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INSPIRING HEALTHY ACTS

MEDICAID EXPANSION & BUDGET NEUTRALITY

1115 Waiver Budget Neutrality Requirements and Other Policy Considerations

Background

Arkansas was the first state granted approval through a Section 1115 demonstration waiver to expand Medicaid utilizing premium assistance to purchase individual qualified health plans (QHPs) available from insurers on the Health Insurance Marketplace. The initial three-year demonstration, known as the "Private Option," received federal approval in September 2013. In 2017, the state was granted a five-year waiver extension for a modified program called "Arkansas Works." In 2018, The Centers for Medicare and Medicaid Services approved an amendment to the waiver which allowed Arkansas to become the first state to implement a work and community engagement requirement, a feature that has since been challenged in court and withdrawn from approval by the Biden administration.[1] Cost-containment strategies in a new waiver program that Arkansas is to submit for approval, Arkansas Health and Opportunity for Me (ARHOME), include more stringent monitoring and management of budget neutrality. This explainer explores what budget neutrality is and how it works.

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 costs):* sum of premiums, CSR payments, and wrap-around costs divided by the number of waiver beneficiaries enrolled in a given month
- *Member months:* The number of waiver beneficiaries participating each month
- *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

1115 Budget Neutrality

A Section 1115 demonstration waiver requires budget neutrality, which means that federal spending under the waiver must not exceed projected federal spending without the waiver.[2] The

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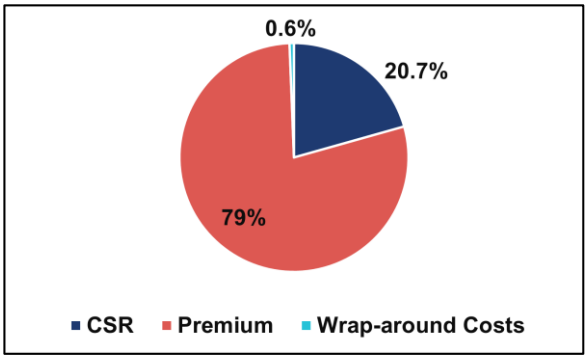
federal government projects what spending would be without a waiver, and it places a cap equal to that amount on federal matching funds during the demonstration period of the waiver and includes the cap in the state's waiver agreement. If the cumulative spending at the end of the waiver period exceeds the total projected budget neutrality cap for the same timeframe, the state is responsible for paying the federal government for the budget deficit.[3]

FIGURE 1: DISTRIBUTION OF PMPM COSTS IN 2020

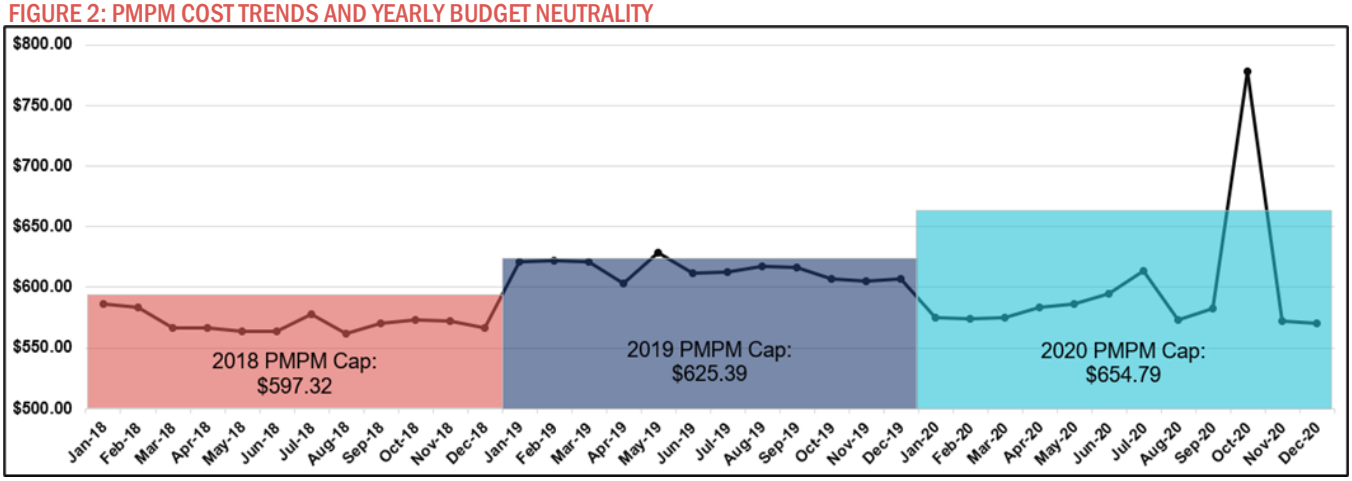


The U.S. Department of Health and Human Services (HHS) requires that every demonstration waiver application submitted by a state include a justification of cost projections with a description of methods and data sources for the projections.[4] States may estimate costs using assumptions, so long as the assumptions are reasonable and explained to HHS. States must provide coverage expansion cost projections (both with and without the waiver) for the time covered by the waiver, including the following:[5]

- An estimate of and methods for establishing 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 costs with the waiver are no greater than projected costs without the waiver.

Projected average monthly PMPM costs represent the budget neutrality caps established in the waiver. Figure 1 provides Arkansas's calculations for the projected distribution of PMPM costs for plan year 2020.[6] The budget neutrality caps established for the Arkansas waiver plan years

FIGURE 2: PMPM COST TRENDS AND YEARLY BUDGET NEUTRALITY



were $597.32 in 2018, $625.39 in 2019, and $654.79 in 2020.[6,7,8] The caps reflect a trend rate of a 4.7% increase from year to year.

TABLE 1: PMPM COST TRENDS AND CHANGES*

	PMPM	ΔPMPM*
Jan 2020	$575.08	
Feb 2020	$573.55	-$1.53
Mar 2020	$575.27	$1.73
Apr 2020	$583.20	$8.04
May 2020	$586.46	$3.28
Jun 2020	$594.46	$8.11
Jul 2020	$613.55	$19.70
Aug 2020	$573.32	-$37.59
Sep 2020	$582.73	$9.56
Oct 2020	$777.70	$260.20
Nov 2020	$572.04	-$151.27
Dec 2020	$569.89	-$2.14

*The PMPM change is the change from the previous month.

Arkansas's Budget Cap Trends

Table 1 provides preliminary PMPM costs for the Arkansas waiver from January 2020 to December 2020, with month-to-month changes in costs.[6] Figure 2 displays the average PMPM cost trend relative to the budget cap from January 2018 to December 2020.[6,7,8]

Cost trends from 2018–2019 include reconciled PMPM costs published by the Arkansas Department of Human Services (DHS) in each year's respective annual report, with cost trends at or below the PMPM budget cap set for both years. PMPM cost trends for 2020 are based on the Arkansas DHS December 2020 monthly enrollment report, which states that "October 2020 adjustments include annual cost-sharing reconciliations to QHP carriers."

Budget Neutrality Observations & Conclusion

Although PMPM costs have remained under the budget neutrality caps for the plan years assessed above, Arkansas's novel approach to Medicaid expansion has faced scrutiny regarding cost-containment. Early on in the implementation of the Health Care Independence Program in 2014, the average PMPM cost grew to its highest point, followed by a slow decline and leveling of costs.

Legislation to continue Medicaid expansion through the proposed ARHOME program was passed in 2021. The legislation includes additional state-based cost-containment measures beyond federal budget neutrality caps. Specifically, the legislation would allow suspension of enrollment or recoupment of payments from QHPs if costs exceed budget neutrality limits. While these additional measures serve as a safeguard from state exposure to costs that exceed the cap, continued monitoring and a rigorous evaluation of the program will be needed to ensure access and quality of care are not diminished.

REFERENCES

For a full list of references, please visit https://achi.net/library/budget-neutrality/