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Medicaid in Other States: Arkansas

To Cover Low-Income Adults, Texas Can Do What Arkansas Did

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Texas Can Take Arkansas' Approach And Enroll Medicaid Expansion Adults In The Health Insurance Marketplace

Word spread like wildfire about Arkansas' recent high-level agreement with the US Department of Health and Human Services (HHS) that would allow that state to increase health coverage for low-income US citizen adults (up to 138% of the federal poverty income) through enrollment in the new health insurance exchange "Marketplace," adding to interest piqued earlier by Ohio's similar discussions with the federal Medicaid authorities. Governors hope to use this latest tool in the flexibility array to craft customized solutions for their states. Lawmakers across the country are looking for ways to accept the ACA Medicaid expansion's enormous taxpayer benefits, support their health care safety nets, and do the right thing by the very poorest of the uninsured. Uninsured adults below poverty will otherwise be left with no path to coverage, while better-off families gain sliding-scale premium assistance in 2014. The premium assistance option allows officials to offer a solution for these poorest uninsured citizens, but without using a traditional Medicaid structure.

March 29 Federal Guidance

In light of the intense interest generated by the AR and OH negotiations, federal Medicaid officials just released new "Q&A" guidance on the "premium assistance" approach being hammered out. The short document does not answer every question, but does lay out several ground rules for other states interested in incorporating the approach.

- HHS clarifies that under premium assistance delivery approaches through the Marketplace, the new enrollees will still be legally Medicaid beneficiaries, and thus still entitled to health benefits that meet minimum standards, and upper limits (varied based on income) for out-of-pocket cost-sharing protections. States like AR are devising ways to "wrap-around" private coverage to make sure this happens.
- The federal law that allows Medicaid dollars to be used to pay for private qualified health plans (QHPs) in the Marketplace, also requires that participation be voluntary (i.e. people must be able to choose to stay in traditional Medicaid). However, the Q&A says that CMS will consider—as they reportedly are in AR's case—proposals for 1115 demonstration projects to require enrollment in QHPs. Under law, 1115 demonstrations must "promote the

objectives of the Medicaid program" and like Texas' current 1115 waivers, are subject to monitoring and evaluation.

- States choosing the premium assistance approach will have to make sure the new enrollees have a choice of at least two qualified health plans (QHPs).
- The Q&A also states that the premium assistance demonstrations should be limited to populations that federal law already allows to be provided a commercial-style benefit package ("benchmark coverage"), meaning that it would not include, for example, individuals who are medically frail, disabled, or terminally ill. The Q&A suggests that this provision both reflects federal law intent and also protects the Marketplace from receiving a high-cost Medicaid population.
- The HHS guidance clarifies that states may choose to target premium assistance in the Marketplace to adults at the income levels more likely to experience "churning:" rolling back and forth between Medicaid and the Marketplace due to small income changes from year to year. The enrollees above the poverty line are also allowed to have higher co-payments more consistent with Marketplace plan co-pays, compared to below-poverty Medicaid enrollees. For example, Ohio is reportedly seeking to enroll just the group above 100% FPL in the Marketplace, and offer more traditional Medicaid HMO care for the below-poverty adults.
- The Q&A also lays out HHS' expectation that states wishing to continue the premium assistance approach past the 3rd year of 100% federal funding of Medicaid expansion will need to be prepared to renew those programs under the State Innovation Waiver option that starts in 2017.

What is the Arkansas Proposal?

As we write, the Arkansas Medicaid expansion "deal" is still not finalized, but state officials have issued some short papers outlining their plan. Key elements include:

- Extension of coverage to US citizen adults to 138% FPL, through premium assistance (paid by Medicaid funds) in the new health insurance Marketplace;
- Cost Sharing Reductions for the newly covered adults, so that co-payments are consistent with the upper-limit protections—that increase along with income—required by federal Medicaid law and rule.
- A benefit package that is based on a commercial plan benchmark (in Medicaid jargon, an Alternative Benefits Plan or ABP). This package is nearly identical to the minimum standard required for the qualified health plans sold in the Marketplace. Both commercial coverage and Medicaid ABP coverage must incorporate the 10 essential health benefits (EHBs) in 2014.
    - States using Marketplace coverage for the under138% FPL adults will likely need to insure access to medical transportation and enhanced care for enrollees aged 19 and 20. Most commercial plans will already cover services of federally qualified health centers, rural health clinics, and family planning.

- Arkansas also plans to use premium assistance to buy higher-income children (over 138% FPL) in the state's CHIP program (ARKids B) into their parent's private insurance where possible, keeping family units together in a single insurance plan.
- Arkansas will incorporate the state's ongoing patient-centered medical home and multi-payer Arkansas health care payment improvement initiative into the coverage plans being offered in the Marketplace.

Is the Marketplace-Premium Assistance Approach to covering the Medicaid Expansion adults Cost-Effective?

Several recent briefs have explained the legal authority under the Social Security Act for Medicaid funds to be used for premium assistance (KFF, RWJ, HealthReformGPS). The Medicaid statute includes several different provisions that provide for Medicaid and CHIP premium assistance, including authority that is not limited to assistance with employer-sponsored coverage; that is, allowing the use of Medicaid funds to buy individual coverage as well.

There is a general requirement that individual private coverage purchases should be "comparable" to the cost of providing coverage directly by the state Medicaid program, including the costs of making sure the private coverage meets minimum benefits and does not exceed upper limits on out-of-pocket expenses. Still, there appears to be enough flexibility in the law and regulation to allow federal authorities to take into account potential offsets to overall costs, which appears to be key to the developing Arkansas approach.

Some of the cost-offsets being promoted by AR include:

- Including the roughly 250,000 low-income adults in the AR Marketplace will double the size of that pool, reducing provider reimbursements by roughly 5%;
- Enhanced care management by Marketplace HMOs and enrollee cost sharing will reduce costs by another 5%;
- AR argues that it would have had to increase physician and other provider rates in traditional Medicaid to attract an adequate network to serve the new enrollees, and that those costs should to some degree not be scored against providing Marketplace coverage;
- If adding the Medicaid population to the Marketplace reduces average prices in that pool, this will also reduce federal costs for non-Medicaid sliding-scale premium tax credits for the population between 138%-400% FPL. AR documents predict over $700 million in federal savings (but are not clear re: over what period).

Enrollees could benefit from the Marketplace subsidy experiment as well. Low-income adults enrolled in the Marketplace would be less likely to have to select a new health plan when their income moves above the 138% FPL Medicaid threshold, providing greater continuity of care in a medical home. The somewhat higher provider payments likely offered by the health plans in the Marketplace would be expected to result in somewhat larger provider networks, offering greater provider choice and shorter waits for appointments.

Based on all these projections, and the assumption that the frailest adults in in expansion group will stay in traditional Medicaid and thus not increase average costs in the Marketplace pool, AR

believes that covering the proposed group in the Marketplace would cost at worst 13-14% more than traditional Medicaid coverage, and at best might actually produce cost savings.

Where There Is A Will…

The Arkansas approach thus far appears to exemplify a good-faith effort at compromise between state and federal officials. If finally approved, HHS would be accepting the risk of higher federal costs in the Marketplace to allow AR to draw down the robust federal funding for private coverage of uninsured US citizen adults up to 138% FPL, but without expanding the state's traditional Medicaid program. In return, federal authorities would gain assurances that while benefits would be based on a commercial package, beneficiaries could still get help with transportation to medical services, and key safety net providers would still be part of provider networks. And while the newly covered adults at all income levels would have co-payments, protections would be there to make sure that ill or injured beneficiaries will not have their extremely limited incomes wiped out by cost sharing.

While Arkansas appears to embrace this negotiation, Tennessee's Governor has in recent days protested having to meet the exact same terms as AR, even suggesting that there can be no justification for providing special protections for his constituents living below the poverty line. This stance stands in contrast to that of Arkansas officials, and those of the Governors of Arizona, Florida, Michigan, Nevada, New Jersey, New Mexico, North Dakota, and Ohio. States that are working in good faith to find innovative ways to expand coverage for their poorest citizens can, and are, reaching agreements with federal Medicaid officials. Texas officials need only approach the task in the same good faith, and we too can gain a win-win agreement that benefits not just our poorest uninsured, but all Texas taxpayers.

For More Information

For more information or to request an interview, please contact Alexa Garcia-Ditta at garciaditta@cppp.org or 512.320.0222, ext. 112.

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