ARKANSAS WORKS PREMIUM AND COST-SHARING REDUCTION BREAKDOWN: SUPPLEMENTAL EXPLAINER

APRIL 2021

Health plans must meet certain standards to be certified as qualified health plans made available through the Health Insurance Marketplace. Plan certification requires an assessment of a plan's actuarial value for the various levels of marketplace coverage represented by metal tiers – bronze, silver, gold, and platinum. "Actuarial value" means the share of healthcare expenses covered for a typical group of enrollees. For example, a silver marketplace plan has an actuarial value of 70%, which means that the plan covers 70% of healthcare expenses. The remaining 30% is covered by the enrollee through cost sharing, which is inclusive of deductibles, copays, and coinsurance.

Federal law limits the amount of cost-sharing exposure for low-income individuals. Individuals with incomes at or below 250% of the federal poverty level (FPL) may receive financial assistance with cost sharing in addition to premium subsidies.[1] The limit on an individual's cost-sharing exposure has the effect of increasing the actuarial value of the plan. Federal law similarly limits out-of-pocket exposure (premiums and cost sharing) for Medicaid beneficiaries to 5% of household income. This is reflected in the state's enabling law for Medicaid expansion authorizing the purchase of "high-value silver plans" for program enrollees.

The graphic below shows the level of assistance provided to Arkansas Works enrollees at various income levels. Enrollees are provided assistance to cover premiums to purchase a plan and cost sharing within the plan. Individuals with incomes at or below 100% of the federal poverty level (FPL) are enrolled in a plan that has 100% actuarial value — meaning that they have no out-of-pocket costs, and individuals with incomes from 101–138% of the FPL are enrolled in plans with 94% actuarial value — meaning that they have limited out-of-pocket costs. The graphic also shows the total cost, inclusive of premiums, cost-sharing reduction, and wrap-around services, paid by Arkansas Medicaid on behalf of enrollees, reflected as an average per-member, per-month (PMPM) cost. The Arkansas Works program is subject to budget neutrality caps, meaning that the state is at risk for PMPM costs that exceed budget neutrality caps. For more information about budget neutrality, see the April 2021 explainer titled "Medicaid Expansion & Budget Neutrality" at www.achi.net.

Arkansas Works Program Definitions:

- Budget neutrality: the state of having no net effect on spending; here, the term refers to the requirement that federal spending over the life of a Section 1115 waiver be no greater than federal spending would have been in the absence of the waiver
- Cost-sharing reduction (CSR) payments: payments to carriers to reduce out-of-pocket costs for beneficiaries to required Medicaid cost-sharing levels
- Premium: amount paid for the insurance plan
- Wrap-around costs: costs for required services directly covered by Medicaid (e.g., non-emergency medical transportation)
- Per-member per-month (PMPM) cap: monthly limit on per enrollee spending established in the waiver; also known as the budget neutrality cap
- Medical loss ratio (MLR): requires carriers in the individual market to rebate payers if less than 80% of premiums are spent on medical care and more than 20% on marketing, administration, and profit
- Reconciliation: process of assessing the difference between CSR and actual costs
- Qualified Health Plans: plans available through the Health Insurance Marketplace

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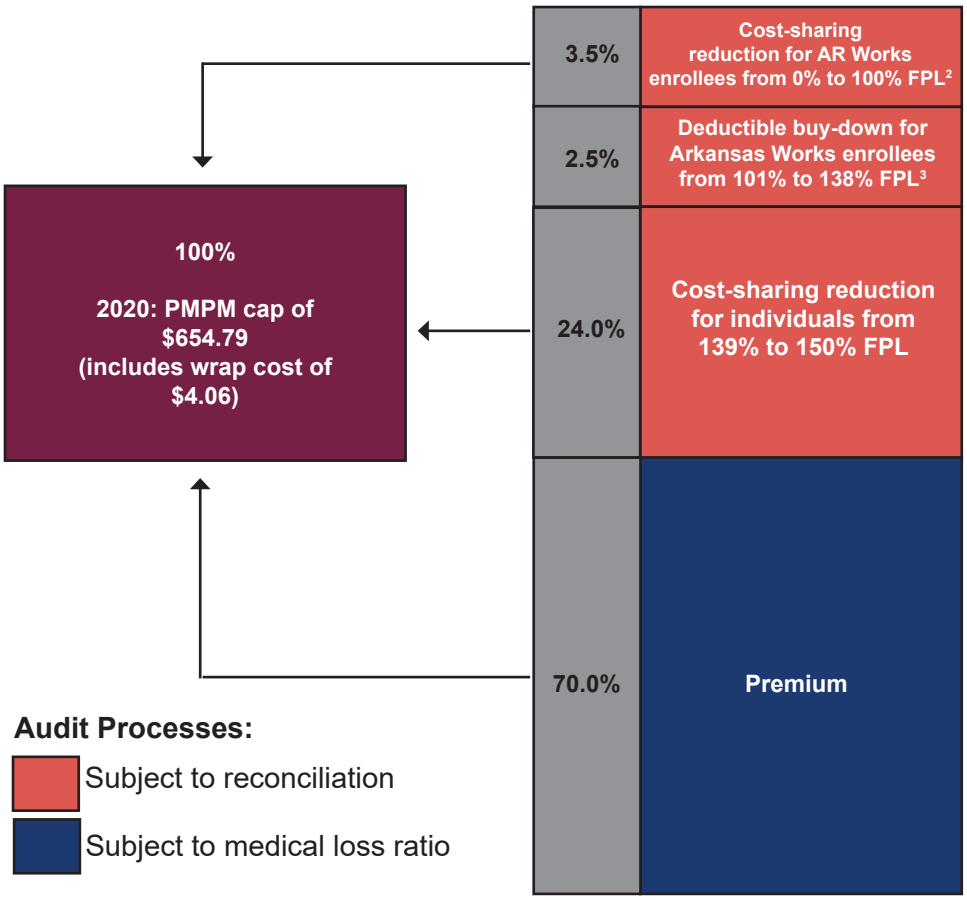

[1]The American Rescue Plan passed by Congress in 2021 provides temporary cost-sharing protections to those who are unemployed through enhanced subsidies.

[2]Enrolles from 0%–100% FPL have no cost-sharing obligations.

[3]Enrolles from 101%–138% FPL have cost-sharing obligations with no deductible.

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