Arkansas’s Section 1115 Waiver and Expansion of Medicaid: A Path Toward Equal Care

*Morgan Carr*

“It is one of the happy incidents of the federal system, that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”

I. INTRODUCTION

Arkansas has established a new way to provide Medicaid to its neediest citizens. Arkansas’s scheme is innovative in that it is offering subsidies for private insurance to Medicaid beneficiaries. This plan is superior to Medicaid offerings in other states because it reduces churning\(^2\), improves access and quality of care, provides a better value for taxpayer dollars, and improves the risk-pool in the insurance exchange by providing a large pool of healthy adults. This article argues that other states should look to Arkansas as an example, and find innovative ways to provide better care to Medicaid beneficiaries. Part II discusses the background of the Medicaid expansion under the Affordable Care Act (ACA). Part III discusses Section 1115 waivers, the mechanism through which Arkansas established its expansion scheme. Part IV discusses the benefits of Arkansas’s plan - which include a reduction in churning, improved access to care, cost effectiveness, and risk.

\(^1\) New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).
\(^2\) Churning occurs when patients are forced to switch back and forth between Medicaid and private insurance as their incomes fluctuate around the threshold. Typically, people lose Medicaid eligibility after their income spikes temporarily from a seasonal job or working extra hours. Jenni Bergal, *Millions Of Lower-Income People Expected to Shift Between Exchanges and Medicaid*, KAISER HEALTH NEWS (Jan. 6, 2014), http://kaiserhealthnews.org/news/low-income-health-insurance-churn-medicaid-exchange/.
pooling. Finally, this article concludes that further innovation is needed in America’s healthcare system, and Arkansas is setting an example that other states should adopt.

II. MEDICAID EXPANSION

The ACA has given states the option to expand eligibility for Medicaid to populations that previously did not qualify for Medicaid coverage. Medicaid is a long-standing government program that provides health insurance coverage to certain qualified people with low-income or disabilities, and has traditionally covered only the “deserving” poor — primarily the blind, disabled, women and their children, and the impoverished elderly. The ACA expands coverage under Medicaid to all Americans earning below 133% of the federal poverty level. This newly eligible population primarily consists of childless, low-income, working-age adults. Pursuant to the ACA and the United States Supreme Court’s ruling in National Federation of Independent Business v. Sebelius, states are given the option to expand their Medicaid programs. Currently, twenty-five states and the District of Columbia have expanded Medicaid, eight have rejected the expansion, and the remainder are deliberating or negotiating alternative expansions with the federal government. If a state chooses to expand, the federal government will pay one hundred percent of the cost of those who

5. Id. at 388. “Single adults earning no more than $14,856 per year—133% of the current federal poverty level—surely rank among the Nation’s poor” NFIB v. Sebelius, 132 S. Ct. 2566, 2636 (2012) (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).
9. Leonard, supra note 4, at 381.
are newly covered by the Medicaid expansion for the first three years.\textsuperscript{10} For years four through six, the federal government will pay ninety-five percent of the cost of care for the expansion population, and then will pay ninety-percent of the cost of care for the expansion population in perpetuity.\textsuperscript{11} The ACA and existing Medicaid law under the Social Security Act allow for some flexibility for states as far as which benefits are provided and how care is delivered.\textsuperscript{12} Some states, such as Arkansas, Iowa, Michigan, and Pennsylvania, have implemented the Medicaid expansion in ways that extend beyond the flexibility provided by law by obtaining approval through waivers under Section 1115 of the Social Security Act.\textsuperscript{13} Section 1115 waivers allow states to test innovative approaches that differ from the federal program rules.\textsuperscript{14}

Congress offered generous funding to incentivize states to opt-in to Medicaid expansion.\textsuperscript{15} The costs to the states for expanding Medicaid would generally be lower than the cost of uncompensated care borne by the states after the implementation of the ACA.\textsuperscript{16} The Department of Health and Human Services (HHS) estimates that hospital uncompensated care costs in 2014 will be $4.2 billion dollars lower than it otherwise would have been because of the twenty-five states, plus Washington D.C., expanding Medicaid at the beginning of 2014.\textsuperscript{17} Studies have shown that previous expansions of Medicaid have led to a substantial decrease in mortality, and that

\begin{itemize}
\item \textsuperscript{10} Id. at 382.
\item \textsuperscript{11} Id.
\item \textsuperscript{13} Id.
\item \textsuperscript{14} Id.
\item \textsuperscript{15} Watson, supra note 6, at 475-76.
\item \textsuperscript{16} Price & Eibner, supra note 3, at 1034.
\end{itemize}
fully expanding Medicaid eligibility in all the states could reduce mortality by ninety thousand lives per year.\textsuperscript{18} Given the generous Congressional funding and the significant reduction in mortality created by expanding Medicaid, states should be eager to expand their Medicaid programs. If costs are of a concern, states should turn to the flexibility offered through Section 1115 Waivers to structure their programs in accordance with their budgets and their population’s needs.

III. SECTION 1115 WAIVERS

The Secretary of HHS has repeatedly stated that the government will waive certain provisions of the Medicaid Act under the authority of Section 1115 of the Social Security Act to allow states to test new and innovative Medicaid programs.\textsuperscript{19} Section 1115 of the Social Security Act gives broad flexibility to the states to experiment in their programs for providing healthcare coverage to the uninsured, as long as costs to the federal government do not increase.\textsuperscript{20} The federal government ensures that the budget does not increase by placing a cap on the amount of federal funds that can be spent over the life of the waiver, and the states are responsible for anything above that cap.\textsuperscript{21} Section 1115 waivers have been used for many years and for many purposes, such as expanding coverage, implementing managed care, and restructuring federal financing.\textsuperscript{22} Section 1115 waivers are intended for research and experimentation, so federal law requires that waivers be formally evaluated periodically.\textsuperscript{23} The ACA creates an additional waiver, Section 1115A, which establishes the Center for Medicare

\begin{itemize}
  \item \textsuperscript{18} Price & Eibner, \textit{supra} note 3, at 1035.
  \item \textsuperscript{19} Watson, \textit{supra} note 6, at 472.
  \item \textsuperscript{20} Leonard, \textit{supra} note 4, at 396.
  \item \textsuperscript{21} Section 1115 waivers are generally approved for five years and then must be renewed. \textit{The Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured: Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers} 1 (2011), \textit{available at} \url{http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf} [hereinafter \textit{"Section 1115 Medicaid"}].
  \item \textsuperscript{22} \textit{Id.}
  \item \textsuperscript{23} \textit{Id.} at 2.
\end{itemize}
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and Medicaid Innovation to test and evaluate different service, delivery, and payment to improve quality and slow cost growth in Medicaid.\(^{24}\)

To obtain a Section 1115 waiver, a state must submit an application to the Centers for Medicare & Medicaid Services (CMS).\(^{25}\) Next, CMS and other HHS agencies review the waiver, and significant negotiations may occur between HHS and the state.\(^{26}\) If the waiver is awarded, CMS issues an award letter to the state, including the terms of approval and a budget neutrality agreement.\(^{27}\)

Arkansas, with approval of the federal government, passed an alternative form of Medicaid expansion where beneficiaries are provided with premium assistance and enrolled in private plans sold through the health insurance exchanges that were established through the ACA.\(^{28}\) Premium assistance schemes are not new - they have been available to the states to use since 1965.\(^{29}\) However, before the ACA, no state has ever chosen to cover a large population of beneficiaries with premium assistance because of high costs and limited coverage options.\(^{30}\) The ACA has made the establishment of large-scale premium assistance programs possible in two ways: first, if a state chooses to expand Medicaid, it receives a large amount of federal funding which will cover the high cost of premium-assistance; and second, the new health insurance marketplaces provide the infrastructure that is necessary to cover large numbers of people in non-employer based plans.\(^{31}\) The marketplaces offer a number of private insurance options called qualified health plans (QHP), which are regulated and must include a compre-

\(^{24}\) Id.  
\(^{25}\) Id. at 3.  
\(^{26}\) Id.  
\(^{27}\) Id.  
\(^{28}\) Leonard, supra note 4, at 383.  
\(^{30}\) Id.  
\(^{31}\) Id.
hensive package of services called essential health benefits. Arkansas is an example of how the post-ACA healthcare landscape has created opportunities for states to innovate their Medicaid programs.

IV. BENEFITS OF ARKANSAS’S PLAN

A. Reduction in Churning

All newly eligible adults in Arkansas are enrolled in premium assistance to increase provider access and reduce churning between Medicaid and private coverage due to income fluctuations. Research suggests that of the ninety-six million Americans who are eligible to receive Medicaid during a given year, up to twenty-nine million of them are likely to churn between coverage options because of changes in income and circumstances. Under a plan like Arkansas’s, when Medicaid eligible individuals are enrolled in a marketplace QHP instead of traditional Medicaid, if their income rises above Medicaid eligibility levels, they can stay in their private coverage rather than switching plans and providers. Switching between Medicaid and private plans month to month can create great difficulty for patients, as it can mean entirely different covered providers and services. Research has shown that churning and coverage disruptions have negative effects on access to care and cause increased administrative costs. Projections show that thirty-five percent of adults will experience a change of eligibility within six months, and fifty percent would have experienced a change within

32. Id.
33. Churning occurs when individuals’ eligibility for Medicaid fluctuates back and forth, and they must switch between Medicaid coverage and private insurance due to income fluctuations, which are often caused by changes in hours and seasonal work. SECTION 1115 MEDICAID, supra note 21, at 8.
34. Crawford & McMahon, supra note 29.
35. Id.
36. Leonard, supra note 4, at 423.
one year. An estimated twenty-four percent would experience two eligibility changes within one year. In Arkansas, premium assistance is expected to reduce churning by nearly two-thirds, resulting in greater convenience and continuity of care.

B. Improved Access to Care

It is generally accepted knowledge that Medicaid coverage is inferior to private health insurance. There is an ongoing debate in the public policy community about whether having Medicaid coverage is any improvement over being uninsured. Beneficiaries enrolled in private plans will likely have better access to care than traditional Medicaid beneficiaries, because more providers accept commercial insurance than Medicaid. A study by the Government Accountability Office in 2012 found that 7.8% of adults with Medicaid had difficulty accessing medical services, compared to 3.3% of similar adults with private insurance. Additionally, a study found that in 2011, nationwide, almost one third of all physicians refused to accept new Medicaid patients, compared to nineteen percent refusing new commercial patients. Medicaid is typically challenged in enlisting sufficient providers because of low rate of reimbursement. Premium assistance eliminates this problem by providing beneficiaries with private insurance that is much more widely accepted by physicians.

38. Id. at 232.
39. Id.
40. Crawford & McMahon, supra note 29.
41. See generally AVIK ROY, HOW MEDICAID FAILS THE POOR (2013).
42. See Scott Gottlieb, Medicaid is Worse Than No Coverage at All, WALL ST. J. (March 10, 2011) available at http://online.wsj.com/articles/SB10001424052748704758904576188280858303612.
43. Crawford & McMahon, supra note 29, at 3.
44. Id.
45. Id. Sandra L. Decker, In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help, 31 HEALTH AFF.1673, 1679 (2012).
46. Leonard, supra note 4, at 423.
47. Id.
C. Cost Effectiveness

CMS has imposed cost effectiveness conditions that apply to premium assistance schemes.\textsuperscript{48} However, CMS has indicated that it will recognize considerations beyond dollar cost when evaluating a plan’s cost effectiveness, including reduced churn, increased competition in marketplaces, and improved access and quality of care.\textsuperscript{49} CMS officially waived Arkansas’s cost-effectiveness requirement, and stated that Arkansas may use state developed tests of cost effectiveness to evaluate its premium assistance scheme.\textsuperscript{50} Actuaries for the state of Arkansas estimate that private option costs will be thirteen to fourteen percent higher than public Medicaid costs.\textsuperscript{51} However, the actuaries noted that while premium assistance would likely cost thirteen to fourteen percent more than traditional Medicaid, this cost does not take into account the likely increase in Medicaid provider reimbursement rates that the state says it would need to pay to secure access to care for a Medicaid expansion population.\textsuperscript{52} Additionally, the State of Arkansas argued that the higher cost of purchasing private insurance on the marketplace for beneficiaries buys better access to care, thereby making the program cost-effective.\textsuperscript{53}

Healthcare providers, especially hospitals have been generally supportive of expansion.\textsuperscript{54} This is because the ACA cut the amount of disproportionate share hospital (DSH) funding, which is federal funding that hospitals receive for treating a disproportionate share of uninsured or underinsured patients.\textsuperscript{55} The ACA cut DSH funding because the expectation was, as a result of the individual mandate and Medicaid expansion, that providers

\textsuperscript{48}. Crawford & McMahon, supra note 29, at 4.
\textsuperscript{49}. Id.
\textsuperscript{50}. Id. at 5.
\textsuperscript{51}. Id.
\textsuperscript{52}. Id.
\textsuperscript{53}. Id. at 6.
\textsuperscript{54}. Leonard, supra note 4, at 412.
\textsuperscript{55}. Id.
would see fewer uninsured patients. However, in states that have not expanded Medicaid, a large group of people that Congress expected to be insured are not, and providers in those states will bear the burden of reduced DSH payments and similar numbers of uninsured patients.

D. Risk Pooling

Increasing the number of people buying insurance on the exchanges will increase demand, which will bring more suppliers into the market, and drive down costs of insurance, which is beneficial for all citizens. Working with independent legal and actuarial consultants, the Arkansas Department of Human Services estimates that introducing 250,000 low-income adults to the marketplace will increase competition among carriers and create price pressure on providers that will result in an estimated five percent reduction in private reimbursement rates on the exchange. Additionally, increasing rates of insured individuals in general in the population will improve overall health and thereby lower healthcare costs. Also, it is a reasonable expectation that the Medicaid expansion population will be relatively healthy because the group largely includes the working poor, and the addition of this group to the marketplace exchange risk pools could improve the functioning of the new marketplaces.

V. CONCLUSION

Arkansas is at the beginning of an experimental journey. Despite the fact that premium assistance for Medicaid beneficiaries was always a possibility before the ACA, it has never been done on such a large scale. Premium assistance for private insurance for Medicaid beneficiaries levels the playing

56. Id.
57. Id.
59. Leonard, supra note 4, at 414.
60. Leonard, supra note 4, at 422.
field and provides our society’s neediest with an acceptable level of care. Private insurance for Medicaid beneficiaries will greatly reduce patients churning between Medicaid and private coverage, will improve access to and quality of care for beneficiaries, will provide a better value for taxpayer dollars, and will pool the risk in the exchanges by adding a large population of healthy adults. There is no doubt that innovation is needed in America’s healthcare system, particularly in Medicaid, and Arkansas is setting forth a new standard that other states should look to as an example.