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A Look at the Private Option in Arkansas

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Executive Summary

In September 2013, Arkansas became the first state in the nation to receive approval from the federal government for a Section 1115 demonstration waiver to require most adults who are newly eligible for coverage through the Affordable Care Act's Medicaid expansion to enroll in Marketplace plans. The initiative, often referred to as the "private option," has allowed Arkansas to cover close to 220,000 Medicaid beneficiaries with commercial provider networks and strengthen its Marketplace. An additional 25,000 medically frail adults are covered through the state's fee-for-service system, bringing to 245,000 the number of newly eligible adults covered in Arkansas as of June 30, 2015. As a result of this coverage, Arkansas has been able to drive down its uninsured rate and reduce uncompensated care costs. The future of the private option is the source of extensive discussion within Arkansas, and it continues to be watched closely by policymakers within the state and around the country. Drawing on a dozen interviews with state officials, providers, insurance carriers, and advocates, as well as early data on coverage, reduced uncompensated care costs, and other topics, this issue brief provides an initial look at implementation. Key findings include the following:

Arkansas cut its uninsured rate among non-elderly adults nearly in half (from 27.5 percent to 15.6 percent) between 2013 and 2014. This reduction, the second largest percentage point decline nationally, was realized in large part due to the coverage pathway offered through the private option as Arkansas had the lowest eligibility threshold for adults in the country prior to 2014. These gains are consistent with the experience of states that expanded coverage through their traditional Medicaid programs. The marked increase in coverage in Arkansas occurred despite limits on funding for outreach and enrollment, eligibility computer system issues, and confusion among some beneficiaries about where to seek enrollment assistance. Arkansas' use of fast track enrollment strategies, by using SNAP data to identify beneficiaries eligible for the private option, contributed to strong early enrollment in the program. Since the time of our interviews in the spring of 2015, Arkansas has been confronting operational challenges in conducting renewals in traditional Medicaid and for the private option. Since these renewal issues are not specific to private option enrollees and arose after the interviews for this brief were completed, they are not addressed in any detail.

Stakeholders reported that private option enrollees are generally able to access services, and hospitals are seeing sharp drops in uncompensated care, while the impact on community health centers is more mixed. Close to four in ten private option enrollees gained coverage for the first time in their lives,¹ and stakeholders reported that enrollees were able to access a broad set of services, including specialty care and providers in rural areas. Hospitals saw a 55 percent drop in uncompensated care

costs and signs of people seeking care in more appropriate community-based settings instead of emergency rooms. Community health centers also are seeing more insured patients, but some reported challenges due to delays in cost-based reimbursement payments from the state or noted that new clinics established by Marketplace plans could “skim off” their insured patients. These findings are similar to the experience of other states that have expanded coverage, regardless of the mechanism used to implement the Medicaid expansion.

Early reports indicate that private option beneficiaries are receiving wrap-around protections for premiums and cost-sharing that exceed Medicaid limits, while access to wrapped benefits required by Medicaid but not covered in the Marketplace was more mixed. Stakeholders credited Arkansas with protecting beneficiaries from having to make burdensome out-of-pocket payments upfront and then be reimbursed; this was accomplished by standardizing the Marketplace plans’ cost-sharing design and having the state make supplemental cost-sharing reduction payments directly to Marketplace plans. Nearly all required Medicaid benefits are provided directly through Marketplace plans, minimizing the need for a “wrap.” However, two benefits – non-emergency medical transportation and Early, Periodic Screening, Diagnosis and Treatment (EPSDT) for 19 and 20-year olds – are provided as a wrap through the fee-for-service system, and stakeholders reported some concern that beneficiaries do not always know how to access these benefits, particularly EPSDT.

The screening tool used to identify medically frail beneficiaries is reported to be working well, although some stakeholders are concerned that it is underutilized. As of June 2015, 9.95 percent of beneficiaries (25,800 individuals) were considered medically frail and served through the state’s traditional fee-for-service Medicaid program, which includes long-term services and supports, instead of in Marketplace plans. While there were no reports that beneficiaries were unable to secure a designation as medically frail, some stakeholders expressed concern that many beneficiaries are auto-assigned into a Marketplace plan, and therefore bypass the screening, raising the possibility that some medically frail individuals are not being identified early on.

The private option has helped to increase competition in the Arkansas Marketplace and contributed to reductions in premiums. The private option has nearly tripled enrollment in Arkansas’s Marketplace, helping to boost the number of carriers offering Marketplace plans statewide from two in 2014 to as many as six in 2016; generating a younger and relatively healthy risk pool; and contributing to a two percent drop in the average rate of Marketplace premiums between 2014 and 2015.

Despite early concerns, the private option appears on track to meet or even outperform federal budget neutrality requirements. Spending on the private option initially was higher than the budget neutrality projections prepared for the waiver, but more recent data suggests that the state is meeting its targets and may even succeed in limiting spending to significantly below the allowable levels. Stakeholders also are closely watching the broader question of whether the private option will prove cost-effective as compared to traditional Medicaid coverage. As part of its waiver, Arkansas is permitted to use criteria that differ from what is otherwise required under federal law to evaluate cost-effectiveness. These include the private option’s impact on coverage, access to care, Marketplace competitiveness, and reductions in churning between Medicaid and Marketplace coverage. While it will be some time before data are available to definitively answer this question, the private option is credited with saving the state over \$88 million and generating new revenue of \$29.7 million in state fiscal year 2015.

LOOKING AHEAD

Slated to continue through 2016, the private option is now part of an active political and policy debate in Arkansas. A state legislative taskforce and a Medicaid advisory group are in the midst of developing recommendations for the future of Arkansas' Medicaid program, including the private option. Many stakeholders expect that coverage for newly eligible adults will continue in some form, building on the foundation established by the private option, and also that the private option will be modified in the years ahead. As importantly, the state will need to consider with the future of its fee-for-service system, which continues to serve the vast majority of the state's beneficiaries, including medically frail adults with the greatest health care needs.

For other states, the Arkansas experience offers lessons on how they might combine their Medicaid programs and Marketplaces, leveraging the buying power of these two markets and potentially providing greater access to care and continuity of coverage. Stakeholders also noted that the private option has proven more administratively complex to implement than a traditional Medicaid expansion, requiring close collaboration across state agencies and other stakeholders. Notably, unlike many other states, Arkansas did not have an established Medicaid managed care delivery system prior to expansion or a fee-for-service network that was equipped to serve a significant number of newly eligible adults. In some states, particularly those that already have a well-developed Medicaid managed care system, the private option may not be a good "fit." However, even in these states, the Arkansas experience highlights the considerable flexibility available to design an extension of coverage to newly eligible adults consistent with a state's delivery system, political culture, and larger health care goals.

Introduction

In September 2013, Arkansas became the first state in the country to secure Section 1115 demonstration waiver approval from the Centers for Medicare and Medicaid Services (CMS) to require adults newly eligible for Medicaid with income up to 138 percent of the federal poverty level (FPL, \$16,243 per year for an individual in 2015) who are not medically frail to enroll in private health plans offered through the Arkansas Marketplace.² (Newly eligible adults who are medically frail are served through the state's fee-for-service system rather than the demonstration, as discussed in more detail below.) Arkansas's demonstration uses Medicaid funds as premium assistance to purchase Marketplace coverage for parents with income from 17-138 percent FPL and childless adults from 0-138 percent FPL. These newly eligible adults are Medicaid beneficiaries and must be provided with all Medicaid benefits and cost-sharing protections, either through a Marketplace plan or via a "wrap" through the state's Medicaid program. The approach, often referred to as the "private option," was designed by the state with goals of increasing access to care by placing beneficiaries in private health plans with a robust provider network; reducing the effects of churning as enrollees move between Medicaid and Marketplace coverage as their income fluctuates; and reinforcing the state's broader health care delivery system reform efforts. The private option expansion now covers close to 220,000 newly eligible adults in Arkansas, and is authorized by CMS through the end of 2016. An additional 25,000 newly-eligible adults are covered through the state's fee-for-service system, bringing the total number covered to 245,000 as of June 30, 2015.³

This issue brief offers an early look at implementation of the private option expansion, drawing on a dozen interviews with a broad array of Arkansas stakeholders and early data on coverage, reduced uncompensated care costs, and other topics. Interviews were conducted in April and May 2015 with state officials, providers, insurance carriers, and beneficiary advocates (The interview guide is contained in Appendix A). The findings also are informed by data and reports from the state Medicaid agency and the state insurance department; state legislative oversight committees; and CMS. The brief provides a short history of the private option expansion; presents key findings along several dimensions, focusing on the implications of the model on beneficiaries; and discusses lessons for other states and prospects for the future of the private option expansion in Arkansas.

History of the Private Option Expansion

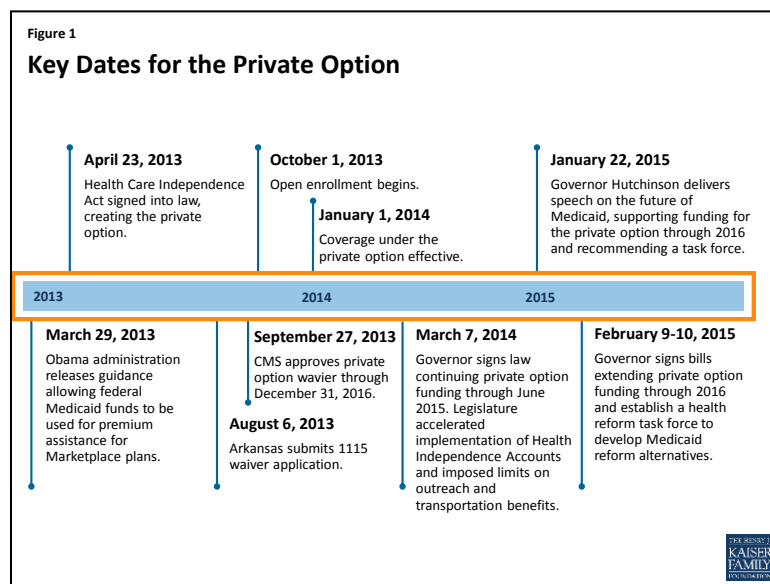
Arkansas was the first state to consider mandating enrollment in Marketplace plans for adults newly eligible for Medicaid. While states have a long history of using Medicaid funds to purchase employer-based coverage for Medicaid beneficiaries, it was not until passage of the Affordable Care Act (ACA) that states began to look closely at purchasing individual insurance policies with Medicaid funds. Prior to the ACA's insurance market reforms, premium assistance models in the individual market were challenging for state Medicaid programs to administer. Insurers were not obligated to issue policies; they could impose pre-existing condition exclusions; and they could charge higher premiums for people with extensive health care needs, making it impossible or prohibitively expensive for states to buy individual policies for Medicaid beneficiaries. The individual market also lacked standardized plans and benefit design. After ACA reforms to the individual insurance market eliminated many of these hurdles, CMS issued regulations to give states the option to use Medicaid funds for voluntary enrollment in premium assistance, including for Marketplace plans, without requiring waiver approval.⁴ In March 2013, CMS released guidance indicating that it would consider approving a limited number of demonstrations that required Medicaid beneficiaries to enroll in Marketplace plans, within certain guidelines.⁵ The private option expansion was designed by state legislative leaders, then-Governor Mike Beebe, and state agency leadership in the second half of 2012 and 2013. At the time, it was clear that the Arkansas legislature would not approve a traditional Medicaid expansion. The Arkansas constitution requires a 75 percent super majority to approve initiatives requiring appropriations, and there were not enough votes in favor of funding a traditional Medicaid expansion. To move forward, the state required an alternative approach. (Figure 1)

After the legislature authorized expansion through the private option, close collaboration was required among state officials and other stakeholders to implement the program. The Arkansas state legislature debated and ultimately approved authorizing legislation, and the private option expansion was signed into law by Governor Beebe on April 23, 2013.⁶ In some respects, though, the detailed work of developing the private option expansion was just beginning. Implementation required a Section 1115 Medicaid waiver from CMS, primarily because Arkansas sought to require beneficiaries to enroll in Marketplace plans. The state submitted its waiver application in August 2013. In relatively short order, but, still less than a week before the launch of the initial open enrollment period for Marketplace coverage, Arkansas received waiver approval on September 27, 2013.⁷

The administrative complexity of operationalizing the private option expansion in a relatively short timeframe required the state to navigate a variety of implementation issues on the state

and federal levels. While waiver negotiations were ongoing, the state also was handling other implementation issues, such as working with insurers to develop their rates for participating in the Marketplace; building the enrollment portal that beneficiaries would use to select a Marketplace plan; and developing educational materials and notices for beneficiaries. The initiative requires the state insurance department to oversee the Marketplace plans that serve newly eligible adults,⁸ while the state Medicaid agency retains ultimate responsibility for ensuring that beneficiaries are provided with coverage that meets federal Medicaid standards. As a result, implementation required what stakeholders described as an unprecedented level of cooperation between the state Medicaid agency and state insurance department. The state began accepting applications for the new program on October 1, 2013, and coverage began on January 1, 2014.

Since 2013, the private option expansion has continued to undergo changes. The Arkansas Senate approved continued funding of the private option expansion in February 2014, but the House voted five times before the required super majority reauthorized it in early March 2015. The final legislation included a ban on using government money to fund outreach and enrollment assistance for health coverage broadly (not just for private option enrollees);⁹ the acceleration of implementation of new Health Independence Accounts through which private option enrollees would pay cost-sharing; and changes to the state’s non-emergency medical transportation benefit.¹⁰



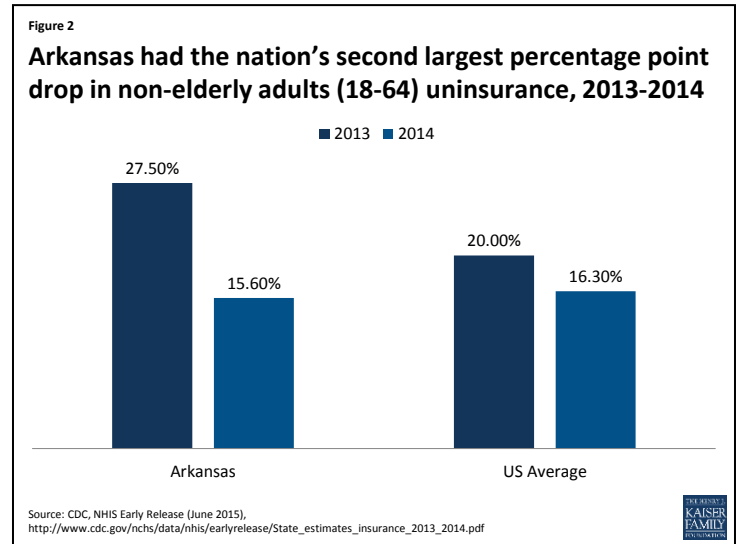
The private option expansion’s future is currently under discussion. On January 22, 2015, the new Governor, Asa Hutchinson, gave a speech outlining his thoughts on the private option. The Governor, who inherited the private option from the earlier Democratic Administration, described the private option as innovative and rooted in market principles. He explained it has offered important benefits to Arkansas residents and the state’s hospitals, while also calling on the legislature to establish a task force to explore more wide-ranging reforms of the state’s Medicaid program.¹¹ In response, the legislature extended funding for the private option through 2016 when the initiative is slated to sunset, and created the Legislative Health Reform Task Force, which will make recommendations by December 2015 for modernizing the state’s overall Medicaid program. The Governor also issued an executive order creating a Medicaid Advisory Committee, headed by the state’s surgeon general, that will provide input into this process.

Key Findings

Interviews with stakeholders and early data reveal the impact of the private option's early implementation in the following areas:

COVERAGE

Since the private option's launch in October 2013, 245,000 people¹² have enrolled in coverage, contributing to Arkansas's role as a national leader in reducing the uninsured rate. Between 2013 and 2014, Arkansas cut its uninsured rate among non-elderly adults almost in half, dropping it from 27.5 percent to 15.6 percent, one of the largest declines in the country (Figure 2).¹³ States that adopted a traditional Medicaid expansion also experienced sizeable reductions in uninsured rates.¹⁴ Advocates, providers and others report that the coverage has been "a blessing" for Arkansans, many of whom never had coverage before and who previously got care only episodically or in emergencies, leaving them with untreated chronic conditions and without reliable access to preventive care. The private option expansion also is credited with reducing the incentive to apply for SSI benefits by making health coverage available and helping people get medical treatment so they can return to work; since the private option expansion was implemented, SSI applications in Arkansas have dropped for the first time, by about 19 percent.¹⁵



The private option expansion is not the only source of coverage gains in Arkansas, but it has contributed substantially to the reduction in Arkansas's uninsured. The state also has some 54,000 people enrolled in Marketplace plans outside of the private option,¹⁶ as well as an increase in enrollment in its pre-existing Medicaid program. As some stakeholders pointed out, the extent of these coverage gains reflects in part that Arkansas had one of the highest uninsured rates in the country prior to implementation, magnifying the importance of the state's decision to establish the private option. Prior to expanding Medicaid, Arkansas covered parents with incomes below 17 percent FPL (\$3,415 per year for a family of three in 2015), one of the lowest eligibility thresholds in the country.¹⁷ It did not provide any coverage for childless adults without disabilities regardless of how low their income was.

OUTREACH AND ENROLLMENT

As the private option expansion was first being implemented in the fall of 2014, the state was able to quickly and efficiently enroll 60,000¹⁸ eligible individuals using "fast track" enrollment strategies offered by CMS. Under fast track enrollment, the state Medicaid agency used data available from SNAP files to identify parents and childless adults who met the private option eligibility criteria and sent them an enrollment form to return if they wanted coverage. By using data it already possessed, Arkansas generated a one-time boost in enrollment that contributed to a strong launch of the private option. Stakeholders also cited the state's rapid creation of the enrollment portal that allows individuals eligible for the private option to select

a Marketplace plan as contributing to the initial enrollment success.¹⁹ However, some interviewees noted that the fact that there are two separate web portals for eligibility determinations and plan selection increases the complexity and administrative burden of the enrollment process for beneficiaries; one stakeholder also noted that even if there was a single portal for eligibility and plan selection, beneficiaries still might feel overwhelmed or confused by the plan choices and not select a plan on their own.

Many stakeholders felt the legislature’s 2014 decision to bar the use of government funding for outreach and enrollment negatively affected beneficiaries. Hospitals, community health centers and advocacy groups stepped in to provide some education and outreach and partnered with churches and local businesses with connections to beneficiaries, such as the poultry industry, to provide enrollment assistance, but they have not been able to fully meet this need. Stakeholders reported that beneficiaries are sometimes confused about their health plan options, where to go for help if they have issues, and which government agency – the state Medicaid agency or state insurance department – is responsible for answering their questions.²⁰ One concern is that the ban on state expenditures for outreach may contribute to a higher-than-necessary rate of auto-assignment into Marketplace plans; lacking sufficient assistance, some beneficiaries may be auto-assigned to a plan and therefore miss the opportunity to complete the medically frail screening process and select a health plan as discussed below.

A number of stakeholders pointed out that the issues confronting Arkansas’s Medicaid eligibility and enrollment system have added to the challenges beneficiaries face in navigating the private option. Like a number of other states, Arkansas has faced challenges complying with the sweeping changes made to Medicaid eligibility and enrollment procedures in the ACA. These larger system issues are not specific to the private option, but they still have resulted in enrollment delays, added to beneficiary confusion, and raised concerns about the timeliness of coverage renewals.

MEDICALLY FRAIL ENROLLEES

Stakeholders thought the medically frail screening tool worked well to identify people with extensive health care needs who would be better served in the traditional Medicaid program.

No one reported hearing about beneficiaries who wanted to be considered medically frail but who could not secure this designation. As of June 2015, 9.95 percent of newly eligible adults – or 25,800 individuals – were deemed medically frail and enrolled in the state’s fee-for-service Medicaid program.²¹ By default, they receive the traditional Medicaid state plan benefit package, which includes long-term services and supports (LTSS) not available to private option enrollees. At their option, medically frail individuals instead can elect to receive the same benefit package as private option enrollees (although they still receive these benefits through the fee-for-service system). In some instances, the private option benefit package may be more useful to a beneficiary depending on individual circumstances; for example, it includes substance abuse treatment services not available in Arkansas’s traditional Medicaid benefit package for adults. To date, the vast majority – 88 percent – of those designated medically frail have remained in the traditional Medicaid benefit package.²² Additional information about Arkansas’ medically frail screening process is contained in the box on the next page.

Arkansas' Medical Frailty Screening Tool

Once determined eligible for Medicaid, newly eligible adults in Arkansas are instructed to visit the state enrollment portal to complete a 12-question screening tool to assess whether they qualify as “medically frail.” The screening tool is designed to identify people with extensive medical needs, such as those with serious and complex medical conditions, disabling mental health disorders, and limitations with one or more activities of daily living. The screening tool includes the following domains: health self-assessment; living situation; assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs); overnight hospital stays (both acute and psychiatric); and number of physician, physician extender or mental health professional visits. It gathers information online (unless an individual requests a paper copy) and consists of yes/no and multiple choice questions. Responses are entered into software that calculates whether the person meets the medically frail criteria. The screening tool methodology is a combination of threshold qualifying characteristics, such as the presence of an ADL or IADL limitation, and a weighted scoring algorithm based on applicant responses to other screening questions.

As of February 2014, out of 105,000 beneficiaries eligible for the private option, 58,000 bypassed the medical frailty screening, 36,000 were screening and determined not to be medically frail, and 11,000 were screened and determined to qualify as medically frail.²³ Of these 11,000 medically frail beneficiaries, 3,000 were automatically deemed medically frail because they have an ADL or IADL limitation; are homeless or living in an institution or group home; or have a history of psychiatric hospital admissions.²⁴ The remaining 8,000 medically frail beneficiaries qualified because they were determined likely to need services placing them in the top 10 percent of costs, based on their self-reported health status, inpatient admissions, and emergency room and office visits for physical and mental health conditions in the last six months.²⁵

Stakeholders expressed concern that some individuals are bypassing the medically frail screening because they are auto-enrolled into plans. As of June 2015, 40 percent of individuals identified as newly eligible in year 2 of the program were auto-enrolled into plans.²⁶ Because they did not go to the enrollment portal to select a Marketplace plan, they also missed the chance to complete the medically frail screening. Beneficiaries who bypassed the medically frail screening included those who were automatically enrolled based on SNAP data and those who applied for coverage on the federal Healthcare.gov website. Despite the large number of enrollees who bypassed the screening tool, Arkansas met its estimate of identifying 10 percent of newly eligible adults as medically frail because 23 percent of those who responded to the screening tool between October 2013 and February 2014 qualified.²⁷

While they can elect to undergo medically frail screening at any time, it is not clear that beneficiaries are always aware of this option. Moreover, the mid-year process that insurance carriers use to identify medically frail individuals is a source of confusion and is used sparingly. To date, only about 18 additional individuals have been identified as medically frail after carriers flagged them for screening based on their claims history.²⁸ Of these, 5 enrollees asked to be moved to fee-for-service Medicaid. The remainder elected to remain with their Marketplace plans raising the prospect that at least some medically frail individuals may prefer enrollment in Marketplace plans if they are not in need of the specialized services available in the traditional Medicaid package.²⁹ The state is including a reminder in the renewal notices sent to people who must take action to continue their coverage that they should return to the enrollment portal to

select a plan and, in the process, undergo screening for medical frailty.³⁰ Beneficiaries also have the opportunity during the open enrollment period to select a new plan and, if they do, they will be prompted to undertake a medical frailty screening.³¹

Arkansas designed its medical frailty screening tool not only to identify those with exceptional needs, but also to minimize the risk that plans would have to cover beneficiaries with the highest costs in the first year of the private option. Arkansas targeted the group of beneficiaries who are expected to incur the top 10 percent of health care costs as a proxy for identifying those who were most likely to need services, such as LTSS, that are not available in the Marketplace plans' benefit package.³² State officials reported that insurers needed information about the private option risk pool to establish Marketplace premiums in the first year, and the 10 percent target helped provide predictability for this purpose.³³ State officials also indicated that the medically frail screening tool was designed to be over rather than under-inclusive initially, by targeting people with "exceptional medical needs" in addition to those who meet the federal definition of medically frail.³⁴ In future years, the state expects to refine the screening tool to eliminate false positives, validate screening responses through claims data, and better identify beneficiaries who need LTSS.³⁵ To date, medically frail beneficiaries (10 percent of newly eligible adults in Arkansas) account for about 17 percent of expenditures for Arkansas' entire Medicaid expansion population.³⁶

Stakeholders highlighted the importance of continuing to improve the state's Medicaid fee-for-service delivery system for medically frail individuals. Medically frail individuals, by definition, are likely to have more extensive health care needs and higher costs than other newly eligible adults. A number of stakeholders pointed out that medically frail enrollees are perhaps in greater need of better provider networks and delivery systems than private option enrollees. Given that Marketplace plans may not be well-equipped to provide some of the more specialized long-term services and supports critical to many individuals who are medically frail, stakeholders did not recommend that this population be mandatorily enrolled in the private option, but rather that steps be taken to strengthen the fee-for-service delivery system available to such individuals or perhaps that they be given the choice of enrolling in the private option when that system could better meet their individual needs.

ACCESS TO CARE AND UTILIZATION

One of the clearest themes to emerge from interviews with stakeholders was that the private option coverage expansion has succeeded in providing beneficiaries, most of whom were previously uninsured, with access to care.³⁷ States that implemented traditional Medicaid expansions also saw significant gains in access to care among adults who gained coverage.³⁸ Stakeholders reported that beneficiaries appreciate having the same commercial insurance card as other Marketplace enrollees and the access to doctors, hospitals, clinics, and specialists that these plans offer. The access to specialists was highlighted by a number of stakeholders as particularly important: while traditional Medicaid beneficiaries often can secure primary and preventive care from community health centers, they may encounter more challenges accessing specialists. An additional advantage of consistent access to care is that it allows private option enrollees to receive care coordination and monitoring of their conditions over time. In the past, many private option enrollees were largely excluded from the health care system – they might have had intermittent care, but they did not have access to continuous coverage. On the other hand, one stakeholder suggested that a

lack of experience with commercial insurance plans might have resulted in underutilization of benefits by private option enrollees.

The private option expansion also may be increasing access to care for all Arkansans. In some instances, the private option is credited with encouraging carriers to develop capacity that generated a positive spill-over effect for all community members. One stakeholder, for example, cited a carrier's decision to set up new outpatient clinics as an outgrowth of the private option coverage expansion. Another noted that some clinics and providers throughout the state are now offering Saturday hours to accommodate the growth in the number of insured patients. This expansion of access may also be related to the state's patient-centered medical home initiative, which also was included in the legislation that created the private option. It is one component of a larger multi-payer comprehensive payment reform effort aimed at incentivizing quality and cost-effective care delivery in which marketplace plans are required to participate.

PROVIDERS

The Arkansas Hospital Association (AHA) reports that hospitals are experiencing a dramatic drop in uninsured patients and uncompensated care costs. In addition, the AHA survey data also point to patients possibly seeking care in community-based settings instead of emergency rooms, with 5.8 percent growth in use of hospital outpatient clinics during the first six months of 2014.³⁹ On the other hand, insurance carriers report relatively high rates of emergency room visits by private option enrollees, suggesting that private option enrollees may still be learning how best to use their coverage.⁴⁰ More clear is that hospitals are experiencing drops in uninsured patients and uncompensated care costs. In 2014, inpatient visits by uninsured patients dropped 48.7 percent, uninsured emergency room visits by 38.8 percent, and uninsured outpatient clinic visits by 45.7 percent (compared to 2013).⁴¹ Hospitals also experienced corresponding gains in financial stability, with uncompensated care losses related to uninsured patients falling by 55.1 percent, or \$149 million, from 2013 to 2014.⁴² States that adopted a traditional Medicaid expansion also experienced sizeable decreases in uncompensated care costs as more of the uninsured gained coverage.⁴³

The private option expansion's impact on Arkansas community health centers is more mixed and varied across the state. Community health center leadership is enthusiastic about the coverage expansion, and centers are actively helping people enroll in coverage, using funds provided by the federal Department of Health and Human Services. Moreover, centers, particularly those in isolated rural areas, are seeing positive impacts from the expansion as more of their patients gain coverage and they receive more revenue as a result. Some community health centers, however, have been surprised to continue to see large numbers of uninsured patients. The reasons are not entirely clear but could include that these patients do not meet Medicaid's immigration and citizenship eligibility criteria; the enrollment process is challenging for people with language and other barriers to navigate; and/or their applications are caught up in the state's eligibility system delays. Of particular concern to many community health centers is that, as of April 2015, the state had not yet fully implemented the system for ensuring that centers receive cost-based reimbursement for private option enrollees.⁴⁴ As a result, while community health centers are seeing new revenue as more of their patients gaining coverage, they are not necessarily experiencing the full gains in financial stability they had expected. In addition, some community health centers are concerned that they will lose newly-insured patients to other providers, including some of the new clinics being established by Marketplace plans, and that they could be left with a greater concentration of uninsured patients.

PREMIUMS, COST-SHARING AND HEALTH INDEPENDENCE ACCOUNTS

Unlike traditional Medicaid premium assistance programs, a major innovation of the private option is that beneficiaries are fully protected from cost-sharing charges without requiring them to pay upfront and be reimbursed. Stakeholders said that the system for the state Medicaid agency's payment of premiums directly to Marketplace plans worked smoothly.⁴⁵ In addition, by combining a standardized cost-sharing design with supplemental cost-sharing reduction payments directly to Marketplace plans, Arkansas ensures that private option enrollees do not incur cost-sharing charges for which they are not responsible.⁴⁶ The cost-sharing reduction payments represent a little more than a quarter (27.4 percent⁴⁷) of the payments made to Marketplace plans on behalf of private option enrollees, although this share is expected to shift when these payments are reconciled based on actual utilization.⁴⁸ An estimated 81 percent of private option enrollees have income below 100 percent FPL and therefore are enrolled in a 100 percent actuarial value plan with the state paying all of the plan's required cost-sharing.⁴⁹ Beneficiaries from 100-138 percent FPL are enrolled in 94 percent actuarial value plans and have some co-payments for services consistent with Medicaid standards.

It is too early to assess the impact of Arkansas's new Health Independence Accounts. In 2014, Arkansas added Health Independence Accounts to the private option, which had been called for by the original legislation creating the initiative. It did so with the goal of promoting personal responsibility and creating greater similarities with the cost-sharing charges people face as they move into other forms of coverage.⁵⁰ Beneficiaries are expected to make a monthly contribution of \$10 or \$15 (depending upon income) to their accounts and are provided with a debit card than can be used to cover their co-payments and co-insurance when they use services.⁵¹ As of July 2015, 45,839 account cards have been issued, 10,806 cards have been activated, and 5,185 beneficiaries had contributed to their accounts.⁵² At the time of the interviews, Arkansas was in the midst of implementing these accounts for individuals above 100 percent of the federal poverty level. Since only about 20 percent of private option enrollees are in this income range, and the program is new, most stakeholders had little or no direct experience with the functioning of these accounts. Hospitals had received training on how the accounts would work so that they could respond to beneficiary questions. Some stakeholders felt that the accounts would be confusing to beneficiaries and complex to administer, particularly given that limited resources are available to educate beneficiaries about how the accounts work. Others viewed them as an important means of providing beneficiaries with incentives to more actively manage their health insurance. The state did not implement the accounts for individuals below 100 percent of the FPL after considering a number of factors, including the administrative expense of the accounts and the size of the contributions that would be made by individuals in this income range.

BENEFITS

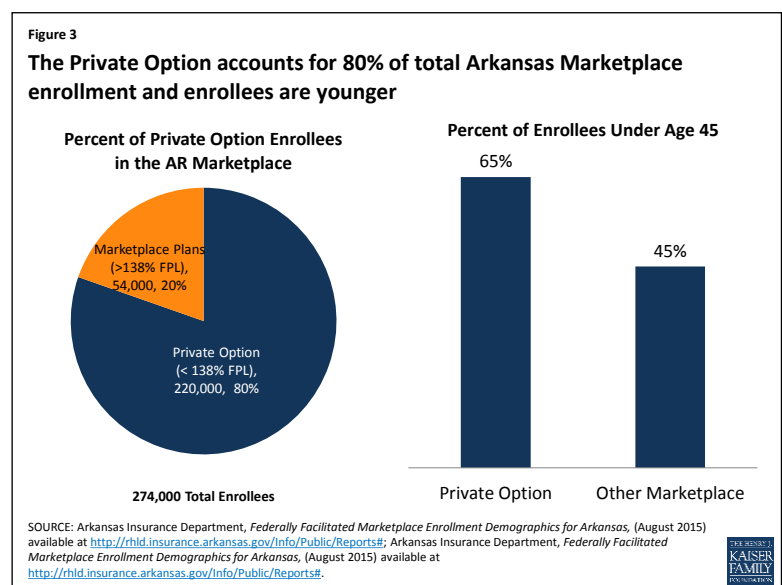
Stakeholders said that beneficiaries generally reported being well-satisfied with their coverage through Marketplace plans.⁵³ The private option benefit package is based on the ten essential health benefits required by the Affordable Care Act, which includes services such as hospital care, lab and x-ray services, and primary and preventive care, among others. The package also includes mental health and substance abuse services, which are not covered to the same degree in Arkansas' traditional Medicaid benefit package for adults. Early on, some private option enrollees selected and received premium subsidies for Marketplace plans that included some dental and vision benefits. These services are not covered for newly

eligible adults in Arkansas, and the state Medicaid agency ceased paying premiums for those plans. These services, however, had been very popular, and beneficiaries were disappointed when they were eliminated.

Arkansas minimized the need for the state to provide required Medicaid benefits outside of Marketplace plans, but beneficiaries may not be clear about how to access the limited services provided through a wrap. By design, there is almost complete overlap between the benefits covered by Marketplace plans and the Medicaid benefits required for newly eligible adults. Consequently, the state offers private option enrollees only two benefits outside of the Marketplace plan: non-emergency medical transportation and EPSDT benefits for 19 and 20-year olds. Stakeholders reported that the state had given providers information about how to assess wrapped benefits so they were able to assist beneficiaries, but they were less confident that beneficiaries would be able to navigate this issue on their own. One interviewee posited that beneficiaries using wrapped benefits most likely did so after learning about them through providers or word of mouth. Some expressed particular concern that 19 and 20-year olds are not necessarily aware of their eligibility for EPSDT benefits, although they had not heard of problems directly from beneficiaries, perhaps because young adults with serious health care needs are more likely to be classified as medically frail and to receive all of their benefits through the fee-for-service system. Finally, stakeholders flagged that the state has had some issues with its non-emergency medical transportation benefit, such as confusion among beneficiaries about how to access the benefit, but they also pointed out that these challenges are not a function of the private option but rather affect all Medicaid beneficiaries in Arkansas.

MARKETPLACE ENROLLMENT AND PLAN OPTIONS

The private option has had a positive effect on the Arkansas Marketplace. When submitting its waiver request for the private option, Arkansas posited that “by nearly doubling the size of the population enrolling in QHPs offered through the Marketplace,” the demonstration would “drive more competitive premium pricing for all individuals purchasing coverage through the Marketplace.”⁵⁴ The private option has exceeded expectations for Marketplace enrollment, with private option enrollees comprising 80 percent of Marketplace enrollment.⁵⁵ As of June 2015, the private option has resulted in an additional 220,000 people using the Arkansas Marketplace, raising enrollment from 54,000 to 273,000 and making it a more attractive market for issuers.⁵⁶ Along with increasing the volume of Marketplace enrollees, the private option also makes the Arkansas Marketplace more attractive to issuers, who can secure new enrollees at any point during the year because Medicaid-eligible adults are not limited to signing up for coverage during open and special enrollment periods. In the 2015 open enrollment period, Arkansas had four carriers selling plans statewide, two of which had offered coverage in some areas of the state in 2014, and expanded statewide in 2015.⁵⁷ Six issuers have submitted bids to offer plans in 2016. Many stakeholders credited the private option with driving a 2 percent average



Marketplace premium rate decrease between 2014 and 2015, as well as the fact that, according to the state insurance department, Arkansas had the second lowest average age of Marketplace beneficiaries in 2015.⁵⁸ (Figure 3)

Arkansas’s use of an auto-assignment algorithm that gave issuers an incentive to enter the Arkansas market may also have contributed to the jump in Marketplace issuers. The algorithm is explicitly designed to distribute private option enrollment across available plans, making the Arkansas Marketplace more appealing to new issuers who might otherwise find it difficult to break in and secure market share in the face of historical dominance by a single insurer. One stakeholder noted that plan options are similar enough to minimize the risk that auto-assignment disadvantages beneficiaries. Some, however, did suggest that the high rate of auto-assignment and the state’s current policy of paying the full premium cost of any certified silver-level Marketplace plan for private option enrollees could reduce incentives for issuers to compete on price. (As discussed below, however, the state plans to subsidize only selected Marketplace plans for private option enrollees beginning in the fall of 2015.)

FINANCING

Since it first became a possibility, there has been significant debate about the financing of the private option. While it will be some time before data are available to evaluate some of the key financing issues, stakeholders were able to provide some initial insights.

Because the state had no experience covering the expansion population, it was challenging for the state to negotiate budget neutrality with the federal government. Budget neutrality is a hypothetical exercise applicable to all Section 1115 waivers that requires states to demonstrate that the waiver will not cost the federal government more than it would have spent on the state’s Medicaid program without the waiver. If a state’s expenditures exceed its budget neutrality target, it is at risk of not receiving federal Medicaid matching funds for the excess spending.⁵⁹ Notably, however, Arkansas secured a provision in the terms and conditions of its waiver that allows it to revisit the budget neutrality targets if the cost of serving newly-eligible adults exceeds expectations. CMS made this allowance for Arkansas and all other states with alternative coverage models because of the difficulty of establishing the budget neutrality baseline for a population with which states have little experience. Even so, the budget neutrality projections are important, and CMS and Arkansas faced two major challenges in establishing them for the private option. First, Arkansas had limited experience covering low-income adults, making it difficult to predict how much the state would have spent on such adults in the absence of the waiver. Second, and more fundamentally, state leaders believed that adding some 220,000 newly eligible adults to the existing fee-for-service Medicaid program would require the expansion of the state’s Medicaid provider network to ensure adequate access to care, particularly in rural areas. Consequently, Arkansas and CMS developed a “without waiver” baseline using historical spending on a similar population (low-income parents below 17 percent FPL who are covered under Arkansas’s traditional Medicaid program) and made adjustments to reflect the need for higher provider reimbursement rates in the fee-for-service system under a traditional expansion to achieve sufficient provider access. The baseline allowed Medicaid spending to increase at an estimated rate of approximately 4.7 percent a year, comparable to national Medicaid expenditure trends.⁶⁰

Despite early concerns, the private option is on track to meet budget neutrality targets and may even outperform expectations. As with all Medicaid Section 1115 waivers, Arkansas must demonstrate budget neutrality over the life of the private option (2014 – 2016), not on a year-by-year basis. This allows the state to incur higher start-up costs and exceed its annual budget target in the early years of the waiver and make up for it in later years. In the early months of the private option, Arkansas’s actual per capita spending on private option enrollees was higher than projected, generating some controversy and debate. Now, however, the state’s actual per capita spending has dropped below projected levels, and concerns that the state might not meet budget neutrality over the life of the waiver have abated. In fact, the state’s success in keeping per capita expenditures below projected targets in 2015 when enrollment is significantly higher than in 2014 – and, thus, a more important factor in the state’s ability to meet budget neutrality over the three-year life of the waiver – means the state may potentially keep spending well below allowable levels. As noted above, the higher-than-expected per capita expenditures in the early months of 2014 are attributable in part to some enrollees selecting and receiving subsidies for plans that included supplemental coverage (such as dental services) not covered for newly eligible adults, an issue that the state Medicaid agency has now remedied. Stakeholders also pointed out that a recent state decision to limit the state’s payment of premiums to the two least expensive silver-level Marketplace plans or any plans with a premium within 10 percent of the cost of the second lowest cost silver plan, beginning in the fall of 2015, will likely solidify compliance with budget neutrality.⁶¹

The private option also will be evaluated based on whether it is “cost-effective,” a broader measure of the impact of the initiative. Under the terms of Arkansas’ waiver, the cost-effectiveness inquiry considers more factors than simply whether the program requires more or less federal Medicaid money to cover the same population through traditional Medicaid and instead is designed to evaluate both the costs and benefits of providing Medicaid coverage through Marketplace premium assistance.⁶² The state can take into account the private option’s impact on beneficiary access to care, Marketplace competitiveness, and reductions in churning between Medicaid and Marketplace coverage as income changes. Unlike the budget neutrality measure, cost-effectiveness is not used to establish limits on the availability of federal Medicaid matching funds, but it is an important measure of whether the private option has met its objectives as a whole. It will be some time before data are available to answer the larger and more complex question of cost-effectiveness, but early signs are that the value of the private option extends well beyond its impact on newly eligible adults. This includes improved access to care for private option enrollees and potential increases in provider capacity for the larger community; the impact on the cost of Marketplace coverage; and benefits to Arkansas’s providers.

Reports also find the private option has generated state savings. According to state officials, the private option saved Arkansas \$30.8 million in fiscal year 2014, and the state expects to save an additional \$88.8 million in fiscal year 2015. Another recent report projects state savings of \$438 million from 2017 to 2021.⁶³ Sources of savings include reductions in uncompensated care spending and in behavioral health care spending,⁶⁴ as well as savings from moving people who previously received coverage under specialized Medicaid categories for adults with disabilities, women with breast or cervical cancer, and others into the expansion’s new eligibility group, for which the federal government pays the enhanced matching rate. In addition, Arkansas expects to collect \$34.4 million in new revenue over 2014 and 2015 from taxes on providers and health plans, producing a total gain for the state budget of over \$150 million in 18 months.⁶⁵ Not included

in these estimates is the potential effect on state health care spending and quality associated with requiring Marketplace issuers to participate in the state's broader delivery system reform efforts on behalf of private option enrollees.

Looking Ahead

For now, the private option expansion is slated to continue at least through the end of 2016.

Over the next several months, state policymakers will be charting the longer-term future of the private option in the context of broader Medicaid reform in Arkansas. Most stakeholders were reluctant to make firm predictions about the future of the private option, preferring to wait until the state legislative task force and Governor's Medicaid Advisory Committee complete their work in December 2015. Many, however, speculated that the extension of coverage to newly eligible adults would continue in one form or another because the alternative would generate significant upheaval for the state's residents and providers. Stakeholders also thought that key elements of the private option, including its use of private plans – rather than the fee-for-service system – would continue to have strong appeal to policymakers, although they might want to integrate the private option into broader Medicaid reforms. On the other hand, with the state expected to finance a share of the cost of covering newly eligible adults in the years ahead,⁶⁶ stakeholders felt that answering some of the critical questions about the cost-effectiveness of the private option – relative to other Medicaid service delivery options available to the state – would be critical. Finally, the state's interest in a Section 1332 waiver is strong, spurred by the potential flexibility it could provide to re-make Arkansas's Marketplace. Discussion about the role that a Section 1332 waiver might play in Arkansas was just beginning at the time of the interviews, however, and stakeholders did not yet have detailed ideas about how such a waiver could be used. It, however, was noted that if the state seeks a Section 1332 waiver, it could potentially tap any federal savings attributed to the private option driving down the cost of Marketplace plans and, in turn, the cost to the federal government of providing tax credits to marketplace enrollees.⁶⁷

Lessons for Other States

States that expand coverage realize substantial reductions in uninsured rates and provider uncompensated care costs along with increased access to care among beneficiaries, regardless of the mechanism used to implement an expansion. After expanding Medicaid through the private option, Arkansas realized considerable reductions in its non-elderly adult uninsured rate and providers' uncompensated care costs along with increased beneficiary access to care. Unlike other effects of the private option in Arkansas, such as the impact on Marketplace enrollment, these gains were not unique to Arkansas' Medicaid expansion delivery model. Most states that adopted the ACA's Medicaid expansion did so without waiver authority and using their existing Medicaid delivery systems, which vary among the states from private capitated Medicaid managed care plans to managed fee-for-service models. In general, states that expanded coverage, regardless of delivery system, experienced the benefits of expansion.⁶⁸

States have significant flexibility to tailor their Medicaid programs for newly eligible adults to fit their particular delivery system and broader policy agenda. In Arkansas, the private option met the needs of the state given that it had a fee-for-service system that was unlikely to be able to absorb more than 200,000 new enrollees without increases in provider payment rates and no Medicaid managed care infrastructure on which to build. In addition, Arkansas's policymakers were committed to using private plans

and competitive market forces as the mechanism for a coverage extension and for furthering the state's delivery system reform efforts. The state had the ability to do so because its Marketplace operates as a Partnership model and can actively shape and monitor the plans offered, allowing for greater alignment between the Marketplace plans and Medicaid requirements. Many other states are not in this situation – they may have well-developed Medicaid managed care programs on which to build, a more limited ability to shape Marketplace plans because they do not operate as a State-based or Partnership model, or a different set of political and policy priorities. Even if the private option does not fit their particular circumstances, a larger lesson from Arkansas is that states have considerable flexibility to tailor coverage extensions to their unique circumstances and priorities.

Implementation of the private option has required unprecedented levels of cooperation between the state Medicaid agency and state insurance department and an enormous amount of time and effort on the part of the state's leadership. State officials and other stakeholders had to work across their silos to develop Marketplace plans consistent with both Marketplace and Medicaid requirements and develop strategies for resolving issues where it initially was not clear whether the state Medicaid agency or insurance department was responsible. One of the biggest and most time-consuming challenges was bringing about what one stakeholder described as a “marriage of different mindsets” – insurance regulators are accustomed to viewing health insurance as the prepaid management of an actuarial risk pool whereas Medicaid officials more often view it as a cost-based enterprise under which the federal government matches the state's incurred costs. Adding to the challenge was that the federal officials charged with overseeing Medicaid and Marketplaces also work in separate divisions of HHS, and they too had to find new ways to collaborate and provide clear guidance to Arkansas.

Strong collaboration with stakeholders and transparency were key to implementation of the private option in Arkansas, but could have been even stronger. Given the unprecedented nature of Arkansas's initiative and rapid implementation timeline, the state worked closely with issuers, providers, and other stakeholders to prepare for the program's launch well in advance of formal approval of Arkansas's waiver. The state adopted a transparent and collaborative approach with carriers during implementation that helped them to navigate a highly fluid environment. One stakeholder described carriers as having almost real-time access to updates on the policy and fiscal assumptions behind the private option and credited this “tremendous transparency” with allowing issuers to design Marketplace plans consistent with Medicaid requirements and emerging fiscal estimates. Some interviewees, however, suggested that the state would have benefited from engagement with a broader group of stakeholders; some community health centers, in particular, suggested the state might have avoided the issues arising with respect to cost-based reimbursement if they had been more involved in the planning stages.

Conclusion

Stakeholder interviews revealed that the private option offers a path to coverage for close to 260,000 newly eligible adults in Arkansas, and enabled the state to use Marketplace plans to cover Medicaid beneficiaries in the absence of an established Medicaid managed care delivery system in the state. Early implementation experience reported by stakeholders suggests that the vast majority of beneficiaries are receiving much-needed care; the state has succeeded in keeping spending in line with its federal budget neutrality agreement; hospitals are experiencing unprecedented declines in their uncompensated care costs; and the state's Marketplace is

stronger and more robust because of the inclusion of private option enrollees. Arkansas continues to discuss what should come next for the private option; what, if anything, the state may do with the emerging opportunity to use a Section 1332 waiver; and whether the state should consider more sweeping changes to its larger delivery system for all Medicaid beneficiaries, including medically frail adults not enrolled in the private option. Any new approach will need to fit with the state’s mission and goals; be consistent with its delivery system; win the political sanction of the state’s leadership, including a super majority in the Arkansas legislature; and secure approval from the federal government.

This issue brief was prepared by Jocelyn Guyer and Naomi Shine of Manatt Health and MaryBeth Musumeci and Robin Rudowitz of the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured. Manatt Health has served as a consultant to the state of Arkansas on aspects of its Medicaid private option plan; this study was conducted independently of that work. The authors gratefully acknowledge the state policymakers and leaders, health plans, providers, consumer advocates and other stakeholders who participated in the interviews on which this issue brief is based. The authors also thank others at Manatt Health and the state who helped with research and review of this brief.

Appendix A: Interview Guide

High Level Questions

1. Please describe your role in designing/implementing/monitoring the private option.
2. In general, what has been the impact of the private option on key stakeholders?
3. What do you consider the key successes and challenges of the design and implementation of the private option?

Overall Impact of Private Option on Consumers

1. In general, how are the consumers who gained coverage through the private option faring?
2. How well do consumers understand the private option?

Eligibility and Enrollment

3. How well is the eligibility and enrollment process working for consumers?
4. How do private option consumers fare at renewal? What is working well and what needs to be improved?
5. How well is the process for identifying medically frail individuals working?

Implementation/Operational Issues

6. In general, what have been the major implementation and operational challenges that the state has faced?
7. How have the Medicaid agency and Arkansas Insurance Department worked together to implement the private option?

Implications for the Marketplace

8. How has the private option affected the Marketplace?
9. How have issuers reacted to inclusion of newly eligible adults in Marketplace plans?

Financing Issues

10. What do you see as the major financing opportunities/challenges created by the private option?
11. What has been the impact of the recent report on the state savings generated by the private option?

Future of the Private Option

12. In general, what are your thoughts on the future of the private option?
13. Process, structure, expected outcomes from new commission for post-2016? What recommendations are being put forward?
14. What do you think of the strategies in place for evaluating the private option?
15. If you were speaking to another state that was considering a Marketplace premium assistance approach, what advice would you give?

Endnotes

¹ Arkansas Times, *The Arkansas Medicaid mess*” (August 2015), available at <http://www.arktimes.com/arkansas/the-arkansas-medicaid-mess/Content?oid=4011897>.

² Both Iowa and New Hampshire obtained waivers that include Marketplace premium assistance as a means of expanding Medicaid, and other states, such as Utah, continue to consider Marketplace premium assistance as they debate whether to cover newly eligible adults. See Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Iowa* (Feb. 2015), available at <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/>; Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in New Hampshire* (March 2015), available at <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-new-hampshire/>; Kaiser Commission on Medicaid and the Uninsured, *Proposed Medicaid Expansion in Utah* (Jan. 2015), available at <http://kff.org/medicaid/fact-sheet/proposed-medicaid-expansion-in-utah/>. For additional background on Arkansas, see generally, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Arkansas* (Feb. 2015), available at <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/>; Kaiser Commission on Medicaid and the Uninsured, *The ACA and Medicaid Expansion Waivers* (Feb. 2015), available at <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>; Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion Through Marketplace Premium Assistance* (Sept. 2013), available at <http://kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/>; Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion Through Premium Assistance: Key Issues for Beneficiaries in Arkansas’ Section 1115 Demonstration Waiver Proposal* (July 2013), available at <http://kff.org/medicaid/issue-brief/medicaid-expansion-through-premium-assistance-key-issues-for-beneficiaries-in-arkansas-section-1115-demonstration-waiver-proposal/>. The Affordable Care Act requires states to expand Medicaid to adults with income up to 138% FPL effective January 1, 2014. However, the Supreme Court’s 2012 decision in *NFIB v. Sebelius* found that this requirement was unconstitutionally coercive of states, and as a result, states effectively have the option to expand Medicaid. See Kaiser Commission on Medicaid and the Uninsured, *A Guide to the Supreme Court’s Decision on the Medicaid Expansion* (Aug. 2012), available at <http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/>; Kaiser Commission on Medicaid and the Uninsured, *Implementing the ACA’s Medicaid-Related Health Reform Provisions After the Supreme Court’s Decision* (Aug. 2012), available at <http://kff.org/health-reform/issue-brief/implementing-the-acas-medicaid-related-health-reform/>. States can expand at any time, and if they do expand, they can elect to terminate the expansion at any time. To date, 31 states (including DC) have implemented the ACA’s Medicaid expansion, most of which have done so through a traditional state plan amendment instead of a waiver. Kaiser Commission on Medicaid and Uninsured, *Status of State Action on the Medicaid Expansion Decision* (July 20, 2015), available at <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

³ According to Arkansas’s Department of Health and Human Services, there were approximately an additional 15,000 newly-eligible adults who were covered in the state’s fee-for-service system for a brief period pending enrollment into a Marketplace plan on June 30, 2015. These individuals are not included in the 245,000 figure.

⁴ 42 C.F.R. § 435.1015.

⁵ These conditions included limiting Marketplace premium assistance to individuals whose Medicaid benefit package closely aligns with Marketplace plans and offering beneficiaries a choice of at least two plans. HHS, *Medicaid and the Affordable Care Act Premium Assistance* (March 2013), available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

⁶ Ark. Code § 20-77-2401 *et seq.*, available at <http://law.justia.com/codes/arkansas/2014/title-20/subtitle-5/chapter-77/subchapter-24/>.

⁷ Centers for Medicare and Medicaid Services, *Arkansas Health Care Independence Program (Private Option) Special Terms and Conditions* (September 27, 2013), available at <https://www.medicaid.state.ar.us/Download/general/comment/HCIWProposedAmend.pdf>.

⁸ Arkansas has a State Partnership Marketplace, a non-profit public benefit corporation, which is overseen by the Arkansas Health Insurance Marketplace Board. The state retains control of plan management and consumer outreach and education functions while the federal government is responsible for eligibility and enrollment functions.

⁹ The Arkansas legislature also included bans on outreach funding in the budget bill for the Insurance Department and for the Department of Health.

¹⁰ Ark. Act 257, § 16, 17 (March 7, 2014), available at <http://www.arkleg.state.ar.us/assembly/2013/2014F/Pages/BillInformation.aspx?measureno=SB111>. The legislation specifies that the state insurance department may not apply for or accept funds, including federal funds, for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Marketplace or the private option. It also prohibits the state from applying for or accepting any funds for the purpose of funding navigators, guides, certified application counselors and certified licensed producers.

¹¹ For a more detailed discussion of the Governor’s speech and the reaction of leading legislators, see Manatt Health, *Manatt on Medicaid: Arkansas Update – Private Option To Continue, Additional Medicaid Reforms To Be Explored* (January 27, 2015), available at <https://www.manatt.com/medicaid-update/Arkansas-Update-Private-Option-To-Continue.aspx#sthash.RPIJXus.dpuf>.

¹² As reported by Ark. Dep’t of Human Servs., Div. of Medical Servs. (June 2015) (on file with authors).

¹³ National Center for Health Statistics, *National Health Insurance Survey Early Release Program* (June 2015), available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/State_estimates_insurance_2013_2014.pdf.

¹⁴ See, *id.*, (noting significant difference in non-elderly adult uninsured rate from 2013 to 2014 in the following states which have traditional Medicaid expansions: CA (-5.7%), DE (-5.3%), KY (-6.3%), NV (-7.2%), OH (-4.5%), RI (-4.0%), WA (-7.4%), and WV (-14.8%)).

¹⁵ Modern Healthcare, *Arkansas disability claims fall 19 percent after Medicaid expansion* (August 2014), available at <http://www.modernhealthcare.com/article/20140826/NEWS/308269939>.

¹⁶ ACHI, *Facts About Arkansas's Health Care Independence Program: Private Option and Marketplace Plan Enrollment* (April 2015), available at <http://www.achi.net/Docs/275/>.

¹⁷ Arkansas had the lowest adult eligibility threshold in the country as of January 2014. See Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility for Adults as of January 1, 2014* (October 2013), available at <http://kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/>.

¹⁸ See Kaiser Commission on Medicaid and the Uninsured, *Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion* (Nov. 2013), available at <http://kff.org/medicaid/issue-brief/fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion/>.

¹⁹ See www.insureark.org. Under the terms and conditions of the waiver, individuals must have a choice of at least two plans.

²⁰ See also Kaiser Commission on Medicaid and the Uninsured, *How Have State Medicaid Expansion Decisions Affected the Experiences of Low-Income Adults? Perspectives from Ohio, Arkansas, and Missouri* (June 2015), available at <http://kff.org/medicaid/issue-brief/how-have-state-medicaid-expansion-decisions-affected-the-experiences-of-low-income-adults-perspectives-from-ohio-arkansas-and-missouri/>.

²¹ The Stephen Group Status Report #1 to Ark. Health Reform Task Force Appendix at 13 (June 11, 2015), available at <http://governor.arkansas.gov/promises/healthcare-taskforce>.

²² As of June 2015, 22,629 medically frail beneficiaries were receiving the traditional benefit package, and the remaining 3,186 received the same benefit package as private option enrollees but on a FFS basis. Ark. Health Care Reform Task Force, The Stephen Group Update Report #2 Powerpoint Slides at slide 6 (July 15, 2015), available at <http://governor.arkansas.gov/promises/healthcare-taskforce>.

²³ Andy Allison, Thomas Seldon, and Joe Thompson, Arkansas Center for Health Improvement, *Arkansas Health Care Needs Questionnaire: Primer on Implementation* webinar, (March 19, 2014), available at <http://www.achi.net/Pages/OurWork/Project.aspx?ID=58>.

²⁴ *Ibid.*

²⁵ *Ibid.*

²⁶ As reported by Ark. Dep't of Human Servs., Div. of Medical Servs. (June 2015) (on file with authors).

²⁷ Andy Allison, Thomas Seldon, and Joe Thompson, *Arkansas Health Care Needs Questionnaire: Primer on Implementation* webinar, Arkansas Center for Health Improvement (March 19, 2014), available at <http://www.achi.net/Pages/OurWork/Project.aspx?ID=58>.

²⁸ As reported by Ark. Dep't of Human Servs., Div. of Medical Servs. (June 2015) (on file with authors).

²⁹ *Ibid.*

³⁰ Some beneficiaries will be automatically renewed based on electronic data available to the state of Arkansas and so will not receive the renewal notice. They, however, can still request a medical frailty screening at any time.

³¹ Andy Allison, Thomas Seldon, and Joe Thompson, *Arkansas Health Care Needs Questionnaire: Primer on Implementation* webinar, Arkansas Center for Health Improvement (March 19, 2014), available at <http://www.achi.net/Pages/OurWork/Project.aspx?ID=58>.

³² *Ibid.*

³³ *Ibid.*

³⁴ *Ibid.*

³⁵ *Ibid.*

³⁶ The Stephen Group Status Report #1 to Ark. Health Reform Task Force Appendix at 13 (June 11, 2015), available at <http://governor.arkansas.gov/promises/healthcare-taskforce>; see also The Stephen Group Status Report #2 to Ark. Health Reform Task Force at 3, 9-12 (July 15, 2015), available at <http://governor.arkansas.gov/promises/healthcare-taskforce> (noting that "the highest cost medically frail newly eligible patients fall far below the average cost of highest cost Traditional Medicaid patients").

³⁷ See also Kaiser Commission on Medicaid and the Uninsured, *How Have State Medicaid Expansion Decisions Affected the Experiences of Low-Income Adults? Perspectives from Ohio, Arkansas, and Missouri* (June 2015), available at <http://kff.org/medicaid/issue-brief/how-have-state-medicaid-expansion-decisions-affected-the-experiences-of-low-income-adults-perspectives-from-ohio-arkansas-and-missouri/>.

³⁸ See, e.g., Benjamin D. Sommers *et al.*, *Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act*, 314 JAMA 366 (July 28, 2015), available at <http://jama.jamanetwork.com/article.aspx?articleid=2411283> (finding that lacking a personal physician and limited access to medications both declined significantly more in expansion states than in non-expansion states).

³⁹ Arkansas Hospital Association, *Survey Reveals Private Option Impact on Hospitals* (November 2014), available at http://www.arkhospitals.org/archive/notebookpdf/Notebook_11-03-14.pdf

⁴⁰ Talk Business and Politics, *Insurance Execs: Private Option Recipients Use ER Five Times More Often* (July 2015), available at <http://talkbusiness.net/2015/07/insurance-execs-private-option-recipients-use-er-five-times-more-often/#sthash.vXiSLOlt.dpuf>

⁴¹ Arkansas Hospital Association, *APO's Hospital Impact Strong in 2014* (July 2015), available at http://www.arkhospitals.org/archive/notebookpdf/Notebook_07-27-15.pdf.

⁴² *Ibid.*

⁴³ See, e.g., Deloitte, *Commonwealth of Kentucky Medicaid Expansion Report 2014* at 35 (2015), available at http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf (finding decrease of \$1.15 billion in hospital uncompensated care charges from 2013 to 2014).

⁴⁴ Federal law requires the state Medicaid agency to reimburse federally qualified community health centers and related clinics for 100 percent of their costs. Because this requirement was not waived by the federal government in the special terms and conditions for the private option, the Arkansas Medicaid agency is developing a system for sending payments to these centers to supplement, as needed, the reimbursement rates that they receive from Marketplace plans for private option enrollees.

⁴⁵ Unlike in a Medicaid managed care environment, the cost of an individual's premium is not set by the Medicaid agency, but rather is set by the commercial carriers competing for business, as regulated by the state insurance department. For any given individual, the specific premium amount that the Medicaid agency pays is a function of the person's geographic region; age; and choice of plan. Arkansas has seven different geographic regions for purposes of its insurance market, and carriers can vary their premium bids by region.

⁴⁶ Arkansas enrolls private option beneficiaries into 94 percent actuarial value silver-level Marketplace plans to meet federal Medicaid rules that limit beneficiary copayments to nominal levels and cap total cost-sharing at 5 percent of household income. With the exception of the plan deductible, these Marketplace plans meet Medicaid cost-sharing standards, charging nominal amounts for individuals above 100 percent FPL and nothing for those below 100 percent FPL. To ease administration of the cost-sharing wrap for Medicaid beneficiaries, Arkansas defined a standard cost-sharing design for its 94 percent actuarial value plans, consisting of a \$664 annual deductible and set co-payments or co-insurance for certain services. Arkansas makes additional cost sharing reduction payments to Marketplace plans to eliminate the deductible for private option enrollees, which otherwise would violate Medicaid cost-sharing protections. For more details, see Manatt Health, *Marketplace Premium Assistance: Creating Alignment Between Medicaid and Qualified Health Plans* (April 2015), available at <https://www.manatt.com/Marketplace-Premium-Assistance-Creating-Alignment-Between-Medicaid.aspx>.

⁴⁷ Arkansas Division of Legislative Audit, *Arkansas Dep't of Human Servs., Medicaid Private Option Program Update, Special Report*, Report Id. SASR50214, at 17, Exhibit XII (December 2014) available at <http://www.thearkansasproject.com/wp-content/uploads/2015/01/FINAL-Medicaid-Private-Option-12-12-2014.compressed.pdf>.

⁴⁸ The initial cost-sharing reduction payments to carriers are based on projections of the amount required to eliminate deductibles and reduce cost-sharing charges to Medicaid-allowable limits. These initial up-front payments are subject to reconciliation and will be revised once data on actual costs are available for those beneficiaries who enrolled in the private option. If the actual cost of buying down deductibles and cost-sharing charges are higher than expected, carriers will receive an additional payment; if costs are lower, they will return some of the cost-sharing reduction payments to the state.

⁴⁹ Arkansas Center for Health Improvement, *Private Option and Marketplace Plan Enrollment: Facts About Arkansas's Health Care Independence Program, April 2015* (April 2015), available at <http://www.achi.net/Docs/275/>.

⁵⁰ Arkansas secured an amendment to its waiver to establish Health Independence Accounts on December 31, 2014. The amendment allows Arkansas to waive Medicaid's comparability requirement to impose cost-sharing charges selectively on those individuals who fail to make the required monthly contribution to a Health Independence Account. See Centers for Medicare and Medicaid Services, *Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration Amendment Approval* (January 2015) available at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf>.

⁵¹ The state also uses Medicaid funds to make contributions to the accounts, ensuring that they are funded at a level sufficient to cover any copayment and coinsurance obligations that otherwise would be the responsibility of enrollees. In effect, this allows beneficiaries to substitute a set monthly contribution for cost-sharing charges that rise and fall with their use of services each month. If beneficiaries fail to contribute to their Health Independence Accounts, they are not terminated from coverage, but they must cover their copayments and

co-insurance out-of-pocket at the point of service. To provide an additional financial incentive to participate, individuals above 100 percent of the FPL making at least six monthly contributions can receive credits to offset premiums they face in the future after leaving the private option and enrolling in other coverage.

⁵² The Stephen Group, Status Report #2 to Ark. Health Reform Task Force at 41 (July 15, 2015), available at <http://governor.arkansas.gov/promises/healthcare-taskforce>.

⁵³ Under federal law, newly eligible adults receive a benefit package known as an Alternative Benefit Plan (ABP), a state-designed package that must cover, at a minimum, the 10 essential health benefits (EHBs) required of all Marketplace plans, plus a limited number of additional services and provider types required by Medicaid. Accordingly, with limited exceptions, the ABP aligns with the Marketplace benefit package. In Arkansas, the ABP includes some benefits not otherwise offered to adults under Arkansas' state plan benefit package for adults, such as coverage of outpatient diagnostic tests without a dollar limit and substance use disorder services, as a result of the EHB requirements.

⁵⁴ Arkansas Department of Human Services, Division on Medical Services, *Health Care Independence 1115 Waiver Application* (August 2013), available at <http://humanservices.arkansas.gov/dms/Documents/Finalpercent201115percent20Waiverpercent20Materialspercent20forpercent20Submission.pdf>.

⁵⁵ Arkansas Center for Health Improvement, *Private Option and Marketplace Plan Enrollment: Facts About Arkansas's Health Care Independence Program, April 2015* (April 2015), available at <http://www.achi.net/Docs/275/>

⁵⁶ Arkansas Center for Health Improvement, *Private Option and Marketplace Plan Enrollment: Facts About Arkansas's Health Care Independence Program, April 2015* (April 2015), available at <http://www.achi.net/Docs/275/>.

⁵⁷ The plans include Arkansas Blue Cross Blue Shield, the national BCBS plan, Qualchoice, and Ambetter.

⁵⁸ D.C. was lower due to significant enrollment among relatively young Capitol Hill staffers. Arkansas Blog, *At least four carriers will sell statewide on Arkansas Health Insurance Marketplace in 2015 (plus more data on 2014 Marketplace enrollment)* (April 2014), available at <http://www.arktimes.com/ArkansasBlog/archives/2014/04/24/at-least-four-carriers-will-sell-statewide-on-arkansas-health-insurance-marketplace-in-2015-plus-more-data-on-2014-marketplace-enrollment>

⁵⁹ In practice, states rarely exceed their budget neutrality targets. If they are at risk of hitting the targets, states typically have a number of options for scaling back their rate of spending or for revisiting their targets with CMS.

⁶⁰ Arkansas Center for Health Improvement, *Health Care Independence Program and Budget Neutrality* (June 2015), available at <http://www.achi.net/Docs/316/>.

⁶¹ Specifically, Arkansas will pay the premiums for any of the following plans: 1) the lowest cost qualifying EHB-only silver-level plan offered in the service area; (2) the next lowest cost qualifying EHB-only silver-level plan offered in the service area that is offered by a different carrier than the lowest cost EHB-only silver-level plan (referenced in item #1 above); and (3) any other carrier's lowest cost qualifying EHB-only silver-level plan, so long as such plan's cost falls within 10% of the second-lowest cost qualifying EHB-only silver-level plan available to private option enrollees in the service area.

⁶² Under federal Medicaid law, states can use Medicaid funds to pay private insurance premiums on behalf of beneficiaries only if it is "cost effective" to do so. The criteria for cost-effectiveness determinations contained in federal Medicaid law include the costs of paying premiums, providing any supplemental Medicaid benefits, paying cost-sharing charges that exceed Medicaid allowable limits, and administrative expenses. Social Security Act § 1902(a)(4); 42 C.F.R. § 435.1015(a)(4).

⁶³ The Stephen Group, Status Report #3 to Ark. Health Reform Task Force at 25 (Aug. 19 and 20, 2015).

⁶⁴ Robert Wood Johnson Foundation, *Medicaid Expansion States See Significant Budget Savings and Revenue Gains* (March 2015), available at <http://statenetwork.org/wp-content/uploads/2015/03/Medicaid-Expansion-States-See-Significant-Budget-Savings-and-Revenue-Gai....pdf>.

⁶⁵ Robert Wood Johnson Foundation, *Medicaid Expansion States See Significant Budget Savings and Revenue Gains* (March 2015), available at <http://statenetwork.org/wp-content/uploads/2015/03/Medicaid-Expansion-States-See-Significant-Budget-Savings-and-Revenue-Gai....pdf>.

⁶⁶ Federal funding for newly eligible adults is set in the ACA at 100 percent in 2014, 2015, and 2016, and gradually decreases to 90 percent by 2020, where it remains indefinitely. The share of federal dollars to cover newly eligible adults exceeds the state's regular Medicaid matching rate, which is 70 percent in FY 2016. Kaiser Commission on Medicaid and the Uninsured, *Federal Medical Assistance Percentage for Medicaid and Multiplier*, available at <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.

⁶⁷ Section 1332 waivers allow states to develop their own initiatives to replace some or all of the Marketplace provisions of the ACA. States, however, must ensure that the alternative provides as much coverage to as many people without costing the federal government more. While these waivers cannot be used as the basis for an alternative Medicaid expansion such as the private option, they can potentially be combined with Medicaid § 1115 waivers to provide Arkansas with some new options. At the request of a state legislator, the Arkansas Health Insurance Marketplace Board and Legislative Oversight Committee commissioned a report that provides some basic information on the role that Section 1332 waivers might play in shaping the future of Arkansas healthcare reforms. The task force and the Governor's advisory committee are reviewing this report, but also more broadly considering a range of options for the future of

the state's Medicaid program. Public Consulting Group, *Section 1332 Waivers and the Future of Arkansas Healthcare Innovation* (April 6, 2015) available at <http://www.publicconsultinggroup.com/news/post/2015/04/16/1332-Waivers-Will-Allow-State-Specific-Variation-to-Health-Care-Reform-Efforts.aspx>

⁶⁸ See, e.g., National Center for Health Statistics, *National Health Insurance Survey Early Release Program* (June 2015), available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/State_estimates_insurance_2013_2014.pdf, (noting significant difference in non-elderly adult uninsured rate from 2013 to 2014 in the following states which have traditional Medicaid expansions: CA (-5.7%), DE (-5.3%), KY (-6.3%), NV (-7.2%), OH (-4.5%), RI (-4.0%), WA (-7.4%), and WV (-14.8%)); Benjamin D. Sommers *et al.*, *Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act*, 314 JAMA 366 (July 28, 2015), available at <http://jama.jamanetwork.com/article.aspx?articleid=2411283> (finding that lacking a personal physician and limited access to medications both declined significantly more in expansion states than in non-expansion states); Deloitte, *Commonwealth of Kentucky Medicaid Expansion Report 2014* at 35 (2015), available at http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf (finding decrease of \$1.15 billion in hospital uncompensated care charges from 2013 to 2014).