Handout #2

Private Option Overview

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Arkansas Department of Human Services
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Overview of major provisions of the Affordable Care Act (ACA):

- Prohibited health insurers from imposing lifetime limits on coverage and from rescinding coverage, except in cases of fraud. Prevents insurance carriers from denying coverage to people for any reason, including pre-existing conditions, and from charging higher premiums based on health status and gender.
- Mandates that most people have health insurance beginning in 2014 or face a tax penalty.
- Mandates that employers offer affordable coverage to their employees, with an exception for small business, or face a tax penalty.
- Requires insurance carriers to spend at least 80% of premiums on medical costs or pay rebates back to consumers.
- Extends coverage for young adults, allowing them to stay on their parents' plan until they turn 26.
- Expands access to insurance coverage for low and moderate income Americans.
- Promotes state-driven health reform initiatives.

ACA: Medicare Cuts

Most Medicare payments to providers are adjusted each year – usually upward – to stay in step with inflation. The new law cuts these increases for hospitals, home health agencies, skilled nursing facilities, hospices and some other Medicaid providers.

In addition, the law cuts Medicare reimbursement to hospitals for uncompensated care. Rand Health estimates that will result in over $1 billion in lost annual revenue in Arkansas.

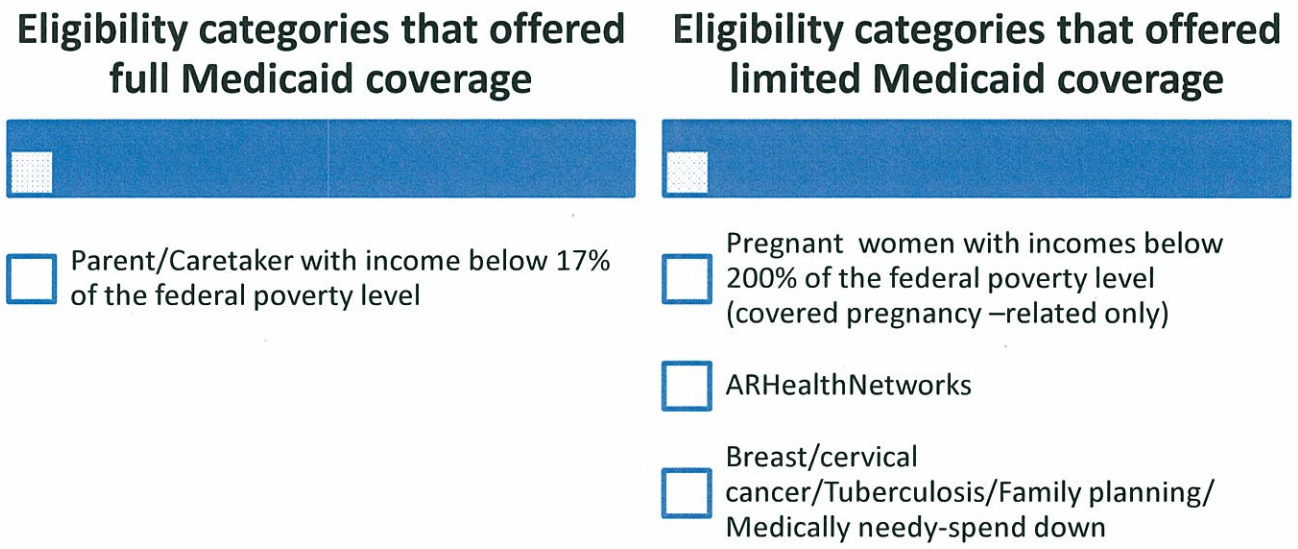
ACA: Access to Health Coverage

One of the goals of the ACA was to reduce the uninsured rate across the country. This expanded access to health insurance in two ways:

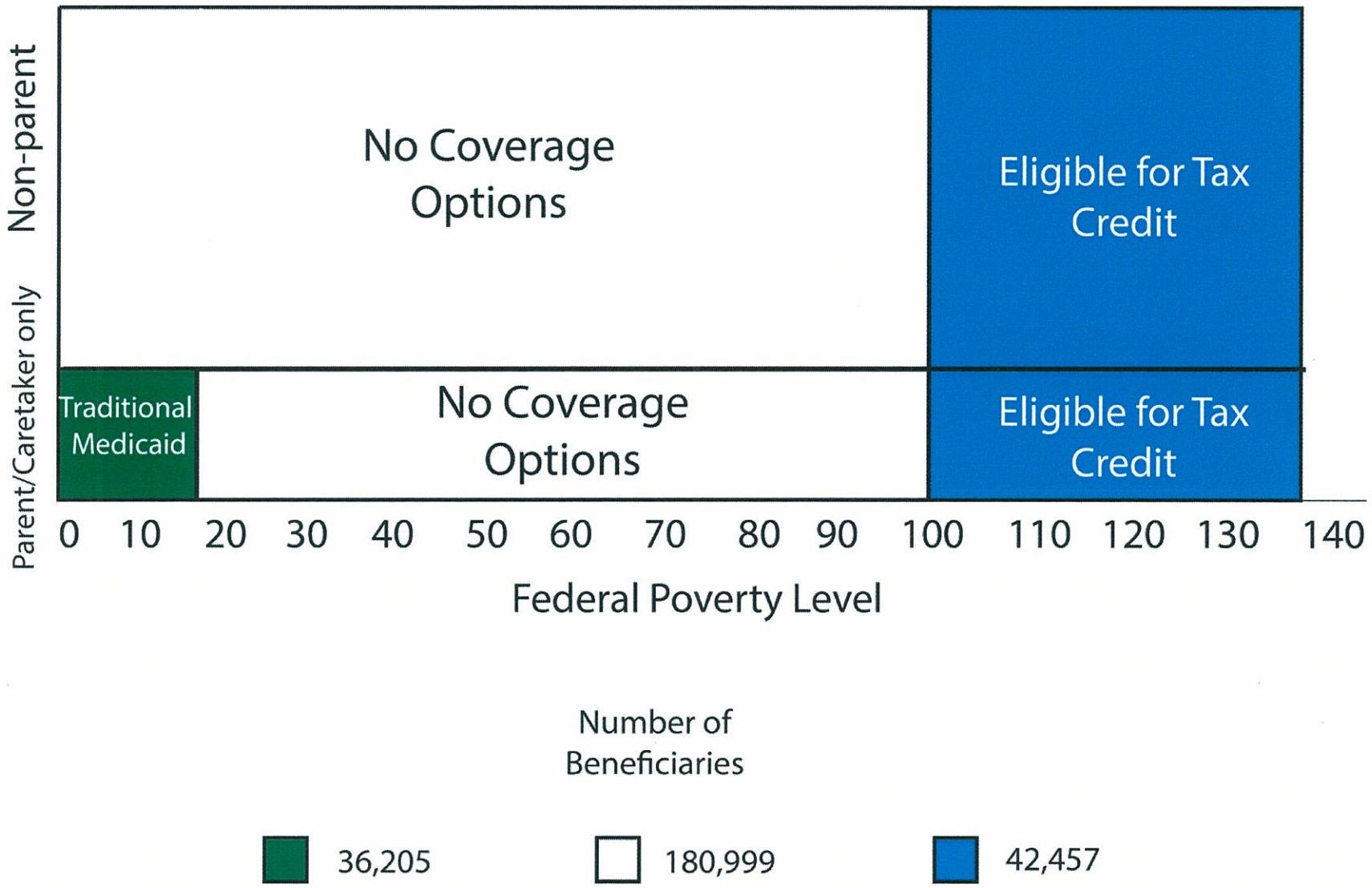
- It created Health Insurance Marketplaces, which are websites where people can buy health insurance coverage, often with financial assistance to help cover premium costs and co-pays for households with incomes between 100-400% of the federal poverty level ($11,670-$46,680 a year for an individual in 2014). Arkansas has a federal/state partnership Marketplace that is overseen by the state Insurance Department.

- It allowed states to expand traditional Medicaid programs so that coverage was available for adults with incomes up to 138% of federal poverty level (about $16,105 a year for an individual in 2014). Because many states didn't want to expand this program, the federal government agreed to allow states, like Arkansas, to test alternative ways to offer coverage.
  - Arkansas received approval to use money earmarked for expansion to cover the cost of private health insurance for people up to 138% of the poverty level via the Private Option (the official name of the program is the Health Care Independence Program). The federal government calls this a "demonstration" program, meaning it is meant to demonstrate better and alternatives ways of expanding access.

Arkansas Medicaid Eligibility Pathways for Non-Disabled Adults Before the Private Option



Coverage Options for Non-disabled Adults up to 138% FPL without the Private Option



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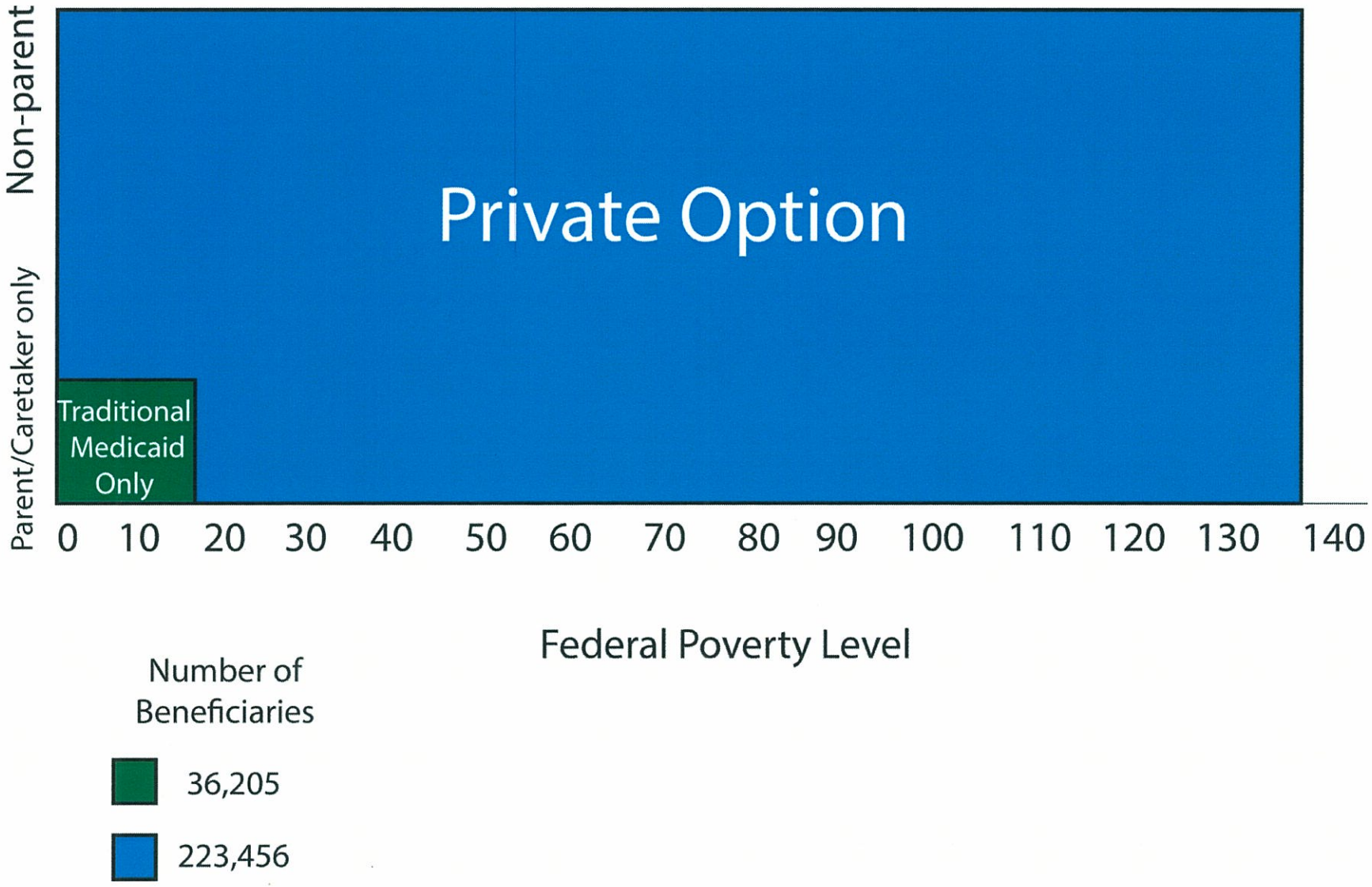
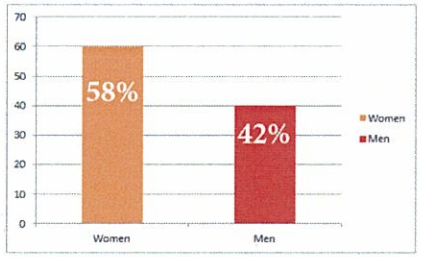
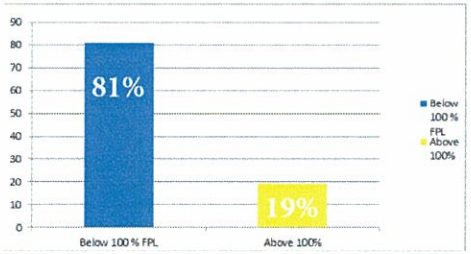


Private Option: Enrollment by County

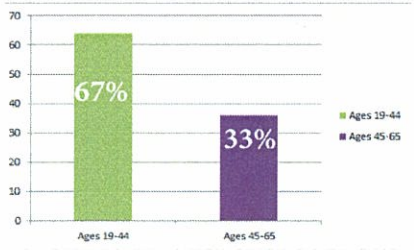
Gender

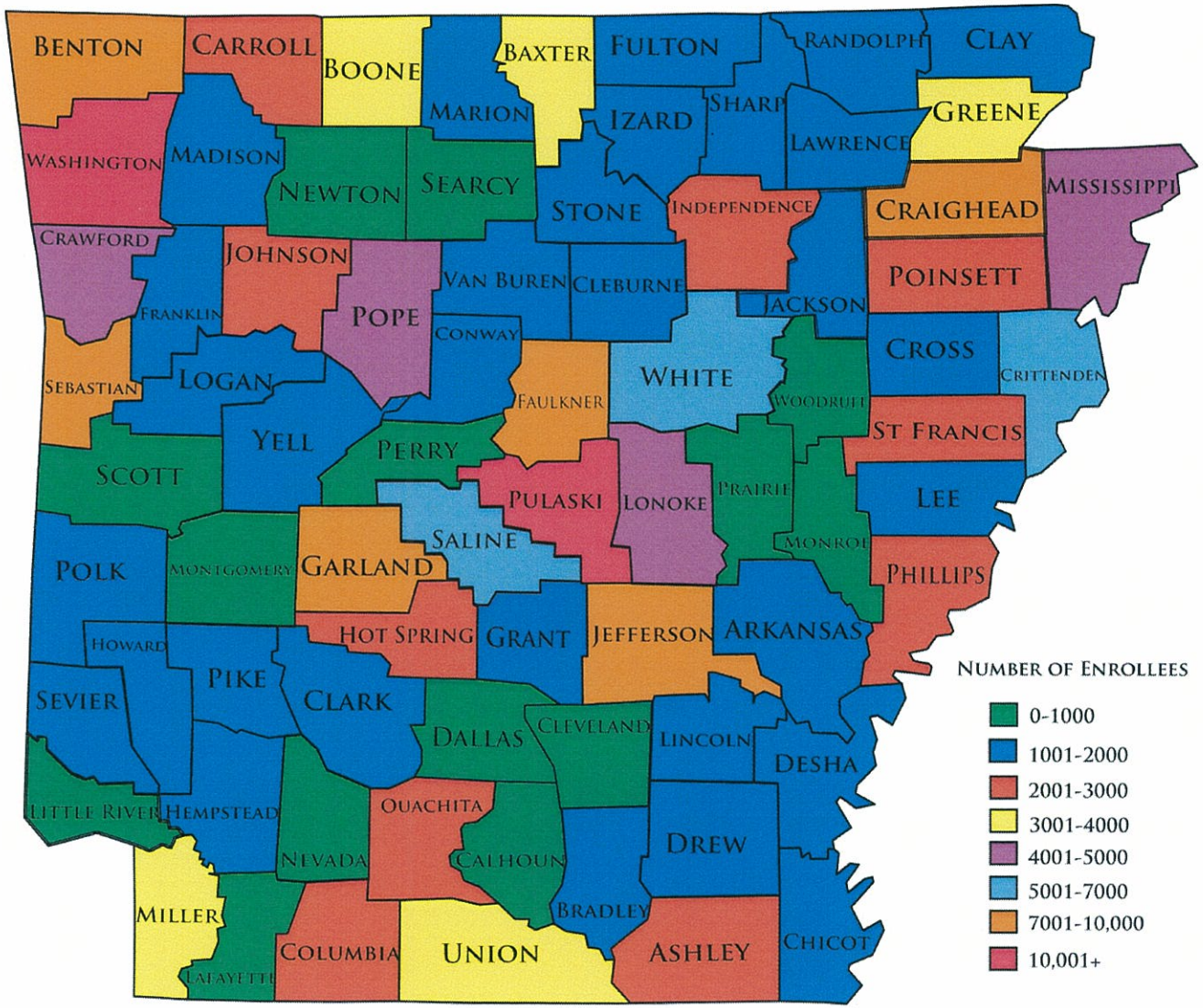


Federal Poverty Level



Age





Private Option: Coverage

- All Private Option enrollees receive coverage for the 10 essential health benefits
- 90% choose private health plans
- 10% medically frail
- All receive enhanced match rate (100% federal first three years)
- Supplemental services available to this population

Enrollment Changes Following Program Eliminations and Program Reductions

	2013 Enrollment	2014 Enrollment
ARHealthNetworks	18,000	0
Family Planning Waiver	57,603	0
Tuberculosis	480	0
Breast and Cervical Cancer	809	0
Medically Needy Spend-Down	1,473	159
Aged, Blind & Disabled	164,750	158,613
Pregnant Women	14,305	7,807
Total	**257,420**	**166,590**

Private Option:
State Costs in 2015 and beyond

- In the years 2014, 2015 and 2016, the costs of Private Option premiums, associated cost-sharing and supplemental (wrap) costs are 100% federally funded. It is estimated that the state will incur administrative costs of between $2 and $2.5 million in State General Revenue each of these years.

- Beginning in SFY2017, the state will begin paying a percentage of the cost (match) until that percentage reaches 10% in 2021.

- To help cover the match, the state is setting aside the money that comes in from the tax on health insurance premiums.

- By SFY2017, when the state is required to pay a match, it is estimated that there will be $69.4 million in premium tax funding set aside.

- The premium tax revenue would go away if the Private Option is not reauthorized.

Private Option: Overall Impact on State Expenditures and Revenues

UPDATED- January 2015

Impact of Arkansas Health Care Independence Program (HCIP) on State Spending

		State Funds										
		SFY14	SFY15	SFY16	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	10 Year Total
	Required State Match	$ -	$ -	$ -	$ 43,023,097	$ 100,090,395	$ 125,086,697	$ 172,975,562	$ 215,195,844	$ 227,563,149	$ 240,641,204	$ 1,124,575,949
	Administrative Costs	$ 2,000,000	$ 2,500,000	$ 2,562,500	$ 2,626,563	$ 2,692,227	$ 2,759,532	$ 2,828,521	$ 2,899,234	$ 2,971,714	$ 3,046,007	$ 26,886,297
	Traditional Medicaid Program Savings	$ (17,464,822)	$ (55,372,719)	$ (58,989,662)	$ (62,825,516)	$ (66,892,115)	$ (71,202,702)	$ (75,771,252)	$ (80,632,933)	$ (85,806,552)	$ (91,312,124)	$ (666,270,397)
	Net Impact on Medicaid Spending	$ (15,464,822)	$ (52,872,719)	$ (56,427,162)	$ (17,175,856)	$ 35,890,507	$ 56,643,528	$ 100,032,830	$ 137,462,145	$ 144,728,312	$ 152,375,087	$ 485,191,849
	Uncompensated Care Savings	$ (13,300,000)	$ (33,400,000)	$ (33,400,000)	$ (40,200,000)	$ (40,200,000)	$ (40,200,000)	$ (40,200,000)	$ (40,200,000)	$ (40,200,000)	$ (40,200,000)	$ (361,500,000)
	Total Impact on Medicaid and Uncompensated Care	$ (28,764,822)	$ (86,272,719)	$ (89,827,162)	$ (57,375,856)	$ (4,309,493)	$ 16,443,528	$ 59,832,830	$ 97,262,145	$ 104,528,312	$ 112,175,087	$ 123,691,849
2.5%	Added Premium Tax Revenue (2.5%)	$ 4,736,719	$ 29,661,616	$ 35,013,510	$ 37,025,737	$ 39,153,606	$ 41,403,763	$ 43,783,238	$ 46,299,460	$ 48,960,290	$ 51,774,038	$ 377,811,978
	Net State Budget Impact of Arkansas HCIP	**$ (33,501,540)**	**$ (115,934,335)**	**$ (124,840,673)**	**$ (94,401,593)**	**$ (43,463,099)**	**$ (24,960,235)**	**$ 16,049,593**	**$ 50,962,684**	**$ 55,568,021**	**$ 60,401,049**	**$ (254,120,129)**
	Influx of Federal Funds	$ 219,201,019	$ 1,378,646,002	$ 1,627,397,344	$ 1,677,900,773	$ 1,719,734,970	$ 1,799,324,031	$ 1,862,031,051	$ 1,936,762,599	$ 2,048,068,345	$ 2,165,770,833	$ 16,434,836,967
4.0%	Macro Economic Impact to the State of Federal Funds (4%)	$ 8,768,041	$ 55,145,840	$ 65,095,894	$ 67,116,031	$ 68,789,399	$ 71,972,961	$ 74,481,242	$ 77,470,504	$ 81,922,734	$ 86,630,833	$ 657,393,479
	Net Impact of AR HCIP including Macro Economic Funds	$ (42,269,581)	$ (171,080,175)	$ (189,936,566)	$ (161,517,624)	$ (112,252,498)	$ (96,933,197)	$ (58,431,649)	$ (26,507,820)	$ (26,354,713)	$ (26,229,785)	$ (911,513,608)

Changes from March 2013 Analysis:

- Medically Frail cost estimate was replaced by emerging experience on Medically Frail population cost
- Carrier premium amounts and enrollee demographics were used in place of previous estimate of non-Medically Frail costs
- Analysis scope limited to AR HCIP (woodwork population excluded)
- Annual cost growth rate adjusted to be consistent with approved 1115 Waiver

Analysis conducted by Optumas Healthcare Actuarial Services.

Private Option: Budget Neutrality

Budget neutrality is the process the federal government uses to ensure that the costs of the Private Option do not exceed what the costs would have been if the state had a traditional Medicaid expansion. The costs are measured over a three year period of the "demonstration" program.

- Budget neutrality requires the state and federal governments to agree on yearly cost limits (with room for adjustment depending on enrollment factors). These limits are described as average per-member-per-month (PMPM) amounts.
- Premiums, cost-sharing reduction and supplemental (wrap costs) are all included in the budget neutrality PMPM.
- Though there are annual limits, the overall budget neutrality will be based on a three-year, cumulative average PMPM.
- Additional factors could impact the budget neutrality calculation, including the impact of cost-sharing reduction reconciliation with insurance carriers and whether DHS requests an adjustment to the year 2 or year 3 PMPM amounts based on enrollment experience.

Private Option: Budget Neutrality continued

	Year 1	Year 2	Year 3
Average PMPM limit	**$477.63**	**$500.08**	**$523.58**
Average expenditures	**$489.85***		

*DHS can request adjustments to the annual Budget Neutrality PMPM limits based on enrollment factors, such as the average age of enrollees being higher than projected. The average PMPM in 2014 appears to be higher than the limit, though the final number won't be available until cost-sharing reduction reconciliation with insurance carriers is completed. DHS did not request adjustment in year one because:

- On average, overall Marketplace premium rates are declining
- Policy decisions likely to result in lower costs
- Purchasing only each carrier's lowest-cost EHB only plan in year two will lower costs
    - Cost were higher in year one because plans were not limited to EHB-only plans
- Changes to non-emergency transportation program expected to lower wrap costs
- Additional changes may be made in purchasing strategy for year three of the demonstration

Private Option: Changes in 2015

Those changes include:

- Limiting enrollees use of the Medicaid non-emergency transportation program.
- Implementing Health Independence Accounts for people above 100% of the federal poverty level, in an effort to create more educated insurance consumers and smooth transition as this population moves into higher incomes and privately-funded insurance.

Questions?