

- _____ The same coverage provided under the State’s approved Medicaid State plan.
- _____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
- _____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- _____ A health benefits coverage plan that is offered and generally available to State employees
- _____ A benefit package that is actuarially equivalent to one of those listed above
- _____ Secretary approved coverage.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

4. New optional populations to be covered as a result of the HIFA demonstration

- _____ The same coverage provided under the State’s approved Medicaid State plan.
- _____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
- _____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- _____ A health benefits coverage plan that is offered and generally available to State employees
- _____ A benefit package that is actuarially equivalent to one of those listed above
- _____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

5. Expansion Populations

States have flexibility in designing the benefit package, however, the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State. The benefit package for this population must include a basic primary care package, which means health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Please check the services to be included.

Empirical evidence suggests that over 90% of routine physician and hospital needs and over 70% of prescription drug needs can be met by a “safety-net” benefit package. This empirical evidence is based on information modeled from multiple small group insurance pools; these populations were privately and fully insured. Data gathered during the demonstration’s Phase I pilot project, will enable us to refine our estimates regarding the percentages of need met by the demonstration.

Based on the empirical evidence and upon recommendations by the Arkansas Health Insurance Expansion Initiative Roundtable, Arkansas plans to cover the following services:

- Inpatient
7 inpatient days per year, which includes acute care hospital and inpatient surgery.
- Outpatient
2 outpatient hospital services per year, which includes: outpatient surgery and emergency room visits
- Physician's Surgical and Medical Services
6 physician service visits per year which includes: clinic visits, MD/DO designated therapies, ophthalmologist/optometrist, certified nurse midwife services, nurse practitioner services, psychological services and chiropractic services.
- Laboratory and X-ray Services
Covered only when associated with a physician visit, inpatient visit or an outpatient service
- Pharmacy
2 prescription drugs per month using the MCO tiered formulary
- Other (please specify)

Please include a detailed description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

F. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private health insurance coverage	Group health plan coverage	Other (specify)
Mandatory					
Optional – Existing					
Optional – Expansion					
Title XXI – Medicaid Expansion					
Title XXI – Separate SCHIP					
Existing section 1115 expansion					
New HIFA Expansion				X	

Please include a detailed description of any private health insurance coverage options as Attachment D to your proposal.

G. Private health insurance coverage options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or “buying into” employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State’s application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

____ As part of the demonstration the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

The State elects to provide the following coverage in its premium assistance program: (Check all applicable, and describe benefits and wraparound arrangements, if applicable, in Attachment D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

- The same coverage provided under the State's approved Medicaid plan.
- The same coverage provided under the State's approved SCHIP plan.
- The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.
- The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
- A health benefits coverage plan that is offered and generally available to State employees.
- A benefit package that is actuarially equivalent to one of those listed above (please specify).
- Secretary-Approved coverage.
- Other coverage defined by the State. (A copy of the benefits description must be included in Attachment D.)
- The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)
- The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory			
Optional – Existing (Children)			
Optional – Existing (Adults)			
Optional – Expansion (Children)			
Optional – Expansion(adults)			
Title XXI – Medicaid Expansion			
Title XXI – Separate SCHIP			
Existing Section 1115 Expansion			
New HIFA Expansion			X

Cost-sharing for children

Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child’s physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as ‘child cost-sharing’ for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family’s income.

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. Accountability and Monitoring

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in your State as of 2001 for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project.

There are approximately 330,000 (20%) uninsured Arkansans aged 19-64; approximately 220,000 of these individuals are employed; approximately 64% of those employed are uninsured resulting in 110,000 potential eligibles.

The coverage rates in your State for the insurance categories for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project:

Private Health Insurance Coverage Under a Group Health Plan

Of those who are insured in the 19-64 age group, 74% are covered by a group health plan.

Other Private Health Insurance Coverage

Of those who are insured in the 19-64 age group, approximately 10% are covered by individual private insurance policies.

Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance)

Of those who are insured in the 19-64 age group, approximately 5% are covered by Medicaid. Each month Arkansas Medicaid covers approximately 105,000 adults, who are 19-64. The State also provides Medicaid QMB coverage (Medicare cost sharing) for approximately 7,000 adults, 19-94; Medicaid SLMB coverage, and QI-1 and QI-2 coverage (Medicare premium only), are provided to an additional 5000 adults who are 19-64.

SCHIP (please separately identify any premium assistance)

Arkansas' SCHIP program was a Medicaid expansion; its recipients are counted in the Medicaid data, above.

Arkansas does not currently have a SCHIP premium assistance program.

Medicare

Of those who are insured in the 19-64 age group, approximately 4% are covered by Medicare.

Other Insurance

Of those who are insured in the 19-64 age group, approximately 3% are covered by CHAMPUS/VA and 4% by other groups.

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

- The Current Population Survey
 Other National Survey (please specify _____)
 State Survey (please specify _____)
 Administrative records (please specify:)

The Arkansas Client Eligibility System was the source of the Medicaid data specified above.

- Other (please specify _____)

The 2001 Arkansas Household Survey of Health Insurance Status was the source for coverage rates specified in this section.

Adjustments were made to the Current Population Survey or another national survey.

Yes No

If yes, a description of the adjustments must be included in Attachment F.

A State survey was used.

Yes No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F.

If a State survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

The State's goal for reducing the uninsured rate is 5% in Phase I. Phase II goals will be contingent upon the amount of SCHIP funds available for this demonstration.

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

_____ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.

VI. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

_____ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at <http://stats.bls.gov>.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not need to submit detailed historical data.

_____ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be \$159,688,920 over its 5 year approval period.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social Security Act (Please check all applicable):

Title XIX:

Statewideness 1902(a)(1)

To enable the State to phase in the operation of the demonstration.

Amount, Duration, and Scope 1902(a)(10)(B)

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

Freedom of Choice 1902(a)(23)

To enable the State to restrict the choice of provider.

Title XXI:

Benefit Package Requirements 2103

To permit the State to offer a benefit package that does not meet the requirements of section 2103.

Cost Sharing Requirements 2103(e)

To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.
--

Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

Expenditures related to providing months of guaranteed eligibility to demonstration participants.

Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:

Expenditures to provide services to populations not otherwise eligible under a State child health plan.

Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

Attachment B: Detailed description of expansion populations included in the demonstration.

Attachment C: Benefit package description.

Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

Attachment E: Detailed discussion of cost sharing limits.

Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

Attachment H: Additional waivers or expenditure authority request and justification.

IX. SIGNATURE

January 23, 2003
Date

Roy Jeffus
Name of Authorizing State Official (Typed)

Signature of Authorizing State Official

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0848. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds	Federal Fiscal Year 1 (FFY 2003)	Federal Fiscal Year 2 (FFY 2004)	Federal Fiscal Year 3 (FFY 2005)	Federal Fiscal Year 4 (FFY 2006)
State's Allotment	\$34,154,500	\$34,154,500	\$34,154,500	\$34,154,500
Funds Carried Over from Prior Years*	\$90,249,043	\$90,436,776	\$87,461,333	\$74,764,815
Subtotal (Allotment + Funds Carried Over)	\$124,403,543	\$124,591,276	\$121,615,833	\$108,919,315
Reallocated Funds (redistributed or Retained that are Currently Available)	\$19,990,464			
TOTAL (Subtotal + Reallocated funds)	\$144,394,007	\$124,591,276	\$121,615,833	\$108,919,315
State's Enhanced FMAP Rate	82.00%	82.00%	82.00%	82.00%
COST PROJECTIONS OF PENDING SCHIP PLAN				
Benefit Costs	\$25,466,840	\$25,976,177	\$26,495,700	\$27,025,614
Administration Costs				
Outreach	\$500,000	\$500,000	\$500,000	\$500,000
Reporting	\$350,000	\$350,000	\$350,000	\$350,000
Quality Assurance	\$300,000	\$300,000	\$300,000	\$300,000
Assessment	\$200,000	\$200,000	\$200,000	\$200,000
Claims Processing	\$800,000	\$800,000	\$800,000	\$800,000
Eligibility	\$679,649	\$736,242	\$793,967	\$852,846
Total Administration Costs	\$2,829,649	\$2,886,242	\$2,943,967	\$3,002,846
10% Administrative CAP	\$2,829,649	\$2,886,242	\$2,943,967	\$3,002,846
Federal Title XXI Share	\$23,203,121	\$23,667,183	\$24,140,527	\$24,623,337
State Share	\$5,093,368	\$5,195,235	\$5,299,140	\$5,405,123
TOTAL COSTS OF PENDING SCHIP PLAN	\$28,296,489	\$28,862,419	\$29,439,667	\$30,028,460
COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL				
Benefit Costs for Demonstration Population Phase 1				
Managed Care	\$1,876,320	\$14,776,200	\$15,514,200	\$16,290,000
PMPM rate @ # of Eligibles	\$78.18	\$82.09	\$86.19	\$90.50
Projected number of Beneficiaries	8,000	15,000	15,000	15,000
Benefit Costs for Demonstration Population Phase 2				
Managed Care	\$0	\$0	\$9,308,520	\$27,150,000
PMPM rate @ # of Eligibles	\$78.18	\$82.09	\$86.19	\$90.50
Projected number of Beneficiaries	0	0	9,000	25,000
Total Benefit Costs	\$1,876,320	\$14,776,200	\$24,822,720	\$43,440,000
Administration Costs				
Personnel				
General Administration	\$50,000	\$1,191,800	\$2,323,000	\$4,280,000
Contractors/Brokers	\$58,480	\$100,000	\$200,000	\$500,000
Claims Processing	\$100,000	\$150,000	\$150,000	\$150,000
Outreach/marketing costs		\$200,000	\$200,000	\$500,000
Other				
Total Administration Costs	\$208,480	\$1,641,800	\$2,873,000	\$5,430,000
10% Administrative CAP	\$208,480	\$1,641,800	\$2,769,572	\$4,887,000
Federal Title XXI Share	\$1,709,536	\$13,462,760	\$22,710,490	\$40,073,400
State Share	\$375,264	\$2,955,240	\$4,985,230	\$8,796,600
TOTAL COSTS FOR DEMONSTRATION	\$2,084,800	\$16,418,000	\$27,695,720	\$48,870,000
TOTAL PROGRAM COSTS (PLAN + Demonstration)	\$30,381,289	\$45,280,419	\$57,135,387	\$78,898,460
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$144,394,007	\$124,591,276	\$121,615,833	\$108,919,315
Total Federal Title XXI Program Costs (State Plan + Demonstration)	\$24,912,657	\$37,129,943	\$46,851,018	\$64,696,737
Unused Title XXI Funds Expiring (Allotment or Reallocated)	\$29,044,574			
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	\$90,436,776	\$87,461,333	\$74,764,815	\$44,222,578

* This figure is dependent on the the approval of the pending state plan approval.

1. The PMPM for the demonstration is based on the Milliman report (Attachment G-1) with the following assumptions. There would be an out of pocket maximum of \$1,000, maternity is not in contraceptives can be one of the prescriptions that is allowed. The three PMPM costs were averaged taking into consideration the estimated makeup of the population.

2. The PMPM for the demonstration was increased each year by the 5% based on the Consumer Price index for medical as of December 2002.

ELIGIBILITY REQUIREMENTS

In this Employer Sponsored Insurance (ESI) initiative, participation in the demonstration will be available only to employers who have not offered group health insurance in the past 12 months and do not currently offer group health insurance. Eligible employers will voluntarily elect to participate or not. Once the employer has elected to participate, employees whose family income is equal to or below 200% of the FPL will be eligible for SCHIP benefits; those employees whose income is over 200% will be eligible for identical benefits but without enhanced Federal Medical Assistance Percentages (FMAP). Each employer will be required to achieve 100% employee health insurance coverage regardless of family income (employers will establish health insurance as a condition of employment.)

A. Employer Requirements

The following requirements must be met by employers in order for them to participate in the state-employer partnership:

1. Employers must not have offered group health insurance as a benefit to their employees in the 12 months prior to enrollment in the program. (This is intended to avert private sector crowd-out.)
2. Employers will only be eligible to join the program during regular open enrollment periods.
3. Employers will be required to commit to 12 months continuous participation, with similar and binding periods or renewal. (This is intended to lessen adverse risk selection and promote program stability).
4. Employers participating in the program will achieve 100% employee participation in health insurance coverage regardless of family income (achieves optimal impact of state/federal funds on the uninsured). The employees of a participating employer will be required to enroll in the ESI program, or in the alternative, strict guidelines will be developed to allow employee opt-out only if they are receiving coverage elsewhere (e.g., through a spouse or parent). Spouses and employees who have access to State health insurance are excluded from this demonstration.
5. Remit funds to the State in the form of a tax. The amount of each employer's tax will be calculated based on the size of the business/firm and will be paid prospectively on a quarterly schedule to coincide with existing State and Federal tax commitments. Employee coverage will be initiated on the first day of the month following the tax payment from the employer.

B. Enrollee Requirements

Because the proposed program is an Employer Group Health Insurance program with a common benefit plan for all employees, insurance coverage will be determined by the employers' program participation decision. Those individuals eligible for enhanced FMAP will receive the same benefits as those above the income eligibility threshold.

To qualify for enhanced FMAP, each of the following individual enrollee eligibility requirements must be met:

1. Age – must be age 19 through 64 years of age (employees and spouses under 19, whose family income is equal to or less than 200% FPL would generally be eligible in either ARKids B or traditional Medicaid; employees under 19 whose family income is greater than 200% FPL will receive benefits in an ARKids B look-alike package with no FFP; employees over 64 are being excluded because they have access to Medicare which provides safety net benefits);
2. Citizenship Status – must be a U.S. citizen or a qualified alien;
3. Residency – must be a current Arkansas resident; there is no durational residency requirement;
4. Income – countable family income must be \leq 200% of FPL. There is no assets test.
5. Uninsured Status – Employed individuals of a participating employer may elect not to participate only by providing evidence of a major medical policy in effect at the time of open enrollment; loss of major medical requires immediate notification to the program and addition of the affected individual to the insurance enrollment. Spouses must be uninsured before they can be covered.
6. Access to State health insurance – If the spouse has access to State health insurance, then neither the spouse nor the employee will be eligible for benefits through this demonstration.
7. Non-pregnant – Generally each individual (employees and spouses) must be non-pregnant. Pregnant Women will be covered under Medicaid. Exception: The Pregnant Women category of Medicaid has an assets test. Thus if the Pregnant Woman is ineligible for Medicaid due to resources, she will be included in the demonstration.

BENEFIT PACKAGE

There is only one expansion population and only one benefit package, as follows:

- 6 clinic visits per SFY*
- 2 outpatient hospital visits per SFY*
- 2 prescriptions per month
- 7 days inpatient coverage per SFY*

* Arkansas' State Fiscal Year is July 1 – June 30

Non-Covered Services

- Ambulatory Surgical Center Services (eligible under outpatient hospital services)
- Audiological services
- Chiropractic services
- Dental services
- Developmental Day Treatment Services
- Domiciliary Care Services
- Durable Medical Equipment
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Persons Under Age 21 (assumes all children <19 y/o eligible for ARKids B)
- End-Stage Renal Disease (ESRD) Facility Services
- FQHC Services: FQHC eligible for negotiated rate with MCO
- Home and Community-Based Waiver Services
- Home Health Services
- ElderChoices Home and Community Based 2176 Waiver benefits
- Hospice Services
- Hyperalimentation Services
- Inpatient Psychiatric Services (rehabilitation chronic services excluded; acute care hospitalizations included under inpatient benefits)
- Inpatient Rehabilitative Services
- Intermediate Care Facility Services for the Mentally Retarded
- Long Term Care (Nursing Facility Services)
- Medical Supplies
- Occupational, Physical, and Speech Therapy Services
- Organ Transplants
- Personal Care Services
- Podiatrist Services
- Portable x-rays (outside hospital services); chiropractic x-rays

- Private Duty Nursing Services for Ventilator-dependent and High-technology Non-ventilator Dependents
- Prosthetics
- Rehabilitative Services for Persons with Mental Illness (RSPMI)
- Rehabilitative Services for Persons with Physical Disabilities
- Rural Health Clinic Services
- Targeted Case Management
- Transportation Services
- Ventilator Equipment
- Visual Services (annual physician/optometrist visit allowable under physician benefit)

ENROLLEE COST SHARING

Enrollee cost sharing will be assessed without regard to family income. The State will require enrollee cost sharing as follows:

- A. \$100 Deductible
- B. 15% coinsurance
- C. \$1,000 out of pocket maximum.

I. State Survey Design Features

The Center for Survey Research (CSR) at the University of Massachusetts was retained by the Arkansas Health Insurance Expansion Initiative Roundtable to conduct the 2001 Arkansas Household Survey of Health Insurance Status, a random digit dial (RDD) telephone survey of 2,625 households, containing approximately 6,000 individuals in the state. The primary purpose of the household telephone survey was to obtain state-level and regional-level estimates of the insured and uninsured adults and children in Arkansas. To generate accurate estimates of health insurance coverage in the state's population of 2.6 million, the Roundtable in collaboration with the CSR used a validated instrument to collect the data, developed a stratified sampling design, and developed methods to adjust for differences in probabilities of selection and non-response to ensure accuracy in reported results.

II. State's Plan to Track Changes in the Uninsured Rate and Trends in Sources of Insurance

The State will use the Arkansas Household Survey of Health Insurance Status to track changes in the uninsured rate and the trends in sources of insurance for Arkansans. There are plans to re-field the survey in calendar years 2004-2005. The State will also use the Census Bureau Current Population Survey (CPS). CPS findings released in 2002 show a decrease in the percentage of uninsured Arkansans from previous years. Notably, Arkansas was one of only a few states to report such a decreased rate.

The State will also collect demographic data relative to the newly insured individuals. This data will demonstrate the State's ability to increase coverage through the demonstration and through increased enrollment in Medicaid.

III. Performance Measures

A. Access to Care

Through the State's competitive bid process, the Arkansas will contract with one or more managed care carriers to establish a statewide provider network to afford beneficiaries ready access to services. The distribution of network providers is anticipated to be similar in scope to the Arkansas State Teachers and State Employees Health Plans, which will be employed as a measurement baseline.

A recipient satisfaction survey will be utilized to measure whether recipients have experienced difficulties in accessing services. Initial baseline results are unknown, however, available data from proxy populations will be collected prior to fielding the instrument.

B. Quality of Services

A recipient satisfaction survey will be utilized to measure perceived quality of services receiving. Baseline data is unknown, but as with access to care measures, available proxy measures will be collected.

C. Preventive Care

Researchers have demonstrated that inclusion of preventive care services is vital in the amelioration of future illness, reduction of avoidable costs, and improvement of health status. Further, reports have shown that the uninsured do not obtain preventive services in a timely or cost effective manner. Covered benefits available to enrollees in this program will include scientifically supported, evidence based clinical preventive care (i.e. United States Preventive Services Task Force recommended services). Utilizing the findings related to receipt of preventive care services by the uninsured as a baseline, program staff will monitor delivery of these services by network providers through available reporting mechanisms (i.e. HEDIS) and others developed in concert with contracted carriers.

D. Enrollee Satisfaction

A recipient satisfaction survey will be utilized to measure enrollee satisfaction with the program. Comparisons will be generated utilizing studies of referent commercially insured populations as a baseline.

E. Participation Rate

Adequate participation employers and enrollees will be vital to the long-term stability of the program. DHS plans to carefully monitor employer / enrollee uptake rate at initial offering and re-offering. Participation will also be measured on an ongoing basis through monitoring of reenrollment. Comparisons will be made against current baseline rates available through the Current Population Survey, Business Pattern data, and the Arkansas Household Survey of Health Insurance Status.

F. Completeness of Coverage

It will be important to measure the effect of the proposed safety net benefit package for currently uninsured Arkansans. As discussed above, a baseline shadow utilization study revealed that this package will provide coverage for the majority of enrollee services. Monitoring will be conducted to determine if actual programmatic utilization comports with this baseline demonstrating the efficacy of this safety net strategy.

ADDITIONAL WAIVERS AND JUSTIFICATION

A. Waiver:

Arkansas is requesting a waiver of the requirements at 42 CFR 457.125 and 457.535 which exempt AI/AN children from cost sharing and require the State to specify its procedures for ensuring such exemption.

Justification:

Arkansas has no Indian reservations nor federally recognized tribes within the State. The Indian population is very small. Also, due to the small number of eligibles who would be AI/AN and would benefit from the exclusion, it would be a hardship to the State to include this exclusion in its program design.

B Waiver:

Arkansas is requesting a waiver of 42 CFR 457.555, which specifies maximum allowable cost sharing charges and 457.560, which limits cumulative cost sharing to 5% of the family's income.

Justification:

Since private health insurance does not adjust cost sharing based on family income, it does not seem appropriate to do so in this demonstration.

The State does not impose a 5% limit on cumulative cost sharing in the ARKids B 1115 demonstration nor in the State's Working Disabled program (TWWIA). Since this demonstration population would generally be considered at less risk than the ARKids B 1115 population and the Working Disabled population, it seems reasonable that the State would not impose a 5% limit on cumulative cost sharing for this group either.