ACHI
Arkansas Center for Health Improvement

ISSUE BRIEF

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

Arkansas's Health Care Independence Act of 2013 • Sept 2013

Health care coverage is essential to personal health and well-being. The absence of coverage and underinsurance among Arkansans has led to high uncompensated care costs among Arkansas health care providers and is a leading cause of personal bankruptcy in the U.S. Those without health care coverage often avoid or delay seeking treatment, resulting in even higher medical costs and more serious illnesses, even death. High uninsurance rates have contributed to maldistribution of our health care workforce, with providers avoiding areas where there is a greater likelihood of their not being paid for their services. Without expansion of health care coverage through the Patient Protection and Affordable Care Act (PPACA), about 250,000 of the most financially vulnerable Arkansans would have no coverage option. To address these problems, Arkansas has taken a novel approach to use the PPACA's expansion of Medicaid benefits by providing health coverage through private insurance plans through the Health Insurance Marketplace.

DEVELOPMENT OF THE HEALTH CARE INDEPENDENCE ACT

The U.S. Supreme Court's June 2012 ruling[1] allowed states to decide whether or not to extend Medicaid benefits to their citizens who qualify under the Patient Protection and Affordable Care Act (PPACA) expansion. Members of the Arkansas 89th General Assembly took a bipartisan approach to this prospect and crafted a unique proposal that will use federal Medicaid funding to provide health care benefits to individuals eligible under the PPACA expansion[2] (Figure 1). These individuals will receive coverage via private insurance plans offered through the new Health Insurance Marketplace established by the PPACA. Commonly known as the "Private Option," the Health Care Independence Act and its accompanying appropriation, which was passed by the required three-fourths majority vote in both the Arkansas House and Senate, was signed into law by Governor Mike Beebe on April 23, 2013.

Figure 1: Purposes of the Health Care Independence Act of 2013[2]

1. Improve access to quality health care
2. Attract insurance carriers and enhance competition in the Arkansas insurance marketplace
3. Promote individually owned health insurance
4. Strengthen personal responsibility through cost-sharing
5. Improve continuity of coverage
6. Reduce the size of the state-administered Medicaid program
7. Encourage appropriate care, including early intervention, prevention, and wellness
8. Increase quality and delivery system efficiencies
9. Facilitate Arkansas's continued payment innovation, delivery system reform, and market-driven improvements
10. Discourage over-utilization
11. Reduce waste, fraud, and abuse

OVERVIEW OF THE HEALTH CARE INDEPENDENCE ACT

The act calls on the Arkansas Department of Human Services (DHS) to explore program design options that reform Arkansas Medicaid so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program using competitive and value-based purchasing to:[2]

- maximize the available service options;
- promote accountability, personal responsibility, and transparency;
- encourage and reward healthy outcomes and responsible choices; and
- promote efficiencies that will deliver value to the taxpayers.

Arkansas DHS has secured approval of a waiver demonstration application submitted to the U.S. Department of Health and Human Services (see below) specifically designed to implement the act's requirements.[3]

Rationale for Expanding Health Care through the Act[3]

Expanding the existing state Medicaid program to nearly all individuals with incomes at or below 138 percent of the federal poverty level (FPL), as set out in the PPACA, would have presented several challenges for Arkansas. First, the newly eligible adults are likely to have frequent income fluctuations that lead to changes in eligibility. In fact, studies indicate that more than 35 percent of adults will experience a change in eligibility within six months of their eligibility determination.[4] Without carefully crafted policy and operational interventions, these frequent changes in eligibility could lead to:

- coverage gaps during which individuals lack any health coverage, even though they are eligible for coverage under Title XIX or Advanced Payment Tax Credits (collectively, along with CHIP, "Insurance Affordability Programs" or "IAPs") and/or
- disruptive changes in benefits, provider networks, premiums, and cost-sharing as individuals transition from one IAP to another.

In addition, if the traditional Medicaid program were expanded to include all individuals with incomes at or below 138 percent FPL, Arkansas would have increased its state Medicaid program population by nearly 40 percent. The state's existing network of participating fee-for-service Medicaid providers is already at capacity. As a result, Arkansas would have been faced with the challenge of increasing providers' capacity to serve Medicaid beneficiaries to ensure adequate access to care.

In short, absent the federal waiver to implement the act, a traditional Medicaid expansion would rely on the existing Medicaid delivery system and perpetuate an inadequately coordinated approach to patient care for those newly eligible under the PPACA. While reforms associated with the Arkansas Payment Improvement Initiative (www.paymentinitiative.org) are designed to address the quality and cost of care in Medicaid and the private market, these reforms do not include increased payment rates needed to expand provider access for the 250,000 new adults who will enroll through the expansion.

Program Information

Eligibility[3]

The act extends coverage to newly eligible individuals who meet the following requirements:

- Childless adults earning between 1 percent and 138 percent of the FPL or parents who earn between 17 percent and 138 percent of the FPL (parents earning less than 17 percent FPL are currently eligible for Medicaid).
- Adults between the ages of 19 and 65 years.
- A U.S. citizen or qualified, documented alien.
- Those not otherwise eligible for Medicaid under current eligibility requirements, such as those who are disabled, children, and dual eligibles.
- Adults with exceptional medical needs as identified by a health care needs questionnaire.

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- Those not enrolled in Medicare.
- Those not incarcerated.

Funding & Cost[2]

The act allows the program to continue in perpetuity during the period of the waiver that has been submitted by the Arkansas DHS but is contingent upon annual appropriations by the Arkansas General Assembly. The waiver has been approved by U.S. DHHS for 2014–2016. The costs of the program are shared by the federal government through provisions of the PPACA. The funding responsibility by year is outlined in Table 1.[2]

Table 1: Funding for the Private Option[2]

Year(s)	State Share	Federal Share
2014–2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020 and on	10%	90%

In ACHI's comparison of options for extending health insurance coverage to low-income Arkansans, the impact of the Health Care Independence Act on the state and federal budgets were estimated as follows.[5]

State Budget:

- State general revenue obligations will be reduced by ~$40 million per year due to avoided uncompensated care.[5]
- State spending will increase by $47 million in FY15 with 100% federal support and $275 million in FY20 at 10% state/90% federal match requirement for expansion population.[6]
- Additional premium tax revenue over the first 10 years of the Private Option will generate $436 million.[6]
- The net impact on the state budget is a favorable $670 million over 10 years.[6]

Federal Budget:

- The federal government will benefit from ~$1.1 billion per year in new taxes and Medicare payment reductions.[7]
- The increase in federal costs for expansion and ongoing Medicaid is projected at $1.59 billion in FY15 and $2.35 billion in FY20.[5]
- The net impact on the federal budget approaches neutrality over 10 years (not including economic stimulant effects).[5]

Private Plans Available to Arkansans

The act requires the state to take an integrated and market-based approach to covering low-income Arkansans by offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program.[2]

An early benefit of this approach can be found in the number of private insurance companies who have expressed their intention to offer

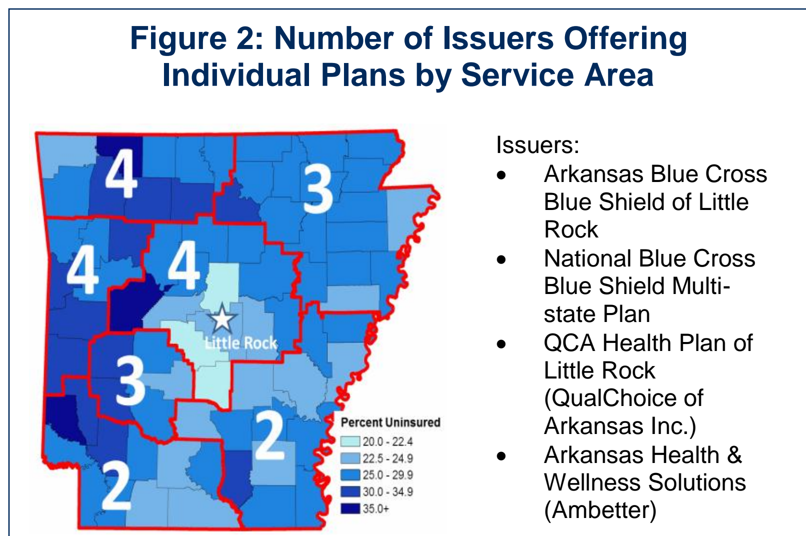

Figure 2: Number of Issuers Offering Individual Plans by Service Area

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plans across the state (Figure 2).[8] As a result, Arkansas citizens living in each region of the state will have a choice of plans from at least two companies.[9] In comparison, neighboring Mississippi had 36 counties without a single plan offered through its health insurance marketplace and has only two participating insurance companies.[10]

ARKANSAS'S HEALTH CARE INDEPENDENCE PROGRAM WAIVER DEMONSTRATION PROPOSAL[3]

The Private Option is crafted to address the provider capacity and care coordination issues noted above. By using premium assistance to purchase qualified health plans (QHPs) offered in the Health Insurance Marketplace, Arkansas will promote continuity of coverage and expand provider access, while improving efficiency and accelerating multi-payer cost-containment and quality-improvement efforts. Further, it is expected that by providing a source of payment to an estimated 250,000 currently uninsured citizens, an economic impetus will be created that will lead to an increase in the supply of health care services available, particularly in currently underserved areas counties. In fact, a recent study sponsored by ACHI and conducted by the RAND Corporation indicated that full implementation of expanded coverage under the PPACA would result in a $550 million annual increase in Arkansas's gross domestic product and the creation of 6,200 jobs, with the majority of this impact accruing to rural Arkansas where the uninsured rates are relatively higher.

Figure 3: Why Does Arkansas Require a Federal Waiver to Implement the Private Option?

A Medicaid waiver is needed whenever states want to waive government-mandated requirements that pertain to state Medicaid programs under certain circumstances. Medicaid waivers are designed to allow states to be more flexible in providing health care options to their citizens, allowing states to save money and patients to have more freedom of choice. Arkansas's Medicaid demonstration waiver details the various facets and nuances of the Health Care Independence program. It answers questions concerning exactly how the program will function, who the targeted population is, what the rationale behind the waiver is, and various other aspects of the program the U.S. Department of Health and Human Services needs to know in order to allow program implementation with federal funds.

For full details of the Health Care Independence 1115 Waiver go to https://www.medicaid.state.ar.us/Download/general/comment/FinalHCIWApp.pdf. For details about the terms and conditions go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf.

Continuity of Coverage

For households with members eligible for coverage under Title XIX or the Health Insurance Marketplace as well as those who have income fluctuations that cause their eligibility to change year to year, the act will create continuity of health plans and provider networks. Households can stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, CHIP (after year one), or Advanced Payment Tax Credits.

Rational Provider Reimbursements and Improved Provider Access

Arkansas Medicaid's reimbursement rates are generally lower than Medicare or commercial payers, causing some providers to forgo participation in the program and others to "cross subsidize" their Medicaid patients by charging more to private insurers. The act will align provider reimbursement across payers, expanding provider access and reducing the need for providers to cross-subsidize.

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Integration and Efficiency

Arkansas is taking an integrated and market-based approach to covering uninsured Arkansans, rather than relying on a system for insuring lower-income families that is separate and duplicative. The transition to private markets under this program is an efficient way to capitalize on the enhanced market competition and to cover Arkansans who often have income fluctuations.

"All Payer" Health Care Reform

Arkansas is at the forefront of payment innovation and delivery system reform, and the Health Care Independence Act will accelerate and leverage its Arkansas Health Care Payment Improvement Initiative by increasing the number of carriers participating in the effort, and the number of privately insured Arkansans who benefit from a direct application of these reforms.

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