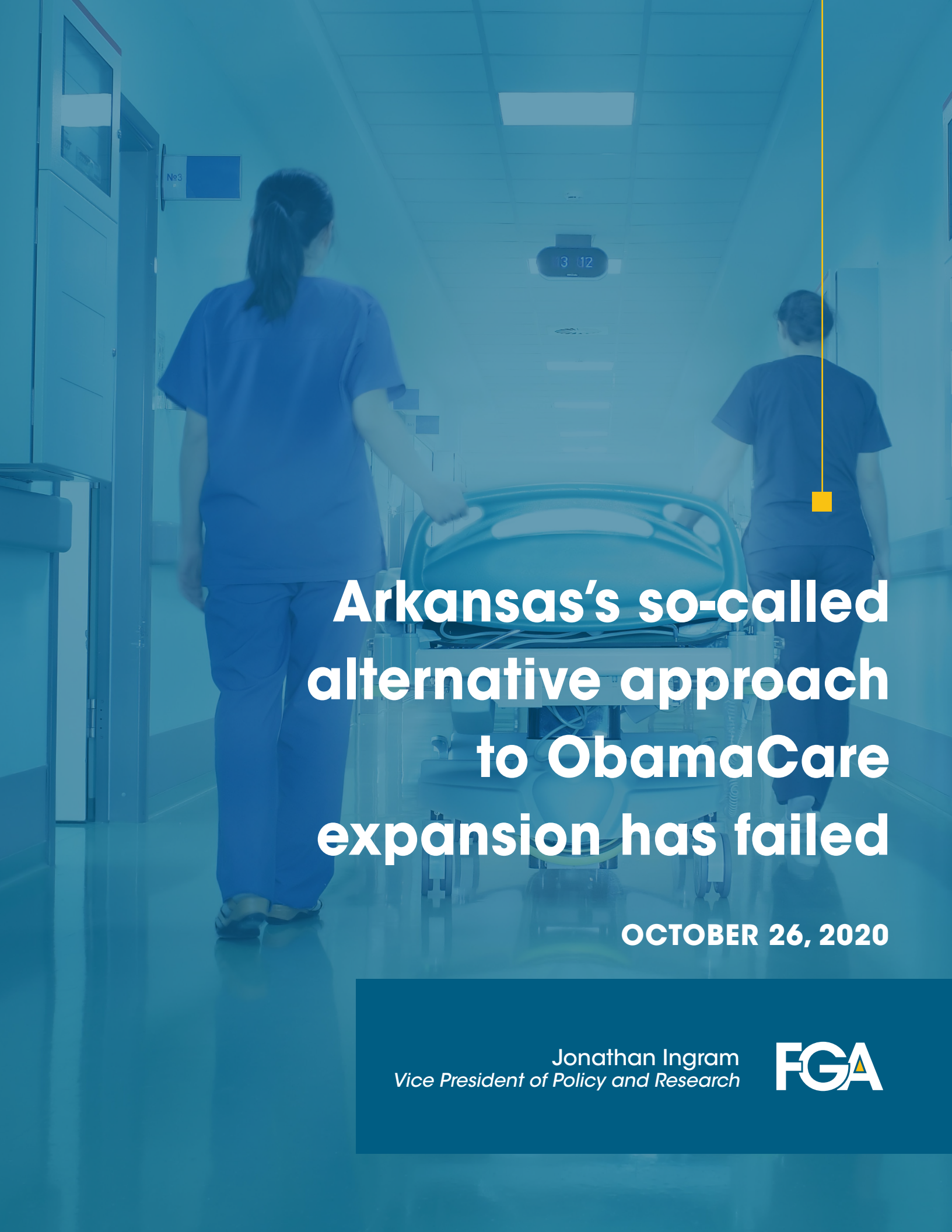

Arkansas's so-called alternative approach to ObamaCare expansion has failed

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Background

The Affordable Care Act, commonly known as ObamaCare, gives states the option to expand Medicaid to a new class of able-bodied, working-age adults. Before this, Medicaid eligibility was traditionally reserved for the truly needy, such as seniors, individuals with disabilities, and low-income kids.

States that have expanded their Medicaid programs under ObamaCare have witnessed skyrocketing enrollment and massive cost overruns.[1-2] States have signed up more than twice as many able-bodied adults as initially projected.[3] In many cases, more able-bodied adults signed up for the programs than state officials predicted would ever even be eligible.[4] Worse yet, the per-person price tag has been nearly twice as high as projected, compounding the cost overruns even further.[5]

> **“Some states have adopted “alternative” ObamaCare expansion models, such as the private option model adopted in Arkansas, Iowa, and New Hampshire.”**

Some states have adopted "alternative" ObamaCare expansion models, such as the private option model adopted in Arkansas, Iowa, and New Hampshire. Originally crafted by a Democrat Arkansas governor and the Obama administration, the private option approach to Medicaid expansion—giving Medicaid expansion enrollees insurance plans that are purchased through the ObamaCare exchange and paid for with Medicaid dollars—has proven to be a political lightning rod, failed to increase competition, led to skyrocketing costs, and increased premiums in the private market.

This model has failed everywhere it has been tested and has proven to be nothing more than a more expensive way to expand ObamaCare. Moving forward, the Trump administration should reject future attempts to replicate this model in other states.

And, in light of the COVID-19 pandemic and an uncertain budget outlook, the state of **Arkansas should scrap this failed model and transition instead to conventional Medicaid expansion.** This simple policy change would free up millions in state and federal funds and preserve limited resources for truly needy Arkansans, all without the political controversy of removing individuals from the program.

The private option model is just a more expensive way to expand ObamaCare

When the private option model was initially conceived, it was sold to the public and Republican legislators as a "conservative alternative" to ObamaCare that would save taxpayers money.[6] Under this approach, the state delivers Medicaid expansion benefits to able-bodied adults through plans sold on HealthCare.gov, the federal exchange. But instead of saving taxpayers money as promised, reports from federal and state officials have revealed that this model has roughly *doubled* the price tag.

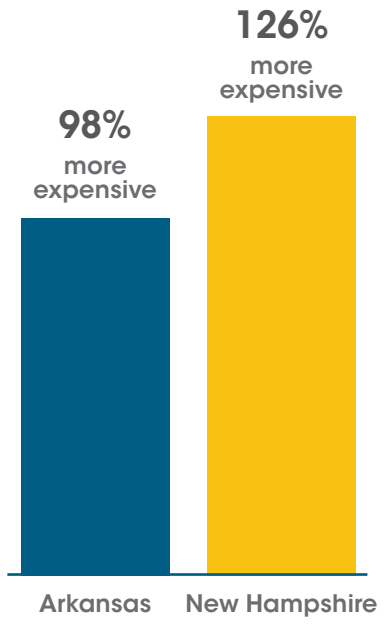
In 2014, the Government Accountability Office (GAO) released an audit of Arkansas's private option waiver.[7] Their analysis concluded that state officials used "questionable methods" to make the proposal appear as budget neutral for the federal government, even though the waiver would cost taxpayers nearly $1 billion more over the first three years than a conventional Medicaid expansion model.[8]

An interim evaluation of the program—spearheaded by the former state surgeon general who helped design the private option—confirmed it: The private option model was **98 percent more expensive** than a conventional Medicaid expansion would have been.[9]

This evaluation, required by the U.S. Department of Health and Human Services, used actual claims data from private option enrollees in 2014 to determine utilization patterns, reimbursement rates, and more.[10]

Even worse, state data shows that per-person costs for expansion enrollees in private option plans are even more expensive than the expansion adults the state classifies as "medically frail."[11] These medically frail enrollees were specifically skimmed and excluded from the private option and instead put into traditional fee-for-service Medicaid coverage due to their higher utilization and expected higher expenses.[12]

THE PRIVATE OPTION COSTS TAXPAYERS TWICE WHAT A CONVENTIONAL MEDICAID EXPANSION WOULD COST



Sources: Arkansas Center for Health Improvement; New Hampshire Office of Legislative Budget Assistant

> **This indicates that taxpayers are spending more to cover the healthiest expansion enrollees through the private option than it costs to cover even the sickest expansion enrollees through fee-for-service Medicaid.**

Even so, these more expensive enrollees are still cheaper to cover than enrollees in private option plans: In 2018, private option enrollees cost taxpayers nearly $7,000 per person.[13] But the adults who were put into fee-for-service Medicaid cost $5,300 per person, even though the state indicated that these enrollees were specifically excluded from the private option because they had significantly greater health needs.[14]

This indicates that taxpayers are spending more to cover the healthiest expansion enrollees through the private option than it costs to cover even the sickest expansion enrollees through fee-for-service Medicaid. If Arkansas were to scrap this model altogether and transition to a traditional expansion, taxpayers could save up to $740 million per year—including $74 million in state funding.[15]

The few states that sought to replicate Arkansas's model found similar results. In New Hampshire, for example, data from state actuaries showed that the private insurance model was more than twice as expensive per person as conventional expansion.[16]

The private option has failed everywhere it has been tried

The only two states other than Arkansas to institute a private option model have since walked away from this construct due to skyrocketing costs and insurer fallout.

Iowa instituted a private-option-style waiver in 2014, delivering Medicaid expansion benefits through health plans purchased through HealthCare.gov. But barely a year into the experiment, Iowa scrapped it due to double-digit premium hikes and insolvent carriers.[17] In fact, one of the state's two carriers recorded a loss of $163 million in 2014 and specifically cited the expansion program as a primary culprit.[18] It went insolvent shortly thereafter.[19] The other carrier faced similar cost issues and stopped accepting expansion enrollees altogether.[20] With both insurers fleeing the market, Iowa scrapped the model entirely in 2015, less than two years in.[21]

New Hampshire also briefly experimented with the private option, buying plans on the federal exchange. But after costs skyrocketed, the legislature pulled the waiver, transitioning the state to a conventional Medicaid expansion.[22] Estimates from the state indicated that, by scrapping this model, the program's costs would be cut by more than half.[23]

> **"Barely a year into the experiment, Iowa scrapped it due to double-digit premium hikes and insolvent carriers."**

The private option drives up premiums in the private market

Despite promises of lower costs, premiums in Arkansas's individual market have soared since the private option was implemented.

In 2013—the year before the private option was implemented—Arkansas had the nation's third-lowest premiums.[24] Since then, Arkansas's premiums have more than doubled, growing 22 percent faster than the national average.[25]

ARKANSAS'S PREMIUMS HAVE MORE THAN DOUBLED, GROWING FASTER THAN THE NATIONAL AVERAGE

The private option bears a large share of the blame for those higher premiums. According to data obtained from Arkansas Blue Cross and Blue Shield—the carrier for 80 percent of all private option enrollees—these enrollees are more expensive to cover than other private market enrollees, which has *increased* premiums in the individual market.

Data from Arkansas Blue Cross Blue Shield also indicates that private option enrollees are increasing the individual market's risk score. Insurers in the individual market participate in a federal risk adjustment program, which transfers funds from insurers covering the least expensive enrollees to the insurers covering the most expensive enrollees as a way to mitigate risk selection.[26] This program operates by calculating risk scores for individual enrollees and plans based on various factors, including medical diagnosis data.

Data provided by Arkansas Blue Cross and Blue Shield reveals that private option enrollees have an average risk score *13 percent higher* than the rest of its exchange and off-exchange enrollees.[27] When adjusted for factors like age, the risk scores' difference is even higher, hitting 19 percent.[28] This means that private option enrollees are significantly more expensive to cover on average, typically have higher claims, and increase premiums in the private market for other Arkansans. Indeed, Arkansas's individual market has the highest risk score in the nation, and actuaries consider the state an outlier precisely because the private option enrollees are driving premiums up.[29] Arkansas's risk score is 28 percent higher than the national average and 24 percent higher than other states in its region.[30]

It is also important to note that this is happening even after the state has skimmed individuals with self-reported chronic medical conditions—those classified as medically frail—out of the private insurance pool.

Ultimately, and unfortunately, higher premiums in the individual market also mean higher costs for taxpayers. In Arkansas, more than 86 percent of HealthCare.gov enrollees receive premium subsidies or tax credits.[31] On average, these taxpayer-funded subsidies cover more than three-quarters of premiums for those receiving them.[32] By driving up premiums on HealthCare.gov, the private option increases federal spending subsidies and tax credits by millions of dollars each year.

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NOT ONLY HAS ARKANSAS FAILED TO PERMANENTLY ADD NEW CARRIERS, BUT COMPETITION HAS ALSO DECLINED OVER THE LAST SEVERAL YEARS

The private option did not generate more competition

Iowa's private option failed to attract many carriers. At its peak, Iowa's program had two carriers.[33] After suffering massive cost overruns, one dropped out of the program, eventually going insolvent before it could make up for the losses.[34] The remaining carriers faced similar problems, even after receiving double-digit premium hikes.[35] It stopped accepting new private option enrollees and soon after dropped out of the program altogether.[36]

A similar phenomenon has played out in Arkansas. Not only has the state failed to permanently add new carriers, but competition has also declined over the last several years. UnitedHealthcare exited the Arkansas individual market altogether in 2017, and Centene purchased its competitor QualChoice in 2019, reducing the number of carriers in Arkansas to just *two*.[37-38]

The Trump administration should reject future requests for private option waivers

When the Obama administration first approved these private option waivers, it ignored the advice of its actuaries and violated its own budget neutrality protocols.[39-40] At the time, GAO warned that these decisions would have negative ramifications, increasing taxpayers' costs.[41] New data from the states that have implemented the private option validates GAO's concerns, proving the private option model costs taxpayers twice what conventional Medicaid expansions would cost and drives up premiums in the private market.

Inexplicably, even though the private option has failed everywhere it has been implemented, some states are still considering replicating it. The Trump administration should learn from the mistakes made by their predecessors and refuse to approve such requests in any other state. In so doing, the administration can protect taxpayers and the truly needy.

As the Arkansas legislature prepares to convene in January 2021 and begins looking for new budget savings to keep the lights on, free up funds for more tax reform, and preserve resources for the truly needy, they should look first at reforming the failed private option: Arkansas Works program. By eliminating the use of private insurance for its Medicaid expansion, Arkansas can free up millions of dollars for the truly needy, tax cuts, infrastructure, and more.

"New data from the states that have implemented the private option validates GAO's concerns, proving the private option model costs taxpayers twice what conventional Medicaid expansions would cost and drives up premiums in the private market."

REFERENCES

1. Jonathan Ingram and Nicholas Horton, "ObamaCare expansion enrollment is shattering projections: Taxpayers and the truly needy will pay the price," Foundation for Government Accountability (2016), https://thefga.org/research/obamacare-expansion-enrollment-is-shattering-projections-2.
2. Jonathan Ingram and Nicholas Horton, "A budget crisis in three parts: How ObamaCare is bankrupting taxpayers," Foundation for Government Accountability (2018), https://thefga.org/research/budget-crisis-three-parts-obamacare-bankrupting-taxpayers.
3. Ibid.
4. Ibid.
5. Ibid.
6. Jonathan Ingram, "The empty promises of Arkansas' Medicaid private option," Foundation for Government Accountability (2014), http://thefga.org/wp-content/uploads/2020/10/The-Empty-Promises-of-Arkansas-Medicaid-Private-Option.pdf.
7. Katherine M. Iritani, "Medicaid demonstrations: HHS's approval process for Arkansas' Medicaid expansion waiver raises cost concerns," Government Accountability Office (2014), https://www.gao.gov/assets/670/665265.pdf.
8. Ibid.
9. Joseph W. Thompson et al., "Arkansas Health Care Independence Program ('Private Option') Section 1115 demonstration waiver: Interim report," Arkansas Center for Health Improvement (2016), https://achi.net/wp-content/uploads/2017/05/Interim-Report-with-Appendices.pdf.
10. Ibid.
11. Author's calculations based upon data provided by the Arkansas Department of Human Services on enrollment and expenditures for expansion enrollees in the private option and in fee-for-service Medicaid. See, e.g., Division of Medical Services, "Monthly enrollment and expenditures report," Arkansas Department of Human Services (2019), https://humanservices.arkansas.gov/images/uploads/Monthly_Enrollment_and_Expenditure_Report_01152019.pdf.
12. Centers for Medicare and Medicaid Services, "Waiver 11-W-00287/6: Arkansas Health Care Independence Program (private option) section 1115 demonstration special terms and conditions," U.S. Department of Health and Human Services (2013), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf.
13. Author's calculations based upon data provided by the Arkansas Department of Human Services on enrollment and expenditures for expansion enrollees in the private option and in fee-for-service Medicaid. See, e.g., Division of Medical Services, "Monthly enrollment and expenditures report," Arkansas Department of Human Services (2019), https://humanservices.arkansas.gov/images/uploads/Monthly_Enrollment_and_Expenditure_Report_01152019.pdf.
14. Ibid.
15. Author's calculations based upon data provided by the Arkansas Department of Human Services on the number of private option enrollees, total costs for private option enrollees, the number of fee-for-service expansion enrollees, total costs for fee-for-service expansion enrollees, and an assumed 98 percent reduction in private option costs for shifting to fee-for-service.
16. Budget Division, "Fiscal note: Senate Bill 313," New Hampshire Office of Legislative Budget Assistant (2018), http://gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&v=SI&id=1972&txtFormat=html.
17. Jonathan Ingram and Josh Archambault, "Iowa scraps waiver for ObamaCare Medicaid expansion," Forbes (2015), https://www.forbes.com/sites/theapothecary/2015/09/14/iowa-scraps-waiver-for-obamacare-medicaid-expansion.
18. Ibid.
19. Ibid.
20. Ibid.
21. Ibid.
22. New Hampshire Chapter Law 342 (2018), http://www.gencourt.state.nh.us/bill_Status/billText.aspx?sy=2018&id=1972&txtFormat=pdf&v=current.
23. Budget Division, "Fiscal note: Senate Bill 313," New Hampshire Office of Legislative Budget Assistant (2018), http://gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&v=SI&id=1972&txtFormat=html.
24. Office of the Assistant Secretary for Planning and Evaluation, "Individual market premium changes: 2013-2017," U.S. Department of Health and Human Services (2017), https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.
25. Ibid.
26. Centers for Medicare and Medicaid Services, "Summary report on the transitional reinsurance payments and permanent risk adjustment transfers for the 2014 benefit year," U.S. Department of Health and Human Services (2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.
27. Author's calculations based upon data provided by Arkansas Blue Cross and Blue Shield on plan liability risk score, member months, total claims, age distribution, administrative costs, and other information, disaggregated by private option, exchange, and off-exchange enrollment status.
28. Ibid.
29. Rebecca Owen et al., "An examination of relative risk in the ACA individual market," Society of Actuaries (2016), https://www.soa.org/Files/Research/research-2016-examination-relative-risk-aca.pdf.

30. Author's calculations based upon data provided by the U.S. Department of Health and Human Services on population-weighted overall individual market plan liability risk scores through 2016.
31. Author's calculations based upon data provided by the U.S. Department of Health and Human Services on the share of enrollees receiving advance premium tax credits or cost-sharing reduction subsidies as a share of all enrollees. See, e.g., Centers for Medicare and Medicaid Services, "2019 marketplace open enrollment period public use files," U.S. Department of Health and Human Services (2020), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html.
32. Author's calculations based upon data provided by the U.S. Department of Health and Human Services on the average advance premium tax credit and average premium after advance premium tax credit among consumers receiving advance premium tax credits.
33. Jonathan Ingram and Josh Archambault, "Iowa scraps waiver for ObamaCare Medicaid expansion," Forbes (2015), https://www.forbes.com/sites/theapothecary/2015/09/14/iowa-scraps-waiver-for-obamacare-medicaid-expansion.
34. Ibid.
35. Ibid.
36. Ibid.
37. Andy Davis, "State exchange to lose 1 insurer for `17; 4 aboard," Arkansas Democrat Gazette (2016), https://www.arkansasonline.com/news/2016/apr/08/state-exchange-to-lose-1-insurer-for-17.
38. Arkansas Health and Wellness, "Arkansas Health and Wellness parent company completes transaction with QualChoice," PR Newswire (2019), https://www.prnewswire.com/news-releases/arkansas-health–wellness-parent-company-completes-transaction-with-qualchoice-300822532.html.
39. Nic Horton et al., "GAO bombshell: HHS cooked the books to expand ObamaCare in Arkansas," Forbes (2014), https://www.forbes.com/sites/theapothecary/2014/10/09/gao-bombshell-hhs-cooked-the-books-to-expand-obamacare-in-arkansas.
40. Katherine M. Iritani, "Medicaid demonstrations: HHS's approval process for Arkansas' Medicaid expansion waiver raises cost concerns," Government Accountability Office (2014), https://www.gao.gov/assets/670/665265.pdf.
41. Ibid.

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