

## 1115 Waiver Private Option and State Plan Option

### Side by Side Comparison

#### “1115 Waiver Private Option”

#### “State Plan Option”

#### ARKANSAS PRIVATE OPTION

#### HEALTHY IDAHO PLAN

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| <b>Plan Description</b>                                    | Integrated, market-based approach through private Qualified Health Plans (QHP) coverage via the Health Insurance Exchange. | Integrated, market-based approach to incentivize personal responsibility for low income Idahoans through contracted health plans equivalent to QHP coverage on the Health Insurance Exchange. |
| <b>Legislation</b>   | Will need statutory changes to Idaho Code §56-254 and §56-255.   | SAME  |
| <b>CMS Approval</b>  | CMS approved 3-year demonstration waiver.  | CMS approved State Plan Amendment/no waiver necessary.  |
| <b>Health Insurance Marketplace</b>                        | QHPs purchased off the Exchange.   | State contracts with “Plans” through the State of Idaho RFP process.  |
| <b>Eligible population</b>                                 | Childless adults 19-64 years old with income up to 138% FPL, excluding medically fragile.                                  | SAME  |
| <b>Covered Benefits</b>                                    | QHP benefit package includes 10 essential health benefits (EHBs).  | SAME  |
| <b>Medicaid “Wrap Services” (EPSDT and Transportation)</b> | Offered through state Medicaid program, not QHP.   | SAME  |
| <b>Qualified Health Plans (QHPs) Selection</b>             | Eligible Medicaid population choose a QHPs silver plan – or they will be assigned to a QHPs silver plan.                   | Use RFP process to select health plans that meet QHPs criteria as established by the State.   |
| <b>Provider Network</b>                                    | QHP offers same provider network to Medicaid participants as for individual market.  | Plans would define their provider network for Medicaid.   |
| <b>Plan Payment</b>  | State uses premium assistance to purchase QHPs from  | State Medicaid program pays selected plans at negotiated actuarially  |

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|   | the Health Insurance Exchange for Medicaid eligibles in the expansion population.   | sound PMPM rate based on the expansion population.  |
| <b>Cost Sharing</b>                       | <ul style="list-style-type: none"> <li>Follows the QHP cost sharing as defined in the plan up to the Medicaid federal limits.</li> <li>Medicaid responsible for cost sharing in excess of federal limits – at enhanced FMAP rate as long as budget neutrality maintained.</li> </ul>  | <ul style="list-style-type: none"> <li>All participants pay co-pay on all services, up to the Medicaid federal limit.</li> <li>Providers can make receipt of services conditional on payment of co-pay for participants with FPL over 100%.</li> </ul>  |
| <b>Consumer Choice</b>                    | Participants can shop and enroll in any QHP on the Health Insurance Exchange at silver plan level. At least two silver plan QHPs must be offered in each rating area to allow for consumer choice. Participants who do not choose a plan will be automatically enrolled in a plan.  | At least two plans will be available to participants through Medicaid RFP process. Participants can choose a plan – if they do not they will be automatically enrolled in a plan.   |
| <b>Budget Neutrality</b>                  | <p>Maximum cost per member for each year of the Waiver identified in the Waiver.</p> <ul style="list-style-type: none"> <li>Rates for the QHPs are adjusted based on the whole population – not contracted with the Medicaid agency.</li> <li>If the rate is exceeded it will be the State’s responsibility to cover the additional costs unless the State can provide acceptable justification of the cost increase to CMS.</li> </ul> | <p>Costs are based on actuarially sound analysis of the Medicaid expansion population at a PMPM.</p> <ul style="list-style-type: none"> <li>Costs are contractual obligations.</li> <li>Method for cost adjustments are identified in the state plan.</li> <li>Cost adjustments made based on the approved state plan process and contractually agreed to by both the State and the plan will receive full FMAP.</li> </ul> |
| <b>Personal Responsibility Incentives</b> | None - unless already included in the QHP.  | Plan design can include incentives to participants to accrue funds to assist with co-pay responsibilities. Monthly statement to participants summarizes their healthcare costs, incentives earned, and co-pays.   |
| <b>Provider Incentives</b>                | None - unless already included in the QHP.  | Providers encouraging patient healthy behaviors benefit from co-pay covered through participant’s accrued funds and improved patient outcomes.  |
| <b>Access to Data</b>                     | No special access to data since Medicaid participants are part of the overall QHP participants.   | Specific data about this population will be required to be shared as part of the contract. State will define data/reports.  |