ARKANSAS WORKS 2.0:

HOW PROPOSED CHANGES TO EXPANDED COVERAGE WILL AFFECT PROGRESS

ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

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by Bruno Showers, AACF Health Care Policy Fellow
January 2018

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5 THINGS YOU NEED TO KNOW:

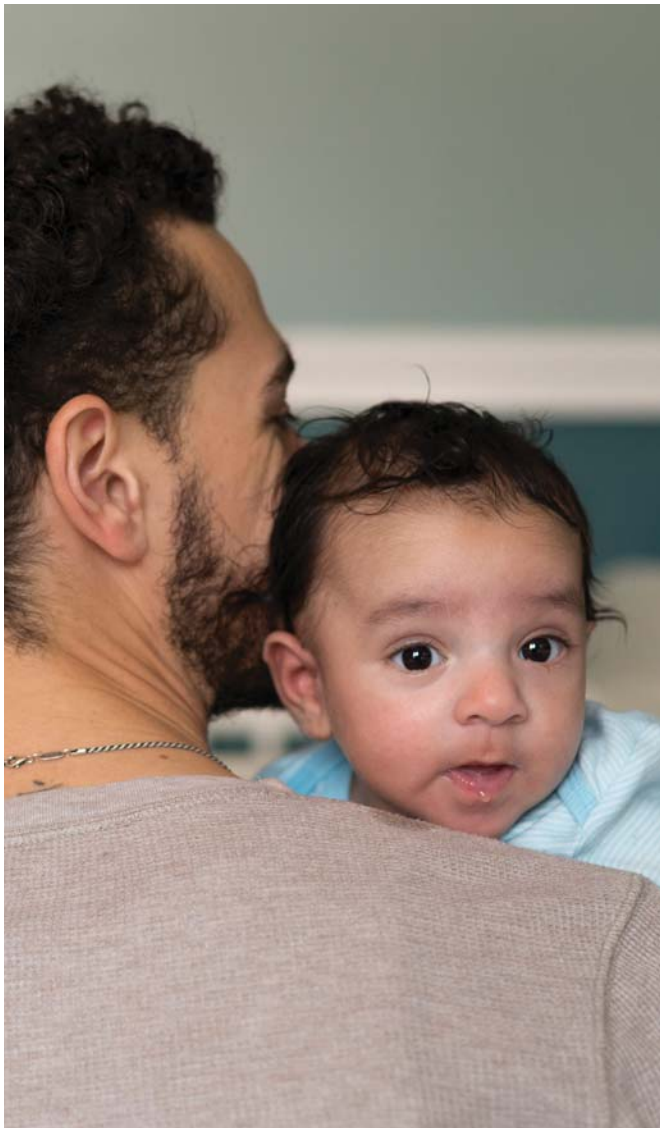
① The state of Arkansas has sharply dropped the rate of uninsured adults — and saved the state millions every year — by expanding affordable coverage to low-income adults through Medicaid expansion, a program originally known in Arkansas as the Private Option.

② This expansion program has already undergone changes when the Private Option was replaced by Arkansas Works. Repeated changes are bad for consumers and can lead to disruptions in coverage.

③ The state is seeking to implement even more changes to the program in 2018, including adding work requirements, changing income eligibility levels that make fewer people eligible, and eliminating retroactive eligibility.

④ These proposed changes would reduce coverage and access to health care services for tens of thousands of Arkansans. They are also not in line with Medicaid's core mission of providing comprehensive health coverage to low-income people.

⑤ If they are approved at the federal level, the state should carefully track the effects of implementing the changes to monitor for unintended coverage losses and to help inform future policy decisions.



INTRODUCTION

Passed in 2010, the Affordable Care Act (ACA) established a health care marketplace in which low- and moderate-income people can receive a tax credit to help pay their premiums. States also have the option to expand Medicaid coverage to low-income adults earning up to 138 percent of the Federal Poverty Level. This currently works out to an income of $16,642 for an individual.

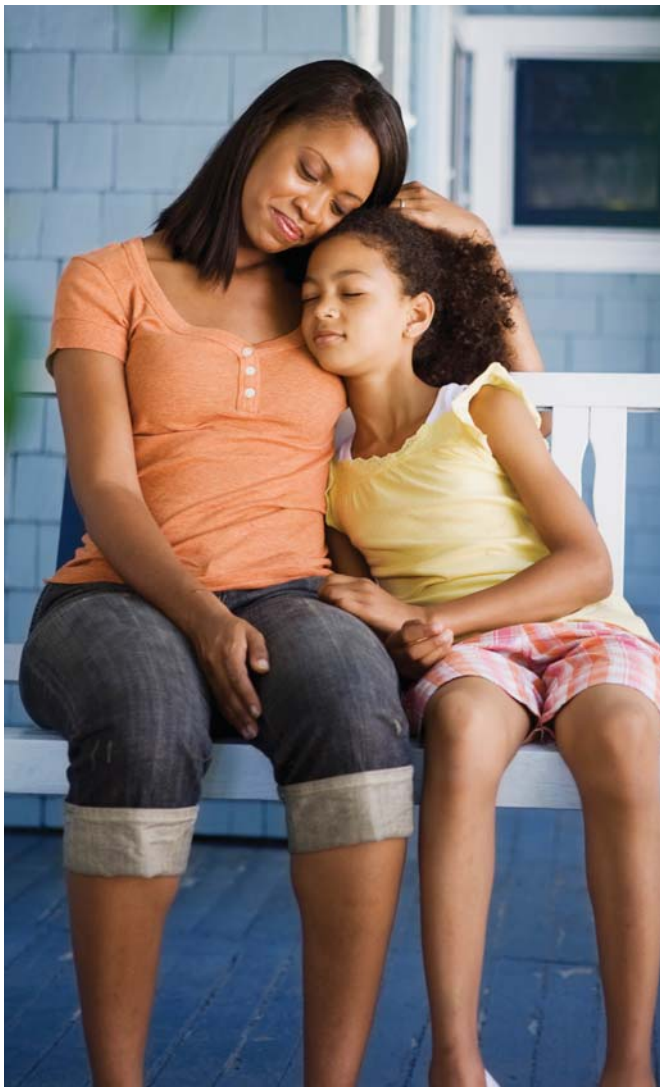
In 2013, Arkansas took advantage of that opportunity by passing a bipartisan measure that expanded Medicaid coverage to low-income families. Arkansas's unique model uses federal and state Medicaid dollars to buy private insurance plans. The Health Care Independence Act, which created the Private Option program that is now known as Arkansas Works, allows individuals between the ages of 19 and 64 with incomes up to 138 percent of the poverty level to enroll in private marketplace plans. The state then uses Medicaid funds to make the monthly premium payments for the enrollees.

Arkansas Advocates for Children and Families (AACF) has been very supportive of this bipartisan effort. Arkansas Works has given more than 300,000 underinsured or uninsured Arkansans access to affordable health care coverage. The program has also been beneficial for children by contributing to a record low 4 percent uninsured rate for kids in Arkansas. This is because of the "welcome mat" effect, which happens when parents enroll their children as they sign up for their own health care coverage[1]. And under Arkansas Works, the uninsured rate for adults ages 19 to 64 plummeted from 23 percent in 2013 to 11 percent in 2016[2].

The proposed changes stand to reverse some of these tremendous gains we've seen.

Arkansas Works has had positive financial impacts for the state budget, too. The additional federal dollars flowing to the state increase economic activity, which grows the state's tax revenue. Expanded health coverage means the state spends less on uncompensated care payments to hospitals to cover costs for patients who can't pay their medical bills. This is good for providers. The cost-savings and revenue-raising measures in Arkansas Works free up millions of dollars yearly in the state budget[3].

The state is currently making several policy changes to the program that will add new eligibility requirements. The proposed changes stand to reverse some of these tremendous gains we've seen. This is especially concerning because this is the third waiver amendment request — the process used to seek these policy changes — since the inception of the program in 2014. That means the program has basically changed every year. This causes confusion, not only among consumers but also providers. That confusion can disrupt coverage and inflate administrative costs.

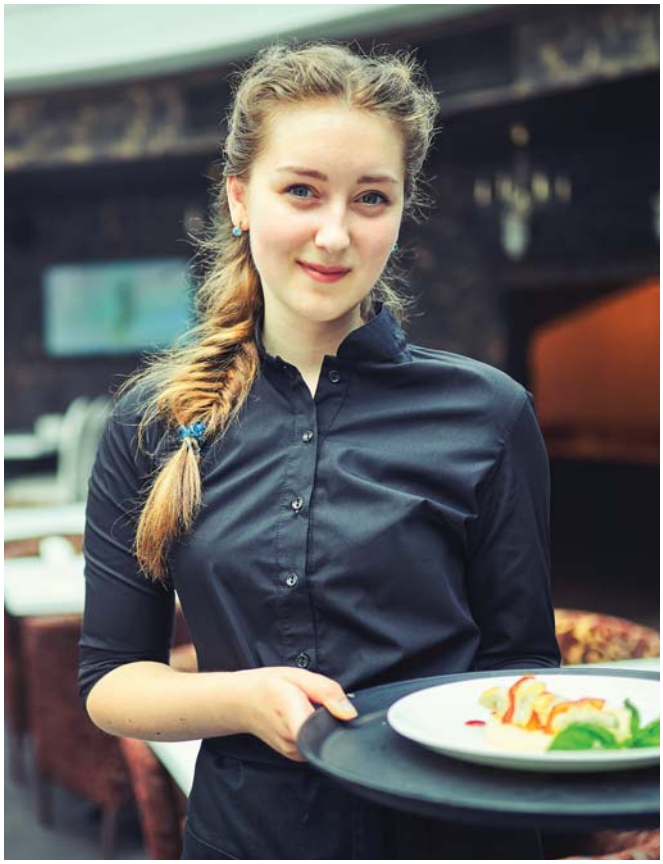


SECTION 1115 DEMONSTRATION WAIVERS

To understand what's at stake, it's helpful to know how changes are made to state Medicaid plans. Section 1115 waivers, named for a part of the federal Medicaid law, have historically allowed states to request approval from the Department of Health and Human Services (HHS) to implement changes at the state level that are "likely to assist in promoting the objectives of Medicaid." Each federal administration has some discretion in determining whether these "demonstration projects" will advance Medicaid objectives.

Under the Obama administration, Section 1115 waivers required states to show that the proposed changes would increase and strengthen coverage, increase access to health care, improve health outcomes, or increase the efficiency and quality of care for Medicaid beneficiaries[4]. In keeping with these objectives, the previous administration approved several Medicaid expansion waivers with features like premium assistance (the Private Option model), healthy behavior incentives, and monthly contributions. But features like premiums for enrollees living below 100 percent of the poverty line were rejected, as were work requirements.

However, under the Trump administration, HHS is likely to approve the proposed Section 1115 Medicaid waivers and make other changes to Medicaid policy that will significantly change the program's objectives. HHS's March 2017 letter to governors[5] and the recent change in criteria for waiver approval[6] signal that the administration is open to approving waivers that will shrink and weaken Medicaid expansion. These regulatory changes seem to encourage broader state "flexibility" than previous administrations have allowed. This would enable at least some of the changes that Arkansas is seeking[7]. The changes may create more barriers to health care coverage, particularly for the low-income adults who became eligible through Medicaid expansion.



We need to watch key policy decisions from HHS, like whether they will approve waivers projected to reduce health coverage; whether they will allow states to make work or work activities a condition for Medicaid eligibility; and to what extent they will consider the administrative costs of these proposals. Any of these policy options will require considerable tracking and monitoring of Medicaid beneficiaries.

This administration's increased flexibility through waivers poses a major threat to the progress we've made in expanding health care coverage. Legislative efforts to repeal the ACA have failed because of public opposition to taking health care away from millions of low-income Americans. But states may soon be able to use Section 1115 waivers to restrict access to Medicaid for these low-income populations in the same way.

PROPOSED CHANGES TO ARKANSAS WORKS

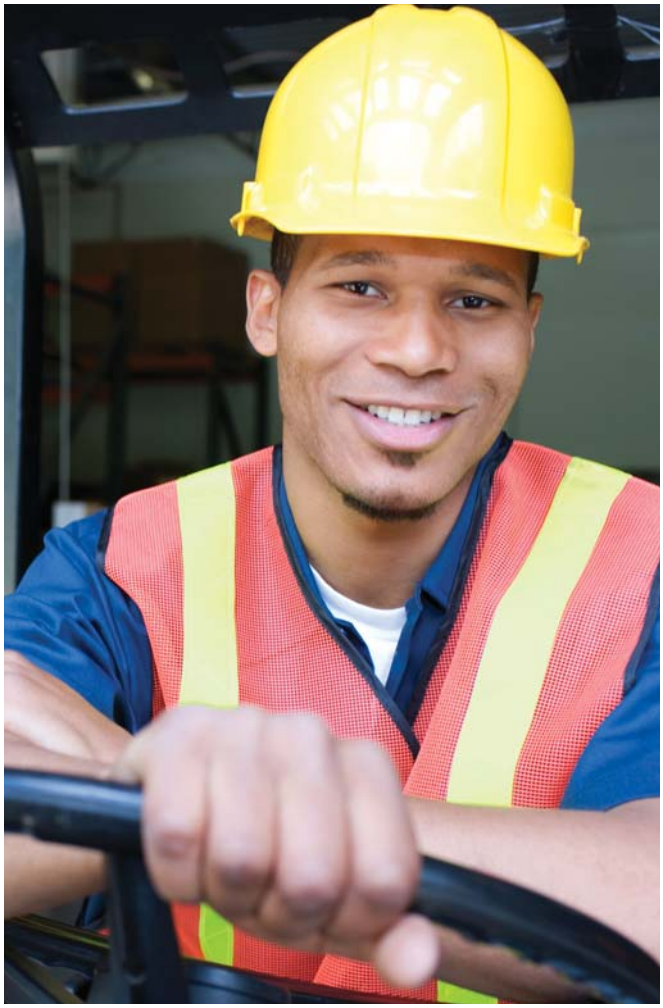
In 2017, Governor Hutchinson convened a special legislative session for lawmakers to consider making additional changes to Arkansas Works by adding new eligibility requirements. During the special session, lawmakers voted to make the following policy changes:

- **Rolling eligibility back to 100 percent of the Federal Poverty Level from 138 percent.** For an individual, this means you can earn no more than $12,060 every year to be eligible for Arkansas Works. Today, an individual can earn up to $16,642 (for a family of four, the income limit will change from $33,948 to $24,600). This policy is expected to remove 60,000 Arkansans from the program;

- **Implementing a work requirement** for Arkansas Works enrollees to be eligible for coverage, with exemption for certain populations; and

- **Eliminating retroactive eligibility.** Currently, the program will cover any medical bills incurred during the 90-day period prior to enrolling in Arkansas Works. This is a long-standing feature in the Medicaid program that helps safeguard low-income families from incurring medical debts that they can't pay. The state proposes to remove that provision.

The Arkansas Department of Human Services (DHS) has submitted a waiver request to federal HHS proposing several changes to Arkansas Works. As required by state and federal law, DHS must submit and seek approval from HHS to make these policy changes. State leaders are awaiting approval, which they are confident they will receive.



While AACF strongly supports the continuation of Arkansas Works, these proposed waiver amendments are deeply concerning and have the potential to undermine the program. They will place undue financial and administrative burdens on low-income families as well as the Arkansas state government. Together, these changes stand to undermine the tremendous gains we've seen under this unique program that is designed to serve Arkansas's population and health system.

REQUESTED CHANGES TO ARKANSAS WORKS

FEATURE	DESCRIPTION
Partial Expansion Model	Lowers eligibility for Arkansas Works from 138% to 100% of the Federal Poverty Level.
Requirement to Work	Requires 20 hours of work or work-activities, like volunteering weekly to remain eligible for Arkansas Works.
Elimination of Retroactive Eligibility	Retroactive eligibility is a standard feature in state Medicaid programs and covers expenses incurred 90 days before an individual is enrolled. This policy would eliminate retroactive eligibility.

PARTIAL EXPANSION

The most concerning waiver request that will negatively impact low-income families is lowering the income level for Arkansas Works eligibility. DHS estimates the proposed change would make 60,000 Arkansans ineligible for Arkansas Works. Federal regulations require the state to make sure that those who make between 100 percent and 138 percent of the poverty level receive comparable coverage to those who remain eligible for the Arkansas Works program. The proposed strategy to meet this requirement is to transition people from Arkansas Works to either Marketplace plans or employer-sponsored coverage.

But research and experience from other states show that many consumers will not be able to afford these alternate forms of coverage. Ample evidence shows that even small premiums and cost-sharing can result in loss of health care coverage. This is precisely what transitioning Arkansas Works enrollees to private insurance would do.

...only around 20 percent of people who were no longer eligible for Medicaid gained coverage through a health plan on the Marketplace.

These effects are especially likely for those with lower incomes closer to the poverty level.[8]

When Rhode Island reduced income eligibility for their state Medicaid program in 2013, only around 20 percent of people who were no longer eligible for Medicaid gained coverage through a health plan on the Marketplace. Of this group, only half managed to pay their premiums and maintain coverage long-term.[9] When someone becomes ineligible for Medicaid coverage because of their income, federal regulations require the state to review whether they might be eligible for another category of Medicaid (for example, pregnancy or disability) to ensure ongoing coverage for affected beneficiaries. This waiver request would eliminate that requirement. The Rhode Island experience shows that Arkansas could miss a lot of enrollees who are still eligible for coverage if this is the new practice. In Rhode Island, approximately one-third of enrollees who were no longer eligible because of their income qualified for coverage through another Medicaid eligibility category. To avoid missing all those who are potentially still eligible for Medicaid in Arkansas, AACF strongly encourages DHS to implement a process to identify Medicaid-eligible individuals under a category other than income. In what's known as an ex parte renewal, the state Medicaid program would use electronic databases to re-determine beneficiary eligibility automatically when people lose coverage. Placing the burden on the state to make re-determinations ensures seamless coverage for consumers.

This is especially important because the future of the federal marketplaces is uncertain. It is premature for the state to assume Arkansas Works enrollees will be able to receive adequate marketplace coverage, especially as attempts are ongoing to change or eliminate large portions of the ACA in ways that would leave millions uninsured.

REQUIREMENT TO WORK

AACF has concerns about the proposal to implement work requirements as a condition of eligibility for Arkansas Works. The proposed work requirement would require Arkansas Works beneficiaries to work or participate in "work activities," like enrolling in vocational or college classes or volunteering, for at least 20 hours a week or 80 hours a month.

But there is little evidence that work requirements increase employment or reduce poverty, particularly in the long-term. Work requirements add an unnecessary barrier to coverage for enrollees and, due to administrative costs, an unnecessary financial strain on the state budget. Work requirements would also lead to an increase in health care costs overall, as individuals denied insurance coverage from failure to comply with work requirements would be forced to seek treatment in more costly emergency room settings.

Work requirements are based on the false assumption that many people who receive Medicaid benefits could be working, but choose not to work. In fact, almost 80 percent of adults on Medicaid are in working families. Of those who don't work, more than half would qualify for an exemption. Those include taking care of an ill family member (28 percent), being in school (18 percent), looking for work (8 percent), or having retired (8 percent).[10] Another 35 percent of Medicaid recipients who do not work report having an illness or disability that prevents them from work – making work requirements especially counterproductive for this population. In fact, research suggests that Medicaid expansion supports and enables more people to work.

The most prominent example of work requirements is the Temporary Assistance for Needy Families (TANF) program, put in place after the 1996 welfare reform bill was enacted. A large body of research finds that, like Medicaid recipients, the majority of TANF enrollees work regardless of work requirements. After five years, TANF enrollees who were not subject to work requirements were just as likely to be working as those who were subject to a work requirement, and sometimes more likely.[11]

Medicaid expansion supports and enables more people to work.

Work requirements are unlikely to be more effective for Medicaid enrollees. Unlike Medicaid, TANF has the express purpose of "promoting job preparation" and "employment," and states spend an average of $3,223 per work slot per year to provide work activities and supports for TANF enrollees. Indiana, in its waiver request to require work activities for Medicaid enrollees, dedicates only $1,080 per enrollee per year for orientation, assessment, job skills training, and job search assistance;[12] Arkansas has indicated that it will work with the state Department of Workforce Services to provide these supports for Arkansas Works enrollees, but provides no additional funding for these functions. However, Workforce Services likely does not have the funding or capacity to deal with the populations that are currently subject to a work requirement, much less the additional burden Arkansas Works participants would represent.

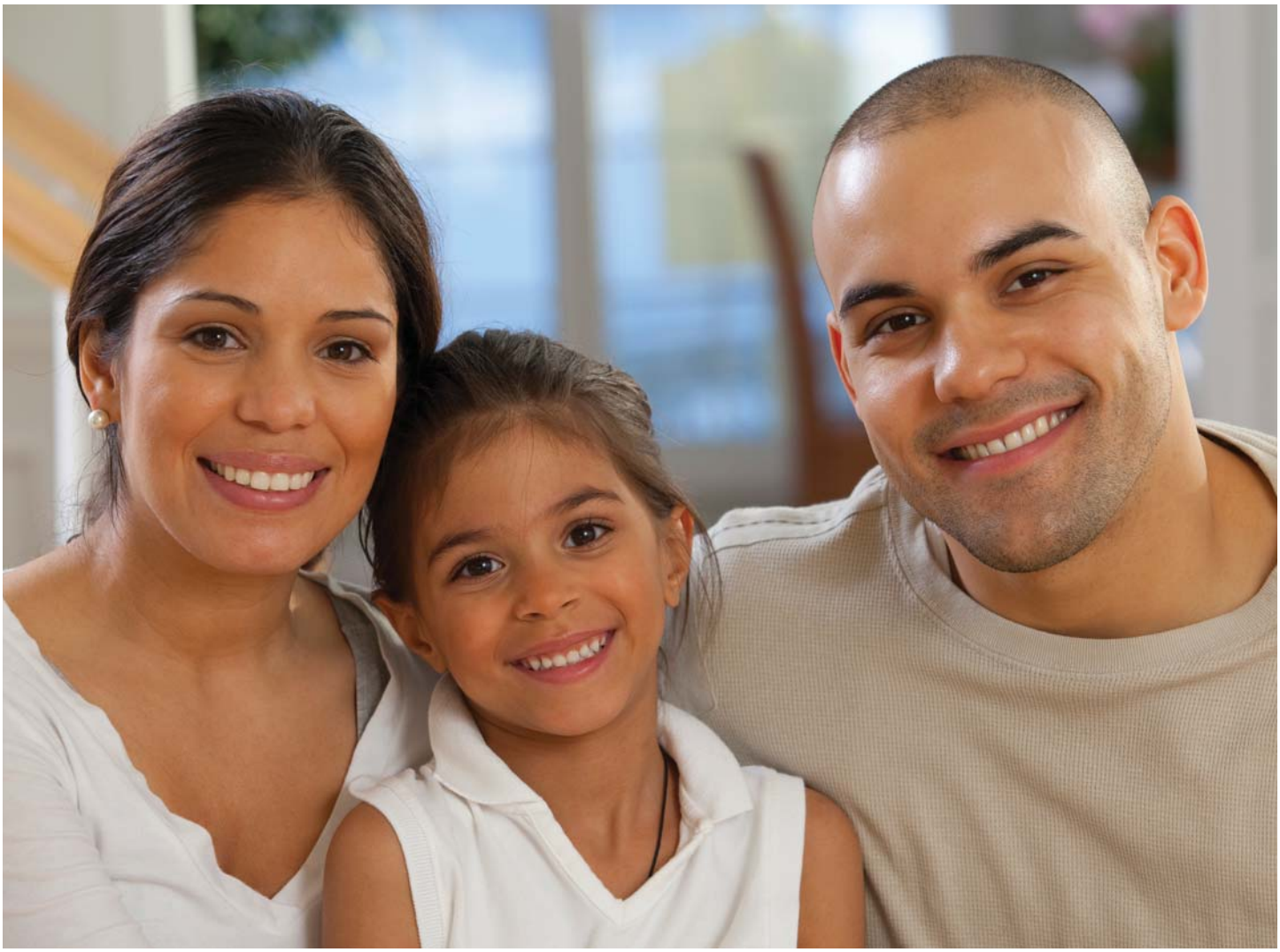
Even without any additional funding for workforce services to mitigate the negative impact of work requirements, they will be costly for the state from an administrative perspective. The state will need to create new systems to track and verify information about work participation, coordinate and share this information between Medicaid, health insurers and providers, and the workforce development system, and create an online portal for enrollees to verify that they have met the work requirement.

ELIMINATING RETROACTIVE ELIGIBILITY

Medical emergencies are unpredictable and costly. The current 90-day retroactive eligibility policy helps ensure that low-income families don't incur burdensome medical debt that they are unable to pay. It covers any medical debt incurred three months prior to enrollment in Arkansas Works. Health care providers and the state also benefit from retroactive eligibility. Doctors and clinics are not left with unpaid bills for treatment they've provided. This means providers and the state both save money in reduced costs of uncompensated care.

A similar request to waive retroactive eligibility was part of the waiver request from 2016. Arkansas received conditional approval to eliminate retroactive eligibility for Arkansas Works enrollees, contingent on changes to Arkansas's process of determining eligibility. One of these changes is the implementation of "presumptive eligibility," a state policy option that allows qualified entities to make temporary eligibility decisions based on, among other criteria, an assessment of family income[13].

Presumptive eligibility allows states to enable established community-based providers to make on-the-spot decisions regarding eligibility. Some agencies that other states currently certify to conduct presumptive eligibility checks include Medicaid and CHIP health care providers, elementary and secondary schools, and Head Start programs. In Arkansas, presumptive eligibility currently only exists for pregnant women[14]. This should at least be expanded to the Arkansas Works population before any elimination of retroactive eligibility occurs.



THE FUTURE OF ARKANSAS WORKS

The core features of this waiver request are deeply flawed and potentially violate federal regulations protecting Medicaid beneficiaries. To continue to see the great success Arkansas has achieved with Arkansas Works, the next steps are critical.

Expanding the assistance available for low-income families to navigate the complex and ever-changing health care landscape could help mitigate the coverage losses that would inevitably follow an approval of these proposed amendments. Without adequate outreach to families and careful monitoring of the impact of these proposed changes, we could be rolling back what has been a remarkably successful effort to improve the health of all Arkansans. To ensure Arkansas Works continues to work for low-income Arkansans, DHS should develop a detailed plan for ongoing outreach and education for both consumers and providers as a condition of implementing the requested policy changes. Health education materials should be offered at the appropriate reading level to ensure consumers can understand them. In-person assistance should be offered to help families navigate our complex health care system and adequately research their coverage options.

DHS should collect data and evaluate the impact of these changes, as well. The criteria DHS should look at includes the number of people who became ineligible for Arkansas Works; the number of former enrollees who applied for a marketplace plan or other coverage; the number of enrollees who successfully paid a premium and enrolled in coverage; and the number of former enrollees who did not sign up for coverage. Information about beneficiaries who are subject to work requirements, including job placements and retention rates, should be gathered and analyzed, too. This data should be collected and reported quarterly.

Amid ongoing debate in Congress about the future of the health care system, it's important that leaders in this state continue to put families first by ensuring everyone has access to comprehensive, affordable coverage.

ENDNOTES

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