EXTENDING MEDICAID THROUGH PRIVATE HEALTH PLANS:
Reactions to Arkansas's Private Option

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Executive Summary

Child advocates are thrilled Arkansas has taken steps to cover the 250,000 Arkansans earning less than 138 percent of the federal poverty level, or FPL (that's $32,499 per year for a family of four) through the "Private Option" extension of Medicaid. Research shows that covering parents is one of the best ways to ensure children get health coverage and the health care they need, and the Private Option will help Arkansas move toward improved access to health care coverage for all children and families.[1] The Private Option requires Arkansas to obtain a Section 1115 waiver since it will be testing coverage approaches that are outside of federal Medicaid rules. Despite supporting the Private Option concept, advocates have some concerns about the impact the law and the draft waiver application could have on Arkansans covered under Medicaid.

This analysis of the Arkansas Private Option extension of Medicaid gives a brief overview of the law and draft waiver application that sets up the framework for its operation, and it touches on the advantages of and concerns about these policies. Formal, detailed comments to Arkansas Medicaid will follow. Arkansans deserve for their tax dollars to be used in an efficient, effective way, and ensuring the appropriate protections for Private Option beneficiaries helps accomplish that goal.

Overview of Arkansas's "Private Option"

On April 23, 2013, Governor Beebe signed the Health Care Independence Act (HCIA) into law. The Act, also known as the "Private Option," provides an avenue for 250,000 low-income Arkansans to access affordable health coverage, the overwhelming majority through a premium assistance model. Premium assistance, generally, means using public funds to purchase private health insurance for eligible individuals. With this alternative to a traditional Medicaid expansion under the Affordable Care Act (ACA), Arkansas's Department of Human Services (DHS) proposes to use Medicaid funds to pay the private health insurance premiums for eligible adults. In late June, Arkansas made public a draft Section 1115 waiver application to be submitted to federal officials that outlines some details of the Private option.[2] The draft waiver is currently in its public comment period until July 24, 2013.

The HCIA enables DHS to implement a premium assistance coverage model for adults age 19-64 who earn less than 138 percent FPL ($15,856 per year for an individual) and do not already qualify for Medicaid.[3] Despite receiving private insurance, enrollees in the Private Option will have the same federal protections they would have under a traditional Medicaid expansion.[4,5] The major provisions of the HCIA are summarized in the text box.[6] The draft waiver application includes additional information about the plans DHS has to implement the law, including six Medicaid provisions that they have requested to be wavied. The waiver term is for three years, mirroring the June 30, 2017 sunset date of the HCIA.

Major Provisions of the HCIA

- Private Option insurance plans will be available through Arkansas's Health Insurance Marketplace, which is overseen jointly by the Arkansas Insurance Department (AID) and the federal government.
- Insurance carriers in the Marketplace must offer a high-level "silver" plan meeting certain qualifications, including participation in some aspects of the state's Payment Improvement Initiative patient-centered medical homes.
- Adults eligible for the Private Option choose among a limited set of qualifying "silver" plans, with the exception of some newly-eligible adults with exceptional health needs who may be deemed "medically frail" and can choose to receive a traditional Medicaid plan.
- Private Option enrollees may have cost-sharing (copays) that falls within federal Medicaid limitations and mirrors what is in the traditional Medicaid program.
- In future years, DHS "anticipates revising the waiver to include parents with incomes below 17 percent of the FPL and children" in the Private Option coverage. Revisions also include an optional health savings account and a high-deductible health plan pilot program called "Independence Accounts" for low-income Arkansans.
- The Private Option requires enrollees to sign a declaration that, among other things, their coverage is not a guaranteed entitlement and is subject to cancellation.
- The Health Care Independence Trust Fund is created to collect "moneys saved and accrued" under the law to pay for future obligations related to the Private Option.
- The Private Option sunsets June 30, 2017 unless the Arkansas General Assembly reauthorizes it.

Proponents of the Private Option maintain that it will reduce "churning" – a term used to describe family income changes that trigger coverage eligibility changes. Private Option enrollees may be able to remain in the same plan as their financial situations move them from Medicaid eligibility to eligibility for premium tax credits and vice versa. Additionally, it has the potential to improve access to health care providers by giving low-income enrollees the same insurance carriers and provider payment rates as higher-income enrollees. Lastly, when entire families have the same type of health coverage, it can be easier for all family members to get the best care possible, provided no additional barriers to continuous coverage are put in place.

Health coverage improves the lives of Arkansas's children and families. Ideally, the Private Option, the Marketplace, and Medicaid/ARKids First should work together to provide all Arkansas families with affordable, comprehensive health coverage that guarantees access to care and protects family finances. This paper analyzes aspects of the HCIA and the draft waiver application prepared by DHS that affect children's and families' access to this comprehensive health care coverage. The State Plan Amendment referenced in the waiver has not yet been released, and other important details, such as a thorough analysis of the cost implications, are not yet known, leaving some issues to be determined.

Child and Family Concerns with the Private Option

When the Health Insurance Marketplace and Medicaid overlap, such as in the Private Option, a complex set of rules interacts. Arkansas's Private Option is a new use of premium assistance: it is not required to follow federal Medicaid managed care rules that govern private insurance plans that cover Medicaid beneficiaries in many states. However, it is also not the traditional fee-for-service program DHS runs today.

The following areas should be carefully addressed to protect families, children, and other consumers from losing services or experiencing barriers to their full benefits under Medicaid.

Children's Coverage ARKids First has proven to be an amazing success story in Arkansas, reducing the rate of uninsured children from 22 percent in 1997 to just 6 percent today. ARKids First A covers children from the lowest incomes up to 138 percent FPL, while ARKids First B extends to 200 percent FPL, yet all ARKids First enrollees have access to the same providers. ARKids First helps ensure children receive comprehensive benefits that ensure healthy growth and development, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT is the "gold star" of health care benefits for children as identified by the American Academy of Pediatrics.[7]

The Private Option seeks to move approximately 75,000 children covered by ARKids First B onto private health insurance as part of its effort to "reduce the size of the state-administered Medicaid program."[8] Federal guidance strongly suggests that children receiving ARKids First A or Medicaid cannot be covered through premium assistance because of the scope of benefits children receive, including EPSDT, would be beyond that included in plans offered through the exchange.[9]

The Private Option is expected to reduce "churn" for adults as their income fluctuates. But including children covered by ARKids First B in the Private Option could actually increase churn and introduce it at a lower income level as children move between ARKids First A and private health insurance plans.[10] Studies have shown that half of families earning less than 200 percent FPL will churn across the 138 percent FPL "threshold" each year and become eligible for a different coverage source. Within six months, 35 percent will.[11] Lastly, if the HCIA is not renewed in 2017, children would have to be transitioned back to traditional Medicaid.

While Arkansas's health care system is undergoing substantial changes, it is best not to disrupt the consistent, comprehensive coverage that ARKids First provides to children until the dust settles. Once it has been shown that the Private Option protects benefits and cost-sharing for adults, moving children to plans with their caregivers may make more sense. Full-family coverage is an important policy goal, but making children more susceptible to coverage changes, reduced benefits, or poor continuity of care is not worth the risk. ARKids First works as administered today and the state should protect that progress in Arkansas.

The draft waiver does not address the ARKids First B transition, other than to say that the waiver will be revised to include children in the coming year. However, waiver amendments are not subject to the same transparency requirements as new waivers, so it will be important for DHS to be open about proposed changes and to take and consider public comments. Moving children to a different coverage source would be a major policy change and should be subject to a transparent public process comparable to new waiver applications.

Benefits Medicaid-mandated benefits must be provided to Private Option enrollees under federal law. Aligning Medicaid's new Private Option coverage with the Marketplace's Qualified Health Plan (QHP) benchmark plan helps bridge the gap between private coverage and Medicaid. However, some services must be "wrapped around" QHP coverage for Private Option enrollees when the private plans do not cover Medicaid-mandated benefits. Transportation to non-emergency medical appointments is the most-often cited example: Medicaid requires this benefit, but most private insurance companies do not cover it, necessitating a "wrapped" benefit.

Scant evidence exists to show that Medicaid beneficiaries in other premium assistance arrangements are receiving all of the additional benefits they are entitled to, pointing to the need to study the effectiveness of wrapped benefits in the Private Option. Additional clarifications and service wraps are needed to ensure Private Option enrollees receive the Medicaid benefits guaranteed to them. Benefits that should be guaranteed for adult Private Option enrollees include:

- Full Early Periodic Screening Diagnosis and Treatment (EPSDT) services for participants age 19-20. In short, "if a health care provider determines that a service is needed, it should be covered to the extent needed and allowed under the federal Medicaid Act.[12]"
- Non-emergency transportation for health care appointments.
- Out-of-network family planning services.
- Prescriptions covered by Medicaid but not covered by private insurance formularies.
- Access to federally qualified health centers (FQHCs) and rural health centers (RHCs). Access to these providers is a mandatory Medicaid benefit.[13]

In general, DHS should provide clarification about how enrollees will be notified of the benefits wrapped around their QHP coverage in an easy-to-understand manner. Will Private Option enrollees have multiple identification cards, or will the private carriers add Medicaid information to their cards? Additionally, DHS should provide additional clarification about how "medically frail" individuals will choose coverage that meets their needs. Special consideration should be given for those needing mental health or substance use disorder treatment. The draft waiver seems to indicate they may have a choice between traditional Medicaid and Private Option coverage, so options should be clearly presented to enrollees so they can choose the coverage best for their situation.

Cost-sharing The draft waiver does not ask to waive Medicaid's cost-sharing protections. Advocates strongly support upholding the cost-sharing protections that protect family finances. As outlined in the AACF brief "*The Facts on Medicaid Copayments: Considerations for Arkansas*," federal Medicaid standards must apply regardless of who provides Medicaid coverage.[14] Private Option enrollees will choose from plans that are required by AID to provide a cost-sharing structure similar to Medicaid's, but there are several discrepancies.[15] For example, copays are not allowed for emergency services for adults earning less than 150 percent FPL, but the Insurance Department bulletin lists the copay for emergency services as $20. Additionally, Medicaid allows nominal deductibles of up to $2.65 for individuals in this income range, but the bulletin lists a $150 deductible. This cost-sharing will affect only Private Option enrollees from 100-138 percent FPL.

DHS should clarify how it will assure cost-sharing protections, specifically the following:

- Federal Medicaid cost-sharing standards, as outlined in recent federal guidance, for deductibles and per-visit copayments or coinsurance.
- Family planning and pregnancy-related services with no cost-sharing.
- The aggregate family cost-sharing maximum of 5 percent of family income.[16]

Access to Care The Private Option draft waiver application request touts improved access to care for enrollees. Sufficient and available providers are key to improved access. Some statements in the waiver about the existing Medicaid provider network do not ring true; a recent Health Affairs article states that 91 percent of Arkansas providers are accepting new Medicaid patients, contrary to several statements in the waiver.[17] DHS should provide thorough and ongoing analysis of provider networks for traditional Medicaid and all Private Option carriers to ensure access to care for all Medicaid beneficiaries.

Many Private Option enrollees currently access health care services through federally qualified health centers and other access points that might not be part of QHP networks. DHS should clarify how it will ensure access to health care through FQHCs, rural health centers, health department clinics, mid-level behavioral health care providers, school-based services, and other providers that are especially important for low-income families. Sufficient provider reimbursements for facilities that serve the underserved should be considered a part of full access to care and be provided by Medicaid.

Eligibility and Enrollment Systems The systems that consumers use to enroll in health coverage are very important in facilitating a successful enrollment experience. Due to system limitations and the short time frame in which the system changes must be made to accommodate the Private Option, the draft waiver application indicates that consumers may have a multi-step process for enrolling rather than the seamless system the ACA envisions. Specific concerns are listed below.

- The new Private Option system should connect seamlessly and instantaneously with the Medicaid system and the Marketplace to ensure a successful enrollment for all families.
- DHS should provide additional details regarding the "notification" that will be sent during the enrollment process, including its timing and its impact on the enrollment experience.
- DHS should take advantage of internal data to enroll qualified individuals, including those enrolled in SNAP or parents with children receiving ARKids First A. Outreach staff for DHS and the Marketplace should be trained fully to enroll individuals in the Private Option and Medicaid, and they should be aware of the consequences of auto-enrollment in Private Option plans.
- The screening for "medically frail" individuals is not explained in any detail. DHS should adopt a comprehensive definition for "medically frail" individuals that mirrors the definition given in recent federal guidance. DHS should provide a public comment period once full details about the screening tool and screening process are made available.[18]
- DHS should detail how current and former foster youth up to age 26, who are exempt from Private Option plans, will be informed of their options for coverage.
- DHS should modify the plan auto-assignment process to consider factors such as continuity of provider relationships and having a whole family enrolled in the same plan.
- DHS should lengthen the "opt-out" period for plan auto-assignment to 60 - 90 days.
- DHS should clarify how Medicaid's continuously open enrollment will interact with private plans' limited open enrollment periods.
- DHS should clarify how communication between Medicaid, Arkansas's Marketplace, and QHPs will ensure enrollees do not "fall through the cracks" during coverage transitions.

On a very positive note, the waiver mentions that newly-eligible adults will have 12-month continuous coverage to help reduce churning. Advocates support this policy that will also promote better quality and continuity of care. Two additional positive features are retroactive coverage and coverage prior to QHP enrollment for Private Option enrollees.

Cost-Effectiveness It is clear the waiver does not go into detail about the evaluation of budget neutrality for the demonstration, a requirement for federal approval. In fact, the budget neutrality forms required for the waiver application have not been made public. Generally, the cost-effectiveness sections of the draft waiver application need quite a bit more detail to ensure that the public can fully evaluate any increase or decrease in expenditures, as required by law.[19] Budget neutrality should be an "apples to apples" comparison with the waiver and without the waiver that includes the cost of coverage, administrative costs, and wrap-around benefits.[20]

Tobacco surcharges should also be considered in budget neutrality determination. Private carriers can charge up to 20 percent more for tobacco users, where traditional Medicaid cannot, and Medicaid will pay the premium.[21] More than 30 percent of adults earning less than $25,000 per year identified as current smokers in the 2008 Arkansas Adult Tobacco Survey.[22] This could have a meaningful impact on budget neutrality.

Advocates for children know that ARKids First successfully covers children in a cost-effective way today. The reference to children transitioning to a premium assistance model will be closely monitored for its cost-effectiveness. Close attention should be paid to optimal solutions for adults before disrupting existing cost-effective coverage for children.

Accountability, Consumer Protections, and Quality Improvement Several concerns with consumer protections and quality improvement exist with the Private Option. The lack of a contractual relationship between Arkansas Medicaid and the private carriers could present issues with accountability for taxpayer dollars. As beneficiaries and providers seek to enforce Medicaid law, a "single state agency" must oversee the program.[23] The lack of formal contractual relationships raises questions about the responsibility for carrying out the requirements of the Medicaid program, including reporting and document disclosure and adherence to federal Medicaid requirements.[24]

Other Medicaid accountability features include the following:

- Guaranteed access to a fair hearing process and other protections in the case of inappropriate denials of covered benefits or wrongful termination of coverage.
- Quality and data reporting by QHP carriers that is made transparent to the public and meets Medicaid standards.[25]

Evaluation of the Private Option's success should be strengthened. Some of the suggested comparisons to traditional Medicaid expansion states, such as Maryland or California, would not provide apples-to-apples evaluation. The draft waiver application mentions some areas to evaluate, but the following components should be added or strengthened in the evaluation plan:

- Successful provision of wrap-around benefits, including services such as EPSDT and non-emergency transportation, cost-sharing protections, and prescription coverage
- Budget neutrality
- Churning and its relationship to administrative costs and 12-month continuous coverage
- Uncompensated care
- Emergency care
- Denial of claims
- Network adequacy for Private Option and traditional Medicaid enrollees
- Continuity of care (how many enrollees must change primary care providers?)

Conclusion

In general, the Private Option is an extremely positive development for uninsured adult Arkansans. Having coverage for parents is incredibly valuable for the state's children, and the law offers many protections for those covered under the Private Option. However, there are a host of concerns about this new model of coverage in Arkansas, especially as it grows out of systems that are still developing. Between now and July 24, advocates have the opportunity to provide comments to DHS regarding concerns and suggested changes. In early August, DHS anticipates sending the waiver to the federal government for its approval process. Again, at the federal level, there will be an open comment period during which feedback is received from local and national stakeholders. Arkansas hopes to receive formal approval from the federal government regarding this 1115 waiver by October 1, when open enrollment for health coverage begins.

There are other tangential areas of concern that affect the Private Option's success. For example, the development of Arkansas's state-based Health Insurance Marketplace, created by Act 1500 of 2013, factors heavily into policy decisions in 2015 and beyond. If Arkansas transitions to a state-based Marketplace in 2015, it could create an unstable transition of ARKids First B to private coverage. Also, the Arkansas Health Insurance Marketplace has a quasi-governmental board of directors consisting of 9 white males and 2 white females, with little consumer representation. This is hardly representative of the diversity found in Arkansas, and corporate interests are overly represented on the board.

As mentioned, the future transition of children and parents to Private Option coverage must be considered carefully. Additionally, the HCIA's intent to implement health savings accounts in later years of the Private option is concerning. Future proposed changes to this Section 1115 demonstration waiver should be subject to a public process allowing for public comment that is similar to a new waiver application.

If Arkansas commits to providing Private Option enrollees the full protections available to Medicaid beneficiaries, risks to families can be mitigated. The state should maintain the gains Medicaid and ARKids First have brought to the state's children, and the foundation laid by this draft waiver application needs meaningful changes in order to protect children and their families fully.

Notes

[1] Strong. Strengthening Medicaid Helps Families. (2012). Arkansas Advocates for Children and Families.
[2] Health Care Independence 1115 waiver. (2013) Last retrieved from https://www.medicaid.state.ar.us/Download/general/comment/InitialHCIWApp.doc.
[3] 2013 Federal Poverty Level Guidelines are as follows, according to HHS:

Household Size	100%	138%	150%	200%	300%	400%
1	$11,490	$15,856	$17,235	$22,980	$34,470	$45,960
2	$15,510	$21,404	$23,265	$31,020	$46,530	$62,040
3	$19,530	$26,951	$29,295	$39,060	$58,590	$78,120
4	$23,550	$32,499	$35,325	$47,100	$70,650	$94,200
each additional person	$4,020	$5,548	$6,030	$8,040	$12,060	$16,080

[4] Bachrach, Boozang. (2013) Purchasing coverage for Medicaid beneficiaries in the exchange: A review of the premium assistance option. State Health Reform Assistance Network. Last retrieved from http://www.statenetwork.org/wp-content/uploads/2013/03/State-Network-Manatt-Purchasing-Coverage-for-Medicaid-Beneficiaries-in-the-Exchange.pdf July 2013.
[5] Medicaid.gov. Medicaid and the Affordable Care Act: Premium Assistance. (2013) Last retrieved from http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf.
[6] Arkansas 89th General Assembly. Act 1497 of 2013. Last retrieved from http://www.arkleg.state.ar.us/assembly/2013/2013R/Acts/Act1497.pdf July 2013.
[7] American Academy of Pediatrics. State roles in defining Essential Health Benefits. Last retrieved from http://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/AAP_EHB_Recommendations.pdf.
[8] Because Arkansas has an incredibly lean non-mandatory Medicaid population, and children make up 66% of the Medicaid program, removing some children is one of the only ways to move people off of traditional Medicaid regardless of consequences of disrupted coverage for children. This is a stated goal of the HCIA draft waiver.
[9] Medicaid.gov. Medicaid and the Affordable Care Act: Premium Assistance. (2013) Last retrieved from http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf.
[10] Rosenbaum and Sommers. (2013). Using Medicaid to buy private health insurance – the great new experiment? N Engl J Med 2013; 369:7-9.
[11] Sommers and Rosenbaum. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. Health Affairs, 30, no.2 (2011):228-236.
[12] Perkins. Medicaid Early and Period Screening, Diagnosis, and Treatment Fact Sheet. (2008). National Health Law Program.
[13] 42 CFR 440.365 and Social Security Act, section 1905(a)(2).
[14] Strong. (2013). The Facts on Medicaid Copayments: Considerations for Arkansas. Arkansas Advocates for Children and Families.
[15] Bulletin No 3B-2013: REQUIREMENTS FOR QUALIFIED HEALTH PLAN CERTIFICATION IN THE ARKANSAS FEDERALLY-FACILITATED PARTNERSHIP EXCHANGE (MARKETPLACE). Arkansas Insurance Department. June 25, 2013.
[16] Strong. (2013). The Facts on Medicaid Copayments: Considerations for Arkansas. Arkansas Advocates for Children and Families.
[17] Sandra L. Decker. In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. Health Affairs, 31, no.8 (2012):1673-1679.
[18] From 42 CFR §440.315: The State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in §438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.
[19] 42 CFR § 431.408.
[20] 42 CFR §435.1015
[21] AID/DHS Plan Management Questions & Answers #2. Last retrieved from http://hbe.arkansas.gov/FFE/AID-MedicaidQA2.pdf July 2013.
[22] Arkansas Department of Health. 2008 Adult Tobacco Survey. Last retrieved from http://www.healthy.arkansas.gov/programsServices/epidemiology/ChronicDisease/Documents/publications/atsReport2008.pdf July 2013.
[23] Social Security Act, section 1902(a)(5)
[24] National Health Law Program. Individual Premium Assistance: Many Unanswered Questions. (2013).
[25] National Health Law Program. Individual Premium Assistance: Many Unanswered Questions. (2013).