Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration Waiver Interim Report Executive Summary

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Executive Summary

Background

The State of Arkansas, navigating the political barriers facing many states, pursued a novel approach to Medicaid expansion through the commercial sector. Through a Section 1115 demonstration waiver, the state utilized premium assistance to secure private health insurance offered on the newly formed individual health insurance marketplace (the Marketplace) for individuals between 19 and 64 years of age with incomes at or below 138 percent of the federal poverty level (FPL). [i]

In 2014, Arkansas successfully established the Health Care Independence Program (HCIP)[ii], commonly referred to as the "Private Option," as designed under the terms and conditions of the Section 1115 demonstration waiver. Through 2015, the estimated target-enrollment population of approximately 250,000 was met. Approximately 25,000 additional individuals eligible under the Patient Protection and Affordable Care Act (PPACA) and deemed to have exceptional healthcare needs were enrolled in the traditional Medicaid program. Finally, approximately 20,000 previously eligible but newly enrolled individuals have also obtained Medicaid coverage.

Healthcare providers have reported significant clinical and financial effects under the HCIP. Federally qualified community health centers (FQHCs) reported increased success in attaining needed specialty referrals for their clients.[iii] The Arkansas Hospital Association (AHA) reported annualized reductions in uninsured outpatient visits, emergency room (ER) visits, and hospital admissions by 45.7 percent, 38.8 percent, and 48.7 percent, respectively[iv]. The state's public teaching hospital reported a reduction in uninsured admissions from 16 percent to 3 percent during the same time period.[v]

Competitiveness and consumer choice in the Marketplace has increased across the seven market regions in the state with approximately 80 percent of the covered lives in the individual marketplace purchased by Medicaid. In 2014, individuals in three out of the seven regions of the state, those marked by extreme poverty, only had access to Arkansas BlueCross BlueShield and BlueCross BlueShield Multistate plans offered. By 2016, five carriers were offering coverage across all seven market regions, with one market region having access to six carriers (the sixth restricted to a single market by Medicaid's purchasing guidance limiting premium assistance to those plans within 10 percent of the second-lowest cost silver plan within the market region).

For 2014, the estimated budget neutrality cap (BNC) was exceeded during the initial enrollment phase of the program. The enrollment of younger individuals over time (affecting net premiums), the rebate of medical-loss ratio (MLR) payments by one carrier not meeting the MLR requirements in 2014, and inflationary expectations brought cumulative program costs within the estimated BNC 2015 limit of $500.08 per-member per-month (PMPM) and well under the 2016 limit of $526.58 PMPM. Importantly, this evaluation examines BNC estimates compared to observed expenditures.

Summary of Interim Findings Based on Evaluation Hypotheses

The HCIP programmatic goals and objectives included successful enrollment, enhanced access to quality health care, improved the quality of care and outcomes, and enhanced continuity of coverage and care at times of re-enrollment and during income fluctuations. These goals and objectives were to be achieved within a cost-effective framework for the Medicaid program compared with what would have occurred if the state had provided coverage to the same expansion group in Arkansas traditional Medicaid's traditional fee-for-service (FFS) delivery

system. This report reflects the experience and findings from the first year of beneficiary experience in 2014 and major findings are summarized below by questions of interest.

1. What were differences across access, quality, and outcomes between those enrolled in Medicaid and those enrolled in commercial Qualified Health Plans (QHPs)?

A major assumption grounded in Arkansas's use of premium assistance through the Marketplace was that by utilizing the delivery system available to the privately enrolled individuals in the Marketplace, the availability and accessibility of both primary care providers (PCPs) and specialists would exceed that of a more traditional Arkansas Medicaid expansion. A comparison of Medicaid and commercial QHP beneficiary results revealed:

- The geographic proximity of available primary and specialty providers were similar for those served by Medicaid and the commercial networks and met network adequacy requirements of the Arkansas Insurance Department;
- However, marked differences in the self-reported accessibility of both primary care and specialty providers were reported with commercial QHP enrollees experiencing increased ability to get needed "care, tests, and treatment" and receiving "an appointment for a check-up or routine care as soon as needed";
- Initiation of care occurred more rapidly for enrollees in QHPs than for those in the Medicaid program following enrollment;
- For Emergency Room (ER) use, Medicaid enrollees not only had a higher number of visits but their visits were approximately 60 percent more likely to be for non-emergent conditions potentially reflecting the access barriers reported above; and
- Although limited in the first year of program experience, differences in care and clinical service delivery were observed with commercial QHP enrollees more likely to receive clinical preventive services (e.g., flu prophylaxis or clinical screenings, and HbA1c assessment for diabetics) than Medicaid enrollees.

2. What were the differences in costs between Medicaid and premium assistance?

The cost of providing coverage for Medicaid beneficiaries through commercial premium assistance in QHPs was expected to be greater than that for Medicaid beneficiaries served through the traditional Medicaid FFS system. Exploration and characterization of the contrasts between the two programs provided a better understanding of the observed variations in access, utilization, and clinical impacts described above. In addition, dramatic differences in payment rates were observed with commercial rates consistently exceeding those in the Medicaid program:

- Physician payment rates across outpatient services were 90 percent higher for enrollees in a commercial QHP compared to their Medicaid counterparts (for PCPs a weighted average per visit of $100.67 compared to $53.07);

- For inpatient hospital stays, average commercial payments were $11,984 per discharge compared to Medicaid payments of $7,778 (a 53 percent difference);
- For ER non-hospitalized visits, commercial payments were $598 per visit compared to Medicaid payments of $196 (a 205 percent difference); and
- Administrative costs were estimated to be $60.61 PMPM--an 18 percent medical loss ratio--for commercial QHPs and a $55.37 PMPM for Medicaid (a 9.5 percent difference).

Utilization differences were also observed but not at the same magnitude as payment differentials. Medicaid beneficiaries, under the FFS system, experienced increased ER visits and hospitalizations. Conversely, Medicaid beneficiaries enrolled in QHPs received more outpatient visit contacts and prescriptions.

3. What were the cost-effective aspects of premium assistance?

Cost-effectiveness for the purposes of this evaluation will evaluate any benefits associated with care delivered through QHPs at increased payment rates. While premature to draw conclusions from the first year of program experience, preliminary assessments through two approaches provide a framework for comparison. First, total program costs for newly enrolled individuals in commercial QHPs were directly compared to their Medicaid counterparts. Second, where plausible, ratios of improvement in care to associated costs were developed (e.g., access improvements compared to payment rate differentials).

- The weighted average payment to commercial QHPs (premium and cost-sharing reductions) was $485 PMPM or $5,820 per year compared to Medicaid costs of $272 PMPM or $3,264 per year for each enrollee (using existing Medicaid payment rates).
- Improved access reflected by self-report of “always getting care when needed right away” suggest a 1.48 percent improvement in access per 10 percent increase in provider payment rates for the general population and a 1.88 percent improvement in access per 10 percent increase in provider payment rates for those with increased need. These findings are consistent with published observations of 1.25 percent improvements in access per 10 percent increase in Medicaid payment rates suggesting Arkansas provider accessibility is dependent upon payment rates.

Over the three year demonstration period, differences in effect will be compared to the additional costs incurred by Medicaid through premium assistance. These comparisons will enable more in depth interpretation of the program’s benefit.

4. What would the Medicaid program have experienced if a traditional Medicaid expansion had been adopted?

Examination of the hypothetical costs of covering the entire expansion population in Arkansas’s traditional Medicaid program and the programmatic changes necessary to achieve a similar outcome to that experienced through premium assistance is a core component of this demonstration evaluation. Arkansas had one of the lowest Medicaid eligibility thresholds for non-disabled adults in the US. In 2013, prior to the PPACA expansion, Arkansas Medicaid covered 24,955 non-disabled adults with a full benefit package. In 2014, following PPACA expansion, an additional 267,000 individuals were covered

representing a ten-fold increase in enrollment. 84 percent were managed externally in the individual commercial marketplace.

Traditional microeconomics suggests that increased demand through the expansion of the Medicaid program would place increasing price pressure on the rate structure of the existing Medicaid program. Observed differences in payment rates between commercial QHPs and Medicaid described above could lead to unsustainable access differentials for Medicaid enrollees. Any potential increase in payment rates could affect not only the new expansion population but also enrollees under the same payment rate schedule across the entire Medicaid program. To model the potential effects, a budgetary impact analysis was conducted on increasing payment rates across the Medicaid program.

Three increasingly conservative scenarios were simulated for alternative expansion purposes through the existing Medicaid FFS system, the counterfactual, to provide policy makers with conditions under which necessary increases to achieve equitable access could be considered. They included: 1) claims potentially associated with wage-sensitive services; 2) restricted claims associated with major medical services; and 3) restricted to claims associated only with physician billed services.

The budget impact analysis revealed:

- Costs to the Medicaid program would exceed the increased costs associated with premium assistance:
  - if wage-sensitive payment rates had increased by 15 percent;
  - if claims associated with clinical services had increased by 25 percent; or
  - if physician-only claims had increased by 35 percent;
- Importantly, under the most conservative scenario of increases restricted to physician-only claims, the physician rate increase at which the Medicaid program costs exceed those of premium assistance remains 61 percent below the commercial payment rates observed. This suggests the likelihood of continued differential access despite increased payments.

These findings suggest that with a ten-fold increase in enrollment of 19-64 year olds, plausible required increases in Medicaid payment rates across the entire program would exceed the costs associated with purchasing commercial coverage through premium assistance.

These results should be viewed with caution for several reasons. First, cost-sharing reduction reconciliation with carriers in 2014 has not been executed and may result in modifications to payments made. In addition, 2014 represented the first year of the program with significant transitions as reflected in enrollment growth. Future assessments during steady-state periods may provide more accurate reflections of both programmatic effects and associated costs.

Conclusion

The examination of the first year experience of the Section 1115 Demonstration Waiver utilizing commercial premium assistance to provide newly Medicaid eligible individuals with insurance coverage has important policy implications:

- First, differential effects on access and quality were observed, this combined with differential provider payment rates, provide insight into the variations in delivery system performance between the commercial sector and Medicaid.
- Second, it is unlikely that Arkansas Medicaid would have been able to absorb a ten-fold increase in enrollees and meet the federal equal access requirements, under which the state is subject to judiciary review, without adjustment to provider rates. Although political discourse has highlighted concerns about the differences in absolute cost between commercial and Medicaid alternatives, Medicaid expansion scenarios under which similar clinical experiences would be achieved suggest budgetary outcomes that may mitigate these concerns.
- Third, these differential payment rates and associated results raise questions regarding the ability of Medicaid programs nationwide to meet the federal equal access requirements through delivery system strategies that pay providers significantly lower rates.

As result, the innovative use of premium assistance and the intimate relationship between the individual commercial insurance marketplace and the Arkansas Medicaid program warrant continued observation. The effect of Medicaid's capacity to purchase coverage through commercial premium assistance and its impact on increased commercial sector competition, the potential to reduce cost-shifting between public and private sectors, the stabilized insurance premiums offered through the Marketplace and, due to federal requirements, off of the Marketplace, and the impact on private sector costs and those to the U.S. Treasury through advanced premium tax credits should be closely followed. If one or more of these effects materialize, important considerations will be required for both existing (e.g., Section 1115) and future (e.g., Section 1332) waiver options between the states and the federal government.

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[i] The Centers for Medicare & Medicaid Services [Letter] to Andy Allison, Arkansas Department of Human Services. September 2013. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf.

[ii] Ark. Code § 2-77-2405 (2014).

[iii] Susan Ward-Jones, MD. Personal Communication. March 12, 2015.

[iv] Arkansas Hospital Association. APO's Hospital Impact Strong in 2014. *The Notebook*. 2015;22(22):1. http://www.arkhospitals.org/archive/notebookpdf/Notebook_07-27-15.pdf.

[v] Dan Rahn, M.D., Testimony before Health Reform Legislative Taskforce. August 20, 2015.