Report on Health Reform Implementation

Arkansas's Alternative to Medicaid Expansion Raises Important Questions about How HHS Will Implement New ACA Waiver Authority in 2017

Andrew Allison
Arkansas Department of Human Services

Editor's note: The two essays in this issue's Report on Health Reform Implementation section emerged from a workshop, generously funded by the Robert Wood Johnson Foundation, that was held in Chicago, Illinois, in January 2014. The purpose of the workshop was threefold: first, to increase communication and learning between state-level policy practitioners and health policy researchers; second, to address key ACA implementation issues that states are currently grappling with; and third, in response to these issues, to identify useful policy instruments and strategies for dissemination across the states. With these goals in mind, we asked several policy practitioners in different states to submit questions on current implementation challenges that might benefit from the insights of a policy researcher. We then identified researchers with significant expertise in applicable areas to respond to a small selection of these important questions. Andrew Allison's question on whether Arkansas should take advantage of the ACA's "Waiver for State Innovation," and John McDonough's response, is an example of the work that came out of this productive process. They represent the first of three sets of essays, which will be published in this section in future issues. We welcome any feedback on the process or the issues.
—Colleen M. Grogan

Abstract This essay presents Arkansas's alternative to Medicaid expansion as a case study motivating John McDonough's assessment of the recommendations states may want to make to the Department of Health and Human Services regarding the implementation of statewide Patient Protection and Affordable Care Act–alternative waivers scheduled to begin in 2017. Arkansas's private option uses federal funds to purchase

Journal of Health Politics, Policy and Law, Vol. 39, No. 5, October 2014
DOI 10.1215/03616878-2813744

marketplace silver-level qualified health plans for low-income, low-risk participants, while "medically frail" adults are covered through Medicaid. By improving the size and risk profile of Arkansas's health insurance marketplace, the private option will also encourage entry of and competition among private carriers. If it succeeds in keeping insurance premiums below the level they would otherwise be in the marketplace, Arkansas's private option could reduce subsidy costs for the federal government. Under the broadened scope of section 1332 waivers, states will be able to capture such savings and use them to support innovation across both Medicaid-funded and Treasury-subsidized programs and populations.

Background

Although Arkansas's economy is growing and the state avoided the worst of the effects of the financial and economic crisis that began in 2008, it remains one of the country's poorest states (ranked forty-ninth in per capita income) and has had one of its highest rates of uninsurance (18.4 percent of the state's population was uninsured in 2012, seventh highest among states) (US Census Bureau 2013). Before January 2014, when the state expanded coverage to all poor adults up to 138 percent of the federal poverty level, Arkansas also had one of the leanest Medicaid programs in the country, providing no coverage to childless, nondisabled adults and covering parents up to just 17 percent of the poverty level.

Arkansas's "Private Option" Alternative to Medicaid Expansion

On April 24, 2013, Governor Mike Beebe signed into law the Health Care Independence Act, which expands coverage to low-income adults via a novel program most commonly referred to as the "private option." The expansion includes all nonaged, nondisabled childless adults under 138 percent of the federal poverty level (FPL) and parents between 17 percent FPL and 138 percent FPL. The private option takes federal funds for this expansion and, instead of expanding Medicaid, uses those funds to purchase certified marketplace qualified health plans (QHPs) for low-risk participants.[1] Higher-risk "medically frail" adults in the expansion group

1. The expansion itself is established through a state plan amendment, while the section 1115 demonstration authorizes the use of the expansion funds to provide coverage through the marketplace instead of Medicaid. Specific waivers of Medicaid requirements include freedom of choice of providers (transferred to choice of QHPs), payment to providers (via private insurance contracts rather than Medicaid or Medicaid managed care), and prior authorization requirements for prescription drugs (private insurance standard of seventy-two-hour response rather than Medicaid's twenty-four-hour standard).

are covered through Medicaid instead of marketplace QHPs. The state estimated the size of the expansion at approximately 225,000,[2] and of that number 200,000 are expected to receive coverage through the marketplace while the remaining 25,000 "medically frail" adults are to be covered through Medicaid. When fully implemented, the private option is expected to make up about half the coverage purchased through Arkansas's marketplace. In the first years of the private option demonstration, only the expansion group of adults under 138 percent FPL is included in the private option. Extension of private option coverage to children and parents already served by Medicaid (less than 17 percent FPL) is planned for consideration in 2014 and 2015.

Goals of the Private Option

Arkansas legislators established the private option with a number of purposes in mind, including

- expanding private coverage and downsizing Medicaid;
- promoting personal responsibility, for example, through cost sharing and the planned introduction of "independence accounts" that reward healthy living and appropriate use of the private option;
- attracting insurance carriers and enhancing competition; and
- improving continuity of coverage, especially in contrast to the churning that would occur if individuals with a change in income were forced to switch between Medicaid and private insurance.

The last goal is to be achieved by giving low-income adults the opportunity to maintain coverage with the same health plan as their incomes fluctuate above and below 138 percent FPL, the new ceiling for federal funding of coverage through Medicaid and the floor for federal funding of private health insurance subsidies.

Choice of Health Plans within the Marketplace

Adults who are deemed eligible for expansion coverage are invited to visit the private option beneficiary Web portal (Insureark.org), where they take an online health care needs questionnaire to determine their status as either medically frail or eligible to be enrolled in a private health plan in the

2. Another 25,000 are expected to be enrolled as a result of the "woodwork" effect, representing increased participation by adults eligible under preexisting rules.

marketplace, that is, a QHP. The questionnaire identifies both (1) applicants who self-report conditions that qualify them automatically as "medically frail," for example, not living independently, and (2) applicants whose reports of recent health care service use lead to an automated prediction that they will have exceptionally high health service usage in the coming year. Those deemed medically frail remain in Medicaid. Those who are not medically frail are presented with QHP options representing silver-level QHPs in their insurance region (Arkansas has seven regions, or "service areas"). The Health Care Independence Act designates silver-level QHPs (only) for purchase on behalf of private option enrollees and requires all issuers on the marketplace to offer a silver-level QHP that meets private option specifications. Private option enrollees are not shunted into separate, tailored QHPs, and they receive QHP cards indistinguishable from other marketplace enrollees.

Auto-Assignments

Because some enrollees do not successfully complete Web-based enrollment and selection of a QHP, a process of automated default QHP assignments is needed. The auto-assignment process provides a default QHP enrollment for private option participants who do not make their own selection at insureark.org. Once a default assignment is made, private option enrollees have thirty days to visit insureark.org and override the assignment by making their own selection of a QHP. Auto-assignments were expected to be especially important in the first year because of known discontinuities in various federal and state web-based eligibility and enrollment processes and made up over half of all QHP enrollments in the private option's first three months. The ratio of auto-assignments to self-selection is expected to decline over time with improvements to these systems. In the meantime, the state is using auto-assignments to further its aim of building a more competitive insurance market by defaulting enrollees into health plans issued by carriers with low market shares.

Alignment of Benefits

In its inaugural form, policy makers in Arkansas sought to align marketplace requirements for the "high silver" plans within the marketplace to meet federal maximum out-of-pocket costs for Medicaid beneficiaries above 100 percent FPL. Other than the presence of a deductible for those above 138 percent FPL, benefits for all QHPs in the silver level are aligned

through guidance provided to carriers by the insurance commissioner so that they meet *both* Medicaid and marketplace rules for income-appropriate cost sharing. Private option enrollees do not pay premiums. Cost sharing is set to zero (the plan that must be offered to Native Americans) for participants below 100 percent FPL and approximates 5 percent of family income—the Medicaid limit—for adults between 100 and 138 percent FPL. The cost-sharing design for the private option expansion is to extend the sliding scale out-of-pocket obligations of the marketplace all the way down to 0 percent FPL.[3]

Planned Impact on Arkansas's Insurance Marketplace

The private option is specifically designed to improve the size, risk profile, and level of competition of Arkansas's health insurance marketplace.

Size. Over time the private option is expected to double the size of the individual insurance marketplace. Because of initially slow enrollment by other adults in Arkansas's federal-facilitated marketplace (FFM), the private option in the first months of enrollment constituted about 80 percent of total QHP enrollment—nearly quintupling the number of premium-paid enrollees as of early March 2014. For this point in time, total enrollment in QHPs by private option participants alone would rank Arkansas as the thirteenth-largest marketplace nationally despite the fact that the state ranks thirty-second in total population. The private option commits a very large group of participants to the marketplace, increasing both the amount and predictability of premium revenue that insurance companies can count on as they consider whether to do business in Arkansas, as they decide whether to expand their coverage footprint in the state, and as they set rates.

Risk profile. The medical frailty screening process described above diverts participants with the highest expected service needs and costs to Medicaid rather than the private marketplace. By early March 2014, more than thirteen thousand adults eligible for the expansion had been diverted to Medicaid coverage because they were expected to have special service needs and/or high costs. Also, because private option participants are relatively young, on average, the private option

3. Consistent with this aim, modest cost sharing is to be added for those 50–100 percent FPL in 2015.

has lowered the median age of Arkansas's marketplace as a whole by ten years as of March 2014. Together, the favorable risk selection and young ages of private option enrollees are establishing Arkansas as arguably the healthiest individual insurance market in the country.[4]

Competition. By significantly improving the size and risk profile of the marketplace, and by employing purchasing strategies such as auto (or default) QHP assignment, the private option is designed to encourage both entry and competition among carriers in a state whose individual market has traditionally been dominated by a single carrier. With only a few weeks in May and June 2013 to respond to the opportunity established by the Health Care Independence Act, marketplace entry by new carriers was limited in plan year 2014. Continued growth in the number and geographic reach of carriers participating in Arkansas's marketplace will be a key test of the private option's design.

Arkansas's 1115 Demonstration Waiver

Through 1115 demonstration waivers, the secretary of the Department of Health and Human Services (HHS) is able to grant states the authority to spend federal Medicaid matching funds in ways that do not otherwise meet federal statutory requirements. One of the Centers for Medicare and Medicaid Services' (CMS) principal criteria for approving 1115 waivers is budget neutrality, a requirement that states cannot spend more federal money as a result of an 1115 waiver than they would have spent without the waiver. Budget neutrality is therefore a comparison of actual spending under the terms of the waiver to an estimate of spending under the hypothetical set of circumstances that would have occurred without the waiver. In practice, states have frequently been able to include new populations that the state "planned" to cover in the calculation of without-waiver spending. In this fashion, Arkansas was allowed to include in its without-waiver baseline a hypothetical expansion of its traditional Medicaid program to the adult expansion population receiving funding through the Patient Protection and Affordable Care Act (ACA) (up to 138 percent FPL). Indeed, Arkansas's private option consists of a simultaneous package of a traditional "state plan" expansion of coverage to this new population

4. The marketplace's actuarial "three Rs" apply to the private option, placing these enrollees fully *within* the marketplace insurance risk pool.

and a 1115 waiver that enables use of those coverage funds to enroll most of these adults in private insurance instead of traditional Medicaid.

Federal Approval Criteria for 1115 Waivers: The Example of Budget Neutrality

A potential obstacle in CMS's approval of Arkansas's private option waiver request was the challenge of demonstrating that the cost of private coverage would not exceed the cost of Medicaid coverage for the expansion population. Early news reports of the legislative debate over the private option in spring 2013 focused on an (unrelated) analysis from the Congressional Budget Office (CBO) that was interpreted to show as much as a 50 percent cost differential between Medicaid and private insurance, a differential that would seemingly make budget neutrality for an expansion through private insurance impossible. Several aspects of the CBO estimate proved inapplicable, including the fact that the cost differential in Arkansas was demonstrably lower than the national average. Nevertheless, the fact remained that in 2013 private carriers reimbursed providers at a higher rate than Arkansas's Medicaid program.

The principal innovation in CMS's approval of Arkansas's 1115 waiver application is its acceptance of the state's assumption that, had it expanded Medicaid, provider rates of reimbursement would have had to increase significantly in order to secure federally mandated levels of access for the expansion population. By federal statute, CMS requires states to ensure that rates of reimbursement "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" (Social Security Act § 1902(2)(30)(A)).

Arkansas's without-waiver spending projection assumes that Medicaid provider rates for the expansion population would have to rise to the level paid by private insurance carriers for policies similar to those purchased for private option participants in the marketplace.[5] In addition, the state assumed that private rates of reimbursement would fall somewhat as providers were able to accept lower rates in return for the influx of new, paying patients and as the buying power of the private option in the state's marketplace increased the level of carrier competition in the state. Put simply, the state contends that the rate of reimbursement needed to achieve

5. In practice, this would manifest in a lower, but across-the-board, increase in Medicaid rates that would apply to both the expansion and preexisting Medicaid population.

sufficient access for the new population is equivalent regardless of whether the payer is public or private, and that rate will end up somewhere between pre-expansion levels for Medicaid and pre-expansion levels paid by private carriers.

While the waiver budget math resulting from this assumption of provider rate equivalency worked for Arkansas, it might not work in a state with a smaller Medicaid expansion or in a state where the initial gap between Medicaid and private rates of reimbursement is greater. In those scenarios states would find it helpful to be able to get waiver budget credit for the savings that are accruing to the federal treasury outside the Medicaid budget as a result of the Medicaid waiver. These are the added savings that accrue to the federal government in the form of reduced premium subsidies if the private option succeeds in keeping provider reimbursement, and therefore insurance premiums, below the level it would otherwise be in the marketplace. If the state's predictions hold true, the federal government will save money that is not being counted in Arkansas's budget neutrality calculation.

How Budget Neutrality Could Work under a 1332 Waiver

Under the waiver authority granted the secretary in section 1332 of the ACA, any requirement for budget neutrality would presumably include federal programs and expenditures for both Medicaid and other marketplace participants. The broadened scope of section 1332 waivers would enable states to capture premium subsidy savings in the budget neutrality calculation, making Arkansas's premium assistance "private option" model—as an example—more obviously budget-neutral or even cost saving for the federal government.

Approval of Arkansas's 1115 waiver by CMS was made more difficult because the scope of policy and programmatic impact of the waiver is broader than the scope of the budget neutrality calculation required for approval. Depending on the criteria that the secretary establishes for acceptance of 1332 waivers, states are likely to seek and obtain approval for a broader array of creative policy reforms using the new 1332 authority when they are able to take full account of the federal budget impact of the reforms made possible by the waiver.

Another example of potential non-Medicaid savings that could accrue to the federal treasury as a result of a state Medicaid policy choice involves "continuous coverage," which is the use of an annual determination of income eligibility regardless of potential changes in income over the course

of the year. Generally, state Medicaid programs keep track of changes in income over the course of a year and disenroll those with increases that bump them over the state's income eligibility limits. Keeping these individuals in Medicaid-funded coverage for a full year would delay transitions from Medicaid-funded coverage below 138 percent FPL to federal tax–subsidized coverage above 138 percent FPL. Such delays would increase Medicaid spending and decrease Treasury-funded premium tax subsidies. For states bearing some percentage of the costs of Medicaid-funded coverage (e.g., beginning in 2017 for Arkansas's expansion population) the direct costs of adopting continuous coverage may be enough to discourage state adoption of the policy. However, if the federal government were to find a way to compensate states for the reduction in Treasury-funded premium subsidies that result from continuous Medicaid coverage, the net financial impact on the state would be more favorable and could tip the scales toward adoption of the policy. With section 1332 waivers, such financial trade-offs between Medicaid-funded coverage for those below 138 percent FPL and Treasury-funded coverage for those above 138 percent FPL may be possible.

Beginning in 2017 with creative application of section 1332 waivers, budget neutrality calculations could potentially reflect the full impact of provider rate equilibration (for states like Arkansas engaged in some form of the private option), continuous coverage, and likely many other creative state policy initiatives, providing opportunities for the federal government to compensate states for their decision to reduce costs to the Treasury. The example of budget neutrality raises the more general question of how the secretary will choose to establish criteria for review and approval of section 1332 waivers, a new authority with the promise to significantly increase long-sought state autonomy in health care insurance and health system reform.

Policy Question

Under section 1332 of the ACA, championed by Senator Ron Wyden, Democrat from Oregon, HHS can consider statewide alternative approaches to the ACA's subsidies, expansion, and marketplace structure. This is much like existing authority under section 1115 for Medicaid demonstration waivers but spans across the 138 percent FPL line, going beyond the confines of Medicaid-only budget and policy considerations. This waiver authority could be especially important to states considering alternative coverage models like Arkansas's private option. What sorts of thresholds for approval

should states recommend that HHS establish for the statewide ACA-alternative waivers scheduled to begin in 2017?

■ ■ ■

Andrew Allison joined the Arkansas Department of Human Services as the Medicaid director from 2011 to 2014. Previously, he was the director of the Division of Health Care Finance within the Kansas Department of Health and Environment and the executive director of the Kansas Health Policy Authority with responsibility for Kansas's Medicaid program, CHIP, the Kansas state employee health plan, and the state's growing health care and health insurance databases. He is a founding board member of the National Association of Medicaid Directors and served as its president from 2010 through 2012. He spent six years at the Kansas Health Institute as a researcher, focusing on health care and health insurance policy in Kansas. He also worked as a Medicaid budget analyst at the Office of Management and Budget in Washington, DC, from 1992 to 1995, providing staff analysis of health reform legislation and reviewing statewide Medicaid waiver applications. He has a PhD in economics from Vanderbilt University, an MPP from Duke University, and a BA in history from Ouachita Baptist University.

Reference

US Census Bureau. 2013. *Current Population Survey, 2013 Annual Social and Economic (ASEC) Supplement.* Washington, DC: US Census Bureau. www.census.gov/prod/techdoc/cps/cpsmar13.pdf.