Arkansas' Private Option Waiver Coverage Expansion: Which Features Could Texas Use?

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Because Arkansas is our neighbor, and was the first state to get a Medicaid 1115 waiver for an alternative to a traditional Medicaid expansion under the ACA, Texas has been paying attention to the developments. Arkansas' Private Option waiver coverage expansion (the Private Option) now covers more than 220,000 adults, was approved for continued funding by a large majority in the Arkansas Legislature in February 2015, and is operating well under its 2015 per-capita cost targets.

The Private Option warrants special attention in Texas, both for features that leaders might replicate to craft a Texas-specific approach to closing the Coverage Gap, and because some features are unlikely to work in other states. This brief will summarize key features and provide links to greater detail about the plan.

The Private Option uses the health insurance Marketplace: Arkansas is the **only state** that has been approved to enroll newly covered adult beneficiaries **below** the federal poverty income level in the health insurance Marketplace (other waiver states use private Medicaid Managed Care health plans for serving the below-poverty income group, but may enroll adults **above** the poverty line in Marketplace plans).

One reason federal Medicaid officials approved this approach in Arkansas is that the low-population, largely rural state lacked an established Medicaid Managed Care infrastructure that could have provided coverage to the new group of adults (i.e., adults earning below 138 percent of the federal poverty income). In contrast, Texas has been in Medicaid Managed Care for over 20 years, and nearly all of our four million enrollees today already choose among approved HMOs for virtually all of their care. Even nursing home services are now included in HMO premiums in Texas Medicaid.

A major challenge for Arkansas leaders negotiating the Private Option was that Marketplace health plans generally have higher premiums than Medicaid Managed Care plans. State Legislatures—not Congress or Medicaid agencies—control what Medicaid pays doctors, hospitals, and HMOs, and states generally have kept rates lower than the private insurance market. Medicaid 1115 waivers have to meet a federal "budget neutrality" requirement that they cannot cost the federal government more than a program following existing law would have. Putting adults who might otherwise have gotten less-expensive Medicaid into higher-cost Marketplace plans made it hard for Arkansas to meet that requirement.

Arkansas' Private Option waiver approval relied on the assumptions that inclusion of the healthy Medicaid enrollees would give the state a larger, healthier Marketplace pool, reduce the average Marketplace costs, and thus create federal savings overall on subsidies. As mentioned above, in the early months of the waiver, average premiums for waiver enrollees caused alarm when they exceeded the initial projections, but those costs have since declined and are now well below the projected levels.

Enrolling uninsured adults below poverty in the Marketplace may not be repeated in other States. Of the five states that have used 1115 waivers as an alternative to traditional Medicaid expansion, only Arkansas was allowed to enroll below-poverty adults in the Marketplace. The other four states (Iowa[i], Michigan, Pennsylvania, Indiana) are delivering coverage through variations on Medicaid Managed Care. Like the Marketplace, those options include co-payments and allow enrollees to choose between plans. They also add monthly premiums, healthy behavior incentives, and Health Savings Account-type elements.

New features with conservative appeal: Arkansas amended its waiver for 2015 to add new monthly premium payment/"Health Independence Account" elements to the Private Option. Enrollees who are up to date with their monthly payments can use the Health Independence Account to cover co-payments and coinsurance. Beneficiaries can take a portion of unspent funds from their account with them if their income increases and they transition to a different form of private coverage.

- **Above poverty level:** monthly payments range from $10 to $25 for beneficiaries between 100 and 138 percent of the federal poverty level (FPL). Enrollees above poverty who *do not* pay monthly premiums will have to pay co-payments and coinsurance, and providers can deny services to those who do not pay.
- **Below poverty level:** monthly payments are $5 for those between 50 and 100 percent FPL. Beneficiaries below the poverty line will continue to have coverage if they do not pay, but *will be required* to pay co-payments and coinsurance. If they cannot afford co-payments they will still receive care, but will owe state repayment.

Arkansas is also implementing new prior authorization system rules for non-emergency medical transportation, for the newly covered adults.

Important enrollee protections: There are protections in federal law that apply to the co-payments and coinsurance in Arkansas' and other states' waivers. Sliding-scale upper limits on co-payments are updated annually for inflation, and when combined with new premium and Health Independence Account (HIA) contributions can't exceed 5% of household income.

In addition, enrollees both above and below poverty will not be denied coverage if they can't afford monthly premium/HIA payments. Those below poverty will not be denied care at the point of service if they can't afford co-payments, but adults above poverty can be turned away.

It is important to note that the new features approved in Arkansas' and other state waivers (premiums, Health Independence Accounts, and the policies associated with them) apply to the newly-enrolled adults (both parents and adults without dependent children), and **not** to the children, seniors, adults with disabilities, or pregnant women covered in the states' traditional Medicaid programs.

Early evidence of Arkansas gains: In a statewide survey, the Arkansas Hospital Association reported that in just the first six months of the Private Option, there was a less than 2 percent increase in emergency department visits. Hospital Association leaders reported, "[W]e expected our emergency rooms to uptick (and) they didn't." A 30 percent decline in uninsured patients overall in that period cut total

uncompensated care by over half (56 percent) compared to the previous year, and saved the state of Arkansas $69 million.

Conclusion

Arkansas' Private Option waiver coverage expansion, though likely not 100% replicable in Texas, nevertheless offers key examples of significant compromise between conservative state officials and federal Medicaid Health and Human Services officials, with unprecedented new consumer cost sharing, healthy behavior incentives, and premium payment-health savings account features. These features are balanced with important protections to ensure that the poorest and frailest of newly covered adults will not be denied medically necessary care because of their special needs, or because of their inability to pay. Along with the lessons from other state waivers like Indiana's recently approved experiment, Arkansas' example underscores that Texas leaders can pursue and achieve a solution to Texas' Coverage Gap. A million uninsured U.S. citizen Texas adults are waiting on our leaders to take action.

[i]Iowa has waiver permission to use Marketplace coverage for enrollees 101-138% of the FPL. However, for the 2015 Marketplace year, only one of Iowa's three Marketplace plans was offering enrollment to the waiver enrollees, eliminating choice. In response, state and federal officials are allowing the higher-income enrollees to choose between the Marketplace plan and Iowa's Medicaid Managed Care plans, until such a time as choice becomes available in the Marketplace again.

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