THE AFFORDABLE CARE ACT AND MEDICAID EXPANSION:
EXAMINING THE ARKANSAS PRIVATE OPTION AS AN ALTERNATIVE
MEDICAID WAIVER DESIGN TO EXPAND HEALTH INSURANCE COVERAGE
FOR THE UNINSURED

A thesis presented by

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To

Doctor of Law and Policy Program

In partial fulfillment of the requirements for the degree of
Doctor of Law and Policy

College of Professional Studies
Northeastern University
Boston, Massachusetts

May 2016
To my parents

Dr. Dermot P. Coyne and Dr. Ann Coyne

Who instilled in me a lifelong love of learning.

That love continues.
ACKNOWLEDGEMENTS

I want to especially thank Dr. Neenah Estrella-Luna, who served as my thesis advisor, for her thoughtful guidance and encouraging support throughout this project. I would also like to thank Professor Kenneth Apfel, who served as my external reviewer, and who provided me with constructive comments and ongoing advice during the writing process. I want to thank Professor Dan Urman, James Passanisi, and all the faculty and staff in the Doctor of Law and Policy Program at Northeastern University for their work to make this program challenging and thought-provoking each and every day. Finally, I would like to thank my family, my wife, Maureen, and my son, Patrick, for their support of me during this journey. It has been a while since I was a student. They put up with my frustrations and shared in my successes. Their love and support was steadfast as I took on this new challenge. I can never thank them enough for allowing me the opportunity to seek the degree of Doctor of Law and Policy. Let me just simply say thank you and I love you once more.
ABSTRACT

The Arkansas premium assistance model, commonly known as the Private Option, is one of six alternative Medicaid waiver designs that have been approved in states to expand coverage for low-income adults. The waiver places adults age 19-64 and under 138% of poverty in the newly established health insurance exchange and uses Medicaid funding to purchase the premium payment for health plan coverage. The program began in January 2014. This qualitative descriptive study examined the key operational and program features of the Private Option in order to provide a formative evaluation of how well it is working at this early stage. The study also examined if this model, or similar models, might offer a promising path for the 19 states that have chosen not expand coverage for populations newly eligible for Medicaid under the Affordable Care Act.

The results of the study suggest that it is a potentially promising model. Arkansas saw the largest drop in the uninsured rate in the country in the first 18 months since the program began. It has also expanded its provider networks, added new health plans to the marketplace, and the program is generating overall net state savings. Politics, policy, and state costs are factors that drive the current debate in states that have not expanded. Framing coverage as a uniquely designed state approach and not Medicaid expansion are key conditions for moving forward. Language emphasizing a private sector approach and personal responsibility are critical factors as well.

There are challenges, however, between Medicaid rules and exchange rules, particularly around the issue of cost-sharing. There is a significant cliff between the two programs in terms of personal financial obligations that will likely need to be remedied in the years ahead. Studies show that as many as 50% of those under 200% of poverty are likely to transition between
eligibility for these two programs in any given year, and these cost-sharing differences apply
despite an integrated program. The Affordable Care Act is part of an ongoing process that has
transformed Medicaid from a social welfare program to an income-based program to provide
health insurance coverage to low-income populations. The integration of these two programs,
Medicaid and the health insurance exchanges, through premium assistance, reflects these
transformative changes and are part of the continuing evolution of our nation’s health care
system.
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<td>ACA</td>
<td>Patient Protection and Affordable Care Act. Commonly known as the Affordable Care Act. Also known as Obamacare</td>
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<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>EHB</td>
<td>Essential Health Benefits</td>
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<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnostic and Treatment benefit</td>
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<td>ESI</td>
<td>Employer-Sponsored Insurance</td>
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<td>ER</td>
<td>Emergency Room</td>
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<td>FMAP</td>
<td>Federal Medical Assistance Percentage</td>
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<td>FPL</td>
<td>Federal Poverty Level</td>
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<td>GAO</td>
<td>Government Accountability Office</td>
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<td>HIA</td>
<td>Health Care Independence Accounts</td>
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<td>HCIP</td>
<td>Health Care Independence Program. Commonly known as the Arkansas Private Option</td>
</tr>
<tr>
<td>HHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary care physician</td>
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<tr>
<td>QHP</td>
<td>Qualified Health Plan</td>
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<td>TANF</td>
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Chapter 1

Introduction and Literature Review

The Patient Protection and Affordable Care Act (ACA), federal legislation designed to reform our nation’s health care system, was signed into law on March 23, 2010. Among its many goals, the ACA was designed to provide health insurance coverage through the creation of a marketplace of health insurance exchanges as well as the expansion of Medicaid for many of the 48 million people who were uninsured in this country before the new law took effect. (Walt, Proctor & Smith, 2013). This historic legislation has been highly controversial. It was passed without a single Republican vote in either the U.S. House of Representatives or the U.S. Senate. It has also lacked broad public support. Most polls show a majority of Republican voters oppose what has become known as ObamaCare, most Democratic voters support it, and Independent voters are split (Clement & Craighill, 2014).

Since its passage, the ACA has faced two U.S. Supreme Court challenges. In June 2012, the Supreme Court, in a 5-4 decision, upheld the law in National Federation of Independent Business v. Sebelius (2012). As part of its decision, however, the Supreme Court ruled 7-2 that Medicaid expansion under the new law was unconstitutionally coercive on the states, but to remedy that violation, ruled that Medicaid expansion must be an optional choice for the states rather than invalidating that portion of the Act. Under the ACA, prior to this decision, if a state opted not to expand Medicaid, it would forfeit all federal funding for its entire Medicaid program.

In the spring of 2015, the Supreme Court again took up the ACA in King v. Burwell (2015). This case involved a challenge to the administration’s statutory interpretation of tax
credit subsidies for people in state and federal health insurance exchanges. Tax credit subsidies are used to offset part of the cost of a health insurance premium for people at certain income levels. Plaintiffs argued that the statute, as written, did not grant the IRS the authority to provide tax credit subsidies to individuals in federal health insurance exchanges. Thirty-four states had opted to allow the federal government to operate federal health insurance exchanges rather than set up their own state health insurance exchanges. The Supreme Court, in a 6-3 decision, held that, while the wording was ambiguous, the IRS regulations were consistent with the overall statute and that tax credit subsidies were meant for federal health insurance exchanges as well as state health insurance exchanges.

Further litigation around the ACA is also likely in the years ahead. The U.S. House of Representatives, voting 225-201, with no Democrats in support of the resolution, filed suit in the fall of 2014 arguing that the Administration had overreached by providing cost-sharing subsidies for people between 100% and 250% of poverty without a congressional appropriation (Parker, 2014). Cost-sharing subsidies reduce the co-payments and deductibles as well as maximum out-of-pocket costs for low-income families and are paid directly to health insurance companies. Preliminary data suggests more than half of all those enrolled in health insurance exchanges are receiving cost-sharing subsidies, and in states that have not expanded Medicaid, the number is close to two-thirds (Jost, 2015). The United States District Court for the District of Columbia in 2015, in a case entitled United States House of Representatives v Burwell (2015), refused to dismiss the case on the argument that the House has no standing to bring such a case, ordering that it move forward on the merits. This action conflicts with previous federal court decisions that members of Congress have no standing to sue in a dispute between the two branches (Jost, 2016). At this point, it is unclear how this litigation will proceed, but it is an indication that the
legal issues around the ACA may continue to be litigated in the months and years ahead.

Many governors and state legislatures have refused to participate in either the health insurance exchanges or Medicaid expansion. Thirty-four states have let the federal government run their state’s health insurance exchange rather than set up their own state exchange. As of the spring of 2016, 19 states have chosen not to expand Medicaid coverage. All but two of these states are led by Republican governors (the two Democratic governors have been supportive of Medicaid expansion but have been unsuccessful in gaining legislative support for their initiatives). Policy, politics, state costs or the long-term outlook for continued federal financial support have fueled this resistance in many states and have added to the overall controversy surrounding the ACA. In states that have not expanded Medicaid, a large number of low-income individuals and families are neither eligible for coverage under health insurance exchanges, because their income is too low, nor for coverage under Medicaid since no program has been established that makes them eligible. Based on earlier studies that looked at the impact of 21 states choosing not to expand Medicaid, approximately four million uninsured individuals will lack access to coverage in the 19 states that have not expanded Medicaid as of the spring of 2016 (Buettgens, Holahan & Recht, 2015).

Together, Medicaid and health insurance exchanges provide the foundation for expanding health insurance coverage. The law provides that adults below 138% of poverty are eligible for Medicaid in states that decide to expand their Medicaid program. In 2016, this threshold ranged from $16,243 for an individual to $33,465 for a family of four (see Appendix E for a poverty table at various income levels and family size). The federal government will pay 100% of all costs for this expansion population through 2016, with the federal share gradually being reduced to 90% by 2020 and beyond. This share is significantly higher than the current Medicaid
program, of which federal support is based on a state’s per capita income, with the federal government paying, on average, approximately 57% of the costs among the 50 states (Paradise, 2015). Similarly, the ACA is designed to provide coverage through federal or state health insurance exchanges for individuals above 100% of poverty who lack access to coverage or cannot afford its cost. Those individuals and families with incomes between 100% and 400% of poverty are entitled to sliding tax credit subsidies in order to help make health insurance more affordable. For those between 100% and 250% of poverty, additional subsidies are available for the cost-sharing components of health insurance coverage (co-payments, deductibles, and maximum out-of-pocket costs).

Despite this comprehensive framework and significant federal funding, many states have been reluctant to expand Medicaid given the political, policy and fiscal concerns. But 19 states in the spring of 2016 is a significant change from the summer of 2014 when 24 states had not expanded Medicaid. Much of that improvement is due to states developing alternative models to traditional Medicaid expansion. Five of the last eight states that have expanded coverage for low-income adults since December 2013 have adopted alternative waiver designs to traditional Medicaid expansion (Pennsylvania, one of the eight states, initially had a waiver approved in August 2014, but the new governor changed the program in 2015 to a traditional Medicaid expansion and is not counted as a waiver state). There are a total of six alternative waivers that have been approved by the federal government (The Advisory Board, 2016). Clearly a number of states are looking for different ways to provide coverage for low-income populations rather than expanding traditional Medicaid.

One alternative model that has emerged, known as the “Arkansas model,” the “premium assistance model,” or the “Private Option,” places the state’s Medicaid expansion population in
the health insurance exchange rather than in its traditional Medicaid program. Premium assistance uses Medicaid funding to purchase the premiums and some or all of the cost-sharing components of products offered by private plans on the health insurance exchanges. Under Section 1115 of the Social Security Act, the Secretary of the federal Department of Health and Human Services (HHS) has the authority to waive existing Medicaid rules in order to further the objectives of the Medicaid program. On April 2013, Arkansas Governor Mike Beebe signed into law an alternative approach to coverage expansion for low-income adults designed to test the use of Medicaid funding to purchase private coverage (Thompson, Wilson, Allison, & Beebe, 2014). The Secretary approved Arkansas’ waiver request in September 2013, and the state began implementation of this premium assistance model in January 2014 (Centers for Medicare and Medicaid Services, 2013a). This was the first of six waivers the federal government has approved to date. Other states have implemented, or are exploring, alternative designs similar to premium assistance, and some states are proposing alternative designs, such as Health Savings Accounts, as a way to expand coverage for low-income adults in their respective states (Williams, 2015). In addition, beginning in 2017, the ACA provides authority under Section 1332 of the ACA for states to develop comprehensive waivers that may include waiving Medicaid rules, Medicare rules, and the new health insurance exchange rules, as long as the waiver provides comparable coverage and provides comparable cost-sharing provisions. A number of states, including Arkansas, are beginning to look at this new statutory authority given that waivers take a great deal of time to develop (McDonough, 2014). This new legal authority has the potential to further transform the healthcare marketplace and spur additional innovations (Allison, 2014).

There appears to be growing interest in some states to explore alternative ideas outside a
traditional Medicaid expansion model. The Arkansas model possibly provides a more acceptable path to expand coverage for low-income adults in many states that have chosen not to expand. The model also may offer a broader long-term framework for the coverage of Medicaid eligible populations – placing all or many low-income populations in health insurance exchanges – as this law matures over time. It is important to the future of the ACA to examine the operational characteristics of this Arkansas model, best known as the Private Option, and assess whether this model might lead more states to expand coverage for low-income adults. The literature review that follows attempts to review many of the key issues associated with this design to provide premium assistance through private health insurance exchanges for Medicaid eligible populations.

**History of Medicaid**

The Medicaid program was created in 1965 as Title XIX of the Social Security Act. The program was initially created to cover certain categorical low-income individuals who received cash assistance through the Aid for Families with Dependent Children (AFDC), Old Age Assistance, and Aid to the Blind. It also provided coverage for those who were “medically needy,” those who incurred significant health expenses but were above cash assistance thresholds and could not afford such medical costs (Cohen, Colby, Wailoo, & Zelizer, 2015). It was a voluntary program for states, with the federal government providing matching funds for those that chose to create this new program. It was considered a welfare program at this point in its history.

Medicaid was a secondary consideration in the larger debate about Medicare. At the time, Medicare was viewed as a fallback position in the face of reform efforts seeking broader universal coverage. Medicare was fiercely opposed by the American Medical Association,
calling it “socialized medicine” and even going so far as to print posters entitled “Socialized Medicine and You” to be used in doctors offices around the country (Cohen, Colby, Wailoo, & Zelizer, 2015, p. 12). Reformers tied Medicare to Social Security and seniors, a significant constituency that could help offset this opposition. On the Medicaid side, the Kerr-Mills Act had been signed into law in 1960 for states to provide coverage for the elderly poor. By 1963, only 28 states had signed up and, to some degree, the program was considered a failure. Southern states, and their Democratic representatives in Congress who controlled the committees, had generally opposed federal programs that did not allow states to control them (or the option to even offer them) because of issues of segregation and race in general. States also put in place rules that essentially limited participation to very few elderly poor. This framework is what was in place under the Kerr-Mills Act as the debate over Medicare began (Cohen, Colby, Wailoo, & Zelizer, 2015; Smith and Moore, 2015).

Those positions began to change with the Civil Rights Act of 1964 and the 1964 elections, in which Lyndon B. Johnson won in a landside and brought along large Democratic majorities in the Congress. The Johnson Administration, through Wilbur Cohen, one of the architects of Social Security Act some thirty years earlier, urged the Ways and Means Chairman, Wilbur Mills of Arkansas, to include Medicaid coverage in a broader bill. In some ways the creation of Medicaid can be characterized as an afterthought or simply the luck of history. The Chairman, without anyone’s knowledge, put a bill before the committee in what has become known as the famous “Three Layer Cake”: Medicare Part A (hospital); Medicare Part B (physician) and Medicaid, expanding on the Kerr-Mills Act of previous years. But the bill was still politically contentious. It narrowly averted defeat from conservatives on a substitute motion to the Chairman’s bill on the House floor. Its passage was attributed to the strong support of the
new freshman Democratic class and to liberals willing to compromise with conservatives to ensure passage of the bill (Cohen, Colby, Wailoo, & Zelizer, 2015).

Many reformers believed that Medicare would be the foundation on which to build and expand universal coverage. Leading reformers would pursue these efforts through most of the 1970s and beyond. Medicare did expand to cover people with disabilities and end-stage renal disease in 1972, but the politics of health care prevented much further expansion. Incremental reform often place constituencies in the position of protecting their gains, rather than assisting in broader expansion efforts. Seniors did not become advocates for broader coverage expansion, but oftentimes saw expansion proposals as threats to their existing benefits. In addition, the costs for Medicare grew significantly. The cost of the program, rather than access, came to dominate the larger health reform debate in these years. What many reformers had viewed as the first step of “Medicare for All” never played out in the years following the passage of Medicare (Cohen, Colby, Wailoo, & Zelizer, 2015).

Paradoxically, Medicaid became the vehicle that allowed for the expansion of healthcare coverage in this country and ultimately redefined it from a welfare program to a central element of the healthcare system. In 1988, in addition to low-income mothers and children and low-income seniors, Medicaid went on to cover pregnant women up to 100% of poverty. In 1996, the new welfare reform law no longer required cash assistance as a condition of Medicaid eligibility. And the Children’s Health Insurance Program (CHIP) became law in 1997 that greatly expanded coverage to children to name but a few major pieces of legislation during this time period. Over the last few decades, eligibility levels for these populations have greatly increased, resulting in substantial increases in coverage. Section 1115 waivers, the section of the law in the Social Security Act that allows the Secretary HHS to waive Medicaid rules and approve demonstration
programs to expand coverage and improve service delivery, have been a significant driver in coverage expansion. Waivers greatly increased beginning in the early days of the Clinton Administration and continuing through the Bush Administration and beyond. By 2008, 40 states had some form of demonstration program in place (Cohen, Colby, Wailoo, & Zelizer, 2015). Medicaid has served as a primary basis for coverage expansion since the creation of these two programs 50 years ago.

It took 17 years before all states adopted Medicaid when the final state, Arizona, began its Medicaid program in 1982. Much like the ACA today, only about half the states adopted Medicaid when the program first began in 1966. The number of states that did not have a Medicaid program dropped to 12 by 1969. However, all states but Arizona had adopted Medicaid by 1972, six years after the program was up and running (Cohen, Colby, Wailoo, & Zelizer, 2015). A similar trajectory can be seen in the historical path of the ACA, with 19 states choosing not to expand Medicaid a little over two years after the program had begun.

**Medicaid Today**

The Medicaid program commonly breaks down coverage populations by categorical populations: children, adults, seniors and people with disabilities. Prior to the ACA, the program was based on categorical eligibility. Coverage for children has greatly increased over time, with the mandatory minimum set at 100% of poverty, but most states have coverage at 250% or higher. Similarly, coverage for pregnant women has been set at 133% of poverty, with the option to expand to 185% of poverty; 39 states, including D.C., are at a level of 185% or higher. Almost half of those covered under Medicaid are children. Pregnant women and mothers account for a significant share of the adult population, which makes up about 25% of total enrollment, with these groups accounting for 75% of the entire Medicaid population (Kaiser
Seniors and people with disabilities generally must be eligible for the Supplemental Security Income (SSI) program, a federal program of cash assistance for low-income seniors and people with disabilities. States can increase eligibility up to 100 percent of poverty. States can also increase eligibility for those requiring institutional care, and they can have a medically needy program for those who are above Medicaid eligibility limits but have significant medical costs (Musumeci, 2014). These populations account for about 25% of enrollment, but approximately two-thirds of the total cost of the Medicaid program. Two particular populations had limited or no access to coverage through Medicaid prior to ACA: parents and childless adults. Many states have used waiver authority to expand coverage for parents. Even so, coverage has historically been somewhat limited. Almost no states have provided coverage for childless adults (Kaiser Commission on Medicaid and the Uninsured, 2013).

Before the ACA, the Medicaid program covered approximately 70 million people (Rudowitz, 2014; Fichtner, 2014). The Congressional Budget Office estimates that Medicaid enrollment will reach 92 million by 2024 because of the ACA (Congressional Budget Office, 2015). Children and adults will account for 80% of the population while seniors and people with disabilities will account for 20%. The proportion of children will drop by about 10% while the proportion of adults will increase by about 13% (Rudowitz, 2014). The shift in these two populations is due to the large number of adults who will now be eligible for coverage. The ACA essentially changed this program from a categorical eligibility program to an income-based program, although categorical eligibility levels remain in place for children and pregnant women. This income-based insurance model defines Medicaid today. Medicaid is a key part of the overall framework for insurance coverage under the ACA that provides full or subsidized
coverage based on income (Mann & Bachrach, 2015a; Mann & Bachrach, 2015b).

**History of Premium Assistance**

As an alternative to traditional Medicaid expansion, states are exploring premium assistance, where states use Medicaid funding to purchase the premium cost of private sector insurance products on the health insurance exchange. The concept of premium assistance is not a new concept for the program. In fact, the idea has been around since the creation of the Medicaid program in 1965. However, premium assistance was originally designed to provide financial support for people with access to employer-sponsored insurance (ESI). Most low-income individuals do not have access to health insurance at their place of employment. As a result, most of these programs were relatively small, with half of the states having fewer than 1,000 people enrolled (U.S. Governmental Accountability Office, 2010). Research suggests that less than one percent of the Medicaid population was in a premium assistance program (Shirk & Ryan, 2006).

Despite the lack of any market, federal and state policymakers have been interested in this concept for some time and created legal authority to establish premium assistance programs in various pieces of federal legislation throughout the history of the Medicaid program. In addition, states began using Section 1115 waiver authority beginning in the 1990s as a way to expand these programs (Watson, 2014). When the ACA was passed in 2010, 39 states had some form of a premium assistance program, up from 15 states in 2006 (U.S. General Accountability Office, 2010; Shirk & Ryan, 2006; Fichtner, 2014)). The broad concept of premium assistance through ESI gained the attention of more and more states over much of the last decade. Arkansas established a premium assistance program for ESI in 2010, with approximately 150 people participating before the waiver ended when the Private Option began in 2014 (Arkansas
Center for Health Improvement, 2015).

**Major Areas of Operational Interest**

The bulk of the literature that has been published recently focuses on the operational elements of a premium assistance model in the individual market. Unlike premium assistance for ESI, which provides Medicaid funding for health insurance through an employer if it is offered, the creation of health insurance exchanges provides a new market where individuals can purchase coverage using Medicaid funding. The major operational and program areas that researchers are examining include: continuity of care; health plan participation and provider networks; premiums and cost-sharing; benefits; medically frail populations; and state and program costs. These operational and program issues are discussed below.

**Continuity of care**

The current framework of traditional Medicaid and the new health insurance exchanges creates a “bifurcated system” that is distinct and separate – one program provides coverage for those with incomes under 138% of poverty ($16,243 for an individual), the other if income is above that level. Studies suggest that for people at 200% of poverty or below ($23,760 for an individual), approximately 50% of them will transition between Medicaid eligibility and exchange eligibility over the course of a year (Sommers & Rosenbaum, 2011). Placing all Medicaid eligible individuals in health insurance exchanges through the premium assistance model has the effect of eliminating this “churn” between two programs. As a result, people do not have to sign up each time their program eligibility changes due to fluctuations of income at or around 138% of poverty. This would have the effect of reducing “enrollment fatigue” where people would eventually drop out after growing tired of enrolling or re-enrolling in various health insurance plans (Sommers & Rosenbaum, 2011). Under a system that places all adult
Medicaid eligible beneficiaries in health insurance exchanges, people would keep their same health plan and same doctor, providing continuity of care throughout changes in program eligibility. Having such continuity of coverage is considered important to improving health outcomes generally (Rosenbaum & Sommers, 2013).

On the surface, these changes seem like immediate positive features of a premium assistance model. Researchers suggest that some caution is in order, however, given that it is new and is not similar to previous premium assistance models associated with ESI. Little data is available at this point to make findings about churn and continuity of care. Evaluation is needed to better understand provider participation, network adequacy, and continuity of coverage (Medicaid and CHIP Payment and Access Commission (MACPAC), 2015; Rudowitz, Musumeci, & Gates, 2016).

In addition to these issues, family coverage could be an important area to evaluate. The literature suggests that parents who have lacked access to health insurance coverage are more likely to have children who are uninsured as well. Covering parents reduces this barrier and has been shown to greatly improve insurance coverage as well as access to health care services for children (Ku & Broaddus, 2006; Schwartz, 2007). While coverage expansion for adults may reduce or eliminate this barrier, families may still face the prospect of having to navigate different programs. In Arkansas, children are covered up to 200% of poverty under Medicaid or the Children’s Health Insurance Program (CHIP). The premium assistance program places all adults 19-64 under 138% of poverty in the exchanges. A family, therefore, could have children in existing Medicaid and CHIP programs and parents in health insurance exchanges, possibly creating a situation where the family has to engage different health programs and different doctors. There is a gap in the literature on whether this framework may create a similar barrier.
in accessing needed care. This outcome likely needs to be examined as part of the evaluation of the premium assistance model and what types of policies might be recommended to mitigate this possible problem for some families under a premium assistance model.

**Health plan participation and provider networks**

Medicaid generally has paid providers at rates significantly below commercial rates. As a result, many doctors do not accept Medicaid patients. The Congressional Budget Office estimated per-capita costs for the exchange 50% higher than Medicaid (Rosenbaum, 2015; Crawford & McMahon, 2014; Piotrowski, 2013). The higher rates on the exchange, in comparison to a traditional Medicaid program, should increase general access to all types of providers. Higher rates for providers are considered beneficial effects to the healthcare marketplace for low-income individuals under a premium assistance model in that it will increase provider participation and expand consumer choice. In addition, the creation of a larger risk pool in the exchanges through a premium assistance program makes Arkansas a more attractive market and creates the possibility of more competition, a healthier population to insure, and a lower cost trend (MACPAC, 2015; Crawford & McMahon, 2014; Piotrowski, 2013).

Before the ACA, there were few private plans operating in Arkansas. Arkansas is viewed as a bit unique given its large uninsured population and lack of a Medicaid managed care market (MACPAC, 2015). Higher rates, together with a large uninsured population and a weak market, should make the market attractive to other private health plans, possibly creating increased competition. This, too, is considered beneficial to the health care marketplace in that competition could lower medical cost trends and also provide more consumer choice.

**Premiums and cost sharing**

The relationship between Medicaid and health insurance exchanges in the area of cost-
sharing is a major area of interest for researchers. Under Medicaid rules, premiums are prohibited for individuals under 150% of poverty. Premiums are the monthly payment made to purchase health insurance. Cost-sharing, or deductibles and co-payments, generally must be nominal, or up to 5% of total household income in the aggregate, with certain services such as family planning services exempt from cost-sharing requirements (Rudowitz & Snyder, 2013). The Arkansas premium assistance waiver has no premium payments for those under 138% of poverty, and has limited cost-sharing to no more than 5% of annual income. For a person at 138% of poverty, or $16,243 in annual income, that limit would be approximately $800 per year (Saloner, Sabik, & Sommers, 2014). Arkansas set its maximum out-of-pocket cost-sharing at $604 (Arkansas Department of Human Services, 2013). Other states with premium assistance programs have sought waivers and have established premiums at 2% of income for those between 100% and 138% of poverty (Crawford & McMahon, 2014). Arkansas passed a law in the spring of 2016 that includes a 2% premium for those between 100% and 138% of poverty beginning in 2017 (State of Arkansas 90th General Assembly, 2016).

Economic theory argues that people need to have some cost, or “skin in the game,” or people will over-consume. Kenneth Arrow, a Nobel Laureate in Economics, wrote a seminal article in 1963 entitled “Uncertainty and the Welfare Economics of Medical Care” (Arrow, 1963). His paper is credited with establishing the field of health economics, and his paper was the first to use “moral hazard” in the field of health insurance (Finkelstein, 2015). Moral hazard asserts that people will over-consume if a good is below equilibrium market price. He stated this concept clearly: “widespread medical insurance increases the demand for medical care” (Arrow, 1963, p. 961). Some argue that insurance deductibles and co-payments are predicated on this theory to limit overconsumption. However, premiums do not play a role in producing more
efficient care once enrolled. Rather, premiums are meant to cover a portion of the cost of insurance coverage (Saloner, Sabik, & Sommers, 2014).

Researchers are concerned that premiums and co-payments may have the effect of limiting enrollment and utilization for low-income populations. There is evidence for both effects. The Rand Corporation conducted an experiment in the 1970s that is considered the best study on this question. They selected random sets of people and provided each group with various co-payment levels. The study showed people were cost sensitive relative to consumption, with particular consumption choices resulting in more adverse health effects for low-income populations. The consumption choices made by middle-income individuals resulted in little or no adverse health effects (Snyder & Rudowitz, 2013). Numerous other studies show a direct correlation between cost-sharing and a reduction in utilizing critical services for low-income populations. In addition, studies conducted by the Urban Institute showed that a one percent premium increase for low-income populations correlated to a 16% drop in enrollment (Snyder & Rudowitz, 2013).

Cost-sharing has significant implications for the premium assistance model. Studies suggest there is a significant difference between Medicaid and exchange rules over cost-sharing and total out-of-pocket spending. One study suggested the out-of-pocket difference was about 50% between Medicaid and exchanges, making it significantly more costly if an individual transitions from Medicaid to the exchanges (Hill, 2015). My pilot study, a small study designed to test out research questions for this larger project, found a similar disparity when looking at potential premium and cost sharing responsibilities at just above and below 138% of poverty based on Medicaid rules and exchange rules in Arkansas. Given that this is a new program, and how past studies suggest strong correlation between cost-sharing and enrollment, as well as
healthcare utilization, there is some uncertainty about the impact of these different cost-sharing rules. It will be important to understand if people who fluctuate around 138% of poverty begin to drop from the program entirely, or refrain from accessing important services, because of those premium and cost-sharing responsibilities. The differences in cost-sharing suggest that there could be a work disincentive as well. If income fluctuates just above the exchange eligibility level and creates significant additional cost-sharing responsibilities, then work-related income gains may be offset or even eliminated. Cost-sharing is integral to the examination of the Arkansas model. Based on the literature, low-income populations are likely to be highly sensitive to any changes in premiums or out-of-pocket cost-sharing requirements. Finding a proper balance will be key to the long-term success of integrating these two programs.

**Benefits**

Benefits are a significant issue in the coordination of care for Medicaid eligible individuals in health insurance exchanges. There appears to be alignment in the basic benchmark benefits between Medicaid and the exchanges given the requirements in the ACA (Baumrucker & Fernandez, 2013). However, in addition to these essential health benefits, Medicaid provides more wide-ranging benefits, such as non-emergency transportation, access to community health centers, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for children up to age 21. These “wrap-around” benefits are required under the Medicaid program and are central to evaluating the premium assistance model (MACPAC, 2015). Arkansas has proposed that these services be coordinated through the Medicaid program on a fee-for-service basis. Other states are pursuing this on a fee-for-service basis as well. However, other states are also seeking waivers to limit those benefits. Arkansas did not limit wrap-around benefits (MACPAC, 2015; Crawford & McMahon, 2014). It considered limiting
non-emergency medical transportation during legislative discussions in the fall of 2015, but did not include it in legislation that went forward (Lyon, 2015b). Much like cost-sharing, researchers note that there is little experience from previous premium assistance models on how this might work (MACPAC, 2015). There are clearly gaps in the literature, given that there is little experience or data, on how well these benefits will be coordinated, and what the impacts might be if states seek waivers to remove these requirements.

**Medically frail**

The medically frail is a category of adults who meet the test of needing additional assistance and support in daily living. These high-cost adult beneficiaries are exempt from the exchanges and are to be placed in the traditional Medicaid program in Arkansas. This exemption is intended to ensure that these individuals get the long-term support and services they need. However, researchers are concerned about the mechanics of identifying the medically frail, since there is little experience with the premium assistance model at this point. Arkansas has proposed individuals self-report their current health status and needs through a questionnaire as part of the enrollment process (MACPAC, 2015). An alternative approach is through claims data, but the literature suggests that health plans could “cherry pick” and attempt to transition high cost beneficiaries, though not medically frail, into the fee-for-service system to avoid that financial risk (MACPAC, 2015; Watson, 2014). This is an area with little experience or data, but is an important component of the overall program and a major interest for researchers as this program moves forward.

**State costs**

Medicaid represents a significant portion of a state’s budget. The National Association of State Budget Officers stated that Medicaid accounted for 25.8% of all expenditures (federal and
state funds) nationally in fiscal year 2014, making it the largest item in state budgets. Elementary and secondary education came in second at 19.5% of all expenditures. Medicaid surpassed total expenditures for K-12 education in FY 2009. Using state-only expenditures, Medicaid is the second largest program in a state budget. Medicaid accounted for 15.3% of the budget while K-12 education accounted for 24.2% of state budgets nationally in fiscal year 2014 (Sigritz, 2015).

Under the ACA, Medicaid expansion is 100% federally funded for the first three years. Beginning in 2017, the match rate drops to 95%. In 2018 it drops to 94%. In 2019 it drops to 93%. And in 2020 and beyond, the federal match rate is permanently set at 90%. The Congressional Budget Office estimates that the federal government will pay for 93% of the costs associated with Medicaid expansion over the nine year period, 2014-2022, with states responsible for the remaining 7% (Angeles, 2012). For Arkansas, this additional federal funding will amount to approximately $1.7 billion in 2017, the first year the state will be required to provide a match for its premium assistance program (The Stephens Group, 2015).

A number of studies estimate that state spending will increase between $73 and $76 billion over this 2014-2022 time period with federal expenditures totaling approximately $950 billion (Angeles, 2012; Holahan, Buettgens, Carroll, & Dorn, 2012). Another study looked at the 21 states that had chosen not to expand Medicaid at that particular point in time, and found that state spending would increase by $38 billion for these states over the 2015-2024 time period if they all expanded (Buettgens, Holahan, & Recht, 2015). These studies pointed out that these baseline numbers do not take into account the net effect. The literature suggests that the net increase in state spending would be around 3% or 4% or even generate net savings for states (Angeles, 2012; Buettgens, Holahan, & Recht, 2015; Holahan, Buettgens, Carroll, & Dorn,
The major effect is what is known as the “woodworking effect,” or a phenomenon where people who were previously eligible but not enrolled now come forward because of new polices (they will come out of the “woodwork”). Under the ACA, people are required to have health insurance coverage. The literature suggests that as many as seven to nine million people will enroll who were previously eligible for Medicaid but had not enrolled prior to this new law taking effect. As a result, these costs will occur whether or not a state expands its Medicaid program to newly eligible populations. The study suggested that $68 billion of the $76 billion in additional costs will come from this woodworking effect, making the overall incremental effect of Medicaid expansion smaller (Holahan, Buettgens, Carroll, & Dorn, 2012; Sommers & Epstein, 2011).

The literature identifies a number of interactive effects that will likely reduce state financial burdens, the biggest being the reduction of uncompensated care. The literature varies on the percent of uncompensated care state and local governments provide, ranging from 24% to 30% to 37%, but it also recognizes there was no standard definition or way to fully measure this cost. Most note that states would be unlikely to recoup all savings through reduced payments to providers, but nevertheless estimate savings between 25% and 50% of total uncompensated care costs (Buettgens, Holahan, & Recht, 2015; Holahan, Buettgens, Carroll, & Dorn, 2012; Bachrach, Boozang, & Lipson, 2015). One report suggests this could completely offset the costs of Medicaid expansion and provide a net savings to the state (Holahan, Buettgens, Carroll, & Dorn, 2012).

Other state programs were identified in the literature that would reduce state financial burdens. Most studies noted that adults with high medical needs, previously eligible for
disability or the medically needy programs, would now apply and be covered under Medicaid expansion at the higher federal match rate. Mental health services, women who become pregnant while enrolled in the Medicaid expansion program, family planning, and breast and cervical cancer screening programs, were also identified as programs that would shift from state funding, or be reimbursed at the higher federal Medicaid match rate, and as a result, provide significant savings and reduce overall state costs (Bachrach, Boozang, & Glanz, 2015; Angeles, 2012).

The literature suggests that many states could see overall state savings from expansion, though it appears that overall state costs could rise due to the woodworkings effect. The literature recognizes that even with small incremental costs, those costs compete with other state priorities, such as education, no matter how small the increase. But the literature emphasizes the significant federal funding that comes with these incremental costs. The literature also notes that there is some concern that the federal government may not continue to provide a 90% match rate for the indefinite future, possibly locking states in to additional future cost burdens (Goodnough, 2015). State costs play an important part in the overall discussion and must be evaluated and balanced with the federal financial support it brings.

**Program costs**

Program cost estimates have already proven to be controversial. The Government Accountability Office (GAO) has challenged how the federal Department of Health and Human Services has reviewed and approved Arkansas’ budget neutrality calculations. These state calculations, which require that the state show that the costs would be no more than a traditional Medicaid expansion, assumed there would be a lack of provider capacity for either a Medicaid expansion or a premium assistance program, and assumed significantly higher rates than the
current program. GAO stated this amounted to be an additional $778 million in costs (U.S. Government Accountability Office, 2014). GAO has criticized budget neutrality calculations for other waivers in the past. There is a long history of conflict between HHS and the GAO over how to calculate budget neutrality in waiver designs going back to the Clinton and Bush Administrations when waiver approvals greatly increased. The literature suggests that states have used, and will continue to use, waivers that require calculations of budget neutrality, and it is likely to be a source of continuing controversy going forward (Thompson & Burke, 2007). These cost questions will be a major part of the policy debate as Arkansas and other states implementing premium assistance programs are evaluated.

All of these operational and program issues are central to evaluating this new program. Most of the literature focuses on these core questions and the need for additional data. However, there are a number of other factors that drive the broader discussion of whether alternative waiver designs might offer a path for states that have chosen not to expand Medicaid. These factors include: the role of the federal government and federalism, as well as the underlying critiques of Medicaid and the ACA in general.

**Role of the Federal Government**

The federal government will play a critical role in states that have chosen not to expand Medicaid but may be considering it. Most states that have expanded over the past two years have pursued alternative models under Section 1115 authority. These waivers have all required federal approval, and they have raised a number of issues. The major change that was approved in Arkansas in its original waiver was the use of Medicaid funding to pay premiums in the health insurance exchanges in Arkansas. Other states have proposed additional premium and cost-sharing responsibilities. In addition, some states have proposed restricting wrap-around
Medicaid benefits available to individuals under a traditional Medicaid plan, and one state has even proposed work requirements as part of eligibility, which the federal government rejected (Crawford & McMahon, 2014; MACPAC, 2015). Arkansas has included a 2 percent premium for those between 100% and 138% of poverty beginning in 2017 (State of Arkansas 90th General Assembly, 2016).

The literature does not suggest how far states may test the federal government on changes to the Medicaid rules nor how much the federal government may acquiesce to alternative designs proposed by states in order to expand coverage. These negotiations over policy may expand or contract depending on how far-reaching the policy proposals may become in the waiver discussions. Waivers are highly political endeavors between states and the federal government. They can be subjective and be based on political leanings. In the past, Democrats tended to pursue waivers based on expanding coverage. Republicans tended to focus more on private insurance (Fichtner, 2014).

**Federalism**

Medicaid is a federal-state partnership. It exemplifies federalism and the ongoing dialogue between states and the federal government over major domestic challenges. The ACA has created tensions within that relationship that will likely be an ongoing source of friction. States have long had primary responsibility for insurance regulation. However, the federal government, particularly with 34 states in the federal health insurance exchange, now has a central role in managing health insurance in various states. In addition, federal law now defines basic rules and responsibilities regarding what insurance products are offered, as well as who is eligible and how prices are to be set (Rosenbaum, 2014). This tension over insurance regulation will possibly create flashpoints in the ongoing dialogue between states. Documents make clear
that the federal government respects the role of the states in insurance regulation. For example, in its exchange guidance to states, the Centers for Medicare and Medicaid Services (CMS) writes: “HHS recognizes that State Departments of Insurance (DOIs) have a longstanding regulatory role with the health insurance issuers that will participate in the FFE (federally-facilitated exchanges)” and wants to preserve that role (Centers for Medicare and Medicaid Services, 2013b, p. 4). With 19 states not expanding and 34 states operating under federal exchanges, “cooperative federalism” may very well be tested (Rosenbaum, 2014). It is an important point that will underlie future discussions about the ACA.

**Criticism and Alternatives to Premium Assistance**

Some policymakers are critical of the premium assistance concept, believing that placing Medicaid eligible populations into health insurance exchanges is simply Medicaid expansion by another name. They argue that all Medicaid benefits are provided for, that there is little to no premium or cost-sharing, and that Medicaid rules still apply (Antos & Capretta, 2014). A fundamental criticism is that the Medicaid program itself is structured in ways that misalign financial incentives and, as a result, does not promote cost savings within the healthcare marketplace. The federal Medicaid match rate, known as the Federal Medical Assistance Percentage, or FMAP, makes it difficult for state policy makers to consider policies that promote efficiencies or reduce costs because of the loss of federal dollars. In states with a 50% federal match, each dollar of state savings reduces federal contributions by a dollar as well. In other words, for states to cut one dollar in program savings, it means two dollars will be lost to the state’s overall economy. For states with higher FMAPs, which constitute the majority of states, the loss of federal dollars is even greater. Arkansas currently has a 70% federal match rate.

Critics also argue that this federal-state matching arrangement incentivizes states to
expand and increase costs, since an additional state dollar spent increases federal contributions. These incentives encourage states to cut programs other than Medicaid since such cuts will have less overall effect on a state’s budget. In addition, the Medicaid program, which offers comprehensive benefits and minimal-to-no cost sharing, increases overall consumption due to the moral hazard (Fichtner, 2014). These factors prevent policymakers from making Medicaid a more efficient program. In response, they argue, states have avoided benefit cuts or limits on eligibility, which provide less immediate savings, and instead seek savings through cuts in provider payments, thereby driving providers away from participating in the Medicaid program (Fichtner, 2014).

To address this, some policy makers recommend that a block grant to the states be established based on a state’s current budget, with a medical trend factor established for future years. The proposal would allow for greater state flexibility in benefits and cost-sharing rules. This would cap the federal component of the federal-state partnership and provide incentives to states to improve efficiencies in the program. A weakness in this approach is that it would lock in high cost and low cost Medicaid states, making it difficult to gain widespread political support (Fichtner, 2014). Critics also point out that, depending on the trend factor, more and more risk would be borne by the individual (Fichtner, 2014).

An alternative to a block grant is a per-capita cap. This program would provide federal funding to states based on the various populations enrolled in the Medicaid program, with each population receiving a separate payment rate. This would have the effect, unlike block grants, of accounting for people who previously did not enroll, changes in enrollment due to economic conditions, and changes in demographics in a state over time. Again, the federal payment would be capped with a cost trend established (Fichtner, 2014). The core of this argument is that
federal financing of Medicaid must be reformed, allowing states greater say in the operations of their program.

Critics of the current program argue that the program must move to market-based solutions. It must change from a defined benefit program to a defined contribution program. As an alternative to the ACA, some have suggested that policymakers consider moving to a “premium support” model. Premium support would provide a refundable tax credit for individuals to purchase coverage on the individual private market, through their employers, or in the Medicaid program. Individuals would not be subject to pre-existing condition exclusions or otherwise denied coverage or offered coverage at higher rates based on health status, provided they maintain continuous coverage in at least a high deductible plan. Medicaid would get a set allotment, or block grant, based on current funding levels and then increase at inflation or some other factor. Individuals could then choose for themselves the type of plan they might want. If the cost was below the tax credit amount available to them, they could keep the savings for future health care costs. These policymakers argue that market forces will improve market competition and improve consumer choice to pick health coverage best suited for them, rather than the full benefits required under Medicaid or health insurance exchanges. They state that this program would make Medicaid essentially a premium and cost-sharing support program in the private market rather than a broken and inefficient governmental program (Levin & Capretta, 2014; Antos & Capretta, 2014; Capretta & Moffit, 2012).

The conceptual framework underlying premium support is found in the Medicare program as well. It is a central topic in the Medicare policy discussions at the federal level today, and it is expected to be included in the House budget package in 2016. The Medicare proposal essentially provides a voucher to individuals who can then go and purchase a Medicare
plan in the marketplace. Individuals would pay the difference between the voucher and the cost of the plan. However, it is a politically polarizing debate. How the cost trend is calculated is key to whether the voucher keeps up with the cost of health care, or whether more and more of the burden is placed on the individual (Van de Water, 2011). There is awareness among policymakers that Medicare politics can affect Medicaid in many ways. If the proposal for Medicare premium support gains legislative support, it will likely have a spillover effect on discussions involving premium assistance.

**Political Landscape**

Underlying the debate over the ACA and Medicaid expansion is, of course, politics. Continued polling suggests strongly partisan views on the ACA. A recent poll showed public disapproval of the new law at 53% with approval at 45%, signifying a sharp difference of views within the public at large. More importantly, this poll showed that Republicans opposed the new law 87% to 11%; Democrats supported it 78% to 19%; and Independents were opposed 58% to 39% (Motel, 2015). This partisan divide has manifested itself in the national political and policy debate. The U.S. House of Representatives has continued to bring to the floor legislation to repeal the ACA. Since it was adopted in 2010, the House has voted 61 times to repeal the law, but failed to get Senate support. In January 2016, both the House and the Senate passed a bill to repeal the ACA, but President Obama quickly vetoed it (Steinhauer, 2016). The efforts to repeal the ACA continue to raise public visibility on the issue and play to the partisan views of the voting base.

This partisan divide is somewhat reflected in the decisions being made at the state level. By the fall of 2014, 23 states had not expanded Medicaid. Of the 15 states that have Democratic control of both the governorship and legislatures, all 15 had expanded Medicaid. Of the 24 states
that have Republican control of both the governorship and legislatures (including Nebraska which has a Republican governor but a nonpartisan Unicameral legislature), only five states had expanded Medicaid. And of the remaining 11 that are divided, seven had expanded Medicaid (Cohen, Colby, Wailoo, & Zelizer, 2015). Reviewing the political composition of the four states that have expanded since the fall of 2014 when this political breakdown was initially done, one is Republican-controlled and the other three are divided. Most of the states that have not expanded are located in the South and in the central and western Plains states. This undercurrent of partisan division over the new law is an important component to the policy discussions at both the federal and state level.

It is unclear if recent developments may change the dynamics in the near term. *King v. Burwell* (2015), which affirmed the federal government’s interpretation that tax subsidies were available to federal health insurance exchanges and solidified the law legally, may or may not alter the political landscape. With a presidential campaign looming, and the issue of the ACA likely to play a prominent role in the election, the debate over the ACA and Medicaid expansion will likely remain a partisan topic. It is unclear if discussions between states and the federal government will be influenced by these dynamics and halt much further action for the rest of 2016.

States that have not expanded traditional Medicaid may require an alternative design and an alternative way to reframe the issue given the politics of the ACA. Most of the program titles for waivers that have been approved make no mention of Medicaid. One of my pilot studies suggests that this was an important feature to any path to expand coverage for low-income populations. Private sector solutions, alternative designs, and reforming, not expanding, programs for low-income populations, appear to be key areas of language to reframe the issue
from one of government program expansion to private sector solutions (Jones, Singer, & Ayanian, 2014). Similarly, there may be more commonality among policymakers on substance, but not the politics, of coverage expansion for low-income populations (Schnurer, 2015).
Language potentially may smooth over some of the politics that is driving the current debate. Language, and how the issue is framed, appears to be a critical element if a state is considering efforts to expand coverage for low-income adults.

**Research Questions Raised**

Much of the literature around the issue of premium assistance is focused on operational questions. Continuity of care for beneficiaries who transition between Medicaid and exchange programs, cost-sharing obligations, changes in benefits, treatment of the medically frail, and overall program costs for both Medicaid and health insurance exchanges are central issues to the Arkansas Private Option. In addition, there is also a general recognition that the underlying politics, the flexibility of the federal government, and state costs are significant factors for states that have not expanded coverage. The literature provides a good overview of these key issues, but many of these questions are difficult to answer without experience and data that will come from implementation of this new program and from a broader qualitative analysis of the factors that might shape future expansion decisions.

My research suggests there are two critical research questions. The first is how well is the Arkansas Private Option working after a little more than two years in operation? Examining how the Arkansas Private Option begins to work in practice through a number of operational metrics that have been identified will make an important contribution to the overall literature. Given the fact most states, if they expand, will do so under an alternative waiver design, much like Arkansas, suggests a second important research question: does an alternative waiver design,
like premium assistance, offer a promising path for many of these remaining states that have currently chosen not to expand coverage for low-income adults? Examining whether this alternative waiver design provides a third way for states to consider beyond expanding traditional Medicaid or not expanding at all, and what factors might drive that decision making process, will help to identify the challenges and opportunities facing coverage expansion in these remaining 19 states.
Chapter 2

Research Methods

My research project used a qualitative descriptive approach. My study was designed to provide a formative evaluation to assess the early impact of the recently created Arkansas premium assistance model, what is known as the Private Option, and to examine the broader question of whether premium assistance, or an alternative waiver design, might offer a feasible path to pursue for other states that have chosen not to expand Medicaid in its current form. A qualitative descriptive method allows the researcher to use a reasonably considered set of sampling and data collection techniques and strategies in order to provide a fulsome description and presentation of the phenomenon studied (Sandelowski, 2000). My project posed two research questions:

- How well is the Arkansas Private Option working after a little more than two years in operation?
- Does an alternative waiver design, like premium assistance, offer a promising path for many of states that have currently chosen not to expand coverage for low-income adults?

These research questions required the collection of secondary data through a literature and document review, as well as key informant interviews with a purposeful sample of experts in the field, to provide a descriptive understanding of this new program and to explore if this design, or type of design, might be feasible for replication in other states. The research project also included two pilot studies, preliminary research projects designed to test out certain research questions, prior to establishing the two research questions for this study. These pilot studies
included: 1) examining the cost-sharing differences between the Arkansas Private Option and the health insurance exchange Marketplace; and 2) assessing how much federal funding and economic pressures may be driving the policy discussions in states. They helped to provide a preliminary understanding of the issue and helped to further shape the research questions and the measurements used in the study.

A qualitative descriptive research approach was consistent with the research questions posed given that the waiver design was still relatively new and therefore required developing an early picture through the collection, and synthesis, of data from various sources.

**Research Design**

In conducting a formative evaluation of the Arkansas Private Option, my research identified ten areas to measure in order to provide an overall picture of this alternative waiver design. These were operational metrics that could be used to assess the impact of the premium assistance model. These measures were compared against baseline numbers or formal projections in order to provide a preliminary assessment of the Arkansas Private Option. They are identified in the Table 2.1 on the following page.
### Table 2.1
Operational Metrics

<table>
<thead>
<tr>
<th>Measures</th>
<th>Definitions</th>
<th>Benchmarks</th>
</tr>
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<tbody>
<tr>
<td>Enrollment</td>
<td>The number and types of people enrolling in the Private Option</td>
<td>Projections</td>
</tr>
<tr>
<td>Provider Networks</td>
<td>The number and types of providers participating in the Private Option</td>
<td>Baseline numbers</td>
</tr>
<tr>
<td>Health Plan Competition</td>
<td>The number of health plans participating in the Private Option</td>
<td>Baseline numbers</td>
</tr>
<tr>
<td>Medically Frail</td>
<td>Individuals identified with significant and complex medical needs</td>
<td>Projections</td>
</tr>
<tr>
<td>Wrap-Around Benefits</td>
<td>Medicaid benefits not provided under Essential Health Benefits in the health insurance exchanges</td>
<td>Projections</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Changes in clinical and service delivery outcomes</td>
<td>Baseline numbers</td>
</tr>
<tr>
<td>Churn</td>
<td>Number of people who transition between Medicaid and exchange eligibility due to change in income</td>
<td>Projections</td>
</tr>
<tr>
<td>Cost-Sharing</td>
<td>Amount individuals may need to pay in premiums, deductibles, and co-payments</td>
<td>Baseline numbers</td>
</tr>
<tr>
<td>State Costs</td>
<td>State funding required to support the Private Option</td>
<td>Projections</td>
</tr>
<tr>
<td>General Observational Metrics</td>
<td>Expert views on overall outcomes</td>
<td>Observations</td>
</tr>
</tbody>
</table>

In addition to secondary data, key informant interviews helped interpret the data and added contextual information not present in the data. Together, they formed the basis for an overall descriptive assessment to answer the first research question.

In examining whether this alternative design model, or other alternative waiver models,
offers a promising path for other states, my research identified six factors likely to be considered in a state’s decision about whether or not to expand. These factors are identified in the Table 2.2 below.

Table 2.2
Areas That Impact a State’s Decision Making Process

<table>
<thead>
<tr>
<th>Factors</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Funding and Economic Pressures</td>
<td>How much does the loss of federal funding create fiscal and economic pressures on a state that has not expanded?</td>
</tr>
<tr>
<td>2016 Presidential Election</td>
<td>How much has the 2016 presidential election impacted the decision-making process in states that have not expanded and will the dynamics change following the November elections?</td>
</tr>
<tr>
<td>Role of Federal Government</td>
<td>How flexible has the federal government been in approving alternative waiver designs and how might those previous decisions impact future decisions?</td>
</tr>
<tr>
<td>States</td>
<td>What has been the role of governors and legislatures in this debate and how have these institutional relationships shaped the policy discussion?</td>
</tr>
<tr>
<td>Politics</td>
<td>What have been the political factors driving the overall discussion and how have states reshaped and reframed the politics and the political debate in order to expand coverage?</td>
</tr>
<tr>
<td>Evaluation</td>
<td>How important is the role of evidence and evaluation in the decision-making process going forward?</td>
</tr>
</tbody>
</table>

These factors, together with the operational metrics addressing the first research question, formed the basis of my initial codebook (See Appendix B for codebook). Interviews with experts in the field enabled me to provide a descriptive picture of the opportunities and challenges of moving forward on a design such as the Private Option, or something similar, and
to answer my second research question.

My research identified eight research reports that, as of this writing, have evaluated the Public Option, or some part of it, and have been made publicly available. These documents included the federally financed evaluation required for the Arkansas health insurance exchange, an outside report requested by the Arkansas legislature as part of a task force reviewing expansion and pre-expansion Medicaid programs, the quarterly and annual evaluation reports from Arkansas Medicaid to the Centers of Medicare and Medicaid Services (CMS) on its Section 1115 waiver, and a number of independent research reports specifically detailing results from Arkansas or, in one report, comparing the early results of the Private Option to states that had done a traditional expansion or no expansion at all. Most of the data was preliminary, with most of these reports beginning to come out in late summer 2015. Like this project, many of these reports were supported by qualitative data through stakeholder and expert interviews to provide an early picture of this new program. As of this writing, the Arkansas Division of Medical Services’ formal evaluation of its 1115 premium assistance waiver has not yet been released, though it is expected soon. These major evaluation reports are identified on the following page and are formally cited in the References Section.
<table>
<thead>
<tr>
<th>Major Evaluation Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health and the Arkansas Foundation for Medical Care for the Arkansas Insurance Department. “Arkansas State Partnership Health Insurance Marketplace Year One Evaluation” (Fall, 2015). Retrieved from <a href="http://rhld.insurance.arkansas.gov/Info/Public/MiscellaneousReports#">http://rhld.insurance.arkansas.gov/Info/Public/MiscellaneousReports#</a></td>
</tr>
<tr>
<td>Sommers, B.D., Blendon, R.J., &amp; Orav, E.J. Health Affairs. “Both the ‘Private Option’ and Traditional Medicaid Expansion Improved Access to Care for Low-Income Adults” (January, 2016). Health Affairs, 35(1), 96-105</td>
</tr>
</tbody>
</table>
These evaluation reports were reviewed and compared against each other as well as with the available literature. Many of these reports focused on specific metrics, such as enrollment or state cost estimates, while others provided a more comprehensive review of the major evaluation components. This data was measured in comparison to benchmarks, which included earlier state projections (e.g., enrollment projections or the estimated medically frail population within the newly eligible adult population), or baseline data (e.g., the number of providers accepting Medicaid payments or the number of health plans operating in the state before the Private Option began). This secondary data analysis was then used as a basis for identifying key issues and developing interview questions to more closely examine these core measurement metrics and to provide for a more rich description of how these measurements fit in to the larger picture.

The interview process used a purposive sampling method. Fifteen people were selected and interviewed. Individuals were identified based on their position or knowledge in the field as well as from discussions with various people who offered suggestions and recommendations. The individuals selected included current and former senior federal and state governmental leaders as well as experts in policy research centers and intergovernmental policy organizations. Efforts were made to balance federal and state perspectives as well as views across a policy spectrum. The goal was to provide a cross section of views among policy experts and governmental leaders. No individual declined to participate in my research project, and all were generous with their time. Ten individuals participated in in-person interviews while five interviews took place over the phone. The interviews ranged from 30 minutes to 90 minutes with the average interview taking about 45 minutes. The interviews took place over a period of three months, from mid-December 2015 thru mid-March 2016.

A semi-structured interview guide was established based on my literature review, my
document review, and my established measures. This interview guide served as the primary instrument for my interviews (See Appendix C for the interview guide). Questions were clustered around operational measurements for Arkansas or factors that may be driving or impacting a state’s decision-making process. For some participants, the interview focused more on Arkansas specifically and the evaluation of the Private Option as well as the state’s dealings with the federal government. For others, the interview focused more on the role of the federal government and state waivers, including the Arkansas premium assistance waiver, or the path forward for states that have chosen not to expand coverage for low-income populations. Still others tackled all of these clustered questions in great detail. Depending on the participant, the interview guide was adjusted, focusing on their factual knowledge and expertise. Some may not have been current on recent Arkansas developments. All participants, however, were familiar with the major topical areas – the Arkansas waiver and the challenges in other states that have not expanded coverage under Medicaid – and all, at least, spoke generally to both research questions.

All interviews were recorded and transcribed by an outside vendor. Mulberry Studio Inc., located in Cambridge, Massachusetts, provided transcription services for all interviews. The transcripts were then uploaded into Atlas.ti, an application designed specifically for qualitative research, which was provided by Northeastern University for this research project. My initial codebook was used to analyze the data (See Appendix B for codebook). Some codes emerged through these interviews that were not part of my initial codebook and, therefore, were added during this process. Other codes were further refined and developed based on a rigorous review of the data following the completion of interviews. These data sets helped to establish my analytic themes. These themes were then used to help evaluate and examine both research
questions.

Limitations

The research design has a number of limitations. The first is that the research project is based on very early data. This early data may or may not be consistent with trends over time. In health care, a market may take a few years to stabilize and, therefore, the data may not normalize in the first years of a new program. While there may be increases in providers and health plans initially, for example, it is not clear that a generalized statement about the long-term market can be made with preliminary data. Preliminary data may not provide many of the details underlying that raw data as well. For example, data showing an increase in providers may or may not show if increases are occurring in areas of critical need such as specialists. Another example is that the overall enrollment data may or may not tell you what might be happening around people churning between Medicaid eligibility and exchange eligibility, with each having significantly different cost-sharing responsibilities, despite continuing to be in combined program. While data may be showing a drop off in paid premiums in the marketplace, early data does not tell you what might be the cause for that downward trend. Preliminary data is helpful to gauge the success of the program broadly, but the very early data may not be able to answer the research questions definitively. Instead it may be more speculative, though the data may help identify where further research may be necessary.

Another major limitation involves the number of interviews. Given the complexity of the health care system, and the number of institutional interests, it may be difficult to get a representative cross-section of views without significantly expanding the number of people interviewed. While the project design attempted to try and balance various perspectives – state and federal viewpoints; government officials and outside researchers; liberal and conservative
views – there may be other important views that were not captured by the purposive sampling technique.

Measures used to assess the early experience of the Private Option might differ in another future study, particularly in studies that might have significantly more data. For example, many would believe health outcomes to be a significant measure of success and should be used as a comparison to other expansion models. Given the need for longitudinal data, early studies will have to rely less on that measure than in future studies. Other measures are important to evaluating a program, such as enrollment accuracy, redeterminations of eligibility, and fraud and abuse. These are not part of the core measures associated with evaluating the Private Option in this study.

Finally, each state is unique and each Medicaid program is different. Similarly, factors such as economic or budget pressures or the impacts of legislatures on debates about expanding coverage can be difficult to measure, though they may help to understand broad patterns within individual states. The future is difficult to predict, and while the data may help to identify major factors and forces, it is limited to just that: to provide an indication of possibilities.

The project design has certain limitations. It is working with preliminary data. It has a limited number of measures to address the research questions. It has a limited number of experts who have been interviewed. And it must attempt to address an uncertain and complex future. Despite these limitations, this study provides an opportunity to understand alternative designs to traditional Medicaid as well as whether such designs offer a promising path forward for many states in the months and years ahead.

Ethics

My research project was reviewed and approved by Northeastern University’s
Institutional Review Board (IRB) on October 20, 2015 (See Appendix A for IRB approval and supporting materials). As part of my IRB, each participant received a letter from me describing my project as well as an unsigned consent form. These documents informed them there would be no foreseeable risks or discomforts to them, that there would be no direct benefits to them, and that his or her participation would be voluntary. The documents also described that the interviews would be handled in a confidential manner. Participants were also informed before the interview began that if they did not care to answer a question, they were under no obligation to do so and could ask that the interview move on to other questions. All participants were informed of these conditions.

The transcripts of these interviews have been kept on a password-protected site, and all efforts have been made to keep them secure throughout the research process. Only the Principal Investigator and External Reviewer have had access to the list of participants in this study, and they are under obligation to maintain confidentiality of this information as well. I have made every effort to write in a way that would not disclose the confidentiality of any of the participants. In addition, my research project has reviewed only publicly available documents. No documents were secured from any official that might be considered a working document or an internal deliberative document.
Chapter 3  
Results and Discussion:  
The Arkansas Private Option

The first research question focused on how well the Arkansas Private Option is working now that the program has been up and running since January 2014, or a little more than two years in operation. Under the waiver, adults age 19-64 and with incomes below 138% of poverty, are enrolled in the health insurance exchange through a Qualified Health Plan (QHP) and receive a set of ten Essential Health Benefits (EHB) as defined under federal rules. Medicaid funding is used to purchase the premiums associated with these QHPs and some, if not all, of the cost-sharing. The Arkansas exchange is formally known as the State Partnership Health Insurance Marketplace (SPM) while the Private Option is formally known as the Health Care Independence Program (HCIP). For purposes of this discussion, those below 138% of poverty will be defined as the Private Option and those above will be defined as the Marketplace.

Placing Medicaid eligible adults in the health insurance exchange through the Private Option raises a number of operational issues that deserve careful empirical examination. The study design identified ten measures in which to provide a formative evaluation of the Arkansas Private Option. These operational and program measures included: enrollment; provider networks; health plan competition; the identification of the medically frail; the delivery of wrap-around benefits; health outcomes; program churn; individual cost-sharing responsibilities; state costs; and general observational views. The results of the data collected from that research are discussed below.
Enrollment

Approximately 260,000 people in Arkansas were newly eligible and enrolled in the Arkansas Private Option or in traditional Medicaid through the Medically Frail program at the end of the fiscal year on June 30, 2015. The Private Option accounted for 223,000 enrollees; approximately 26,000 were identified as Medically Frail and placed in its traditional Medicaid program (Arkansas Department of Human Services, 2015c). By all accounts, in its first 18 months in operation, the Arkansas Private Option saw significant enrollment increases.

According to a Gallup survey, Arkansas had the most significant drop in the uninsured rate of any state by the middle of 2015, its uninsured rate dropping 13.4%, from 22.5% to 9.1% (Witters, 2015). The enrollment gains were widely acknowledged by all experts interviewed.

Enrollment exceeded all projections. According to one report, Arkansas Medicaid enrollment was projected to reach a maximum enrollment of 215,000 people. It exceeded that estimate by 18% within the first 18 months of operation (Archambault, 2015). Arkansas agency documents suggested that actuaries projected the enrollment for those eligible for the Private Option or the Medically Frail program of about 175,000 in its first year, or by the end of 2014 (Arkansas Insurance Department, 2013). As one governmental official noted, the significant enrollment and reduction in the uninsured rate is “something concrete that we can point to at this point” in terms of demonstrating its overall success.

Yet experts also noted that the Private Option itself may not correlate to the increases seen in Arkansas, but rather the increases were simply a function of Medicaid expansion. As one policy expert noted, there is research “suggesting that the Private Option itself is not necessarily responsible for that; it’s just the mere fact of doing Medicaid expansion.” In fact, large decreases in the uninsured rate were seen in states with traditional Medicaid expansion programs. The
state with the second largest decrease, Kentucky, also a southern state, showed an 11.4% drop in its uninsured rate, but it operated under a traditional Medicaid expansion program (Witters, 2015). A recent study comparing Arkansas (an alternative design), Kentucky (a traditional expansion state), and Texas (a state that has not expanded), showed that both Kentucky and Arkansas had “similar improvements in access to care” (Sommers, Blendon, & Orav, 2016, p. 104).

Enrollment in the Marketplace, compared to the Private Option, was a different story. The Arkansas legislature limited any expenditures for outreach activities for the exchange beginning in July 2014. Enrollment reached 43,000 at the end of the first open enrollment period in early 2014. It grew to 68,000 in the second year (University of Arkansas for Medical Sciences Fay Boozman College of Public Health and the Arkansas Foundation for Medical Care (UAMS), 2015). The Marketplace now has 74,000 enrolled following the close of 2016 open enrollment (Norris, 2016). These enrollment figures are significantly below projections. Actuaries initially estimated that 211,000 would enroll in the Marketplace (Arkansas Insurance Department, 2013). One governmental official commented that he would have estimated the exchange to be at 150,000 by now, though it has always been clear that Medicaid expansion would dominate within the overall health insurance exchange.

The Arkansas Insurance Department’s first year evaluation report on its exchange stated that the number estimated to be eligible for the Marketplace was 227,000. After its first year, it had enrolled 19% of those eligible. The nationwide average was 28% in the first year, ranging from 11.1% to 85.2%. Sixteen states ranked lower than Arkansas in terms of percentage of enrollment, but clearly it was on the lower rung of states in terms of enrollment (UAMS, 2015). Given the funding cutoff for outreach for the Marketplace, one expert noted that the state, despite
some obstacles generally, “did a phenomenal job in…pulling people into the system” through the Private Option. A broader question raised was whether this combined program, the Private Option and the Marketplace, made it easier to enroll individuals compared to other states or whether differing rules that limited outreach and enrollment for one program, as happened in Arkansas, would possibly impact enrollment in both programs. One expert noted that that question seemed “up in the air” at present, but did not seem to affect enrollment in the Private Option.

The Private Option has accounted for 80% of the enrollment within the overall health insurance exchange in its first 18 months of operation. In defining the characteristics of this enrollment population, 54% had income from 0 to 50% of the Federal Poverty Level (FPL). However, 40% of the population had no income at all. Twenty-eight percent had income from 50 to 100% of the FPL. And 18% had income from 100%-138% of the FPL. The legislative report noted, however, that it is difficult to evaluate the Private Option by income levels without data on family size. They also made note that this was self-reported data from applicants and, therefore, not a good data set to do analysis (The Stephens Group, 2015). These numbers indicate that the number of people between 100%-138% of FPL to be significantly less than the national average. Of those states that have not expanded Medicaid, states that are concentrated in the South, studies have found that the average is about 35% in this 100%-138% FPL range, significantly higher than what the Arkansas data suggests (Garfield & Damico, 2016). These numbers become important in discussions about cost-sharing and churn later in this report.

The enrollment data also highlights that those in the Private Option are younger than those in the Marketplace. Sixty-five percent of those in the Private Option are under 45 years of age compared to 45% of those in the Marketplace (The Stephens Group, 2015). As one
governmental official commented, Arkansas has “the youngest enrollee pool in the nation” in its health insurance exchange. This has implications in cost trends, which is discussed later in this report as well.

In addition to income and age characteristics, 60% of those enrolled in the Private Option and the Marketplace were female. Common perceptions are that the newly eligible are likely to be male given that the newly eligible are childless adults and parents. Some of this may be accounted for by the fact that Arkansas Medicaid eligibility for parents prior to the ACA was at 17% of poverty, and therefore a large percentage of female parents were not covered prior to the new law. Nevertheless, it is a number that stands out given the common perception of who was likely to be covered under the ACA.

Enrollment data also shows that, of those enrolled in both programs, 19% were African American and 4% were Hispanic, compared to 15.6% and 7% respectively for the state as a whole. The Arkansas evaluation report noted that these enrollment characteristics and population demographics were somewhat different, suggesting more women and African Americans, and fewer Hispanics, were enrolling than the state demographic numbers might suggest (UAMS, 2015). Finally, 45% of those enrolled in the Private Option have insurance for the first time since turning age 18 compared to 20% of those enrolled in the Marketplace (UAMS, 2015). As a number of experts mentioned, it is too soon to understand the possible implications of what this coverage may mean in the future. This could mean that there are future challenges around health literacy given the lack of experience with the healthcare system. It could also mean that there may be pent up demand for health services since many have not had access to health services as an adult.
Provider Networks

Preliminary data in Arkansas suggests a substantial increase in the number of healthcare providers under the Private Option. Medicaid claims data prior to the Private Option showed payments to 6,409 providers. Under the Private Option and the Marketplace, claims payments went to 15,859 providers, an increase of 9,450 providers. While the report expressed some concern about inconsistencies in provider identifiers, the large increase suggested provider access has greatly increased under the new program. One of the stated objectives of the Health Care Independence Act of 2013 in Arkansas was to improve access. As the report noted, the results appear to show that it “is meeting that objective” (The Stephens Group, 2015, p. 36). The report also indicated that 64% of beneficiaries went to providers that saw fewer than 10 people eligible under the Private Option during the year, and 90% of all beneficiaries went to providers that saw 90 or fewer beneficiaries. The percentages suggested that a large number of providers who entered this program were small providers or individual physicians (The Stephens Group, 2015).

All experts agreed that increasing provider payment rates, rather than trying to establish a combined program using existing Medicaid rates, drove this significant expansion in provider networks. Before the program came into being, these rate assumptions were approved under the Centers for Medicare and Medicaid Services (CMS) budget neutrality rules as part of the Section 1115 waiver agreement. Under these federal rules, a state must show that federal funding will not increase under the waiver compared to expansion without a waiver, and states must present their methods for such a comparison. The General Accountability Office (GAO) sharply criticized the budget neutrality calculations, stating that the program costs increased by $778 million over the waiver period than if payment rates had remained the same under a traditional
Medicaid expansion (U.S. Government Accountability Office, 2014). As one government official noted, “They have criticized all of the budget neutrality decisions, not just this one.” There seemed to be little concern about the methodology used in this waiver and the general view was that rates would need to be increased in order to implement this waiver design. As one researcher commented, you need a “sophisticated analysis” but you are likely to give a state “the benefit of the doubt that it is budget neutral.” Another government official commented that every administration has used budget neutrality to achieve its policy objectives and that budget neutrality is simply the working assumptions of a state’s Medicaid program and where they expect to go with that program in the future. But another recognized that the waiver design is more costly simply because “Medicaid basically pays lower prices.”

The data does not break down types of providers. A common criticism of the Medicaid program generally is a lack of access to both primary care and specialists. One observer noted, however, that access has tended to be less of a concern in southern states than in other states that have emphasized expansion over provider rates. In places like California and New Jersey, where rates were exceptionally low, access has always been a problem. As one expert stated, “You wouldn’t necessarily think that, but in Arkansas, even before the ACA, if you were fortunate enough to be in the Medicaid program, generally you had access. Other researchers and government officials echoed this view, particularly in regards to primary care. As one researcher stated, access to primary care providers was “not something we heard a lot about in particular in Arkansas” prior to the ACA.

Yet there was some concern about access to specialists. As one government official noted, the expectation was that coverage at pre-existing rates would have impacted access to specialists, but not necessarily primary care, though they lacked data to back this up. The state’s
primary care initiatives have helped to ensure access to primary care providers. Other researchers made similar comments, but also made statements that these observations were without clear data. There was anecdotal evidence of problems with access to dental care, some areas of specialty care, and mental health specialty care, but this researcher stated that access was probably better than what people might think. “Perceived access” was also raised by one of these researchers, explaining that in addition to networks, timely appointments and patient experiences were important areas to measure in the future as well.

Equally important to provider networks is the issue of churn between Private Option and Marketplace enrollees and maintaining continuity of coverage with providers. For those under 138% of poverty, or $16,243 for an individual or $33,465 for a family of four, the Medicaid program pays most or all of one’s costs to enroll in the Private Option. For those above 138% of poverty, the Marketplace and exchange rules kick in and help provide subsidized coverage for individuals and families up to 400% of poverty. For those between 100% and 250% of poverty, additional subsidies are available for the cost-sharing components of health insurance coverage.

Provider networks remain the same. This has the effect of ensuring continuity of care with existing providers for individuals and families if income changes, a key feature of the Private Option. All interviewees recognized this key feature of the design and that providing individuals with the same doctor and the same health plan was a clear benefit in providing access and ensuring continuity of coverage. However, little data is available at this point to understand the extent of churn taking place in Arkansas. Some studies place churn as high as 50% for those between 100% and 200% of poverty (Sommers & Rosenbaum, 2011). As one government official noted, “The income survey data suggests more churn than we’re hearing about at this point.” The recent report on the first year of the Arkansas exchange noted that understanding
churn in 2014 was not achievable without “full access to insurance claims data” (UAMS, 2015, p. 136).

Although the Private Option places adults in the health insurance exchange, and children would continue to remain in traditional Medicaid or the Children’s Health Insurance Program (CHIP), there seemed to be little concern about the possibility of families having to navigate separate programs and possibly creating barriers to coverage. Despite the possibility that children would be in the Medicaid or CHIP program and parents in the Private Option, one researcher commented, “The Kaiser Commission on Medicaid did a series of focus groups last year that looked at this question, in part to prepare for the CHIP debate, and this is not really what families cared about.” This researcher went on to say, “I am not convinced that it is a compelling motivator for families.” Families are more concerned about cost and easy access to see a doctor than being in the same program. Children not in the same plan together, however, was considered a big concern, which has come up in other states with auto-assignment in Medicaid. But, according to this researcher, it has not been a concern that has been raised in Arkansas.

Generally, there was a strong sense that the Private Option has created a robust provider network and offered individuals the benefit of keeping the same doctors and health plans even as their income changes over time. Understanding those networks, and quantifying those impacts by types of providers, as well as measuring the amount of churn taking place at 138% of poverty are areas of important research going forward to better evaluate the overall impact of the Private Option in the healthcare system.

**Health Plan Competition**

The Private Option and the Marketplace began operations in Arkansas in 2014 with three
health plans, with one operating statewide. In 2015, that number increased to four and all selling statewide. Beginning in 2016, five health plans were operating and all selling statewide, though the market, at the time of the 2016 rate announcement in August 2015, continued to be dominated by a single plan, having between 70% and 80% of market share (Wishner, Holahan, Upadhyay, & McGrath, 2015). In April 2016, United Health Group, one of the five plans operating in Arkansas, announced that they would not operate in the state in 2017 (Davis, 2016b). A government official stated that they believed another multi-state plan was still considering entering the market next year, but at the time of the interview it was still uncertain if that would happen.

Nationally, the number of plans operating in health insurance exchanges range from one plan in New Hampshire and West Virginia to 17 plans in New York. According to the most recent evaluation, the average number of plans operating in states was five, with the most common number of plans operating in a state at two. Ten states had two plans operating in their exchanges in the first year of operations (UAMS, 2015). A government official noted, “four is a competitive marketplace over time” but went on to say that the definition of competition is not well conceived at this time. “That’s not a question most insurance regulators and policymakers have actually engaged. Nor have researchers answered it.” Another commented that five was a good balance and stated that it is a “delicate balance between ensuring that you have adequate competition and not being overwhelmed by consumer choice.” Others commented that health plans were surprised that the Private Option population was healthier than anticipated and found “no hesitation or complaint that they be integrated within the exchange.” One government official noted that the number of carriers in Arkansas supporting the individual market was viewed as “unprecedented for the state” and a healthy sign of the market in its early years.
The Private Option has helped support the development of a competitive market because of its scale. Eighty percent of the initial market for the exchange came from the Private Option. One commented that without the Private Option, the exchange could have remained at one insurer in the individual market prior to the ACA, and “presumably that’s where the market would have ended up.” Another researcher commented that many exchange markets, not just Arkansas, were likely to have trouble establishing a stable risk pool. The Private Option “unwittingly shored up that exchange risk pool, but unwittingly also, I think, helped smooth out a little the transition between Medicaid and private insurance.”

A key component to market development was the establishment of auto-assignment as a way for new entrants in the market to gain members. Auto-assignment is a process where if a new beneficiary does not pick a health plan within a specified period of time, the state will assign that person to a health plan based on an algorithm established by the Medicaid agency. Second year data suggested that 40 percent of those enrolled in the first six months of 2015 were auto-assigned to a plan (Guyer, Shine, Musumeci & Rudowitz, 2015). Auto-assignment has had the effect of assisting health plans enter a market that has been dominated by a single health plan. A government official commented, “The auto-assignment process has worked. That helps create this force, an initial spreading of enrollment across Qualified Health Plans, which of course, in turn, means that it provides a foot-hold, a toe-hold, for new insurance carriers.” The number of carriers currently operating in Arkansas suggests this provision may be a key component in the development of a competitive market. One report, however, raised concerns that auto-assignment could hamper the identification of those who are Medically Frail, an issue that will be discussed later in this chapter.

Health plan competition is viewed as an important factor in keeping rates low and
slowing the overall cost growth. The Arkansas exchange average rate increase for 2015 actually declined by 2%. Rates for the 2016 calendar year went up an average of 4.3%. These numbers compare to national averages of an increase of 2% in 2015 and 7.5% in 2016 (Ramsey, 2015b).

One government official commented that the 4% rate increase in 2016 was unrelated to the Private Option, but was related to a loss of a tax credit that insurance companies had used in the past. Without that change, this individual believed rates would have remained flat for the 2016 calendar year. Rates for the 2017 calendar year have not yet been set. These trends, while early, are potentially significant. As one commented, these rate trends “should begin drawing attention as a point of departure from market trends around the country.” One key factor that seemed to be widely recognized is that individuals in the Private Option were younger and therefore likely to be healthier. The average age for people enrolled in the Private Option was 36 years of age; for the Marketplace, the average age was 42 years (UAMS, 2015). As a government official had noted previously, Arkansas has “the youngest enrollee pool within the nation.” This same official also noted that without the Private Option, while state budget costs would rise, exchange cost trends would rise significantly, suggesting possible large rate increases in future years for the Marketplace if not for the Private Option.

Others commented that, in addition to the population characteristics of Private Option enrollees, the state has been an aggressive and active purchaser, which has helped to create competition and hold down rates. State leadership has been viewed as important component to market development. For example, this year the state stated that it will only pay premiums in the Private Option for plans that are no higher than 10% of the second lowest silver plan in the market (Thompson, Wilson, & Ramirez, 2015). One government official commented that it was important for the state to “price signal” through “modest initial price targets” and “base
assumptions in the actuarial estimates” as well as to take steps in the area of “market management” such as auto assignment and plan selection in order to prevent overpricing and bring greater competition to the state. This active role was viewed by some as critically important in the development of the Private Option that has made the market competitive and kept medical cost trend low. Another commented that the state could continue on this path if it “continues to promote competition and maintain price sensitivity in its purchase.” Active purchasing was viewed as an important and unique characteristic of this market.

These rate trends have placed the Private Option well below the costs established under the waiver through its budget neutrality calculations, and it appears that it will remain under the approved waiver budget. And it has quickly established a market where before, in Arkansas, Medicaid has operated on a fee-for-service basis. As one researcher noted, “You couldn’t add a quarter of a million people, and not have them enrolling into something, just walking around with Medicaid cards. So, I think that it was this innovation in buying a market instead of building your own market that made the Private Option so interesting to people.” The Private Option created scale, attracted health plans, created competition, and, so far, has been able to keep the medical cost trend low. These results are generally viewed as promising by all those interviewed about the Private Option in its early years of operation.

Medically Frail

Medically Frail is a category comprised of individuals who have significant and complex health needs that may have difficulty with one or more activities in daily living or may have disabling mental health disorders or chronic substance abuse disorders. CMS does not define how states must determine who qualifies as Medically Frail. Arkansas established its own methodology. The state estimates that approximately 10% of its Private Option population
would be identified as Medically Frail and, therefore, would be eligible to remain in traditional Medicaid in order to receive other Medicaid benefits, such as long-term services and supports, not provided through the Private Option (Allison, Seldon & Thompson, 2014). A recent evaluation report stated that 9.95% of those newly eligible through June 2015 were identified as Medically Frail and 88% of those chose the traditional Medicaid program. Others eligible for the Medically Frail category were likely to have chosen the Private Option benefits package since it provides benefits, such as substance abuse services, not available in the traditional Medicaid program (Guyer, Shine, Musumeci, & Rudowitz, 2015). At this fundamental level, as one person commented, “the mechanics work” and Arkansas was able to put in place “the first in the nation upfront screen for medical conditions…and divert them back to Medicaid.” Another government official commented that the 12-question medical frailty screen that was developed by disability experts at the University of Michigan and the federal Agency for Health Care Research and Quality (ARHQ) has done a very good job. “We thought we would be around 10%. We have stayed at a pretty steady state there.” And one government official summed it up by saying the Medically Frail screen “will end up being one of the innovative contributions that the Private Option has made.”

It is interesting to note, and another potential side benefit to the Private Option: Supplemental Security Income (SSI) disability claims, a federal cash assistance program that automatically links eligibility to Medicaid, has decreased in Arkansas by 19% in the first year of the Private Option (Guyer, Shine, Musumeci, & Rudowitz, 2015). This suggests that the Private Option, or eligibility through a Medicaid expansion program, may provide federal savings from those with complex health needs since some may simply be seeking health care coverage rather than federal cash assistance through the SSI program. One researcher also commented that it is a
source of state savings, too, since these participants would now be defined as newly eligible and come on to Medicaid under the higher federal match rate. It is data point for the federal government that deserves further examination.

One report raised concerns that auto-assignment may fail to identify people who would meet this Medically Frail criteria. As noted earlier, 40% of those enrolled in the Private Option did so through auto-assignment in the first half of 2015. As a result, these individuals did not take steps in the enrollment process to complete the screen, raising the possibility that they might be missed. Concerns were also raised that people may not know that they can be screened once enrolled in the Private Option. While the report identified these concerns, it also stated that, “there were no reports that beneficiaries were unable to secure a designation as medically frail” (Guyer, Shine, Musumeci, & Rudowitz, 2015). In response to those concerns, one expert noted that there are mechanics in place to address potential problems in screening for Medically Frail. Those that might be eligible could be referred for review by one of the insurance carriers to what they called a “midyear transition process.” A medical team would then review to be sure that person was eligible, and simply not an expensive case for a health plan, which the state would not pick up. Its early verdict: “It’s worked pretty well.” The data and the stakeholder comments suggest that that is true at this early stage, though it should be an area of ongoing review.

The legislative report also suggested that the state might consider changing its process for identifying Medically Frail. It noted there are four approaches: self report, data review, administrative, and clinical. Most states use self report, but some states use other approaches. In its recommendations section, the Stephens Group suggested that after one self-reports and is determined eligible, a clinical determination should also be conducted. A number of people had serious concerns with clinical evaluation as the means to Medically Frail eligibility. One noted,
simply, that it is “operationally a huge challenge” to add this step to the process for all those identified as potentially eligible. Another also commented that clinical evaluation has somewhat the opposite effect than what might be recommended here – to potentially limit the number identified as Medically Frail – in that it is likely to “be routinely biased in favor of the individual. It is not at all clear that clinical evaluation is an improvement.” In general, as one expert noted, “As anyone one who has run a Medicaid program that has clinical evaluations knows, that clinical evaluation has turned out to be systematically gamed.”

Wrap-Around Benefits

Benefits for both the Private Option and Marketplace beneficiaries are closely aligned except for two Medicaid benefits: non-emergency transportation benefit and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for 19 and 20 year old adults who, because of age, are eligible under the Private Option as an adult beneficiary and not traditional Medicaid. The primary EPSDT benefit for these young adults are comprised of dental and vision benefits. Dental and vision are not a required benefit on the exchange, though pediatric dental and vision benefits are required for those under 18 years old. EPSDT benefits under Medicaid cover children up to 21 years of age. Under the 1115 waiver, EPSDT and non-emergency transportation would be administered separately through the Medicaid fee-for-service system outside of the Private Option.

All observers recognized that one of the strengths of the Private Option for the newly eligible adult population was the alignment of benefits between Medicaid and the Essential Health Benefits (EHB) in the exchange. As one governmental official observed, “there would be minimal amount of wrap-around to present problems for beneficiaries.” Others observed that the state “wanted to stay out of coordination of benefits to the greatest extent possible….and they
have had to do very little wrap in that regard.” They also wanted a design, as one researcher who has been following this noted, that was not “administratively difficult.” As a general observation, most thought the state has generally done a good job in implementing this benefit. Recent evaluations placed the per-capita wrap-around costs at just under $5 per month, or around $950,000 overall per month, translating into a little more than $10 million per year (Arkansas Department of Human Services, 2015b).

Early data, however, appears to be inconclusive about wrap-around benefits. Initial estimates projected wrap-around costs at between $8 and $9 per month (Arkansas Department of Human Services, 2013). Some researchers expressed concern that beneficiaries might not know about these benefits since they were outside of their health plan and operate within the fee-for-service Medicaid system. This same point was echoed in a recent evaluation report, though that reported also noted that they had not come across any particular incidents in their stakeholder discussions (Guyer, Shine, Musumeci, & Rudowitz, 2015). Other researchers expressed concern about the prospect of expanding the Private Option to children as a way to combine children and parents under one plan as a next step in Arkansas. One researcher noted, “EPSDT benefits is a complex benefit for kids. It’s a very comprehensive benefit. I don’t see a wrap working well for kids.” Another concern raised was limiting the non-emergency transportation benefit, something other states have done as part of their waiver design. One expert called it simply a “stupid idea. In Arkansas, if someone doesn’t have a car, you either want them to get health care or you don’t – and eventually states are going to agree to provide that benefit.” The legislative study also highlighted the cost-benefit of providing a transportation benefit, stating other studies have found a return on investment of approximately 10:1. The report recommended keeping this benefit in place (The Stephens Group, 2015).
Health Outcomes

Arkansas has some of the lowest health indicators in the nation. It ranks 49th in the nation in population health; 48th in obesity; 44th in diabetes; 47th in cardiovascular deaths; and 50th in stroke. Child health measures are also low. The state ranks 44th in overall child health; 50th in childhood immunizations; and 39th in infant mortality (The Stephens Group, 2015). In order to assess health outcomes, it is widely recognized that more longitudinal data is needed to make any type of measurement. As one of the evaluation reports noted, one to two years of claims data would be required, something not available at the present time. As a result, a “full evaluation is not possible” (UAMS, 2015, p. 82). This was reiterated in interviews, with one expert suggesting, that at this point in time, only rudimentary measures on the process side may be helpful in the early evaluation of this new program.

Initial data showed that 62% of those in the Private Option visited a physician in 2014, with 38% not visiting a doctor in that first year. The report noted that the Private Option showed “moderate success” in getting people into a primary care setting (Stephens Group, 2015, p. 39). The report noted, however, that 27% of those in the Private Option visited an emergency room in 2014. And of that group, 36% visited three or more times in a month. These numbers indicate that nine percent of all Private Option members are visiting the emergency department regularly. They are often called “frequent fliers” in Medicaid parlance. Compared to the existing Medicaid program, the overall number visiting the emergency room was slightly lower for the Private Option, but the number of frequent fliers was significantly higher. The report noted that this early data suggested that the Private Option “is not yet achieving the goal of moving beneficiaries fully into using PCPs (primary care physicians) for access to the system” (The Stephens Group, 2015, p. 45).
Health literacy is a recognized challenge. As one government official commented, “health literacy, in general, is a big concern…and getting people to understand – here is your policy, and this is what you can use it for, and this is where you should seek services, as opposed to the ER.” This was reiterated in one of the evaluation reports. It noted that health literacy was an issue, particularly among the Hispanic and Marshallese communities, who were likely to be experiencing insurance for the first time. Interviews with providers for this year one evaluation report made similar statements, with a number of them stating that people often did not understand what type of coverage they had and little or no awareness about possible co-pay and cost-sharing requirements. This was viewed as problematic since the Private Option and the Marketplace have different cost-sharing requirements (UAMS, 2015).

Consumer Health Survey data for 2014 allowed evaluators to provide a “partial assessment” of quality indicators such as access to care, customer service, cultural competency, and health promotion. The report noted that the customer service composite was significantly higher than the national average, and called that “an area for celebrated success” (UAMS, 2015, p. 85). The Arkansas results were lower than national averages on getting care quickly, rating of health plans, specialists and health promotion and education. The report cautioned its overall use at this particular point in time. The survey included both the Private Option and the Marketplace while national data is for Medicaid only. The report stated that longitudinal trend is a more important indicator and urged continued surveys in this area (UAMS, 2015).

While health outcomes data is critically important to evaluating this new program, one researcher commented that insurance coverage and access do not necessarily improve overall population health. The researcher commented, “There is a lot of countervailing pressures on people’s health” and made reference to what the researcher called a commonly held view that
“90% of people’s health is not dependent on the healthcare system” but lifestyle and environmental issues. The researcher made clear, however, the importance of healthcare coverage, access, and improved clinical outcomes. These indicators are important measures in assessing the healthcare system generally.

Cost-Sharing

When the Health Care Independence Act of 2013 was passed in the spring of 2013, creating what is known as the Private Option, Arkansas did not seek waivers to impose any additional cost-sharing requirements than what was allowed under current Medicaid rules. Existing Medicaid rules do not allow premiums for those at 150% of poverty or below, and it limits cost-sharing to no more than 5% of household income with specific maximums for types of service such as outpatient and inpatient services, prescription drugs and non-emergency room care use. The Private Option did not impose any premiums, meaning the state would pay premium costs in full directly to the exchange, and its cost-sharing amounts were consistent with existing Medicaid rules. Cost-sharing for various services in Arkansas were generally considered low. As one researcher noted in a recent journal article, the Arkansas Private Option represented a “high water mark” in evaluating premium assistance programs in that it did not impose additional cost-sharing provisions or benefit cuts as part of its initial design (Rosenbaum, 2015, p. 208).

Since the program was created, the state amended its waiver in late 2014 to create “Health Care Independence Accounts” (HIA) for individuals from 50% to 138% FPL to make monthly contributions for their cost-sharing responsibilities. These accounts would be used to cover all cost-sharing responsibilities. Those monthly contributions were to range from $5 to $25 per month, but they would be no more than 2% of income. For those that did not contribute
to these accounts, cost-sharing responsibilities would be collected at the point of service for those above 100% FPL. A provider could deny service to those above 100% of poverty if cost-sharing payments were not made at that point of service. For those between 50% and 100% FPL, those cost-sharing responsibilities would be credited to their account for future payment. Failure to make monthly payments, or pay cost-sharing at point of service, could not be a basis for denying Medicaid eligibility (The Henry J. Kaiser Family Foundation, 2015). Since this amendment was approved by CMS in late 2014, the state has limited HIA accounts to only those between 100% and 138% FPL and has set the monthly payment at $15 per month. Maximum out of pocket cost-sharing responsibilities at point of service were set at $604 (Arkansas Department of Human Services, 2013).

In addition, the new governor, Asa Hutchinson, who was elected in November 2014, proposed in the spring of 2016 that Private Options beneficiaries between 100% and 138% of poverty begin to pay a monthly premium of $19 per month beginning in 2017, or roughly 2% of income if an individual was at 100% of poverty. Incentives would be established, such as dental benefits, for those that make monthly contributions and seek annual wellness check ups with their primary care physicians (Davis & Fanney, 2016). Failure to pay could not be a basis for denying Medicaid eligibility. A variation of this proposal was contained in the legislative task force report that was released in the fall of 2015. These changes to cost-sharing were part of an overall set of recommendations passed by the legislature and signed into law in April 2016.

Preliminary data suggested that the HIA accounts are not working well. The legislative report noted that 45,839 cards had been issued. That translates into roughly 20% of the 226,000 eligible for the Private Option, the estimated population size that is between 100% and 138% of the poverty level and part of this new cost-sharing payment program. Only 10,800 cards have
been activated. For the first six months of 2015, 5,185 members have contributed, but the number of monthly contributions has averaged around 2,500 during this time period. Transactions with providers have averaged around 4,000 per month. Total monthly payments from the state to providers from these accounts have averaged about $36,500, translating to about a $450,000 annual cost (The Stephens Group, 2015).

A government official noted that for low-income individuals, highly sensitive to costs, a number of factors could be in play. One could be utilization. For $15 per month, or $180 per year, that monthly contribution would protect an individual from a maximum out-of-pocket cost-sharing payment of $604. If someone is a low-utilizer of health services, however, that monthly cost might seem exceptionally high to them. They noted that for someone above 100% of the poverty level, co-payments for a primary care visit is $4. They stated, “If you think that you are only going to go to your PCP maybe once that month, then the $4 might look more attractive than paying additional dollars to the Health Independence Accounts.” This same point was reiterated by another government official, saying even if the upfront costs might save you in the long-run, it is likely to depend on your current utilization: “You could spend more by contributing to your HIA than you would by making payments when going to the doctor.”

The other factor in play noted by a number of people was the actual practice of collecting co-payments. There is a strong belief that, since payment at point of service does not have to be enforced, it may or may not be enforced in practice. Payments are generally low, they can be viewed as a hassle to try and collect and not worth the effort, and consumers may or may not know their cost-sharing obligations. These comments, particularly about health literacy, were borne out in the interviews conducted for the Arkansas exchange first year evaluation report. Interviews for this study echoed that finding. As one government official noted, “it is viewed as
a bit of a penalty…there was also policy confusion in the sense this program was killed almost as soon as it began. The publicity of that has had to have had an effect…I don’t know what providers have been messaging consumers. But unless they charge the co-pay, why would a consumer do this?” They went on to comment that it is also a cultural issue. “Are you going to charge people more? Should you? Providers have to decide whether to buy into this too.” Still another researcher commented: “I suspect that cost-sharing is a problem for physician’s offices, and it may well be a problem for beneficiaries.” These comments suggest such point-of-service practices might be in play. As another government official summed it up, “It’s optional at the point of service. Providers can choose to enforce the cost sharing or not. So I haven’t heard much about it.”

Policy observers raised a number of important issues regarding the operation of this provision. One researcher, highly critical of cost-sharing for low-income populations, expressed concern that if a system of cost-sharing for the poor cannot work, “we need to know that, because what is the point of allowing anybody legally to set up a system like that if it doesn’t work and it can’t be operationalized?” Another raised the question regarding the policy aims: “I sometimes think we are just making up cost sharing and premiums just to make them up. And, to the extent they create barriers to both enrollment and access to needed care, one has to raise concerns.” Still another raised the issue of fairness: “The philosophy is that if other people are paying cost-sharing and premiums, low-income populations should too. This shouldn’t be an open ended entitlement that is for free.” The issue of fairness was also described in relation to the law itself. As one commented, due to the unique nature of how the ACA was passed in the early 2010, there are “two different definitions of affordability” for those between 100%-138% FPL. For those in expansion states, affordability, and by extension cost-sharing burdens, are
defined by Medicaid rules. For non-expansion states, affordability is defined by exchange rules since those between 100-138% FPL are eligible for the exchange. These cost-sharing rules create a different definition of what is affordable depending on whether a person is operating under Medicaid or exchange rules. And finally, another suggested in response to the fairness and operational issues that maybe a policy response would be that “you buy yourself out of cost-sharing with a premium” as a way to operationalize and make a program work that is more consistent with exchange cost-sharing rules. These are difficult questions for policymakers in Arkansas as well as elsewhere, given how low-income populations are likely to be extremely cost-sensitive, and the data to date suggests that Arkansas officials will be struggling with this issue for some time to come.

Another major cost-sharing issue concerns those who may transition from the Private Option to the Marketplace, or vice versa, as individual or household income fluctuates above or below 138% of poverty. As the literature has noted, approximately 50% of people between 100% and 200% of poverty may transition between Medicaid eligibility and exchange eligibility over the course of the year. Current cost-sharing in Arkansas ranges from $180 through the Health Care Independence Accounts to $604 maximum out-of-pocket costs at point of service. Those overall costs for an individual in the Private Option will increase in 2017 as Arkansas institutes a $19 per month premium payment for those between 100% and 138% of poverty, or a $228 yearly premium cost. For those just above the 138% FPL and in the Marketplace, cost-sharing requirements increase. Data from the Healthcare.gov calculator, the website for federal and state partnership exchanges, can be used to examine cost-sharing responsibilities with income at $16,243 and above to measure changes in the financial burden for individuals and families if their income fluctuates. Using the healthcare.gov portal, a 30 year old single non-
smoker male from Little Rock, Arkansas making $17,000 per year, or approximately 145% of poverty and eligible for subsidized coverage, his annual premium payment was approximately $50 per month, or $600 per year. This is based on a $273 per month premium and a tax credit subsidy of $222. Based on income in this particular example, maximum out of pocket expenditures in Arkansas is limited to $854 for those below 150% of poverty (Arkansas Insurance Department, 2016). These numbers suggest that a $750 change in income, from Private Option eligibility to Marketplace eligibility, could increase one’s premium from $228 to $600 and one’s overall cost-sharing from $180 (or $604) to $854 depending on health care utilization.

There is no data at this point to determine the number of people churning between these two programs and the impact these differing cost-sharing responsibilities might be having on the program. The first year evaluation of the Arkansas exchange noted that it was not possible to examine the transition between these two programs without health plan claims data, which they did not have at that point. What the report did identify, however, is the number of people on the exchange who were current in their monthly premium payments. The data showed that those participants who were either current, whose first payment was pending, or was still in a grace period, dropped from 96% in June 2014 to 82% in April 2015, a period of 11 months. While the report stated that the percentage of current payments “varied somewhat from month to month,” the data showed a monthly downward trend in all months but January 2015 (UAMS, 2015, p. 136). This data could suggest that individuals are cancelling their policies as they churn into the exchange with a higher cost-sharing requirement. It could also mean that people are cancelling as they transition to the Private Option. Although the data is inconclusive as to the precise cause, the 14% drop in current premiums in less than a year is concerning. Further research into this
drop off, and whether cost-sharing plays a role, is an important area of study going forward. It is an area with little data at this point. As one government official noted, “the income survey data suggests more churn than what we are hearing at this point.”

What is widely recognized is that there is a cost-sharing cliff as the example discussed earlier demonstrates. As one government official commented, in any income-based program you will have cliffs. “Cliffs aren’t new in our world.” This official went on to say that the cliff is greater at 250% when the additional cost sharing subsidies end. Another government official commented, “Cliffs are never good. We learned that lesson a long time ago…There is an effect.” Another researcher commented that Arkansas may have softened that trajectory with some proposed cost sharing increases. The researcher stated that “Arkansas is kind of easing them into the exchange a little bit, but they are still pretty low in comparison.” Another stated that the major problem with cliffs is that the exchange subsidies are too low and called it the “Achilles heel” of the ACA. And one researcher commented policy changes here likely will require movement in both directions, some increased Medicaid cost-sharing and some additional exchange subsidies, as a way to meet in the middle somewhere. Cost sharing is a significant issue not only with the Private Option, but with all states, given the different rules and requirements and the cost-sensitivity low-income individuals and families are likely to experience as they transition between the Private Option and Marketplace.

**State Costs**

Beginning in calendar year 2017, Arkansas will be required to provide a 5% match for all newly eligible Medicaid beneficiaries enrolled in the Private Option, with the federal government paying the remaining 95% of those costs. Under the ACA, states that expanded Medicaid received a 100% federal match rate for the first three years of the program. That match
rate drops to 95% in 2017, 94% in 2018; 93% in 2019; and 90% in 2020 and beyond. Under traditional Medicaid, the Arkansas federal match rate is 70% for 2016. That rate is adjusted through a formula based on a state’s per capita income. The floor for all states is a 50% match rate, with the highest federal Medicaid match rate currently just over 74%. The average is 57% (Kaiser Commission on Medicaid and the Uninsured, 2012).

The state match for this new program has become an important new issue in the overall legislative debate in Arkansas about the Private Option. The Private Option requires an annual appropriation that must receive a three-fourths majority in both the House and the Senate. Without such approval, the program would be terminated. It narrowly passed both houses in the spring of 2014 for continuation in 2015. The new governor, in 2015, requested that the Private Option continue in 2016 to allow time to review the program, and the legislature approved that request. A task force was created to review the program. The legislature began debating in the winter and spring of 2016 the future of the Private Option for the 2017 calendar year. Governor Hutchinson’s proposal included changing the name from the Private Option to Arkansas Works, establishing a two percent premium, and providing subsidies for employer-based insurance for those that have it at work. The bill narrowly passed in early April 2016 and was quickly signed into law by the governor.

The legislative report estimated that the Private Option would bring in additional federal dollars totaling just under $2 billion per year, or a five year total from 2017-2021 of $8.996 billion. The state match in Fiscal Year 2017 would be $43 million due to needed state funding for only part of the fiscal year, but the average state match contribution would be about $150 million per year, for a five year total of $656 million. Savings would accrue from state costs associated with the reduction of uncompensated care by $200 million over that five year period.
The state would see savings from the shifting of certain costs from the traditional Medicaid program to the Private Option, such as people with disabilities, the medically needy, and pregnant women who enroll first in the Private Option and subsequently become pregnant later and, therefore, remain in the Private Option. Other state funded programs, such as breast and cervical treatment programs and family planning services, for example, would now be covered for under the Private Option. These program shifts would provide savings of just over $200 million over a five year period as well. Premium tax revenues on health plans would provide an additional $200 million over this five year period. And additional taxes resulting from economic activity, such as taxes for medical equipment, would provide an additional $360 million during that five year period. In total, the report estimated that the state would save $438 million by continuing the Private Option even with the additional state match requirements over this five year period (Ramsey, 2015a). Since the report was issued in the summer of 2015, the consulting group has estimated that the overall savings now total $757 million. The revised estimates are based on lower projected costs as well as higher projected enrollment in the Private Option (Davis, 2016a). Before passage, the governor stated that if an appropriation was not approved, the state would face more than a $100 million shortfall in the state budget in the 2017 fiscal year (Wickline, 2016).

The data from this report highlighted the significant budgetary impact that the Private Option has had in Arkansas and how the overall framework has mitigated the additional state costs required as the state begins to budget for its share of the match rate. This view was generally shared by those interviewed. As one governmental official commented: “Arkansas is one of the best examples of how much has been documented by various different consultants that the program brings state savings, state budget savings.” Others commented that it should be
widely recognized that such an expansion will provide state savings “from other kinds of funding that is currently being used to support the care of uninsured people, be it mental health, substance abuse, uncompensated care, county dollars and state dollars.” According to one government official, Arkansas was careful in how it put its estimates together. The estimates “were always conservative” to protect the state from fiscal surprises, or “the surprise in the future would be it’s better than we thought.” All told, the data suggested that Arkansas has limited its exposure to the additional state costs required to fund the Private Option.

Budget issues will play a major role in the debate over the ACA, and it is being highlighted in the Arkansas debate. A number of individuals commented that, despite the broader political fight over the ACA, it would be difficult for Arkansas to defund the Private Option given “the significant hurdles” associated with the state savings that have accrued. However, one expert noted that it is easier to frame the debate as one about the state match rate and state costs rather than a broader discussion of overall state savings. The larger discussion becomes as much about accounting. The budget must have a line item for the new state match, but then other line items are reduced and revenues are raised, creating a larger overall budget, but larger savings as well. Said one expert, “You can do the arithmetic pretty quickly and say ‘gee, that’s a big cost,’ but it is much harder to highlight the offsets…For opponents of expansion, it’s a relatively easy argument to make, at least it’s one that is kind of black and white.” This debate over state costs, and net effects, will likely continue in the years ahead given the requirement that an annual appropriation requires a three-fourths majority in the legislature. There are new state costs associated with the program beginning in 2017, but also substantial budgetary effects on both spending and revenue associated with the Private Option.
General Operational Metrics

Among those interviewed for this study who had specific knowledge about the Arkansas Private Option, there was a consistent view that it was generally meeting many of the 11 purposes set out in the Health Care Independence Act of 2013 and the corresponding Section 1115 waiver. As one government official succinctly stated: “I think it has done just what it was designed to do.” Many commented on enrollment as one of the key measures of its early success, though some cautioned that the enrollment gains may not be directly attributed to the Private Option itself but rather it was simply the expansion of Medicaid itself. Others commented that it had been operationalized “the way people thought it would work.” A market was put in place that allowed for this large increase in enrollment “to get itself situated in a way that was just essential for the expansion.” Another commented that “the jury was still out” on one of the most important metrics, the direct impact on beneficiaries, but went on to state that operationally it was doing well.

Arkansas’s delivery system reform and its active purchasing role allowed the state “to use its leverage in ways that promoted competition leading to competitive price.” One policy expert commented that this may be somewhat unique to Arkansas and that the Private Option might not be able to be “replicated in other states without a similar commitment in delivery reform aspects.” This expert went on to say that there may not be a “one-to-one correlation between market competition and the same success in limiting cost growth. I think it could help, but I don’t think it is a certainty.” Similar comments were made about the strength of inter-agency collaboration. Medicaid and the Arkansas Insurance Department must work closely together on regulatory issues and program coordination. “Inter-agency turf issues” play a role in these complex program designs, said one expert. And another commented that the biggest challenges
to the success of a program like this involved state staffing capacity, data analytics capacity and infrastructure. The Arkansas success is likely attributable to many of these important operational characteristics.

There remain operational and programmatic challenges. The legislative report noted that there may be participants in the program who are living outside the state, who may be deceased, or who may be incarcerated. Recent reports last summer suggested operational challenges regarding annual eligibility verifications for those on Medicaid and the Private Option, and the governor placed a temporary hold on terminations to address this issue (Lyon, 2015a). There are general issues around how cost-sharing might be working. And there is a lack of data on the effects of people transitioning from the Private Option or the Marketplace, as well as a lack of data on health outcomes given the need for more longitudinal data. But generally, according to observers, and a general reading of the early evaluation reports, the Arkansas Private Option has succeeded on these general operational metrics.

But the need for additional data to assess the long-term success of the program remains clear. As one government official stated about the future of the Arkansas Private Option: “When we get an actual historical path and see that it is different in Arkansas than in other states, that will be when the test occurs. Because until then, it is all prediction and hypothesis. It is really hard to win battle after battle over time on old data and concept.” The early data has provided an important snapshot of this alternative waiver design to expand coverage for low-income populations. But the concept itself is also being debated within the larger context of political hostility to the ACA generally, a reality highlighted by the fact that 19 states have chosen not to expand coverage for low-income adults through a traditional Medicaid expansion or an alternative 1115 waiver design. It is that larger question of whether the premium assistance
model offers a path forward for other states that this study now turns.
Chapter 4

Results and Discussion:

The Path Forward

The second research question focused on whether this conceptual waiver design, as well as other similar alternative waiver designs, offers a path forward for the 19 states that have not expanded coverage for low-income adults. Five of the last eight states to expand have done so through a Section 1115 alternative waiver design. Arkansas was the first to gain approval of an alternative design, making six states that are operating under these alternative waivers. There was a consistent view among those interviewed that most, if not all, states that expand going forward will do so under a Section 1115 alternative waiver design. The interviews identified the major factors that shape that path forward, and they are discussed below.

Federal Funding and Economic Pressures

The amount of federal funding for Medicaid expansion is significant. Under the ACA, Medicaid expansion is paid for with 100% federal funding in the first three years, dropping down to a 95% federal match in 2017 and gradually going down to a 90% federal match in 2020 and beyond. In this joint federal-state program, Medicaid expansion is predicated on substantial federal financial support. To many observers, the June 2012 Supreme Court decision in NFIB v. Sebelius, which ruled 7-2 that Medicaid expansion must be an optional choice for states and not contingent on losing all state Medicaid monies if a state chose not to expand, was a surprise. Many believed, however, that given the size and scope of the funding, states would quickly expand. As one government official stated: “The assessment was we believed everybody was going to come in, and they would come in relatively quickly because it was so ridiculously crazy
not to…The resistance, I think, was surprising.”

There was significant effort to highlight the substantial economic benefits accruing to states to counter that resistance. In July 2014, the White House Council of Economic Advisors released a report stating that the 24 states that had not expanded were potentially losing a combined $88 billion in net federal spending over the 2014-2016 period when the federal match was at 100%. The report provided a state-by-state estimate on federal funding as well as potential employment and Gross Domestic Product (GDP) gains (The White House Council of Economic Advisors, 2014). The Urban Institute issued a similar report in August 2014 that estimated lost federal funding over the ten year period to be approximately $424 billion. It also detailed this data on a state-by-state basis and provided estimates of lost hospital reimbursement for each state, totaling, in the aggregate, $168 billion (Dorn, McGrath, & Holahan, 2014). A number of states did their own fiscal and economic estimates as well. Despite these compelling numbers, only five additional states expanded coverage from the summer of 2014 to the spring of 2016. Two of those states changed governors and parties during this period. A third, Pennsylvania, changed governors and parties but had already expanded Medicaid prior to the 2014 election. These economic numbers did not overcome the political, policy and fiscal resistance that was in place in a large number of states. As one expert commented: “If it was about economics, we would have virtually all states now having passed authorizing legislation and implementing Medicaid expansion. It clearly is far beyond that.”

Yet federal funding and economic pressures continue to play a large role in states that have not expanded. As one government official commented on the changing dynamics in states: “I think that pressure is continuing to build at the state level.” That official went to say that “a different kind of coalition” is emerging that includes local chambers of commerce in addition to
hospitals and advocates. This was echoed by a number of others. In addition to the pressures to expand coverage for low-income adults, a major focus of lobbying efforts, particularly among advocates, the role of hospitals was widely discussed in interviews. The economic pressures on struggling rural hospitals were mentioned by a number of people as adding additional pressures to the political debate. It was mentioned that in some states there already have been hospital closures. Another expert noted that many of the states that have not expanded have fairly significant rural populations. In addition, comments were made that hospital associations were open to provider taxes as a way to create a path toward expansion that reduced state fiscal obligations associated with the expansion.

Other economic pressures may also be changing the dynamic from two years ago. One researcher commented that with the drop in energy prices, oil and gas states may be feeling economic pressures, possibly providing added incentives for states to bolster their economies through this additional federal funding. Another commented that two states have uncompensated care pools that need to be renegotiated. This potential cut in funding adds additional economic pressures to these states as well. There appeared to be broad agreement that the economics of Medicaid expansion will be a significant driver that will likely be one of the catalysts to spur additional state action.

The economics of rising health care costs will also likely impact Medicaid expansion. One national policy expert, speaking broadly about the future, noted that most states will ultimately expand and use that expansion to help transform healthcare within those states. Transformation and expansion go hand-in-hand, given the role Medicaid plays in the healthcare system where “our current trends are not sustainable.” Another simply commented that the “economics are just very, very compelling together with the inequities of having such a low-
income population remaining uninsured.” Although many experts were surprised that the substantial economic benefits potentially accruing to states did not overcome the opposition in these states, those same experts believed that economic pressures will increasingly cause states to reconsider and will be a continuing underlying factor in the overall debate.

2016 Presidential Election

The 2016 presidential election contest clearly impacted the debate in many states, but not necessarily all. President Obama and the Administration continue to push to find ways for states to expand during this election season. The president included in his 2017 budget a legislative proposal to provide 100% federal funding for the first three years for the 19 states that have not expanded Medicaid and to then follow the same step down to a 90% federal match over the following three years (O’Donnell, 2016). The president also mentioned Medicaid expansion in his meeting with the National Governors Association in February 2016. As one government official commented, the president and the secretary are committed to “getting as many states in as possible…If he is visiting a state, he rarely misses an opportunity to point out whether there’s been an expansion or not.” But the presidential race is impacting that decision-making process. As this same government official commented, there are “less than a handful of states that are actively debating it right now, but most states are waiting to see what happens.” Another government official commented, “I would have thought there would be a complete shutdown during 2016 because of the elections. And there’s actually been more activity than I would have thought.” Despite the Administration’s efforts, however, it is unlikely that many more states will expand before the results of the presidential election are known. “Getting past this election is really going to matter for most of those states,” said one observer.

Although there was wide agreement among those interviewed that the elections would
have a major impact on expansion going forward, there were diverging views on the impact of
one party winning the presidency or the other. The more common view was that many states
would likely figure out how to move forward with expansion if a Democrat was elected. One
noted that the two Supreme Court cases dealing with the ACA, *NFIB v. Sebelius* (2012) and *King
v. Burwell* (2015), reinforced a feeling that the ACA is here to stay. A Democratic victory would
build on that point. But another commented that, throughout the process, there is always
“something just over the ridge,” such as a future primary, and “if I just bide my time and wait, I
will be vindicated. And my lack of action will be rewarded.” But, generally speaking, there was
a strong belief that there likely would be a lot of activity to expand coverage in many states if a
Democrat is elected.

There was some differing opinion about how much federal flexibility there might be
under a new Democratic administration. Some believed that a new Democratic administration
would likely be more “pragmatic” and provide states with more flexibility in the design of their
waiver programs in order to get as many states to expand as possible. Others suggested the
opposite. A new Democratic administration would have more leverage over states that are
feeling pressures to find a path toward expansion and, therefore, may be less reluctant to make
some of the concessions that have been advanced in previously approved waivers. A widely
expressed view was that much of the current hostility to expansion was a result of personal
political hostility toward President Obama. With the President out of the way, that hostility
might “wane” in a new Democratic administration, creating opportunities for states to find a path
forward without the kind of political resistance felt at home. But it remains unclear whether
states wishing to expand will be able to advance the Arkansas model or the Indiana model, the
two most discussed waiver designs already approved. Under a Democratic administration, those
interviewed believed many states would come forward in the next couple of years, but the design of their plans would be dependent on a number of factors, such as the approach of the new administration and what evaluative evidence there might be to support the alternative waiver designs currently in place.

Opinions varied widely on the impact of a Republican administration. Republican presidential candidates have campaigned to repeal the ACA. As one observer pointed out, “history states that you cannot have an issue as visible as health care will be in the general election and then just say ‘never mind’ once you come in to office.” But this policymaker went on to say that that statement must be contrasted with how difficult it will be to roll back those policies, and compared it to how difficult it has been for governors that have been elected and campaigned in opposition to the ACA to actually do that. “We have seen that in Arkansas. We have seen that in Kentucky.” Another observer commented that it would be very difficult to eliminate programs up and running in more than 30 states because many of these governors would actively oppose legislation without some alternative in place. Thirteen of these states currently have Republican governors. This conservative commentator noted: “The idea that you are going to just throw all those off on your first day in office is completely ridiculous and not even possible.” He went on to say that the Republicans must start developing alternative plans or they “will enter office without enough ammunition. And they just won’t be able to do it.”

Block grants and per capita caps were mentioned as possible alternatives to simply eliminating coverage for low-income populations under a Republican administration. Block grants would provide an annual appropriation to states, as opposed to an open-ended entitlement for individuals, with an annual trend established. A per capita cap would establish a per-beneficiary payment limit based on the number of enrollees. Certain populations, such as people
with disabilities, would have different per-beneficiary caps than other populations. As one stated, Republicans must avoid the stereotype that they simply do not care about low-income populations and must provide an alternative framework that “is an improvement in the way the program works for low-income people. That is very hard to do….and you have to get Congress to go along with it.” It was suggested that a new administration might be forced to let states decide for themselves to keep the current expansion or to pursue an alternative waiver design, such as a per capita cap arrangement, as a way to move forward on a policy alternative without facing the possible hostility of state governors that have already expanded coverage.

The 2016 elections will have a significant impact on the path forward for states. Both scenarios have significant implications. The election outcome may create a tipping point where many states come forward with alternative waiver designs. It may also create a new political debate, as one expert commented, of protecting what has been established and fighting over what the future might like look like for states going forward. All recognized that there would be significant activity following the 2016 presidential contest. As one researcher succinctly commented: “My only prognostication post-election is that we are going to see a lot of waivers either way. The waiver business will remain robust.” The 2016 presidential election remains a critical factor in determining the path forward for coverage expansion.

Role of the Federal Government

Medicaid is a joint federal-state program, and the federal government plays a significant role in its overall operation beyond the federal financial support it provides. The federal government sets broad rules for the program. But the Secretary of the Department of Health and Human Services (HHS), under Section 1115 of the Social Security Act, has authority to waive those rules for demonstration projects to test new ideas and concepts. The key requirement in
the regulations is that a demonstration will likely “assist in promoting the objectives of Medicaid” (Department of Health and Human Services, 2012, p. 11678). In addition to this requirement, the demonstration must test a hypothesis and be evaluated, must have public input, and must be budget neutral, meaning the demonstration cannot cost more than what it might cost without the demonstration (Rosenbaum & Hurt, 2014).

Arkansas was the first Section 1115 demonstration to be approved for the expansion of coverage for adults age 19-64 under the ACA. Currently there are six waivers that have been approved. Two are testing the premium assistance model. Most are testing premiums or monthly cost-sharing contributions. One is testing co-payments above the statutory limits under Medicaid. A few are testing incentives for wellness and healthy behavior. Two have waived the non-emergency transportation benefit. And two have waived retroactive eligibility for Medicaid coverage (Rudowitz & Musumeci, 2015). These changes, along with a few others, are the major features of these alternative designs, although a number of specific proposals were not approved because they were viewed as not furthering the objectives of the Medicaid program.

A theme that emerged in interviews involved the issue of insurance versus welfare, and this broader philosophical view appears to be an important guide to understanding the policy discussions taking place. Medicaid was initially based on categorical eligibility. If you were disabled, pregnant, or had children and were below a certain income level, you were entitled to cash assistance and Medicaid coverage. That link was broken in 1996 when the welfare reform law was passed. Cash assistance was no longer required as a condition of Medicaid eligibility, but Medicaid was still linked to categorical eligibility. Under the ACA and the expansion of Medicaid to the adult population, that link shifted to income-based eligibility for those who had previously been ineligible, though categorical eligibility remains for some populations, such as
children and pregnant women, above 138% of poverty. Medicaid expansion, together with premium tax credits in the health insurance exchanges for those between 100% and 400% of poverty, formed the basis of an insurance model for subsidized coverage rather than a welfare model for low-income adults. Medicaid has become part of a larger comprehensive framework to provide insurance coverage for all.

A set of principles was often used in interviews to describe the federal approach following *NFIB v. Sebelius* when Medicaid expansion became an option for states. Common among those statements was that waivers must include coverage up to 138% of poverty, not 100% when exchange eligibility kicked in, since that was the law for Medicaid, and that waivers must enhance the Medicaid program in accordance with Section 1115 authority. As one government official commented, other than a “relatively few kinds of bright lines…anything was on the table.” Outside observers for organizations that track these negotiations echoed that federal flexibility was apparent. But another expert, somewhat critical of the program, commented that the administration was “hung up” on covering populations “our way” and that a new administration will become better able to make “business decisions” with states because “it is not the Obama Administration anymore.” The general view, however, was that in order to get states into the “yes” column, the federal government was “willing to be somewhat flexible with states.”

Yet despite that view, all participants recognized the many challenges facing waiver approvals. A number of state ideas were viewed by some policymakers to contradict the notion of subsidized insurance and did not comport with furthering the objectives of Medicaid. The issue of work requirements and lifetime limits came up in interviews as not meeting these tests. All those interviewed believed this administration would not accept such proposals, and the
Administration has made clear to states that they would not budge on these issues. But interview participants also noted that the federal government has tried to provide flexibility by allowing states to refer enrollees to work training programs while not making these programs a condition of eligibility.

There appeared to be more openness by the federal government to the ideas of premium and cost-sharing in Section 1115 waiver designs. Medicaid prohibits premiums for people under 150% of poverty and limits cost-sharing to nominal amounts with the total not to exceed 5% of income. Many commented that in states that have not expanded Medicaid, people between 100%-138% of poverty are eligible for the exchange and will pay a premium of about 2% of income. A number of people commented that premium and cost-sharing could be termed as a fairness issue when compared to states that have not expanded. It would be difficult to make the argument to prevent states from imposing some cost-sharing when cost-sharing was occurring in other non-expansion states for this same income group. Another noted that cost-sharing at this level helps make Medicaid look more similar to insurance and the private market. And another expert noted that it was very unlikely to see conservative states come forward to expand Medicaid without some premium and cost-sharing requirement, and also stated, “Many states will want to go a little bit below that as well.” Others raised concern that research suggests low-income people are highly sensitive to out-of-pocket costs and it would ultimately create barriers to coverage. All but one of the six waiver states have an approved waiver to implement cost-sharing, and it is generally viewed that other states coming forward will ask for cost-sharing and will likely receive it with certain limitations. Arkansas legislated a two percent premium beginning in 2017 in addition to its existing cost-sharing requirements previously approved in its amended waiver in 2014.
A “balancing act” was a phrase used in a number of discussions on more complex political and policy questions. That balancing act refers to the federal government providing states with flexibility in their plans while limiting the number of waivers based on experimentation and testing of new ideas. As Arkansas was negotiating with the Centers for Medicare and Medicaid Services (CMS) over its premium assistance model in 2013, CMS issued guidance through a Frequently Asked Questions document to identify what the agency would and would not approve. It also stated it would, at that point, only “consider approving a limited number of premium assistance demonstrations” (Centers for Medicare and Medicaid Services, 2013c). Indiana’s Section 1115 waiver, which many noted gave the administration discomfort, was approved in January 2015 and included a Health Savings Account premium and a lockout provision for those that failed to pay their premium. States were informed that Indiana received a waiver for a lockout provision because such a provision was in that state’s previous waiver. The federal government made it clear that it was not approving additional lockout provisions. As one outside observer commented: “Very, very quickly after the Administration approved Indiana, it said: ‘This is not a trend. This is an experiment.’ The administration hedged its bets a little. It pushed itself out of its comfort zone to approve it. But then it stopped its exposure by saying no more.”

Underlying these waiver approvals was a recognition that they create precedents that impact future discussions with other states. At a political level, many commented that these precedents are closely watched by states. As one government official noted, it becomes a fairness issue. Governors will likely seek what other states have received. The federal government must balance that with testing new ideas. But it was also noted that it was important to be clear and transparent through guidance and state discussions that what may have been
approved in one state may not be approved in another state. As one government official commented, “you don’t want it to be a guessing game” and “you can’t treat governors any other way.” It was widely noted that, internally, the federal government is acutely aware of the precedents these policies may create and it is widely discussed as part of the waiver approval process. But these waiver approvals, like the ones in Arkansas and Indiana, may be limited and do not guarantee that other states can get approval for these same designs. One government official was careful to comment that waivers are meant to be demonstrations, to experiment and to test out new ideas. This administration, or possibly a new administration, might not approve 19 premium assistance models without data and careful evaluation of the initial results of the Arkansas demonstration. Though this official went on to say, “We have never had to test that question so far, because we haven’t had the floodgates.”

Many of the state waiver proposals are based on the concepts of personal responsibility, healthy behavior, work, and private coverage. These ideas have raised some concerns among some more liberal policymakers about what the overall impact might be. As one policymaker commented: “The Administration is trying to balance the desire to have every state expand with the fear that the unintended consequences could be significant.” There was concern about how far the federal government might go. As one commented: “Will the next administration drop the floor more?” There was a recognition that the federal government has stepped out of what might have been traditionally expected. As one researcher commented on the Indiana waiver: “They’ll never go for that. And then they go for that. It’s like ‘Wow I didn’t see that one coming!’ I thought they would hold the line on that one.”

The federal government has significant authority and a significant role to play in addressing the remaining states that have not expanded coverage for low-income adults. In
many ways, themes about insurance versus welfare have framed the discussion with states and have set the broad parameters of these discussions. It was generally recognized, though not by all, that the federal government has been relatively flexible to date with states to find a path under Section 1115 alternative waiver designs, though they have also been somewhat cautious by stating they would limit the number of demonstrations to test new ideas. In that regard, there appears to be an openness to seeing other states pursue a premium assistance model, but with possible limitations on the number of waivers granted.

States

The decision on whether or not to expand coverage under the ACA, and in what form, through traditional expansion or a Medicaid waiver, ultimately rests with the states. Of the 19 states that have chosen not to expand, Republican governors head up the executive branch in all but two of those states. Without a governor supporting coverage expansion, or at least acquiescing to a legislative proposal, there is little likelihood that a state will expand coverage. There was a fairly common view that a significant number of governors, nearly half, are interested or have been carefully exploring ways to find a path to expand coverage within their state. In a broader sense, it was mentioned that the origins of the Arkansas premium assistance model was predicated on the fact that either a governor or legislature, or both, were not going to be able to support traditional Medicaid expansion and that alternative models were required to deal with this political challenge. It was noted that a private sector approach, together with the ability to withdraw if the federal government reduces its financial commitments, provided a framework to narrowly pass the Arkansas Private Option in 2013. It was also noted that the Private Option was not a “cookie-cutter approach from Washington,” but rather was designed to “meet the needs of Arkansas.” But these facts, one noted, do not necessarily suggest that other
states will pursue the “exact Arkansas model,” though another noted it was one of the models that many states are examining.

What emerged in the discussions, however, was that the challenges many governors face centered on finding a political and policy path that could gain the support of legislatures. As one commented, “Legislatures have been instrumental in how this has proceeded.” This viewpoint was widely shared. Some states are looking for policy alternatives that politically can make it “appealing” to their legislatures. Policy designs must work from an operational perspective, first and foremost, one commented, but then, secondarily, it must be examined in terms of the votes it brings. Negotiations over possible waiver approaches are partially designed to “give enough political maneuvering room to actually get legislators to vote for it.” Oftentimes this policy process is played out at the margins, with discussions of policy ideas focused on a few legislators in order to find a path for passage. Policy, politics, and state costs were discussed as three important, and intertwining, pieces to the overall puzzle. As one noted, if you reduce your exposure to state costs, through a hospital tax for example, but have not addressed the other two pieces, you will not likely succeed. Reducing state costs “might be necessary, but it is not sufficient.” Most suggested that the governors are taking a pragmatic approach to an alternative waiver design that is, in many ways, shaped by legislative vote counting.

While all commented that the 2016 elections might change that waiver dynamic, several participants discussed the role of future state elections as well. A number of people mentioned that, following the 2016 elections, 36 gubernatorial elections will take place in 2018. In addition, state legislative contests for some or all members take place every two years. Some suggested that future gubernatorial elections will continue to limit opportunities, much like the current presidential contest. As one commented, there is always “something just over the ridge.”
Others suggested that many governors might be nearing the end of their two terms and may feel more emboldened to try to push through coverage expansion before their term expires. Still others commented that House members typically serve two years and are likely to be more susceptible to political pressures, suggesting that these legislative bodies, with a few exceptions, may be a continuing challenge for states that may be trying to pursue expansion opportunities. But, with that being said, a number of interview participants commented that almost all states had expanded Medicaid within four or five years following passage of Medicaid in 1965, and that all but one state had established a state Medicaid program by 1972. Most believed that a similar pattern may emerge with regards to Medicaid expansion under the ACA. As one federal official summarized this optimistic view: “So nearly two-thirds of the country is in in the first two years, which is, given the politics of this issue and the politics around the country with 31 Republican governors, pretty astounding in and of itself.”

Many experts referred to a “tipping point” in connection with expansion dynamics among states. A number of people commented that the states that have not expanded coverage are concentrated in the South. There was some belief that if some states in that region began to take steps to expand, more would follow. Said one government official: “I think if one or two of those southern states started to come up with a program, then it starts to be a little easier for others to follow. So someone is going to have to take the next plunge in a region of the country, if you will, and they won’t do it with traditional Medicaid. They will do it with some alternative program.” One expert suggested the Private Option was a possible path for a number of states. This official commented that a number of states that border Arkansas seem well suited for this waiver design. This official went on to state, “Medicaid enrollment could be actually pretty big, and they have non-competitive or weakly competitive private insurance markets. That is the
sweet spot.” The current market conditions in some states suggest that the Private Option is a possible viable model for a number of states going forward.

A number of people raised concerns that this waiver design may be more difficult with federal health insurance exchanges. Arkansas currently runs a state partnership exchange where it is responsible for certain functions of the health insurance exchanges. These other southern states operate under a federal health insurance exchange. A couple of experts also commented that agency coordination and agency capacity and expertise are key components to embarking on a complex waiver design such as the Private Option. Some states may simply not have the capacity at this point to design such a program even if it broadly appeals to them as an alternative waiver design. The interviews suggested that a significant number of states are trying to find a path to provide coverage for low-income populations, but they will continue to struggle with fundamental questions about how to piece together a design that can be supported within that state, as well as whether the state has the capacity to implement a complex waiver design such as the Private Option.

Politics

The politics of the ACA, or what is known as Obamacare in the political arena, has shaped the political debate of many states on whether or not to expand coverage for low-income adults through the Medicaid program. Polling has shown that Republicans oppose Obamacare by a large majority and Democrats support it by a somewhat smaller majority. The divide among the political bases of each party has created divisive politics since the start. As one federal official commented, “Politics has played a huge part in the reluctance of the remaining states to expand.” This political divide has led to what a number of experts describe as an ideological hardening of the policy debate on this new program. One expert described how a
number of states expanded because they see coverage expansion as a proper role for government. At the other end, many states were completely opposed because they do not see it as a proper role for government, that it is creating a welfare state. And in the middle, there are a number of states that have strong ideological concerns on both sides of the debate, but budgetary and other political or policy concerns, played a role, or are playing a role, in the politics of the Medicaid expansion policy debate. This middle group of states is not static, and the resistance does not necessarily reside exclusively in the executive or legislative branches. But it is among this group of states that most of the activity is currently occurring.

There was widespread agreement among those interviewed that the politics have become personal against President Obama and is even more significant than the ideological concerns about the ACA. As one expert noted, the visceral opposition is political, not ideological or fiscal, though all of these factors play a role. Numerous people talked about how “it has been so tied to him” and that his departure from the political scene will likely change the political equation. As one government official noted, “Symbolically, when Obama leaves office, it will be one more obstacle out of the way for a governor and a legislature.” Another commented, “It has just been so toxic, because it is his initiative. And I think it will be a little bit freeing having a new president.” There was a strong belief among all those interviewed that the political intensity might wane and that new opportunities might emerge as it becomes less and less associated with the president personally.

Outside national groups have played an important role in debates within states. One group singled out was Americans for Prosperity, a conservative advocacy group founded by the Koch brothers, as a key player in these political debates. It was noted that, in Tennessee, for example, which was considering a coverage expansion proposal, this group entered the debate in
a major way and that ultimately the legislators “balked.” This group was a leading voice in opposition to the current Arkansas governor’s successful effort to reshape and extend the program (Lyon, 2016).

State advocacy groups have led the political opposition in a number of states as well. A well-funded conservative group, founded by the current governor of Nebraska years earlier, developed a detailed policy paper arguing against a premium assistance model that the legislature was considering. They used the GAO report to argue that the Arkansas Private Option cost nearly $800 million more than a traditional Medicaid expansion and that its costs have been far higher than projected. The document also stated that cost-sharing differences between Medicaid and the exchange would discourage work and create a new “welfare cliff” (Ingram & Horton, 2016). A common theme for opponents is that that premium assistance and waivers generally are simply Obamacare by another name. These political advocacy efforts have intensified the debates in states with Republican-led governors and legislators. But they are also pitted against powerful coalitions of hospitals, health advocacy groups, and local chambers of commerce that have been vigorously lobbying for expansion in many of these states. These local efforts have ensured that the debate about expanding coverage will remain a central policy matter in many state capitols.

These pressures, for and against expansion, have intensified the debate about what coverage expansion through these alternative waiver designs in Medicaid actually means – is it Obamacare or is it not? Reframing the debate has been central to the politics of coverage expansion. It was widely noted that the politics of coverage expansion over the past few decades has included a rebranding of the program. Many noted how almost all states “individualized” the Children’s Health Insurance Program, a bipartisan bill that was passed in 1997, despite the fact
that it generally had widespread support. As one expert noted, states want to define coverage expansion as “our program, not their program” and has been a consistent theme in health care politics and Medicaid for years. One expert noted that previous coverage expansions had a “local flare…It’s Peach Care. It’s Tenn Care. It’s Dirigo. It’s Badger Care.” The use of language and reframing has been central to recent waivers as well. The Arkansas Private Option, Healthy Indiana Plan 2.0, the Iowa Wellness Plan, and Healthy Michigan Plan are a few examples of how states have branded these programs specific to their states as part of providing coverage for low-income adults. A number of people commented that the word “Medicaid” was rarely used in program designs because of its connotation to welfare. Many discussed how this framing was important to the politics of coverage expansion. One noted, when discussing possible future waivers and the use of state-specific language and the lack of reference to the Medicaid program, “You will continue to see it.”

Making coverage expansion unique to a state and as a way to contrast the broader political debate about Obamacare were central themes in how states might move forward. Said one government official: “This is really not what Washington wants us to do. We’re doing our own thing. We are fashioning our own plan. We have our own design. It is something that can work for the citizens of the state.” Another expert stated: “Not only is it politically important to contrast expansion with Obamacare, but also to gain greater confidence and investment in those programs at the state level.” This political debate is, in many ways, what defines the path forward in states seeking waivers. As one government official noted, “The conservative people are going to say it’s just Obamacare by another name. The liberal people tend to say that, no it isn’t, because look at all these state-specific changes that we have made in order to make this work. I think that the truth is probably somewhere in between.”
This definitional debate through language is evident in Arkansas today as the new governor has attempted to make changes to the Private Option, including changing the name to “Arkansas Works.” In the winter of 2016, he addressed head-on the charge from his conservative and liberal critics that support for his proposals was tantamount to support for Obamacare. In the press conference, he stated, “It is perfectly consistent, it is perfectly conservative and logical to oppose Obamacare as federal policy and yet to accept federal dollars under the Medicaid program in Arkansas. It is a logical position, it is an Arkansas-oriented position, and it does not embrace the federal policy that is the framework of Obamacare.” In that press conference he went on to state, “It’s important that we make decisions that are right for Arkansas” (Ramsey, 2016b). Americans for Prosperity, a national group in opposition, issued a press release directed at legislators during the vote to extend the program stating that support for the new program, Arkansas Works, meant support for Obamacare and Medicaid expansion (Lyon, 2016).

This framing was used when the original Private Option was debated in Arkansas three years earlier, in 2013. In a document highly critical of the Private Option, numerous quotes were compiled from the legislative debate that took issue with the characterization of the legislative bill in an attempt to reframe it. The language is instructive. One senator stated the “Private Option alternative is not Medicaid expansion.” Another senator noted that the Private Option “gets people off Medicaid and gets them into private insurance and gives them skin in the game and encourages some personal responsibility.” This senator also stated, “The Private Option will be authorized under 1115 waiver authority, not the Affordable Care Act. And a representative made clear, “A vote for the Private Option in Arkansas is a vote against Obamacare.” Still another senator called the Private Option “Medicaid block grant funding” (Ingram, 2014).
The importance of reframing the debate and establishing “their own imprimatur on it, having it called their own, and making it uniquely theirs” was echoed throughout all of the interviews. So, too, was the need to contrast it politically from Obamacare as a condition of moving forward. Supporters of expansion also employed free market, private sector, and personal responsibility terminology to gain support for their reforms. The use of language of was considered a key factor in the political debate and was discussed by a number of experts. One official noted that the Arkansas waiver was predicated on the private sector: “They’re private pay, they’re privately insured, and they’re on the exchange.” This expert went on to say that “without that kind of combination – without those political optics – there’s no way it would have happened.”

The concept of personal responsibility appears to be a key political value for states considering expansion. A couple of experts noted that personal responsibility is one of the key justifications in recent waiver applications. The need for some form of cost-sharing in order to have “skin in the game” and have ownership in your health plan responsibilities, such as wellness visits and healthy behavior, were mentioned as likely key tests for future waivers. One commented that cost-sharing was politically necessary as part of a waiver package even if premium or cost-sharing payments were not collected because it confers some value: “Just the ability to say, we are charging a premium whether or not it is paid, whether or not it is collected. That’s enough because that reinforces that this is a value proposition, that we are valuing the time of the physicians and we are respecting the adulthood of the consumer.” Another noted that it characterized a fairness to the system, since other people have cost-sharing responsibilities. The interviews suggested that private market integration, some form of personal responsibility through cost-sharing and healthy behavior, and emphasizing a unique state design to contrast
state efforts from Obamacare are key components of future waivers and will be defined by such narrative language in order to obtain the political support going forward in these states.

**Evaluation**

Experts stressed the need to evaluate the performance of existing alternative waiver designs in order to inform the debate over the future of coverage expansion. Many stated that this is an important component to the discussions that cannot be overlooked. But as important as evaluation is, it must also compete within the broader political landscape. As one researcher noted, “I am not here to say that evidence trumps politics, because it usually doesn’t. But sometimes it has a little impact.”

A number of experts reiterated the fact that waivers are demonstrations, and that Section 1115 waivers require an evaluation of those demonstrations. Federal officials noted that they would likely only approve a “limited number” of demonstration waivers until they had the opportunity to be evaluated. One researcher noted that, politically, many states might struggle with expansion discussions until there is more evidence to demonstrate impacts. One government official also commented that evaluative evidence would be the true test of the Private Option – showing that it produces different results than other states without such a design.

A number of experts commented on the challenges facing evaluations of these 1115 waivers. One noted the complexity of evaluations: “I worry about getting good evaluations because the policy interactions are so complicated that I am not sure, even if you had no political considerations, that you really will be able to tease it out. I think it is tough to begin with, and then you have these political challenges as an overlay.” Another researcher commented that one of the key questions, particularly around cost-sharing, is evaluating whether the program design can in fact be operationalized. If you have cost-sharing at the point of service, but then providers
are not collecting it, this researcher went on to ask, how can you say this is operationalized and how can you say this is working? A couple of researchers also commented on the need for independent evaluations. States have a vested interest in their evaluations, and state-commissioned studies can be biased. As one expert noted: “They don’t always get to say what they need to say. I have seen that happen in many places over the years.”

Numerous experts commented on the importance of evaluation around enrollment, cost-sharing, wrap-around benefits, the medically frail, cost trends, or health outcomes. But these evaluations will take place within a political environment. As one researcher noted: “I think evaluations play a role, whether they are a leading role probably depends on the state and the political situation as well.” There was broad agreement among researchers, federal officials and state officials, however, that evaluating these alternative waiver designs was a critically important task. “Detecting if something really works,” as one researcher commented, is an important factor going forward and will likely help shape the future of coverage expansion in the remaining 19 states.
Chapter 5

Recommendations and Conclusion

Signed into law by Governor Mike Beebe in the spring of 2013, the Private Option has undergone changes since it began operating a little more than two years ago. In late 2014, the state’s waiver was amended to include monthly contributions to Health Care Independence Accounts (HIA) for people between 50% and 138% of poverty to pay for cost-sharing responsibilities (the state suspended these accounts for people between 50% and 100% of poverty shortly thereafter). The waiver was designed to test and make more seamless cost-sharing impacts as people transition between the Private Option and the Marketplace (Arkansas Department of Human Services, 2014a). In April 2016, Governor Asa Hutchinson signed additional changes to the program into law, including changing the name to “Arkansas Works.” As in previous years, extending this program has been a continuing challenge for the state’s lawmakers. In a legislative sleight-of-hand, the bill continued the program for six months before it would terminate in December 2016, but then the governor, using his line-item veto authority, vetoed the expiration date. Appropriation bills require a three-fourths majority, and the bill passed with no votes to spare in the Senate and one vote to spare in the House. This action allowed people to vote for ending the program while still allowing the state to operate the program for the upcoming fiscal year. The governor, in commenting on the legislative action, stated that he “invested some political capital” to get this done (Lyon, 2016).

The new law includes many changes besides changing the name to Arkansas Works. It establishes a $19 per month premium payment for those between 100% and 138% of poverty. It provides incentives, such as vision and dental benefits, for those that remain current on premium
payments and have annual wellness check-ups. It directs the state to seek a waiver from the federal government to provide incentives for employers to enroll those eligible for this program in employer-sponsored insurance. It also directs the state to seek a waiver to eliminate retroactive eligibility. For those under 50% of poverty, it establishes a work referral program for job training and job search activities to increase workforce participation, though this is a voluntary program and not a requirement of eligibility. And finally, it directs the governor to seek block grant funding if federal law changes or if the federal government will allow a block grant to be approved (State of Arkansas 90th General Assembly, 2016). The premium assistance model continues to evolve and change even in its third year of operation.

The Arkansas Private Option

The formative evaluation of the Private Option suggests that it is a promising model and is meeting most of the purposes it was set out to accomplish. Enrollment has exceeded projections and the Private Option today has the largest number of enrollees within the overall exchange, though it seems clear that expansion itself, not the features of the Private Option, has driven coverage expansion. Arkansas had one of the highest uninsured rates before the program started, and the large enrollment increases can likely be attributed to that factor alone. But it is worth noting that this enrollment increase occurred despite the fact that funds for outreach and education for the Marketplace were eliminated, and continue to be withheld, making the enrollment gains within the Private Option all the more impressive. It is, indeed, as one official commented, an area of concrete achievement in these early days of the program. Continuing to examine the population characteristics of enrollment, particularly among the Hispanic and the Marshallese community, which the enrollment data suggests are below the demographic characteristics of the state as a whole and includes populations that have little experience with
the healthcare system, is an important area for research going forward in order to better understand the possible barriers to enrollment for all segments of the population.

The mechanics of the Private Option appear to be working as well. The early data suggests the Medically Frail are being properly identified, and the state’s screening program, both at initial enrollment and during the course of the year, seems to be redirecting those with complex health needs to the Medicaid program reasonably well. The screening tool, as one commentator noted, was developed with outside experts in the field, and is likely a model for other states. Given the state’s projections and the general qualitative data that suggests there are not any identifiable problems at the moment, other states will likely look to Arkansas to develop this screening tool. Ongoing research should continue to test whether the screening process is identifying those that require additional long-term support and services and are properly placed in the traditional Medicaid program.

Similarly, wrap-around benefits appear to be getting to their intended beneficiaries despite being administered outside a health plan’s benefit package through the state Medicaid program on a fee-for-service basis. The data suggests that monthly costs for this program are slightly below the initial state projections. However, the qualitative data suggests that, at this point, there have not been any identifiable concerns. The lower costs could be an indicator that people are unaware that this benefit is available to them or could be simply the fact that higher projections were used to protect the state from unforeseen costs. There is a need to better understand the breakdown of this benefit to properly understand how much of this current payment is going to EPSDT or for non-emergency medical transportation and if the program is accurately capturing all those who are eligible. It is important going forward to conduct research that examines both of these wrap-around benefits and compares them in relation to projections or
past experiences in the Medicaid program. With these benefits being administered outside of the overall benefit package, this seems to be a particularly important area to continue to monitor and examine.

The large increase in the number of providers and health plans participating in the Private Option suggests that premium assistance and the integration of these two markets have been two of the most important design features of the program. The waiver allowed for market-based rates to be established, and the data suggests that a large number of providers have entered the Private Option market compared to the traditional Medicaid program. The increase in providers will likely allow greater access and consumer choice for new entrants into the healthcare delivery system. Since early data only provides a raw picture of the number of providers, it will be important to understand the breakdown by type of provider to identify if there are particular gaps in certain regions of the state or gaps among certain specialists. But the early data suggests there has been a substantial increase in providers willing to participate in the new program, likely mitigating some concerns that have plagued all Medicaid programs for years, particularly around access to specialists.

Provider rates, together with a larger enrollment pool in the overall exchange due to the Private Option, suggest that the elements are there for a growing competitive market in Arkansas. Five plans are participating in the exchange, up from three initially, though one nationally-based company that currently has a limited number of members in the Arkansas exchange has announced its intention to leave the market in 2017 (Davis, 2016b). Auto-assignment for those enrollees who do not choose a health plan and are thus assigned a plan through a formula seems particularly well-suited to help attract health plans to the market and establish market share. The state’s payment and delivery reform initiatives, making the state an
active purchaser, was recognized by many as important in creating a successful and competitive market, and it appears that these initiatives are central to the success of the overall market. Rate increases each year have remained low. It remains to be seen if this is a trend or an aberration. But the early data suggests that the steps the state has taken to attract health plans and to create a competitive market are on a positive path. These actions appear to be important components for other states to consider if they begin to contemplate a premium assistance model. Health plan participation, the spreading of market share, and ongoing medical cost trend are important features to watch in the coming years.

Net state savings also appears to be a positive benefit of the Private Option. The state, in just its third year, is projecting net state savings over a five year period of $757 million despite the fact that it is now responsible for a five percent match in 2017 and increasing to a 10% match in 2020 and beyond (Davis & Fanney, 2016). While much of that savings can be attributed to savings associated with any Medicaid expansion program, such as state savings from reduced uncompensated care and the transfer of certain state-funded programs now funded under the newly expanded program, additional savings are generated through premium taxes that are allowable under Medicaid. For states operating under a fee-for-service system rather than a private sector system, or for states that have not established premium taxes on health plans, these premium taxes represent a lost potential for revenue to help support the program. In Arkansas, a state that has operated Medicaid on a fee-for-service basis, the Private Option, with all members enrolled in health plans that are subject to a premium tax, helps contribute to the overall financial picture of the state’s budget. State savings are significant. There are also numerous studies documenting potential savings through expanded coverage. The Private Option provides additional evidence to that argument. The results should provide other states considering
expansion proposals with clearer frameworks of the interactive budgetary effects that are likely to occur if such proposals are pursued.

The integration of the Private Option and the Marketplace also has helped to eliminate churn as income fluctuates between Medicaid and exchange eligibility levels. While some states, like Nevada, have attempted to address integration by requiring Medicaid managed care plans to participate in health insurance exchanges to reduce churn, there appears to be potential weaknesses in that approach which the Private Option addresses. Medicaid plans are paid by states based on capitated payment rates that are established for certain populations, such as children, pregnant women, or people with disabilities. These rates are typically lower than market rates. Medicaid plans will face pressures to increase rates in order to attract providers that will be willing to participate in both Medicaid and the exchange, but those rates might possibly be lower than other competitors just operating on the exchange because of these state capitated payment rates. Their provider networks may, therefore, not be as robust as what is being seen in Arkansas today. More importantly, this alternative has the effect of keeping the enrolled population in the health insurance exchange relatively small in comparison to a combined program. In states with smaller populations, their limited scale may affect how stable the overall exchange market may be. As one expert commented, this increased scale, and the corresponding beneficial effects of increased provider networks, health plan competition, reduced churn, and lower medical cost trend through a larger pool, is likely an important “point of departure” of the Private Option from other states. While the examination of size and scale of health insurance exchanges in comparison to other states was beyond the scope of the study, it is a critically important point. The long-term success of health insurance exchanges is dependent on a strong and stable market. Whether premium assistance helps contribute to strengthening the
exchange market is an important research issue going forward, and the evidence from the Private Option is an important data set for that broader examination.

Despite these positive features, there are a number of challenges facing the Private Option. The early evaluation data suggests that emergency room utilization is a continuing problem for the program. While the data suggested fewer people in the Private Option used the emergency room than traditional Medicaid enrollees, and did in fact access primary care providers, there was a higher rate of regular emergency room usage for those that did access emergency care. In fact, the data points out that nearly nine percent of all Private Option enrollees used the emergency room three or more times in a given month, which was significantly higher than the Medicaid population (The Stephens Group, 2015). This has always been a challenging problem for Medicaid programs, and the data suggests that elements of that problem continue in the Private Option at this early stage in the program. Health literacy is an important component in addressing this problem, together with providing co-payments for non-emergency use of ER to discourage this high-cost utilization. Many enrollees are new to health insurance and how it works. Prior to obtaining coverage, their only available option, if uninsured, was likely to have been emergency rooms, community health centers, or free clinics. The evaluation reports, as well as many experts, spoke to the need for education of this population who have likely never had insurance before, have had sporadic engagement with health insurance, or possibly only having had it as a child through Medicaid.

The state’s decision to defund any outreach and education activities for the Marketplace, while somewhat tangential to the Private Option, seems particularly short-sighted. The state has built an integrated private-sector approach to insurance coverage that is designed to provide healthcare services through the most appropriate and cost-effective means. Outreach and
education initiatives should be a central part not only for enrollment, but also for increasing health literacy to those new to the program. The state should reconsider its decision in this area, and should also examine how to increase education and health literacy initiatives. There should be a statewide conversation on how insurance works given the new program’s existence. While many non-profit groups, providers, and health plans are, in fact, active and involved in this area, more should be done to help improve overall health literacy as part of providing coverage for this adult population. The state can play a particularly important role in that effort.

The early evaluative data has also identified concerns around Arkansas’ new cost-sharing program, which was instituted following approval of the state’s amended waiver. The Health Care Independence Accounts (HIA), a voluntary program designed to pre-pay cost-sharing through a $15 monthly payment, or $180 per year, to cover the maximum out-of-pocket cost-sharing expenses totaling $604 per year, does not appear to be working well. Less than a quarter of the 46,000 cards have been activated, and only about five percent of the total eligible pool makes monthly contributions. The legislative task force recommended that the program be discontinued (The Stephens Group, 2015). Interviews suggested that those with low utilization may prefer paying point-of-service payments and may see it as less costly than a $15 monthly payment. Interviews also suggested that some providers may not be collecting cost-sharing given the nominal payments and the hassles in collecting such payments. There was some concern that the state’s announcement that the program was being discontinued for those between 50% and 100% of poverty may have contributed to confusion around the program as well. For heavy utilizers of health services, however, there is tremendous savings associated with this pre-payment program. Despite the administrative difficulties in running this program, further research should be conducted to better understand who is using these accounts and who is
not before making any policy decisions. The voluntary nature of the program provides Private Option members choice in how they might manage their cost-sharing obligations. That choice should continue unless further evidence suggests it is not serving Private Option members well.

The most challenging issue confronting the program as a whole appears to be the premium and cost-sharing cliffs between the Private Option and the Marketplace. The literature recognizes that a significant portion of people with incomes between 100% and 200% of poverty are likely to have fluctuating incomes and transition between Medicaid and exchange eligibility at 138% of poverty, or $16,243 for an individual. Medicaid rules and exchange rules have different definitions of what might be considered affordable. Under Medicaid rules, premiums are not allowed for those under 150% of poverty and limit cost-sharing to no more than five percent of income. Arkansas is currently seeking a waiver, which other states have received, that will establish a $19 per month premium, or $228 per year, for those between 100% and 138% of poverty, reflecting a premium rate of about two percent of income for those at 100% of poverty (about 1.45% of income for those at 138% of poverty). In addition, maximum out-of-pocket costs are capped in the Private Option at $604, or approximately five percent of income for individuals at 100% of poverty (or 3.7% of income for those at 138% of poverty) unless an individual elects to make monthly contributions to his or her Health Care Independence Account.

In the Marketplace, for someone making $17,000, or just over 138% of poverty, the monthly premium is about $50 per month, or $600 per year, reflecting a rate of approximately 3.5% of income. Under federal exchange rules, premiums for those between 138% and 150% of poverty are capped on a sloping scale between three and four percent of income that is calculated based on actual income within that range. The Arkansas Insurance Department has set the maximum out-of-pocket cost sharing in the Marketplace for those between 138% and 150% of poverty.
poverty at $854, or approximately five percent of income (Arkansas Insurance Department, 2016).

The problem is an obvious one. For an individual in Arkansas Works making $16,243 or less and is a low utilizer of health services without any cost-sharing obligations, total costs for that individual are now the $228 yearly premium. For those making $17,000 and in the Marketplace, and also having no cost-sharing obligations, the premium cost is approximately $600 per year, or a difference of $372 from the Private Option. Half of the $750 income gain for a low-income individual, in this example, will go to finance the increased premium. For high utilizers, the numbers are even greater. An individual in the Private Option who reaches the maximum cap will spend either $408 per year in premium and cost-sharing payments, if he or she elects the Health Care Independence Account, or $832 if cost-sharing payments are made at the point of service. In the exchange, for a person making $17,000 a year, premium and maximum out-of-pocket spending will total $1,454 if that person reaches the maximum cost-sharing cap. The difference here ranges from $622 to $1,046 depending on whether that person pre-paid cost-sharing or elected point-of-service payments in the Private Option. All income gains are wiped out or are nearly wiped out in this particular example. Those with moderate utilization will be somewhere within these ranges, but will also see more than half – and likely much more than half – of any income gain offset by additional premium and cost-sharing requirements in the exchange.

The foregoing illustration highlights a number of important issues. First, given the significant cliff in costs for a person who transitions between the Private Option and the Marketplace, there is possibly a work disincentive created since much, or possibly all, of the economic gain is lost in order to pay for health services. Second, the cliff in cost-sharing could
affect utilization patterns, possibly discouraging use of appropriate care. And third, the cliff has the potential to force people to drop out of the program entirely given that low-income people are likely to be highly sensitive to costs. The cliff is worrisome. The data shows that there has been a steady decline in those current – meaning paid, payment pending, or in a grace period – with their Marketplace premiums. Those current with their premium payments have dropped 14% over an 11 month period at the beginning of this program, going from 96% to 82%, and the data suggests a linear monthly downward trend. Research is needed to understand this phenomenon and to identify if these changes in premium and cost-sharing obligations, as one transitions between programs, are, in fact, driving this downward trend or if there are other factors that may be contributing to people dropping out of the Marketplace. There is no data at this point to quantify the amount of churn taking place between the program or what is likely causing that downward trend in paid premiums. It should be an urgent area of study.

One expert noted that the subsidies for cost-sharing for exchange-level eligibility are too low and are the “Achilles heel” of the ACA. The early data provides little clear evidence at this point, but the simple illustration and the drop in those current with their premiums in the Marketplace suggest that this may possibly be true. The slope for increased premiums and cost-sharing obligations rises quickly as income increases beginning with those at 139% of poverty despite the premium tax credits and cost-sharing subsidies to help offset some of these overall costs. While the premium rises between three and four percent of income for those between 139% and 150% of poverty, the cap ranges from four to six percent of income for those between 150% and 200% of poverty and continues to increase within each income grouping, hitting a maximum premium level of just over 9.5% of income at 400% of poverty, or an income of $47,080 for an individual, if the premium is above that cap. Above 400% of poverty, there is no
cap (Fernandez, 2014). One expert noted that the bigger cliff for cost-sharing subsidies is at 250% of poverty and not at 138% of poverty. Cost-sharing subsidies are gradually reduced and end at 250% of poverty, or $29,425 for an individual. For those at 250% of poverty, the maximum out-of-pocket costs are estimated to be $4,000 for an individual (Center on Budget and Policy Priorities, 2015). Maximum out-of-pocket cost-sharing obligations for an individual above 250% of poverty are capped at $6,600 for an individual (The Henry J. Kaiser Family Foundation, 2014).

The slope of increased premium and cost-sharing obligations is steep, and the cliffs are clearly noticeable at both ends of this income range. They go back to the question of the definition of affordability between these two programs. While there is little political interest in addressing this issue, given the costs associated with it and the polarized political environment, there is likely a need to make cost-sharing obligations more linear between the two programs and to lower the slope of that increase. As one expert noted, there is likely a need for increasing premium and cost-sharing payments for those at Medicaid eligibility levels, as many states are doing through waivers, including Arkansas, in order to make the transition between these programs more seamless. But it also will likely require additional subsidies in the exchange in order to make that transition more linear and affordable for low-income populations. These are fundamental questions for the long-term future of the ACA and need to be a critical area of research going forward.

The Federal Government

In addition to the evaluative issues of the Private Option, the federal government and the states are faced with challenges in finding a path forward. The ACA has helped transform Medicaid from a categorical welfare program to an income-based health insurance program for
low-income adults in this country. Together with health insurance exchanges, Medicaid is part of a comprehensive framework to provide subsidized health insurance coverage for those that need financial assistance. But there remains a tension between an insurance model and the historic role Medicaid has played as a safety net for low-income people. These tensions become evident in discussions with states over the shape and design of alternative waiver designs. The federal government has refused to grant waivers requiring workforce and job training referrals as a condition of eligibility, stating it does not meet the objective of the Medicaid program. But just as important, such requirements do not comport with the broader notion of an insurance model where all citizens are eligible for coverage without categorical conditions. Similarly, the federal government has rejected efforts to put lifetime caps and time limits on Medicaid, in theory akin to time-limited benefits for cash assistance through the Temporary Assistance to Needy Families (TANF) program. These, too, do not comport with furthering the objectives of Medicaid and an income-based insurance model. Lifetime caps, widely criticized in the health care system for years, were eliminated entirely in the ACA. The federal government’s views reflect this new fundamental principle in the operation of the nation’s healthcare system.

But other issues confront that tension in more direct ways. Arkansas has adopted a two percent premium for those between 100% and 138% of poverty in its Arkansas Works legislation beginning next year. The state has also provided additional incentives, such as vision and dental benefits, for those that make their premium payments and get an annual wellness checkup. The federal government will likely approve it as part of the state’s waiver application. A number of states that have approved waivers have established a two percent premium for those in this income range. This level of premium payment matches the premium for individuals in this same income range in the health insurance exchanges in states that have not expanded Medicaid.
Experts noted that most states coming forward will likely require premiums as a condition of a future waiver. This reflects an insurance model that requires some sort of premium payment as part of a coverage offering. Yet the literature suggests that low-income individuals are highly sensitive to costs, and that increased premium payments are directly correlated to drops in overall enrollment for this population. The literature also suggests that cost-sharing for low-income populations does discourage inappropriate use of health care services but also has the effect of limiting utilization for necessary services at the same time.

One state has been granted waiver approval for cost-sharing rates above the federal allowable limits, and other states are proposing, or are likely to consider, similar increases in cost-sharing requirements. Increasing premiums and cost-sharing, however, could result in people not seeking appropriate care or dropping coverage altogether, resulting in higher uninsured rates, greater use of emergency rooms, higher state uncompensated care costs, and more complex health conditions due to lack of access to early preventative care. These are the safety net concerns inherent in protecting the most vulnerable low-income citizens. The federal government is faced with fundamental choices in how to balance these competing aims of an insurance model while protecting the safety net for low-income populations. As of this writing, it appears the federal government will allow for premiums to be set at exchange levels within this income range and will allow for some experimentation with higher cost-sharing payments, though the federal government has also rejected a number of other cost-sharing proposals, most likely because of these safety net concerns. The impact of increasing premiums and cost-sharing for low-income individuals should be an area of continued research given the likelihood that other states will likely come forward with cost-sharing waivers in the foreseeable future.

Retroactive eligibility and lockout provisions are equally challenging issues. Under
Medicaid rules, individuals who qualify for Medicaid are provided three months retroactive coverage from the time of application in order to address possible earlier medical expenses, such as a hospital stay. Lockout provisions, which are not allowed under Medicaid, call for a state to drop a Medicaid eligible beneficiary from the program due to a lack of payment of premiums, generally after a 60 or 90 day grace period, with proposals limiting that lockout period to six months or to whenever the past premium payments are made (Rudowitz & Musumeci, 2015). Arkansas Works includes a directive for the governor to seek a waiver to eliminate retroactive eligibility. In the winter of 2015, the governor said he was interested in establishing a lockout provision, and it was reported that he remained interested in the issue before meeting with federal officials in February of 2016 (Ramsey, 2015c; Ramsey, 2016a). The legislative task force included lockouts as part of their recommendations in their fall 2015 report. But, in the end, it was not included in the final piece of legislation submitted to the legislature.

The argument against retroactive eligibility is that that the program should mimic the private commercial market, which provides insurance coverage once a premium is paid, and does not allow a person to be covered retroactively. In addition, the theory is that, over time, all low-income individuals should be enrolled in health insurance, given the individual mandate that requires all eligible citizens sign up for coverage and not only after they have incurred an expense. Similarly, in the private insurance market, an individual is disenrolled for nonpayment of premiums over a certain period of time and that person is usually not allowed to reenroll until the next open enrollment period in order to prevent people from paying up simply when they are sick. Yet, much like cost-sharing, these provisions have the practical effect of potentially dropping people from coverage, again resulting in higher uninsured rates and raising state costs for uncompensated care. Balancing these competing claims against an insurance model and a
safety net program is a vexing challenge for the federal government. To date, they have limited the testing of lockout provisions and retroactive eligibility to two each in a total of three states (Rudowitz & Musumeci, 2015). Interviews suggested that the federal government will be hesitant to go further until these waivers are evaluated, but the issue of lockouts and retroactive eligibility highlight the ongoing tensions with many of these proposals under an evolving and transforming Medicaid program. Because these waiver proposals represent clear departures from current program rules, there is a great need for further research and evaluative evidence regarding the impacts of these initiatives.

Incentives and penalties – carrots and sticks – are a key part of policymaking in order to influence behavior, and the insurance system is no different. Incentives, such as vision and dental benefits, are designed to encourage regular premium payments and regular wellness visits. Elimination of retroactive eligibility is partially designed to encourage enrollment before needed care occurs. Health Care Independence Accounts are designed to incentivize low-income individuals to pre-pay future cost-sharing and to take personal responsibility in managing and reducing their overall exposure to costs. Cost-sharing is also meant to monetize a service and discourage inappropriate utilization. Premiums are meant to place a value on the product and to have individuals share in its overall cost. And lockouts are penalties designed to encourage regular payment of premiums. While there are policy justifications for many of these proposals, adopting them can also undermine efforts to create a comprehensive insurance system and to protect the safety net. Many will likely have the effect of increasing the number of uninsured and raising overall state costs. But, more importantly, these incentives and penalties affect real people, citizens who may be struggling financially over a period of time through loss of a job, reduced hours at work, changes in family living arrangements, or an immediate financial crisis or
unexpected expense. For low-income people, the ability to bridge those costs and maintain coverage can be, at times, particularly challenging.

All of these proposals, many of which are contained in the new Arkansas Works law, deserve careful evaluation and evidence as to their effectiveness as the program moves forward. Evaluation can help to be a better guide as the federal government attempts to balance the tensions behind this income-based insurance model while protecting the safety net for low-income individuals and families. One expert noted that evidence does not usually trump politics, but sometimes it does. The need for evaluation and evidence in this political environment seems particularly important as these changes in how the program operates are tested and explored. The federal government seems willing to test new ideas, using incentives and penalties, though some on a much more limited scale, consistent with this insurance model philosophy. A future administration will likely establish its own guiding principles and evaluate the evidence before it on these issues. But it will also be confronted with the fundamental question of how it sees the role of Medicaid within the larger healthcare system, and possibly how to balance competing tensions, as new leaders take up the ongoing challenges and future of the ACA.

States

States face opportunities and challenges as well. The Private Option appears to be particularly well suited for many states that have not expanded coverage to low-income adults. A number of these states may have a more limited population in the exchange, given their demographic size, possibly creating a less stable exchange market. Placing some or all low-income adults into the exchange through a premium assistance model has the effect of significantly increasing the overall size of the exchange pool and likely strengthening that market. Similarly, many states may currently have a weak competitive market dominated by a
single health plan or two. Creating a larger risk pool, and taking steps to allow other entrants into the market, such as auto-assignment for those who do not choose a health plan, may attract additional health plan participation and possibly create a more competitive market. For states to succeed, the evidence in Arkansas suggests that states must be an active purchaser in payment and delivery reform to help shape that market and create a competitive market place. These are important factors for states to evaluate as part of assessing whether a premium assistance model can improve the overall marketplace. The Arkansas Private Option provides good early evidence of how that market is being transformed and the steps the state has taken to achieve those goals.

A fundamental operational challenge related to premium assistance, however, may be that most of the states that have not expanded have a federal health insurance exchange rather than a state exchange or a state partnership exchange. All three states that have pursued a premium assistance model, Arkansas, Iowa, and New Hampshire, operate a state partnership exchange. A state partnership exchange is set up where the federal government operates the enrollment function through healthcare.gov, but the state retains some marketplace functions, such as outreach and consumer assistance. In a federal exchange, the federal government is responsible for overall market management of the exchange. A number of experts commented that one of the key attributes of the success of the Private Option was the close cooperation and coordination of Arkansas Medicaid and the Arkansas Insurance Department. The Private Option is a complex undertaking requiring inter-agency coordination. One expert noted that there are important questions about how a premium assistance model might work with the federal government fully managing the federal health insurance exchange in a state. It adds another layer of complexity to the design, and it is an important question that deserves careful study and evaluation. Research that helps identify the challenges a premium assistance model might face
within a federal exchange marketplace in order to develop an operating framework that can address these potential challenges is critical given the number of states operating with a federal health insurance exchange.

One of the most significant challenges facing states, however, is the need to create a new definitional framework about what it means to expand coverage for low-income adults in an evolving marketplace. The Private Option has allowed Arkansas to take a private-sector approach and design a program that is uniquely situated for the state. It has built off that program in the new law, Arkansas Works, to add additional incentives to encourage more personal responsibility through the establishment of premiums, for example, and added benefits for those that remain current on premiums and get an annual wellness visit. This continuing evolution of the program, based on its own state design and goals, has allowed lawmakers to garner the necessary legislative and political support to move forward. Experts commented that defining a program that is uniquely designed for the state, and not a Washington cookie-cutter approach, is evident in all waiver designs that have been approved. A uniquely state-based approach is a central component for states finding a path forward.

But moving forward is also a political debate, and the language within that debate is critical to finding a path forward. On one side, the debate is framed as Obamacare by another name or Medicaid expansion by another name. On the other side, it is defined as a unique state approach that addresses core policy values such as market-based solutions, private sector approaches, and personal responsibility. Within that larger political debate, the discussions about specific policies and costs also emerge and are defined by the broader narrative and language used to frame that debate. As one expert commented, it is about politics, policy, and budgets. All three must be addressed in tandem for a state to succeed in moving forward.
Policies must be shaped to mitigate political resistance, the language of the political debate must define an approach consistent with lawmakers’ philosophies and views, and the evidence of state costs, savings, and economic impacts must be clear. In the end, it must be designed and debated in ways that can gain majority support in legislatures. The fact that Arkansas Works narrowly passed in April 2016, is an example of that legislative challenge. For many governors in the 19 states that have not expanded, but have been attempting to seek ways to expand coverage, those elements have not aligned. In most cases, the language of Obamacare and Medicaid expansion continues to frame the broader narrative in these states. The result is that the alternative policies proposed, and the positive economic impacts identified, cannot overcome this critical definitional debate. It remains to be seen if that will change in the years ahead.

The Private Option has shown promising results at this early stage in its existence. Equally important, Arkansas was the first state to receive a Section 1115 waiver, signaling an alternative path for other states to pursue that were opposed to a traditional Medicaid expansion. Five of the last eight states that have expanded coverage for low-income adults have been through Section 1115 waivers, and it is likely that most, if not all, states that find a path forward will do so through an alternative waiver design. It is unlikely that any more states will come forward in 2016 as most legislatures have now completed their sessions as of this writing and the 2016 presidential contest nears. But the premium assistance model, given the early evidence in Arkansas, is likely to be part of a broader discussion in many states going forward if the ACA continues to be the law of the land.

The ACA, reflecting a long and oftentimes bitter debate about our nation’s healthcare system since the days of President Truman, has fundamentally transformed how this nation will provide health insurance coverage to many of its citizens. And it has transformed the role of
Medicaid within that overall framework. Chief Justice John Roberts, writing for the majority in the Supreme Court decision upholding the law, eloquently described that transformation:

“The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. See 42 U.S.C. § 1396a(a)(10). Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program for care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage” (National Federation of Independent Business v. Sebelius, 2012, pp. 53-54).

But despite that transformation, the ACA, and the option to expand coverage through Medicaid within that law, remain politically controversial. It has lacked broad public support, and the political parties are sharply divided on its merits. That division is reflected in the fact that 19 states have chosen not to expand coverage for an estimated four million people as allowable under the law. Broad public support is necessary to sustain a program over a long period of time. Without such support, it will continue to be controversial and challenged in the political arena.

History notes that the Social Security Act was controversial when President Roosevelt signed it into law in 1935. So, too, was Medicare and Medicaid when President Johnson signed them into law in 1965. But both programs overcame this initial political opposition and have been weaved into the fabric of American life. They enjoy broad public support today. It remains to be seen if the Affordable Care Act, and expanded health care coverage for low-income adults and their families through this continually evolving and transforming Medicaid program, will follow that same path forward.
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APPENDIX A

Northeastern

Notification of IRB Action

Date: October 20, 2015       IRB #: CPS15-10-08
Principal Investigator(s):    Neenah Estrella-Luna
                              Brian Coyne
Department:                  Doctor of Law & Policy
                              College of Professional Studies
Address:                     20 Belvidere
                              Northeastern University
Title of Project:            The Affordable Care Act and Medicaid Expansion: A Look at
                              an Alternative Design to Expand Coverage for the Uninsured
Participating Sites:         N/A
Informed Consent:            One (1) unsigned consent

As per CFR 45.46.117(c)(2) signed consent is being waivered as the research presents no more than
minimal risk of harm to subjects and involves no procedures for which written consent is normally
required.

DHHS Review Category:       Expedited #6, #7
Monitoring Interval:         12 months

Approval Expiration Date:   OCTOBER 19, 2016

Investigator’s Responsibilities:
1. Informed consent form bearing the IRB approval stamp must be used when recruiting participants
   into the study.
2. The investigator must notify IRB immediately of unexpected adverse reactions, or new
   information that may alter our perception of the benefit-risk ratio.
3. Study procedures and files are subject to audit any time.
4. Any modifications of the protocol or the informed consent as the study progresses must be
   reviewed and approved by this committee prior to being instituted.
5. Continuing Review Approval for the proposal should be requested at least one month prior to the
   expiration date above.
6. This approval applies to the protection of human subjects only. It does not apply to any other
   university approvals that may be necessary.

C. Randall Colvin, Ph.D., Chair
Northeastern University Institutional Review Board

Nan C. Regina, Director
APPENDIX A

Northeastern University, Department of: College and Professional Studies

Name of Investigator(s):  Dr. Neenah Estrella-Luna, Principal Investigator  
                       Brian D. Coyne, Student Researcher

Title of Project:  The Affordable Care Act and Medicaid expansion: A look at an  
                  alternative design to expand coverage for the uninsured

Request to Participate in Research
We would like to invite you to take part in a research project. The purpose of this research is to examine alternative designs to traditional Medicaid expansion, specifically the Arkansas waiver known as the “private option” or “premium assistance” model. The research will examine the key features of this model and evaluate whether the model offers a possible path for coverage for 20 states that have chosen not to expand Medicaid under the Affordable Care Act.

If you decide to take part in this study, I will ask you to participate in an interview focused on the key features of the premium assistance model, to comment on what the early data from Arkansas shows, and to provide your expert views on whether a model like this offers a promising path for other states to pursue.

You must be at least 18 years old to be in this research project.

There are no foreseeable risks or discomforts to you for taking part in this study.

There are no direct benefits to you for participating in the study. However, your answers may help us to learn more about alternative designs to traditional Medicaid expansion.

Your part in this study will be handled in a confidential manner, though it may be possible that you potentially could be identified by readers of the study based on your unique position or experiences. Only the researchers will know that you participated in this study. Any reports or publications based on this research will only group data and will not identify you or any individual as being part of this project unless you choose to allow your name to be used.

The decision to participate in this research project is up to you. You do not have to participate and you can refuse to answer any question. Even if you begin the study, you may withdraw at any time.

You will not be paid for your participation in this study.

If you have any questions about this study, please feel free to call Brian D. Coyne, Student Researcher, the person mainly responsible for the research at 202/437-0678. Coyne.b@husky.neu.edu. You can also contact Dr. Neenah Estrella-Luna, the Principal Investigator, Northeastern University, 20 HV, 360 Huntington Avenue, Boston MA 02115. 617/373-6472. N.Estrellaluna@neu.edu.

If you have any questions about your rights in this research, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 617.373.4588, Email: n.regina@neu.edu. You may call anonymously if you wish.

You may keep this form for yourself.

Thank you.

Brian D. Coyne

APPROVED

NU IRB
VALID THROUGH 10.27.15

Northeastern University - Human Subject Research Protection
Rev. 4/21/2015
APPENDIX A

Recruitment Letter and Phone Script

Recruitment Letter

Dear [Name]:

I am a doctoral student in the law and policy program at Northeastern University in Boston, MA. My doctoral thesis is on the Affordable Care Act and the Medicaid expansion provisions of that act. Specifically, I am interested in evaluating an alternative design that has been approved in Arkansas known as the "private option" or "premium assistance model."

I am interested in interviewing experts in the field of Medicaid about the private option model and how it has fared during its first 18 months in Arkansas. In particular, I am interested in your evaluation of key features of the private option and whether they may be improvements over a traditional Medicaid expansion program. I am interested in examining what you may gain – and what you may lose – by adopting the premium assistance model. In addition, I am interested in your evaluation of whether an alternative design, such as the Arkansas model, offers a path for other states to expand coverage for low-income populations that, to date, have chosen not to expand their Medicaid programs.

My hope would be to have between 30 minutes and an hour of your time. I would request that I record the interview. Your comments would be confidential and you would not be identified within the thesis if you chose not to have your name be used. I have attached a consent form which is required as part of my research design. If you have any questions about the consent form, please do not hesitate to ask.

I hope you might be interested in being interviewed for this project. I will follow up with you in the next few days. If you do not wish to be contacted again regarding this study, please email me at coyne.b@husky.neu.edu to opt out. Thank you for your consideration.

Sincerely

Brian D. Coyne
Doctoral Candidate, Law and Policy Program
Northeastern University
Coyne.b@husky.neu.edu
202/437-0678

Phone Recruitment Script

Hi. My name is Brian Coyne. I am a doctoral candidate at Northeastern University. As I mentioned in my email, my research is on the Affordable Care Act and the Medicaid provisions of that Act. Specifically I am interested in evaluating an alternative design that has been approved in Arkansas known as the "private option" or "premium assistance" model.

I am calling because you are an expert in the field. I am interested in interviewing you to evaluate the key features of the private option and whether these features are an improvement over a traditional Medicaid expansion program. In addition, I am interested in your evaluation of whether an alternative design, like the Arkansas model, offers a
promising path for other states to expand coverage for low-income populations that, to date, have chosen not to expand their program.

The interview would take between 30 to 60 minutes and would be recorded. Your comments would be confidential and would not be identified within the thesis. I would need your verbal consent to conduct this interview as part of my research design.

If you have any questions about the research project or your participation in it, I would be happy to answer them. I hope I might be able to get on your calendar for an interview sometime in the next few weeks.

Let me know if you are interested and, if so, how we might proceed.

Refuse to participate or want to consider request.

Thank you for your time. If you are interested [or change your mind] in participating in the study, please feel free to contact me. I can be reached at 202/437-0678 or by email at coyne.b@hsnky.neu.edu. Thank you for your consideration of my request.
Appendix B

Codebook

<table>
<thead>
<tr>
<th>Codes</th>
<th>Code Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Presidential Campaign</td>
<td>Use when describing impact presidential campaign is having on policy discussions</td>
</tr>
<tr>
<td>2018 Gubernatorial Campaigns</td>
<td>Use when describing impact future gubernatorial campaigns may be having on policy discussions</td>
</tr>
<tr>
<td>Benefits</td>
<td>Use when describing benefits generally and in comparison to benefits in health insurance exchange</td>
</tr>
<tr>
<td>Budget Neutrality/Cost Effectiveness</td>
<td>Use when describing 1115 waiver requirements for budget neutrality</td>
</tr>
<tr>
<td>Cliffs between Medicaid and Exchange/Cost-Sharing</td>
<td>Use when describing cost-sharing responsibilities between people under 138 percent of poverty (Medicaid eligible) and over 138 percent of poverty (eligible for cost-sharing subsidies on exchange)</td>
</tr>
<tr>
<td>Coalitions</td>
<td>Use when describing groups coming together to promote (or oppose) coverage expansion</td>
</tr>
<tr>
<td>Cost sharing</td>
<td>Use when describing how Medicaid rules for premium and cost-sharing may be waived by the federal government and how that may shape the program design</td>
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<tr>
<td>Data (lack of)</td>
<td>Use when describing the challenges of policy making due to lack of available data</td>
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<tr>
<td>Economic Theory</td>
<td>Use when describing how economic theory may impact waiver design considerations</td>
</tr>
<tr>
<td>Employer Insurance</td>
<td>Use when describing policies to use Medicaid funding to support</td>
</tr>
<tr>
<td>Enforcement</td>
<td>Use when describing rules that would allow states to enforce payment of premiums as a condition of continued coverage</td>
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<tr>
<td>Enrollment</td>
<td>Used when describing and interpreting Arkansas enrollment trends under the Private Option</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Use when describing the role of evaluation under waiver proposals and the role evaluations may play in other states considering expansion</td>
</tr>
<tr>
<td>Exchange Cost Trends</td>
<td>Use when describing Arkansas Marketplace exchange cost trends</td>
</tr>
<tr>
<td>Exchange at 100 FPL</td>
<td>Use when describing how decisions for exchange eligibility were made at 100 percent of poverty and Medicaid eligibility at 138 percent of poverty</td>
</tr>
<tr>
<td>Fairness</td>
<td>Use when describing a premise for policies between existing Medicaid and exchange rules, particularly for populations between 100 and 138 percent of poverty</td>
</tr>
<tr>
<td>Codes</td>
<td>Code Definitions</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Federal Funding and Economic Pressures</td>
<td>Use when describing amount and impact of federal Medicaid funding in a state and the pressures it may bring in the policy discussion</td>
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<td>Federal/State tensions (chipping away at benefits/cost-sharing)</td>
<td>Use to describe how waiver approvals in one state may impact waiver discussions in another state, with each successive waiver approval creating pressures to approve in all states, including previously approved states</td>
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<td>General Operational Metrics</td>
<td>Use when describing broad observations of Arkansas Private Option to date and how it may or may not be meeting the goals outlined in the Health Care Independence Act of 2013</td>
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<tr>
<td>Government programs</td>
<td>Used when describing a premise of Medicaid expansion</td>
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<tr>
<td>Governors</td>
<td>Use when describing how Governors may or may not be attempting to move forward with expansion</td>
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<tr>
<td>Health Outcomes</td>
<td>Use when describing Arkansas health outcomes under the Private Option</td>
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<tr>
<td>Health Plan Competition</td>
<td>Use when describing increase or decrease in health plan participation under the Arkansas Private Option</td>
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<tr>
<td>Insurance v Welfare</td>
<td>Use when describing a premise behind Medicaid expansion</td>
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<tr>
<td>Language</td>
<td>Use when describing role language plays in shaping policy debate around Medicaid expansion</td>
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<tr>
<td>Legislatures</td>
<td>Use when describing how legislatures may or may not be attempting to move forward with Medicaid expansion in states.</td>
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<tr>
<td>Leverage</td>
<td>Use when describing how much influence a state may have with federal government on waivers following NFIB v. Sebelius</td>
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<tr>
<td>Market</td>
<td>Use when describing characteristics of the healthcare marketplace with or without Medicaid expansion</td>
</tr>
<tr>
<td>Medically Frail</td>
<td>Use when describing how Arkansas has handled this population that is exempt from the Private Option</td>
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<tr>
<td>Moral Imperative</td>
<td>Use when describing this premise as a basis for Medicaid expansion</td>
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<tr>
<td>NFIB v. Sebelius</td>
<td>Use when describing impacts on Medicaid expansion following NFIB v. Sebelius Supreme Court decision</td>
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<td>Obama – Personal Animosity</td>
<td>Use when describing how the politics of the Affordable Care Act is related to personal hostility to the president</td>
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<tr>
<td>Obamacare</td>
<td>Use when describing how the ACA has been politically defined</td>
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<td>Personal Responsibility</td>
<td>Use when describing how personal responsibility is an important cornerstone for some states in expanding Medicaid</td>
</tr>
<tr>
<td>Private Sector</td>
<td>Use when describing how the private sector is an important cornerstone for some states in expanding Medicaid</td>
</tr>
<tr>
<td>Provider Churn</td>
<td>Use when describing how people may change between Medicaid and exchange eligibility based on fluctuations in income</td>
</tr>
<tr>
<td>Codes</td>
<td>Code Definitions</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provider Networks</td>
<td>Use when describing increases or decreases in provider Networks in Arkansas marketplace</td>
</tr>
<tr>
<td>State Costs/State Savings</td>
<td>Use when describing impacts on a state budget when expanding Medicaid.</td>
</tr>
<tr>
<td>State agency issues</td>
<td>Use when describing state factors that may impact decisions on how a state may expand Medicaid.</td>
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<tr>
<td>Stigma</td>
<td>Use when describing this premise for expanding Medicaid or placing all in commercial insurance.</td>
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<tr>
<td>Testing of alternative designs</td>
<td>Use when describing various proposals to expand Medicaid outside a traditional Medicaid expansion proposal</td>
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<tr>
<td>Tipping Points</td>
<td>Use when describing how politics of states or regions may impact other states</td>
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<tr>
<td>Uncompensated Care</td>
<td>Use when describing and interpreting Arkansas Private Option and its impact on uncompensated care and hospitals</td>
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<tr>
<td>Unique to State</td>
<td>Use when describing features that make expansion unique to a state</td>
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<td>Waiver Delivery Reform</td>
<td>Use when describing waivers to improve delivery reform in a state</td>
</tr>
<tr>
<td>Waiver Experimentation</td>
<td>Use when describing how 1115 waivers are used to experiment with new ideas</td>
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<td>Waiver Principles</td>
<td>Use when describing principles established following NFIB v Sebelius</td>
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<tr>
<td>Work Requirements</td>
<td>Use when describing proposals for work requirements as part of Medicaid expansion waiver proposals</td>
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<tr>
<td>Wrap Around Benefits</td>
<td>Use when describing and interpreting success in providing wrap around benefits required under Medicaid for the Arkansas Private Option</td>
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### Group Codes

<table>
<thead>
<tr>
<th>Group Code</th>
<th>Codes</th>
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| 1115 Waivers                | • Testing of alternative designs  
                            | • Evaluation  
                            | • Federal/State tensions (chipping away at benefits/cost-sharing)  
                            | • Leverage |
| Arkansas Operational Metrics| • Enrollment  
                            | • Provider Networks  
                            | • Health Plan Competition  
                            | • Provider Churn  
                            | • Medically Frail  
                            | • Wrap Around Benefits  
                            | • Uncompensated Care  
                            | • Exchange Cost Trends  
                            | • Data (lack of)  
                            | • General Operational Metrics |
| Benefit and Cost Sharing    | • Cliffs between Medicaid and Exchange/Cost-Sharing |
| Federal Funding and Economic Pressures | • Federal Funding and Economic Pressures |
| Federal Government          | • NFIB v Sebelius  
                            | • Waiver Principles  
                            | • Waiver Delivery Reform  
                            | • Waiver Experimentation  
                            | • Benefits  
                            | • Cost sharing  
                            | • Work Requirements  
                            | • Enforcement  
                            | • Budget Neutrality/Cost Effectiveness |
| Health Outcomes             | • Health Outcomes |
| Politics and Ideology       | • Obamacare  
                            | • 2016 Presidential Campaign  
                            | • 2018 Gubernatorial Campaigns  
                            | • Obama – Personal Animosity  
                            | • Coalitions  
<pre><code>                        | • Tipping Points |
</code></pre>
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<tr>
<td>Reframing</td>
<td>• Language</td>
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<tr>
<td></td>
<td>• Unique to State</td>
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<td></td>
<td>• Private Sector</td>
</tr>
<tr>
<td></td>
<td>• Personal Responsibility</td>
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<tr>
<td>State Factors</td>
<td>• Governors</td>
</tr>
<tr>
<td></td>
<td>• Legislature</td>
</tr>
<tr>
<td></td>
<td>• State Costs/State Savings</td>
</tr>
<tr>
<td></td>
<td>• Employer Insurance</td>
</tr>
<tr>
<td></td>
<td>• State agency issues</td>
</tr>
<tr>
<td></td>
<td>• Market</td>
</tr>
<tr>
<td>Theories and</td>
<td>• Government programs</td>
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<td>Premises</td>
<td>• Insurance v Welfare</td>
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<td></td>
<td>• Economic Theory</td>
</tr>
<tr>
<td></td>
<td>• Fairness</td>
</tr>
<tr>
<td></td>
<td>• Moral Imperative</td>
</tr>
<tr>
<td></td>
<td>• Exchange at 100 FPL</td>
</tr>
<tr>
<td></td>
<td>• Stigma</td>
</tr>
</tbody>
</table>
Appendix C

Interview Guide

I. The Arkansas Private Option

1. Any general observations about how the Arkansas Private Option is working so far? Is it generally meeting the operational and program goals it was designed to accomplish?
   a) Can you discuss enrollment?
   b) Can you discuss provider networks?
   c) Can you discuss health plan competition?
   d) Can you discuss the identification of the medically frail?
   e) Can you discuss wrap-around benefits and how that is working?
   f) Can you discuss issues around health outcomes at this point?
   g) Can you discuss the churn between the two programs?

2. Can you discuss cost-sharing in Arkansas? There is a bit of a gap between Medicaid and exchange eligibility. Can you discuss the differences in cost-sharing obligations between the Private Option and Marketplace and what impacts those differences might create?

3. GAO has criticized the budget neutrality calculations made for the Private Option. Is this a serious concern for Arkansas or for other states considering premium assistance?
II. The 2016 Presidential Election

1. Will the presidential election change the dynamic for many of the 19 states that have chosen not to expand coverage at this particular point in time?

2. Does the presidential campaign freeze any additional activity for the remainder of the year?

3. Can you discuss the various scenarios and what the possible impacts might be on coverage expansion?

4. How about future elections like the 2018 gubernatorial elections?

III. The Federal Government

1. How did the federal government respond following *NFIB v. Sebelius* that made Medicaid expansion optional?

2. What do you think were the major concerns in the federal government with a premium assistance model when it was first proposed by Arkansas?

3. The federal government has approved other alternative waiver designs that include more concessions than the Arkansas Private Option, such as premium payments and the elimination of some wrap benefits such as non-emergency medical transportation. Arkansas is now coming back to some of these ideas that have been approved in other states. How far might the federal government go in providing states more flexibility in developing alternative waiver designs? What is the role of evaluation?

4. Will we see a “chipping away” over time on each waiver approved that states will come back to these issues – and then possibly add other ideas?
IV. The States

1. What are the key steps or forces that might drive a state forward with proposals to expand coverage?

2. How significant are the economic and budgetary pressures on states due to the federal funding associated with coverage expansion?

3. What has been the role of legislatures in this debate?

4. Private Option is showing state savings. How important is state costs to the general equation?

5. How important is language to the debate and reframing it to something like the Private Option or Health Indiana 2.0?

6. Do you think premium assistance is a likely model for states that have not expanded?

7. Do you think most states coming forward now will do so with a Section 1115 waiver?

V. Final Questions

1. When I started this project, 23 states had not expanded coverage. Today there are 19 states. Do you see all states someday expanding coverage? Do you see it similar to Medicaid in 1965 where all states by Arizona were in by 1972? How do you see the future?

2. Any topics or issues that I didn’t cover that you would like to add?
Appendix D

Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Care Act</td>
<td>Federal health reform law passed in March 2010. Designed to expand coverage to the uninsured among its many provisions. Commonly known as the ACA or Obamacare</td>
</tr>
<tr>
<td>Arkansas Works</td>
<td>State legislation passed in April 2016. Changes name of Arkansas Private Option to Arkansas Works. Includes a number of provisions, such as requiring a premium for Medicaid eligible members over 100% of poverty and providing work referrals for those under 50% of poverty (though not a requirement of eligibility)</td>
</tr>
<tr>
<td>Budget Neutrality</td>
<td>Federal rule that requires Section 1115 waivers to not cost more than what it would cost absent the waiver. States must develop methodologies to estimate costs with or without the waiver. The Government Accountability Office often criticizes the methodologies used to approve these waivers.</td>
</tr>
<tr>
<td>Children’s Health Insurance Program</td>
<td>Commonly known as CHIP program. Created in 1997 following the unsuccessful attempt at health reform in 1993 and 1994. Together with Medicaid, expands coverage for children. CHIP is not an entitlement and must be reauthorized every few years.</td>
</tr>
<tr>
<td>Churn</td>
<td>Term used to describe transition between Medicaid level eligibility and exchange level eligibility at 138% of poverty based on fluctuations in personal income. A significant number of people are likely to transition between these programs in any given year.</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td>Commonly known as CMS. An operating division within the federal Department of Health and Human Services. Responsible for overseeing the Medicare, Medicaid and CHIP programs.</td>
</tr>
<tr>
<td>Cost-Sharing</td>
<td>Term to describe personal out-of-pocket payments for health services, which are usually deductibles, co-insurance, and co-payments. Does not include out-of-pocket monthly premium payments.</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Essential Health Benefits</td>
<td>Commonly referred to as EHB. Federal rule that defines the 10 benefits that are required to be provided in order to be a Qualified Health Plan (QHP) that can participate in health insurance exchanges.</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment</td>
<td>Commonly referred to as EPSDT. Benefit required for children under 21 years of age. Allows for regular screening and treatment services that may be beyond the Medicaid benefit in order to provide additional health services for this population.</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Commonly referred to as ER or ED. Under law, an emergency room cannot deny emergency services based on ability to pay. Non-emergent care can be denied based on ability to pay.</td>
</tr>
<tr>
<td>Exchanges</td>
<td>Organized marketplaces that have been established under the ACA to purchase health insurance coverage. There are federal exchanges, state exchanges, and state partnership exchanges depending on the state.</td>
</tr>
<tr>
<td>Fee-for-Service</td>
<td>Term used to describe payment for each individual service.</td>
</tr>
<tr>
<td>Federal Medical Assistance Percentages</td>
<td>Commonly referred to as FMAP. Formula based on a state’s per capita income to determine the federal match rate for a state’s Medicaid program. Lowest rate is a 50% federal match rate while the highest rate today is approximately 74%. Average rate is 57%.</td>
</tr>
<tr>
<td>Government Accountability Office</td>
<td>Commonly referred to as GAO. Independent organization that works for legislative branch to examine and audit governmental programs.</td>
</tr>
<tr>
<td>Health Care Independence Act of 2013</td>
<td>Arkansas law that created the Private Option. Sets out 11 purposes under the Act. Law established the basis for the Arkansas Section 1115 waiver.</td>
</tr>
<tr>
<td>Health Care Independence Accounts</td>
<td>Program created following Arkansas’s amended waiver in late 2014. Allows Private Option members from 100% to 138% of poverty to make a monthly payment to cover all out-of-pocket cost-sharing costs. Program was discontinued for members between 50% and 100% of poverty.</td>
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<tr>
<td>Health Care Independence Program</td>
<td>Formal name of the Arkansas Private Option.</td>
</tr>
<tr>
<td>Marketplace</td>
<td>Term used to describe people in Arkansas who are above 138% of poverty and have exchange level eligibility, not Private Option eligibility.</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medically Frail</td>
<td>Individuals with complex medical needs that are likely to require additional long-term services and supports. In premium assistance model, these individuals are to be identified and placed in traditional Medicaid program.</td>
</tr>
<tr>
<td>Non-Emergency Medical Transportation Benefit</td>
<td>Medicaid benefit not included in the 10 Essential Health Benefits required to be covered by Qualified Health Plans in the health insurance exchange. In premium assistance model, this service is provided for Private Option members through Medicaid on a fee-for-service basis.</td>
</tr>
<tr>
<td>Obamacare</td>
<td>Term used to describe the Affordable Care Act, or ACA</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>Commonly referred to as PCP. Physicians who provide ongoing preventative care and diagnosis.</td>
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<tr>
<td>Premium Assistance</td>
<td>For those eligible for Medicaid, allows for Medicaid funds to purchase employer-sponsored health insurance or to purchase the premium payments for adults in health insurance exchanges.</td>
</tr>
<tr>
<td>Private Option</td>
<td>Term used in Arkansas to describe adults age 19-64 under 138% of poverty who are eligible for coverage through the health insurance exchange.</td>
</tr>
<tr>
<td>Provider Networks</td>
<td>Term used to describe physicians, hospitals and other health care providers that have contracted with a health plan to provide services to their members.</td>
</tr>
<tr>
<td>Qualified Health Plan</td>
<td>Commonly referred to as QHP. A plan that is certified to participate in the health insurance exchange by providing the 10 Essential Health Benefits and limiting cost-sharing to what is spelled out in federal rules.</td>
</tr>
<tr>
<td>Retroactive Eligibility</td>
<td>Medicaid rule that allows for an individual eligible for Medicaid to be considered covered up to three months before actually applying for coverage.</td>
</tr>
<tr>
<td>Section 1115 Waiver</td>
<td>Legal authority for the Secretary of the Department of Health and Human Services to waive certain Medicaid rules for demonstrations that test new ways to improve the Medicaid program. These waivers must further the objective of the Medicaid program</td>
</tr>
<tr>
<td>State Partnership Health Insurance Marketplace</td>
<td>Formal name of the Arkansas health insurance exchange. Includes both Private Option and Marketplace members.</td>
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<tr>
<td>Temporary Assistance for Needy Families</td>
<td>Commonly referred to as TANF. Federal program to provide cash assistance to low-income families and children. Benefits are limited to five years and have a lifetime cap. Replaced Aid to Families with Dependent Children (AFDC) with passage of the welfare reform law in 1996.</td>
</tr>
<tr>
<td>Wrap-Around Benefits</td>
<td>Term to describe Medicaid benefits not covered under the 10 Essential Health Benefits required in exchange. The two primary benefits are non-emergency medical transportation and EPSDT. These benefits are provided for Private Option members through Medicaid on a fee-for-service basis.</td>
</tr>
</tbody>
</table>
Appendix E

Federal Poverty Table
2015

<table>
<thead>
<tr>
<th>Household Size</th>
<th>100%</th>
<th>138%</th>
<th>150%</th>
<th>250%</th>
<th>400%</th>
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<tr>
<td>1</td>
<td>$11,770</td>
<td>$16,243</td>
<td>$17,655</td>
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<td>2</td>
<td>$15,930</td>
<td>$21,983</td>
<td>$23,895</td>
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<td>$63,720</td>
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<td>3</td>
<td>$20,090</td>
<td>$27,724</td>
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<td>$80,360</td>
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<td>4</td>
<td>$24,250</td>
<td>$33,465</td>
<td>$36,375</td>
<td>$60,625</td>
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</tbody>
</table>

The Department of Health and Human Services releases poverty guidelines each year, usually in late January of each year. The Table above is poverty guidelines for the 48 contiguous states. The rates are calculated by using the poverty number. For example, 138% of poverty is $11,770 x 1.38, or $16,243. Numbers may slightly differ due to rounding.

The poverty guidelines come out each year, usually in late January. They can be used in state and federal programs as soon as feasible following the release. These numbers were used for federal exchanges beginning in November 2015 for 2016 calendar year calculations.

For more information, see https://aspe.hhs.gov/poverty-guidelines