Health Care Independence Program and Budget Neutrality

ACHI
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Arkansas's use of a premium assistance model to finance healthcare coverage for low-income Arkansans has brought praise from advocates for the state's innovative approach, replication from other states seeking an alternative to traditional Medicaid expansion, and scrutiny from those wanting to ensure cost containment.[1,2] Arkansas's model—formally called the Health Care Independence Program (HCIP)[3]—required a federally approved Section 1115[4] demonstration waiver for implementation. Demonstration waivers under Section 1115 of the Social Security Act provide states with federal matching funds for projects that test new approaches in how Medicaid programs operate. A requirement that must be demonstrated prior to waiver approval is budget neutrality. In other words, the cost of the waiver program cannot exceed federal spending that would have otherwise occurred absent the waiver. This fact sheet provides general information about budget neutrality and its assessment, scrutiny of Arkansas's budget neutrality assessment and spending relative to budget neutrality caps, and progress on state spending under the waiver to date.

1115 BUDGET NEUTRALITY

Demonstration Waiver Definitions

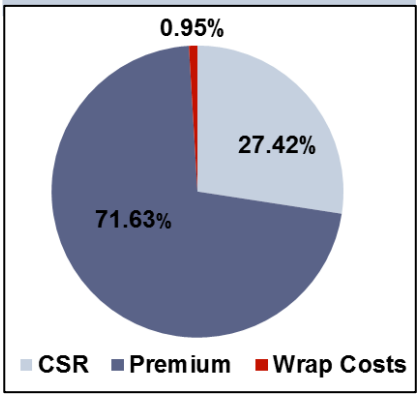
- *Budget neutrality cap:* per-member per-month cost threshold over the period of the waiver
- *Cost-sharing reduction (CSR) payments:* payments to carriers to reduce out-of-pocket costs for beneficiaries to required Medicaid cost-sharing levels
- *Premium*: amount paid for the insurance plan
- *Wrap-around costs*: costs for required services directly covered by Medicaid, e.g., non-emergency medical transportation
- *Per-member per-month (PMPM):* sum of premiums, CSR payments, and wrap-around costs divided by the number of waiver beneficiaries
- *Member months:* The number of waiver beneficiaries participating each month
- *Medical-loss ratio (MLR):* requires carriers to rebate payers if less than 80 percent of premiums are spent on medical care only and more than 20 percent on administration
- *Reconciliation:* process of assessing the difference between the CSR payments and the actual costs
- *Qualified Health Plans (QHPs):* plans available through the Health Insurance Marketplace
- *Essential Health Benefits (EHBs):* healthcare services that QHPs must cover

Section 1115 demonstration waivers require budget neutrality. In other words, federal spending under the waiver must not exceed projected federal spending without the waiver.[5] If the cumulative spending at the end of the three-year waiver period exceeds the total projected budget neutrality cap for the same timeframe, Arkansas will be responsible to pay the federal government for the budget deficit.[6] The federal government establishes budget neutrality by placing a cap on federal matching funds during the demonstration period of the waiver and by including those caps in the state's waiver agreement.[7]

The U.S. Department of Health and Human Services (HHS) requires that all demonstration waiver applications submitted by states include a justification of cost projections with a description of methods and data sources for the projections.[5] States may estimate costs using assumptions, so long as the assumptions are reasonable and explained to HHS. States must provide coverage expansion cost projections (for both with and without the waiver) for the time covered by the waiver (2014 to 2016 for Arkansas), including the following projections:[8]

- An estimate of and methods for cost trends from year to year.
- An estimate of per-member per-month (PMPM) costs and of the number of member months—this considers projected demographics of the population and member utilization.
- A comparison showing that projected waiver costs are no greater than projected without-waiver costs.

Figure 1: 2014 Contributions of PMPM Cost Variables[9]



Average monthly PMPM costs represent the budget neutrality caps established in the waiver. Figure 1 provides preliminary calculations for the distribution of PMPM costs for plan-year 2014.[9]

The budget neutrality caps established for the Arkansas waiver plan years are $477.63 in 2014, $500.08 in 2015, and $523.58 in 2016. The caps reflect a trend rate of a 4.7 percent increase from year to year.[8] This trend rate is less than the average growth trend in Medicaid spending from 2000-2012 and approaches the average growth trend nationally.

ARKANSAS'S BUDGET CAP TRENDS

Table 1 provides preliminary PMPM costs for the Arkansas waiver from January 2014 to September 2015, with month-to-month changes in up-front costs.[9] Figure 2 displays the average PMPM cost trend relative to the budget cap from January 2014 to September 2015[9] and shows that preliminary up-front payments to carriers were above the budget cap for 2014, primarily due to a slight under-projection of the average age of the population.[10] Waiver expenditures began to decline in April 2014 and have now flattened out at a level below the budget cap, despite an increase from June to July 2015 when eligibility redeterminations began.

Actual costs for the HCIP in 2014 are not yet known. The initial up-front payments are subject to MLR calculations and reconciliation and will be revised as follows once data on actual costs are available:

- MLR: If carriers' expenditures for medical claims and for activities that improve the quality of care are lower than 80 percent of the up-front premium prices, then the state will receive a rebate from the carriers.[6]
  - For the 2014 plan year, MLR determinations are expected in late 2015.[7]
- CSR payments: If actual costs are lower than the CSR payments, the state will receive a reconciliation payment from the carriers. If actual costs are higher than the CSR payments, the state will owe the carriers.[6,9]
  - For the 2014 plan year, CSR reconciliations are not expected until mid-2016.[9]

Figure 2: PMPM Up-Front Cost Trends and Yearly Budget Neutrality Caps[9]

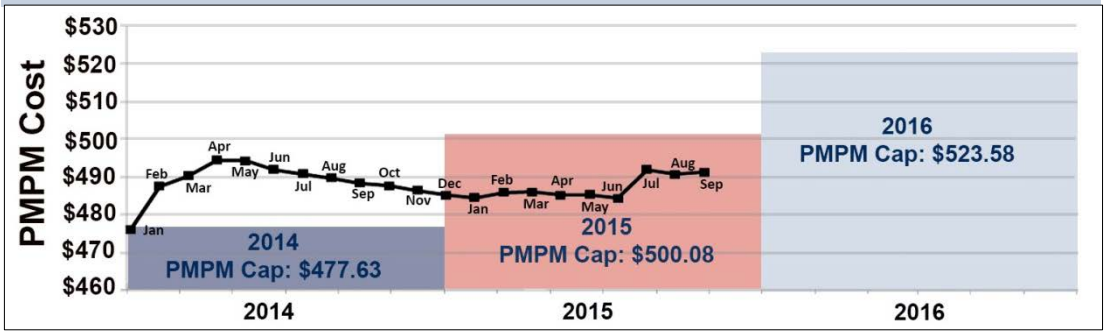


Table 1: PMPM Up-Front Cost Trends and Changes[9]

	PMPM	ΔPMPM*
Jan-14	$476.56	
Feb-14	$488.10	$11.53
Mar-14	$490.98	$2.88
Apr-14	$495.09	$4.11
May-14	$494.94	-$0.15
Jun-14	$492.58	-$2.36
Jul-14	$491.44	-$1.13
Aug-14	$490.30	-$1.28
Sep-14	$489.03	-$1.28
Oct-14	$488.26	-$0.77
Nov-14	$487.07	-$1.18
Dec-14	$485.84	-$1.23
Jan-15	$485.10	-$0.74
Feb-15	$486.47	$1.37
Mar-15	$486.61	$0.14
Apr-15	$485.87	-$0.74
May-15	$485.91	$0.04
Jun-15	$484.94	-$0.97
Jul-15	$492.50	$7.57
Aug-15	$491.27	-$1.22
Sep-15	$491.83	-$0.56

*The PMPM change is the change from the previous month

BUDGET NEUTRALITY OBSERVATIONS

There has been significant local and national interest in the Arkansas waiver's budget neutrality projection, the state's expenditures toward budget neutrality, and the HHS methods for examining budget neutrality. Perhaps the most notable inspection of the Arkansas waiver's budget neutrality was from a report generated by the Government Accountability Office (GAO). The report investigated Arkansas's waiver submission, and concluded that HHS did not ensure budget neutrality due to allowing "inappropriate methods" of determining the budget caps.[5] More specifically, the report found fault with approval of a budget cap based, in part, on an assumption that the state Medicaid program would have had to significantly increase provider reimbursement rates to care for beneficiaries under a traditional Medicaid scenario.

HHS responded that the state's projections and their approval were consistent with HHS's policy that budget neutrality should be based on the best available data, and that Arkansas provided an explanation of how its program would achieve budget neutrality and the data to support its rationale. Arkansas officials responded that the GAO report reflected a continuing disagreement with HHS about the process for assessing budget neutrality and that the report failed to consider whether Medicaid rates would have to increase with a traditional expansion of coverage.[11]

Critics expressed concern about the transparency of cost estimates and that up-front 2014 expenditures exceeded projected costs.[12,13] With costs below projections thus far in 2015 and assessment of MLR and CSR reconciliation in the coming months, the performance of HCIP versus its budget remains to be seen, although the trajectory is promising.

CONCLUSION

In April 2014, the average PMPM cost for Arkansas's HCIP grew to its highest point, followed by a slow decline and leveling of costs. Factors contributing to relatively flat premium costs from 2014 to 2015—and, therefore, a relatively flat average PMPM cost—include a restriction of plan offerings available to HCIP participants and expanded carrier competition in the state. In a continuing effort to contain costs, the state will implement plan-purchasing guidelines for plan-year 2016. The state will purchase EHB-only plans that are no more than 10 percent more expensive than the second-lowest plan offered in the region.

Although the HCIP may continue under the waiver through December 31, 2016, the program will cease by the terms of the Arkansas Health Care Reform Act of 2015,[14] which created a task force to explore new coverage options and efficiencies. That is the point at which HCIP budget neutrality will become more apparent. Variation from projected costs during the first year—caused by a lack of previous claims information about the HCIP population and programmatic changes that allowed the state to decrease spending—reflects the difficulty and risk of subjecting the state to a capped budget, whether global or per person. The Health Care Task Force should consider this risk when deliberating about the future of Medicaid in Arkansas.

Aside from budget neutrality, the HCIP evaluation testing the program's cost-effectiveness is an important component to assess program success. That evaluation will weigh program costs against improved access, quality, outcomes, and continuity of care and coverage experienced by the beneficiaries.

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[14] *Act 46* of 2015.