



STATE OF ARKANSAS

ASA HUTCHINSON
GOVERNOR

January 10, 2017

The Honorable Kevin McCarthy
House Majority Leader
Congress of the United States
Washington, D.C. 20515

The Honorable Kevin Brady
Chairman
House Committee on Ways and Means
Congress of the United States
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
House Committee on Energy and
Commerce
Congress of the United States
Washington, D.C. 20515

The Honorable John Kline
Chairman
House Committee on Education and the
Workforce
Congress of the United States
Washington, D.C. 20515

The Honorable Greg Walden
Chair-Elect
House Committee on Energy and
Commerce
Congress of the United States
Washington, D.C. 20515

The Honorable Virginia Foxx
Chair-Elect
House Committee on Education and the
Workforce
Congress of the United States
Washington, D.C. 20515



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Dear Majority Leader, Chairmen, and Chairs-Elect:

Thank you for your letter of December 2, opening a dialogue with Governors and state insurance commissioners regarding the implementation by House Republicans of *A Better Way* to reform healthcare by lowering costs, improving quality, and empowering states and the hardworking taxpayers we serve. We salute the leadership shown by choosing to engage with us as you begin the great debate ahead on this matter in the 115th Congress, as we agree that states “play an integral role in the health system and will be invaluable partners” in this process.

While this letter will address each of the nine questions posed to us, our overarching request with regards to crafting a replacement for the Affordable Care Act (ACA) is straightforward: return power to the states to manage their private insurance markets and enhance their healthcare systems. States regulated health insurance before the ACA, and we are ready to do so again without overly-burdensome federal rules and regulations that a) do not respect consumer choice or reflect local market realities, b) result in unnecessary and expensive taxpayer-funded dual reviews, and c) reduce states’ ability to craft solutions that best fit the needs of our citizens. We do not merely seek flexibility within a federal regulatory framework; we seek the freedom to again fully exercise our roles and responsibility to regulate the health insurance industry.

In addition to the recommendations and requests outlined below, we strongly encourage the Trump Administration to implement two immediate fixes through regulatory action or Executive Order. First, states should have the ability to tailor their Medicaid eligibility to levels that are appropriate for their demographic and economic situations. As such, we call on the Administration to enable states to set Medicaid eligibility at levels below 138% of the federal poverty level (FPL) and receive the enhanced federal medical assistance percentage (FMAP). Secondly, we ask that the Department of Health and Human Services (HHS) fully exercise the Secretary’s authority under Section 1115 Demonstration Projects to discourage the use of Medicaid as a permanent solution for our able-bodied citizens. Specifically, we urge HHS to enable states to institute work requirements, increase beneficiary cost-sharing, and design benefits in a manner that better aligns with private sector coverage. We encourage you to look to Arkansas Works, our state’s new innovative approach to

Medicaid expansion, as a model for programs that help individuals move up the economic ladder and off of Medicaid, while smoothing the transition into the commercial market.

Once again, we thank you for the beginning of an “ongoing and open dialogue,” and we respectfully submit the following answers to your questions. To ensure this important conversation continues and results in a successful ACA replacement plan, we urge you to convene a small working group of Governors to collaborate over the coming months in the development of policies that reflect states’ critical perspective. Arkansas would welcome the opportunity to contribute its healthcare experience to such an effort.

Sincerely,

A handwritten signature in black ink, appearing to read "Asa Hutchinson", written over a horizontal line.

Asa Hutchinson
Governor

A handwritten signature in black ink, appearing to read "Allen Kerr", written over a horizontal line.

Allen Kerr
Commissioner, Arkansas Department of Insurance

1. What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choices and lower premiums?

First and foremost, Congress should repeal the ACA and return the power of regulating insurance to the states. As such, Arkansas supports abolishing the Center for Consumer Information and Insurance Oversight (CCIIO) at HHS, as there is no need for a national insurance commissioner. Similarly, we see no need for a federal health insurance exchange. Exchanges existed prior to the ACA and should be established and operated by states and the private sector as appropriate for their local markets in the future.

The ACA interfered with states' ability to manage our marketplaces, which has resulted in market segmentation, duplicative reviews by both federal and state agencies, and burdensome regulations that create confusion for consumers, insurance companies, and stakeholders across the healthcare system. There is no need for federal coverage mandates on individuals or employers, as states can best determine their own market participation requirements and set rate and form-filing deadlines to meet their particular goals. To truly restore states' oversight of our insurance markets, Congress must also eliminate the federal Essential Health Benefits (EHB) requirements. This would enable states to utilize more and better-tailored benefit design options to fit our populations' needs.

We strongly support the use of federal tax credits for any commercial health insurance product to promote access to affordable coverage. We encourage Congress to use the Earned Income Tax Credit (EITC) as a model to implement this initiative, with assistance provided on a sliding scale based on income and not subject to an affordability test. We believe that the Department of the Treasury should administer these tax credits, thus eliminating the unnecessary middleman role currently played by HHS in providing health insurance subsidies.

2. What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance markets?

Congress must end the federal individual and employer mandates – this is especially important as Washington returns the power of regulating health insurance to the states. The mandates established under the ACA penalize work through reduced hours, wages, and jobs, and create fiscal cliffs for workers receiving subsidies. Further, as mentioned above, the Administration should allow states to expand Medicaid to a level that appropriately reflects local economic realities. For instance, in Arkansas, expansion to 138% FPL has caused individuals to shift from employer-sponsored and individual coverage to Medicaid. Flexible expansion limits will enable states to better align their Medicaid programs with their commercial health insurance markets.

HHS should restrict the Centers for Medicare & Medicaid Services (CMS) from conducting market conduct or other form, template, or rate reviews of rate and plan filings that are already being performed by state insurance regulators—especially for states committed to plan management and certified as Effective Rate Review (ERR) states, like Arkansas. In addition to being duplicative and unnecessary, these reviews create confusion among insurers, who are subject to the demands of multiple regulators. Arkansas' experience has shown that when CMS fails to coordinate with state regulators while conducting insurance reviews, unnecessary issues arise in the review process. State regulators are more nimble and efficient than CMS; and CMS often acts to address issues that have already been resolved by the issuer and their state regulator.

Congress and HHS can eliminate more wasteful, redundant federal activities by stopping duplicative data collection. There is no need for the federal government to require the reporting of the same data states collect as part of its review process. For instance, the practice of federal network adequacy reviews in states already conducting these reviews should cease. In Arkansas, we have found that our network adequacy work far exceeds the efforts of our federal counterparts and that federal activity in this space encumbers our efforts.

Additionally, Congress and the Administration should:

- Approve Interstate Compact agreements between various states to allow the sale of health insurance products across state lines in an expeditious manner, including fast-track consideration of legislation to approve such agreements to eliminate uncertainty in the marketplace.
- Clarify the scope of non-discriminatory rules and legislation to ensure that they do not preempt state law or regulation.
- Eliminate federal page-limit requirements on benefit plans to promote competition between carriers and give consumers the tools to make better-informed choices regarding their health insurance.

3. What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable?

In addition to the executive actions on Medicaid described above, Congress should give states the option to receive some of their Medicaid funding through block grants. This approach will enable states that choose to participate to tailor their program to more appropriately meet the needs of the different populations enrolled.

For the non-elderly, non-disabled population, we recommend designing a block grant using the successful Children's Health Insurance Program (CHIP) as a model, so that states could receive formula-based capped allotments and exercise maximum flexibility to administer the program, including the management of benefit design and operations, such as managed care.

In order to balance budget predictability for states and the federal government and to reduce incentives and disincentives under the current matching system, we strongly encourage Congress to replace the state match with a Maintenance of Effort (MOE) requirement to ensure federal funding contingent on a set state contribution.

Under this approach, even states that choose to accept a block grant would keep beneficiaries with more complex care needs, such as individuals with disabilities and seniors, in Medicaid with an open-ended match rate for their preventive and acute health services. Congress should create an additional block grant option for states interested in broader flexibility to provide long-term services and supports (LTSS) to this population. Such an option would allow states to eliminate the institutional bias in federal law and level the playing field between institutional care and home and community-based services while protecting the federal budget.

States have seen firsthand the inefficiencies that result from the federal government's siloed approach to regulating Medicaid and the other public assistance programs states administer. We believe the current program-centered approach to state assistance should be replaced with a person-centered approach to enable state agencies to creatively pool resources to help citizens requiring multiple services. As such, we strongly urge Congress and the Administration to facilitate the integration of multiple support programs, such as workforce, housing, and others, with Medicaid, thus allowing states to efficiently administer these programs and ensure the best outcomes for those we are serving.

To accomplish this goal, Congress should pass legislation instructing the Office of Management and Budget (OMB) to authorize pilot projects in states interested in blending the funding streams of the health and social support programs they administer. We recommend placing the authority with OMB to avoid lengthy and repetitive reviews at the federal level and to enable strong coordination of the federal agencies involved.

Lastly, we support the notion that states are laboratories for innovation. When one laboratory discovers something that works, others should be able to capitalize on those discoveries, as appropriate for their populations. Going forward, it is imperative that pilot and waiver programs are structured to allow states to quickly build upon the good ideas and best practices of their peers.

4. What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?

In addition to providing the tax credits described above for commercial insurance, Congress should eliminate the ACA's definitions of large group employer (LGE) and small group employer (SGE) to put all employers on equal footing. Under current law, LGEs can offer minimum essential value, but do not have to offer EHBs. SGEs, by contrast, are required to offer EHBs with few limits. This places a significant burden on small businesses and creates an arbitrary distinction between businesses of similar size.

Additionally, we support defining a group as "two or more." However, should Congress return to states the power to manage their own markets, this issue can be addressed by our General Assembly and state insurance regulators.

We encourage Congress and the Administration to allow small businesses to create associations to offer health insurance to their workers, including across state lines. Prior to 2010, associations were utilized for this purpose. However, association policies are now treated like individual policies, which is contrary to the reasons such groups were given additional purchasing power in the past.

5. What key long-term reforms would improve affordability for patients?

By returning the power to regulate health insurance to states, affordability and cost predictability will increase, due to the lack of federal rule-making and parameters that have changed the marketplace each plan year under the ACA.

6. Does your state currently have or plan to enact authority to utilize a Section 1332 Waivers for State Innovation beginning January 1, 2017?

No.

a. If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovation Waivers for benefit year 2017?

Not applicable.

b. If allowed, would your state utilize a model waiver for expedited review and approval similar to the Medicare Part D transition and assistance for Hurricane Katrina evacuees?

Model waivers have proven to be useful in the past in response to a short-term emergency situation. The model waivers used for Part D and Katrina were useful because the federal government and many states were facing the same problem and the waivers were used to expedite federal approval to meet unforeseen circumstances. Moreover, the emergencies were resolved within a matter of months. Thus, we do not view the model waivers as long-term solutions. We also note that in the Katrina/Rita waivers, states were held harmless financially.

c. If allowed, which requirements would your state seek to waive under a 1332 waiver?

At this time, we do not foresee a need for a Section 1332 waiver in the context of repealing the ACA. A waiver, by definition, is to diverge from what the law requires a state to do. Repeal, rather than a waiver, is the preferable pathway to restoring state authority over the health insurance system.

d. If allowed—and if applicable—what changes would be necessary to current guidance to accelerate your state's ability to pursue a 1332 waiver.

A Section 1332 waiver does not provide new authority to change Medicaid. The December 2015 guidance from HHS was unnecessarily restrictive and served to discourage widespread use of Section 1332, because states were not allowed to count savings from changes in Medicaid policy. We believe repeal, rather than a waiver, is the preferable pathway to restoring state authority over the Medicaid program and the health insurance system. We also would be interested to see waiver authority

broadened across additional public assistance programs, with savings in all programs and new revenue due to increased economic activity counted in calculating deficit neutrality.

7. **As part of returning more choice, control and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?**

Arkansas currently has a law in place authorizing a high-risk pool and would be interested in restarting it. However, implementation is contingent upon federal funding.

8. **What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and insurance rate and form review requirements, should we consider while making changes?**

Arkansas has the necessary experience to again regulate health insurance and stands ready to manage its own marketplace, including providing oversight of the industry. We are confident that we can adjust to the repeal of the ACA within 90 days and do not foresee any need for a lengthy transition period.

9. **Has your state adopted any of the 2010 federal reforms into state law? If so, which ones? What impact would repeal have on these state law changes?**

Arkansas has enacted laws related to the state's health insurance exchange and Medicaid expansion waivers, all of which were written to account for possible changes to federal law.