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On September 27, 2013, Arkansas became the first state to obtain federal approval for a Section 1115 demonstration waiver to require adults eligible for the Affordable Care Act’s (ACA) Medicaid Expansion to enroll in private plans offered through the state’s new Health Insurance Marketplace rather than traditional Medicaid. Hailed as a “game changer,” Republican lawmakers dubbed this Marketplace Premium Assistance approach a new Medicaid “private option.” Others described it as a potential “middle ground” in efforts to expand Medicaid that may be more politically palatable for those who oppose “Obamacare.”

States’ interest in Marketplace Premium Assistance is part of the post–NFIB v. Sebelius federalism dance that heated up when the Supreme Court made the ACA’s Medicaid Expansion for adults voluntary for states. The ACA extends Medicaid to adults under age 65 with incomes at or below 133% of the federal poverty line, effective January 1, 2014, with full federal funding for

1 Professor of Law, Saint Louis University School of Law Center for Health Law Studies. Thanks to MaryBeth Musumeci for comments and suggestions on this Article, and her research and writing about this issue. Thanks also to Nathaniel Carroll, Saint Louis University School of Law, J.D., 2015 for research help, and to Courtney Thiele, Saint Louis University School of Law, J.D., 2015, and Alixandra Hallen, J.D./M.P.H., 2016, for editorial help. Special thanks to the student editors at the Kentucky Law Journal.


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the first three years and at least 90% funding thereafter. However, even with this generous federal support, HHS must still entice recalcitrant states into expanding Medicaid. The Secretary of HHS has repeatedly expressed that the administration is eager to let states find their own ways, and that Section 1115 of the Social Security Act allows the Secretary to waive certain provisions of the Medicaid Act to allow states to test new and innovative demonstration programs likely to assist in promoting the objectives of the program.

Arkansas’s Section 1115 Premium Assistance demonstration waiver was conceived in a state with a Democratic governor, who needed the votes of three-quarters of a Republican controlled legislature to pass enabling legislation to expand Medicaid. The “Arkansas Plan” succeeded in garnering enough bipartisan support that it passed by one vote and was signed into law on March 26, 2013. Since then, other states with strong two party systems have proposed their own variants of an “Arkansas Plan.” On May 23, 2013, Iowa, a state with a Republican governor and a Democrat controlled legislature, became the second state to pass a Medicaid Expansion that relies on mandatory Marketplace Premium Assistance; and on December 11, 2013 it too obtained federal approval for a Section 1115 demonstration waiver. In December 2013, Pennsylvania, another state with a Republican governor, also filed its own Section 1115 waiver request seeking to use Marketplace Premium Assistance as part of a Medicaid Expansion. Other states are likely to follow.

Premium Assistance is not new to Medicaid, but using it as the avenue through which the Medicaid Expansion population gets coverage will dramatically expand its use. Moreover, using Premium Assistance to purchase individual coverage is relatively uncharted territory. The ACA’s reforms of the individual market and the new Health Insurance Marketplaces create new opportunities to use Medicaid funds to provide access to private plans.

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5 Ramsey, supra note 3. Legislative leaders sent the Governor to ask HHS if the State could use a Marketplace–offered private insurance instead of traditional Medicaid. Id. When HHS said that existing Medicaid rules authorized such an approach, the plan moved forward. Id.


9 See id. (indicating Tennessee is likely to follow); see also Virginia Young, Nixon Makes Push for Medicaid Changes, St. Louis Post-Dispatch (Jan. 1, 2014), http://stltoday.newspaperdirect.com/epaper/viewer.aspx (suggesting Missouri is likely to follow).
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However, tying the Medicaid Expansion to the brand new Health Insurance Marketplace creates potential risks as well as benefits for enrollees, insurance pools, providers, the health care delivery system, and the public fisc.

Part I of this Article describes the two different approaches the ACA creates to finance access to affordable insurance coverage: Marketplace plans subsidized through federal tax credits and the Medicaid Expansion. The ACA retained and expanded Medicaid as coverage for the nation's poorest in great part because actuarial analysis by the Congressional Budget Office (CBO) and others concluded that it cost less to insure people using Medicaid rather than with private insurance. At the same time, creating two tiers of subsidized insurance, one public and the other private, creates potential disruptions as personal income fluctuates. This Part discusses why policy experts and lawmakers are intrigued by the possibilities created by using Marketplace Premium Assistance, rather than traditional Medicaid, to provide coverage for those newly eligible for Medicaid.

Part II briefly describes Medicaid's joint federal-state structure, core mandatory and state option requirements for services and program administration, and Section 1115 demonstration waivers. It discusses long-standing federal Medicaid law authorizing Premium Assistance for employer-sponsored insurance and the use of Section 1115 waivers for Premium Assistance in that context. It ends with an explanation of how those programs have evolved, and why they have remained only a miniscule part of overall Medicaid spending.

Part III examines recently issued regulatory and sub-regulatory guidance on Premium Assistance for individual policies in general and Marketplace plans in particular. New federal regulations clarify that states have the option to offer adults newly eligible under ACA's Medicaid Expansion, and others, the choice of enrolling in Marketplace plans subsidized by Medicaid funds. In sub-regulatory guidance HHS has also outlined the conditions under which it will also consider granting a limited number of state requests for Section 1115 Medicaid waivers to implement mandatory Marketplace Premium Assistance demonstrations that require Medicaid Expansion eligible adults to obtain coverage through Marketplace plans rather than direct Medicaid coverage.

Part IV examines in more detail Arkansas's new Medicaid Section 1115 Marketplace demonstration waiver in light of this new federal guidance, and the possibilities and risks created by replacing traditional Medicaid with Marketplace Premium Assistance. Arkansas has obtained federal approval for a Section 1115 demonstration waiver that will require Medicaid Expansion adults, who are not medically frail, to enroll in Marketplace plans. Arkansas's waiver closely tracks the guidance for mandatory Marketplace demonstration

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10 See Ramsey, supra note 3.
12 Letter from Marilyn Tavenner to Andy Allison, supra note 2.
projects outlined by HHS. However, questions remain about what impact the Arkansas Marketplace demonstration will have on Arkansas’ new Marketplace, on those required to enroll in Marketplace Premium Assistance, and especially on beneficiaries who will continue to rely on traditional Medicaid. Also still unanswered is how much this experiment will cost, and how HHS will evaluate this grand experiment.

I. Health Insurance Marketplaces, Medicaid Expansion, and Federalism Post–NFIB

The Affordable Care Act uses a variety of insurance options to guarantee American citizens and some legal immigrants access to affordable health insurance. Those who have affordable employer-sponsored insurance keep it; but, effective 2014, those without affordable employer-sponsored insurance have new options. Health Insurance Marketplaces offer individuals and small employers access to insurance plans that provide better coverage and offer increased financial protections. Pre-existing condition exclusions are outlawed for adults and premiums no longer vary based upon health status.

Two different programs help make insurance more affordable for low- and moderate-income individuals and families. Those earning between 100% and 400% of the federal poverty line (FPL) ($11,490 to $45,960 for an individual in 2013) who do not have access to other “minimum creditable coverage” qualify for new sliding-scale federal tax credits to subsidize the costs of premiums for individual plans purchased on the Marketplace. Those with incomes between 100% and 250% FPL also qualify for additional federal tax credits to reduce their out of pocket costs for deductibles, copays, and coinsurance. For adults earning below 133% FPL ($15,282 for an individual and $31,322 for a family of four in 2013) the ACA creates a Medicaid Expansion to provide new public insurance coverage.

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14 ACA §1401 (codified at I.R.C. §36 (2012)).
15 BERNADETTE FERNANDEZ & THOMAS GABE, CONG. RESEARCH SERV., R41237, HEALTH INSURANCE PREMIUM CREDITS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) 1, 12–13 (2013). For those eligible for cost-sharing subsidies, the actuarial value of the plan for those with incomes between 100% and 150% FPL is increased to 94%; between 151% and 200% FPL it rises to 87%, and between 201% and 250% FPL it increases to 73%. Id. at 14–15. The silver plan has an actuarial value of 70%. Id. at 15. So the cost-sharing subsidies mean that certain eligible applicants in silver plans have lower out-of-pocket spending limits and they also pay lower deductibles and co-payments. Id. at 13.
16 ACA §2001(a)(1) (codified at 42 U.S.C. §1396a); FERNANDEZ & GABE, supra note 15, at 9 tbl.2. The Medicaid Expansion for adults covers those ages 18 to 64 who are not Medicare-eligible, pregnant or already covered by a mandatory category of Medicaid eligibility, like low-income parents or those eligible for SSI. ACA §2001(a)(1) (codified at 42 U.S.C. §1396a). A 5% income disregard in section 1004(e) of the Health Care and Education Reconciliation Act of 2010 brings the income cut-off effectively up to 138% FPL. Health Care and Education Reconciliation Act of 2010, §1004(e), 42 U.S.C. §1396a(e)(14) (originally enacted as ACA §2001(a)) (adding to the So-
However, the Supreme Court’s decision in *National Federation of Independent Business v. Sebelius* (NFIB) shifted the political balance of power for the Medicaid Expansion from the federal government to the states, making the Medicaid Expansion a state-level decision. The Supreme Court held that the federal government could not compel states to implement the Medicaid Expansion for adults through the threat of loss of all Medicaid funding. The Court remedied the constitutional infirmity by holding that the Medicaid Expansion stood, but as a voluntary option rather than a mandatory requirement for states. Suddenly, a new political and policy debate erupted over whether states should and would opt to implement the ACA’s Medicaid Expansion for adults. Some states, particularly those with Republican controlled legislatures or Republican governors, began negotiating with HHS, seeking more state autonomy to design an ACA-funded Medicaid Expansion for adults.

Section 2001(a) of the ACA, the section at issue in NFIB, creates a new category of Medicaid eligibility for non-elderly adults with income that “does not exceed 133% of the [federal] poverty line.” Section 2001(a) also provides especially generous federal financing for this new adult Medicaid Expansion category: The federal government pays 100% of the costs from 2014 to 2016, gradually declining to 90% in 2020 and thereafter.

The ACA Medicaid Expansion for adults, with its enhanced federal match, removes a major federal law impediment to Medicaid eligibility: Prior to the ACA, the federal Medicaid statute only authorized states to cover poor children, pregnant women, the elderly, people with disabilities, and parents with dependent children. The statute did not give states the authority to cover adults who were not parents of dependent children. The only way states could cover these so-called “childless adults” was by using a Section 1115 demonstration waiver. However, these waivers require that any expansion in eligibility be done in a manner that is budget neutral for the federal government, limiting the ability...
of states to leverage additional federal dollars to cover the costs of Medicaid coverage for more low-income adults. The ACA's Medicaid Expansion up to 133% FPL provides statutory authority and new federal match funding to enable states to cover an estimated 15.1 million additional adults, potentially expanding the size of the program by almost a quarter.

As the post-NFIB federalism dance began, some states considered expanding Medicaid for adults but only up to 100% FPL, rather than 133% FPL, in an effort to shift the insurance costs for adults with incomes between 100% and 133% FPL from Medicaid to the new federal premium tax credits for Marketplace coverage. States assumed that such a "partial Medicaid expansion" would save them money because it would allow state Medicaid programs to cover substantially fewer adults. Of the estimated 15.1 million adults newly eligible for Medicaid, about 3.6 million, approximately 24%, have incomes between 100% and 133% FPL. However, because the ACA's Medicaid Expansion carries with it such a generous federal match up to 133% FPL, it actually costs states more to implement a "partial expansion" and insure fewer adults.

The ACA's enhanced federal matching funds of 100%, and then 90%, are only available to states that implement Section 2001(a)'s Medicaid Expansion for all adults earning up to 133% FPL. In December 2012 and again in March 2013, HHS issued policy guidance confirming that the ACA does not authorize an enhanced federal match for a Medicaid Expansion that only goes up to 100% FPL. States may still propose Section 1115 demonstration waivers for a partial expansion for adults, but demonstrations are funded at the state's regular federal match rate, 50% to 73.43%, depending on the state's per capita

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24 See Kenney et al., Opting out of the Medicaid Expansion under the ACA, supra note 23.

income.\textsuperscript{26} It actually costs states more to opt for a partial expansion only to 100% FPL than to take advantage of the ACA's Medicaid Expansion with its enhanced federal match.\textsuperscript{27}

Even as states' interest in a partial Medicaid Expansion waned, that conversation sparked broader interest in using Marketplace plans to cover adults eligible for the ACA's Medicaid Expansion. Health policy experts had already identified several potential benefits of using Marketplace plans to cover Medicaid enrollees.\textsuperscript{28} For Medicaid beneficiaries, enrolling in Marketplace plans could reduce some of the potential disruptions that come from the ACA's use of multiple types of insurance, called "churning."\textsuperscript{29} Churning occurs when people's incomes fluctuate and they move back and forth between Medicaid and Marketplace tax credit eligibility, potentially having to change insurance plans and provider networks.\textsuperscript{30} Researchers have estimated that 28 million Americans annually—almost 35% percent of those eligible for new affordability support—are likely to churn across the 133% FPL Medicaid–Marketplace divide each year.\textsuperscript{31}

Buying Marketplace plans with Medicaid funds might shield families from the impact of small income changes since they could keep their Marketplace plans and providers regardless of whether Medicaid or federal tax credits were paying the premiums at any given moment. Researchers estimate that using Medicaid to purchase Marketplace plans could reduce churning by as much as two-thirds, to only about 10% per year in states like Arkansas that presently have highly restrictive eligibility for adults, and about 15% per year in states


\textsuperscript{27} CMS 2012 FAQs, supra note 25, at 12.


\textsuperscript{29} Id. at 8.

\textsuperscript{30} For example, a family may have one parent with employer-sponsored insurance, a second parent with Medicaid coverage, and children covered by the Children's Health Insurance Program (CHIP). If Medicaid and CHIP could pay the premiums for the employer-sponsored or Marketplace plan insurance, then the whole family would be able to enroll in the same insurance plan.

like Ohio that offer more generous coverage. If states can create a process by which people moving from Marketplace Premium Assistance to federal tax credits could stay in the same plan and provider networks, requiring close coordination between Medicaid coverage and the Marketplace.

Enrolling Medicaid beneficiaries in Marketplace plans might also give them access to more robust provider networks. One perennial concern about Medicaid is that only about 70% of physicians accept new Medicaid patients. While Medicaid enrollees report similar access to care as privately insured patients, Medicaid beneficiaries have traditionally had a different choice of physicians than those with private insurance. Medicaid patients rely more heavily on a smaller group of safety net providers, for example, federally qualified health centers (FQHCs), as their source of primary care. Using private plans for Medicaid should both address physicians’ concerns that Medicaid payment rates are typically lower than private rates and effectively “mainstream” Medicaid beneficiaries into the delivery system serving privately insured patients. It should also alleviate states’ concerns about whether their existing Medicaid fee-for-service and managed care programs have enough capacity to absorb the 37.4% increase in Medicaid enrollment, an increase of 18.1 million children and adults if all states expand, which is anticipated after full implementation all the ACA changes, including the Medicaid Expansion.

Moving adults that are newly eligible for Medicaid into Marketplace plans could also strengthen the new Marketplaces, benefiting all those in the individual market as well as the federal government, which funds the new tax credits. Moving Medicaid Expansion adults into Marketplace coverage could more than double the size of the Marketplace pool in the short run, and increase the size of the pool by as much as 75% in the long run. These larger

34 See Medicaid Primer, supra note 23, at 17; see also Sidney D. Watson, Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race and Equity, 55 How. L.J. 835, 857, 867 n.76 (2012).
37 See Cong. Budget Office, CBO-43472, Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court De-
numbers could make the Marketplaces more attractive for private insurers, increasing insurance competition, and potentially lowering premium costs for both individuals and the federal government.

However, an influx of lower income people into the Marketplace could also increase prices in the Marketplace. Lower income people tend to be less healthy than those who earn more, which means they are more costly to insure. The CBO estimates that Marketplace premiums will be 2% higher if there is an influx into the Marketplaces of people earning between 100% and 133% FPL. A study by the Rand Corporation concludes that Marketplace rates will be between 8% and 10% higher in Texas, Louisiana, and Florida, because those states are not expanding Medicaid in 2014, and people earning between 100% and 133% FPL will be purchasing Marketplace plans. A Medicaid strategy to move those with incomes below 100% FPL, as well as those with incomes between 100% and 133% FPL, into the Marketplaces could raise Marketplace premiums even higher.

Moving people from Medicaid to Marketplace Premium Assistance also carries risks for enrollees. Marketplace plans provide different coverage, have higher premiums, and have fewer cost-sharing protections for enrollees. Many lawmakers like this aspect of Marketplace Premium Assistance because they believe lower income families should have more “skin in the game” and should not have more generous coverage than moderate income Americans. However, two decades of research indicate that the typical private insurance plan leaves a low income family with higher out of pocket costs that creates barriers to appropriate care and places them at financial risk when illness strikes. The CBO also estimates that the higher premiums and cost sharing for Marketplace plans will create barriers to enrollment, resulting in lower enrollment in Marketplace plans compared to Medicaid and higher rates of uninsurance.

For conservative state lawmakers, private Marketplace plans offer a more politically palatable insurance option than a public insurance program like Medicaid. These legislators began talking about Marketplace Premium Assistance as a new Medicaid “private option.” While this rhetoric may be attractive in the political arena, it can be hard for health policy experts to square with the reality of how state Medicaid programs actually deliver service. Most non-disabled adult Medicaid beneficiaries are already covered by private

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38 See id. at 15.
39 See id.
41 Id. at 14.
plans. About half of Medicaid beneficiaries nationwide are enrolled in private Medicaid managed care plans. Medicaid already has a very extensive “private option.”

Yet the biggest obstacle to Marketplace Premium Assistance is cost. Congress included a Medicaid Expansion in the ACA extending eligibility for adults up to 133% FPL in part because this Medicaid Expansion, even when funded 100% with federal dollars, costs the federal government less money than federal premium tax credits for private insurance. Medicaid costs less per person than private plans, primarily because Medicaid pays providers less and has lower administrative costs. The CBO estimates that it will cost about 33% more to cover people using Marketplace plans rather than Medicaid, about $9000 per person for Marketplace plans compared to $6000 per person for Medicaid coverage.

Thus, Marketplace Premium Assistance offers interesting possibilities but also carries risks for enrollees, Marketplace premium rates, and the public fisc. In assessing the risk–benefit ratio it is important to understand the differences between Premium Assistance and direct Medicaid coverage, the protections available to the Medicaid beneficiaries, and the role that the Medicaid state agency plays in assuring access, quality and cost effectiveness. It is also helpful to understand the history of Medicaid Premium Assistance for employer-sponsored coverage.

II. A Look Back: Medicaid and Premium Assistance for Employer–Sponsored Insurance

Medicaid is a joint federal–state entitlement program that provides open-ended federal financial assistance to states operating an approved Medicaid state plan. As a federal–state partnership, each state designs and operates its own Medicaid program within broad federal guidelines. Federal law outlines core “mandatory” state plan requirements that state Medicaid programs must comply with for eligibility, covered services, and program administration, but states retain considerable flexibility to cover additional “optional” categories of eligibility, services, and administration. Those who qualify for Medicaid coverage have a legal entitlement to receive all medically necessary services, both mandatory and optional, provided for in the Medicaid state plan.

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43 CBO ESTIMATES 2012, supra note 37, at 16.
44 Id. at 15–16. (based on estimates of 2022 premium costs)
46 See id. §§ 1396a, 1396d (2012).
States may also seek "waivers" from the Secretary of Health and Human Services to use federal Medicaid funds in ways not otherwise authorized by the federal statute and regulations. Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive specific provisions of the Medicaid Act to allow research and demonstration projects to test new approaches to program design and administration. Although not required by statute or regulation, under longstanding administrative policy, Section 1115 waivers must be budget neutral for the federal government. This means that federal spending under a waiver must not be more than projected federal spending would have been for that state without the waiver. States have used Section 1115 waivers to expand eligibility, alter benefits and experiment with new delivery system designs.

While states have great flexibility in defining their Medicaid benefit packages, federal law requires that Medicaid state plans cover a set of "mandatory" services some of which are typically not covered by private insurance, like nursing home care, Early Periodic Screening Diagnosis and Treatment (EPSDT) for children, federally qualified health centers (FQHC) services, and expansive family planning services. Medicaid's EPSDT package for children under age 21 is the country's most comprehensive preventive health and treatment program for children. Coverage for FQHC services recognizes the special role these providers play in providing primary care to low-income communities and helps support the services they provide to the uninsured. State Medicaid programs are also required to cover non-emergency transportation to and from necessary medical care, a benefit that helps alleviate one of the biggest barriers to care for low-income individuals and families.

Generally, states must cover the same Medicaid benefits for all enrollees statewide, but adults eligible for the new ACA Medicaid Expansion who...
are not medically frail or have other special medical needs are entitled to an “Alternative Benefit Plan” (ABP) which states can benchmark more closely to private insurance coverage, excluding at state option some otherwise mandatory services, most significantly nursing home care. However, state ABPs must still cover certain mandatory services including medically necessary transportation, EPSDT benefits for those under age twenty-one, FQHC services, and family planning services. While states have the flexibility to specify different ABPs for different groups of newly eligible adults, all ABPs must cover the ten essential health benefits now required for individual and small group private insurance including, among other services, preventive care, rehabilitative and habilitative services, and mental health. Moreover, ACA eligible adults who are medically frail or have special health needs remain entitled, at their option, to an ABP that includes all mandatory and optional services covered by the state plan assuring that those who have more extensive medical care needs have access to the state’s full Medicaid benefits package, especially nursing home and other long term care services.

Federal Medicaid law also restricts states’ ability to impose premiums and cost sharing. Premiums are prohibited for children and adults with incomes at or below 150% FPL. Cost sharing—deductibles, copays, and coinsurance—is prohibited altogether for some groups and limited to “nominal” amounts for adults with incomes below poverty. Most children and adults with incomes between 100% and 150% FPL can be charged higher cost sharing, but for all Medicaid beneficiaries the total amount of premiums and cost-sharing is capped at 5% of monthly or quarterly income.

While Medicaid is a public insurance program, Medicaid beneficiaries, like other Americans, receive their care primarily through private providers and private health plans. Some states pay for services on a fee-for-service basis with the state Medicaid program paying hospitals, doctors, and other providers directly for each service. In other states, Medicaid beneficiaries receive all or part of their care through insurance companies, called Managed

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58 45 C.F.R. § 440.315 (2013). State definitions of those who are medically frail must, at a minimum, include individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness); individuals with chronic substance use disorders; individuals with serious and complex medical conditions; individuals with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program (the State plan criteria). Id.
59 42 U.S.C. § 1396o and §1396o–1. HHS recently recodified the federal regulations on premiums and cost sharing. See 42 C.F.R. §§ 447.15–447.56 (2013)
60 42 U.S.C. § 447.36
61 42 U.S.C. § 447.56(f)
Care Organizations (MCOs) in Medicaid. MCOs are paid a monthly premium—called a capitation rate—for each enrolled beneficiary and assume the financial risk for providing a defined set of benefits. Most states operate their Medicaid programs using some combination of these and other approaches.62

Within this federal–state structure, Premium Assistance is a long-standing Medicaid state option that has allowed states to use Medicaid funds to subsidize the purchase of employer-sponsored insurance.63 One potential benefit of using Premium Assistance for employer-sponsored insurance is cost savings: If employer premium contributions are generous enough, then employer-sponsored coverage may cost the federal and state governments less than traditional Medicaid.64 Employer-sponsored family coverage can also provide a vehicle for expanding coverage to family members not eligible for traditional Medicaid.

However, Premium Assistance for employer-sponsored private insurance also raises concerns because private insurance typically does not cover long term care, EPSDT, FQHC services, extensive family planning, or medically necessary transportation that are part of the traditional Medicaid benefit package. Employer-sponsored coverage also often has higher enrollee premiums and cost sharing than traditional Medicaid.65

To address these concerns, statutory authorization for Premium Assistance for employer-sponsored plans specifies that those enrolled in Premium Assistance remain Medicaid beneficiaries entitled to all Medicaid services, cost sharing, and other protections.66 The private employer plan and Medicaid operate together as two sources of insurance: The private health plan becomes the primary payer for benefits and services it covers, with the state Medicaid program legally obligated to have mechanisms in place to provide “wrap-around” services to supplement the private insurance to the extent that private benefits are less or cost-sharing obligations are greater than traditional Medicaid. Premium Assistance enrollees get services covered by their employer-sponsored plan through that plan, then Medicaid pays for long term care, medically necessary transportation, EPSDT, and other services covered only by Medicaid. Medicaid also pays any employer-sponsored plan deductibles, copays, or coinsurance that exceed those allowed by Medicaid.

64 Id. at 2.
65 This article focuses on Medicaid coverage, so will focus solely on Medicaid programs and law. However, the Children's Health Insurance Program (CHIP) also authorizes states to use CHIP funds for Premium Assistance. Id. For more on CHIP Premium Assistance, see id.
66 Id. at 10. Section 1906 authorizes HIPPP programs to pay premiums for Medicaid-eligible individuals and, in some cases, their family members who are not Medicaid-eligible.
Since 1990, Section 1906 of the Social Security Act has authorized state Medicaid programs to operate Health Insurance Premium Payment (HIPP) programs that pay premiums for group health plans, primarily employer-sponsored plans. Under the Section 1906 option, if private group coverage is deemed cost-effective, Medicaid beneficiaries may be required to enroll in employer-sponsored coverage using Premium Assistance. However, Section 1906 beneficiaries remain entitled to all Medicaid benefits and cost-sharing protections provided by the state’s Medicaid plan. If private coverage offers less generous benefits or higher cost sharing than Medicaid, states are required to provide wrap-around Medicaid benefits so that Premium Assistance enrollees receive the same benefits and cost-sharing protections as other Medicaid beneficiaries.

In 2009, Congress created a new Section 1906A, giving states another option to use Premium Assistance to pay for employer-sponsored insurance for parents and children. Section 1906A requires that employers contribute at least 40% toward premium costs and, unlike Section 1906, requires that individuals be given the choice of traditional Medicaid or Premium Assistance. As with the Section 1906 option, Section 1906A Premium Assistance must be cost-effective, and beneficiaries are entitled to the full Medicaid benefit package and cost-sharing protections. Beginning January 1, 2014, the ACA gives states the option to offer Section 1906A Premium Assistance to all Medicaid-eligible individuals.

The ACA adds new statutory provisions specifying how cost effectiveness is calculated for both Sections 1906 and 1906A. For both sections, cost-effectiveness must now take into account the cost of providing wrap-around services and cost-sharing protections, and the administrative costs of running the Premium Assistance option. States had been using

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68 ACA § 10203(b)(1) (codified at 42 U.S.C. § 1396e(a)(3)).
70 ACA §§ 2003(a), (b), 10203(b)(a) (codified at 42 U.S.C. § 1396e–i(b)(1)(B), (d)(2)).
71 ACA §§ 2003(a), (b), 10203(b)(2) (codified at 42 U.S.C. § 1396e–i(a), (e)). States are also prohibited from using section 1906A to subsidize high deductible policies, health flexible spending accounts, or coverage in the individual market. Id. §§ 2003(a), (b), 10203(b)(2) (codified at 42 U.S.C. § 1396e–i(b)(3)).
72 ACA §§ 2003(a)(1), 10203(b)(2)(B) (Section 2003(a)(1) reads as if this is a mandatory state requirement, but section 10203(b)(2)(B) declares this requirement null and void thus rendering it an option) (codified at 42 U.S.C. § 1396e–i).
73 ACA § 10203(b)(1) (codified at 42 U.S.C. § 1396e(c)(2)). For more details on the statutory language and administrative interpretation, see Premium Assistance in Medicaid and CHIP,
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different methods for calculating cost effectiveness, making it hard to compare programs and impossible to determine whether these Premium Assistance programs were cost–effective compared to direct Medicaid.74

Prior to 2010 and the ACA’s Medicaid Expansion for adults, the Centers for Medicare and Medicaid Services (CMS) also approved sixteen Section 1115 demonstration waivers allowing states to use Premium Assistance programs to expand Medicaid to adults, including childless adults, not otherwise eligible for coverage.75 Subject to the budget neutrality requirements for Section 1115 demonstration waivers, some of these demonstrations authorized states to experiment with Premium Assistance that provided fewer benefits and higher cost sharing than traditional Medicaid as a way of offering expanded eligibility within federal budget constraints.76 Twelve of these sixteen Premium Assistance demonstrations provided only partial or no wrap–around Medicaid benefits.77

Most state Medicaid programs now use Premium Assistance for employer–sponsored coverage. In 2009, thirty–nine states operated such programs, with Section 1906 HIPP programs being the most popular.78 States have used Premium Assistance to target a wide variety of eligibility groups, but programs have tended to focus on more expensive individuals, such as pregnant women and children with disabilities, where leveraging job–based coverage is more likely to be cost–effective.79

Yet, in 2009 Premium Assistance enrollees accounted for only about one percent of Medicaid spending.80 Premium Assistance for employer–sponsored insurance has proved hard to implement because not only has employer–sponsored insurance become less common generally, but low–wage workers are less likely than others to be offered employer–sponsored insurance.81 States have also had a hard time figuring out which services various private plans covered to be able to determine the necessary wrap–around services and cost effectiveness.

It is also hard to judge how well Premium Assistance for job–based coverage works because states have not generally collected data on access and quality for those enrolled in Premium Assistance.82 Anecdotal evidence suggests that the biggest challenge is that individuals may not be aware of their rights to

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74 GAO Medicaid and CHIP, supra note 63, at 10–11.
75 Id. at 7.
76 Id. at 6–7.
77 Id. at 9.
78 Id. at 13–16.
79 Premium Assistance in Medicaid and CHIP, supra note 28, at 7.
80 Id. at 6.
81 GAO Medicaid and CHIP, supra note 63, at 11.
82 See id. at 9. In a GAO survey of 43 Premium Assistance programs, thirty–four did not monitor access to care or utilization of services. Id. Of the remaining eleven programs, seven monitored utilizations, three monitored utilization and access, and one program did not report. Id.
Medicaid wrap-around benefits and cost-sharing protections to supplement their employer-sponsored insurance. Advocates complain that those enrolled in Premium Assistance do not receive the full scope of Medicaid benefits to which they are entitled, losing access to services like medically necessary transportation, long-term care, and EPSDT for children. However, without data it is impossible to determine how well these employer-sponsored Premium Assistance programs do in providing access to services or improving health status compared to direct Medicaid coverage.

III. Medicaid Premium Assistance, Marketplace Plans, and Medicaid Expansion

In 2009, when Congress expanded options for Premium Assistance in the employer-sponsored market, Congress intentionally moved away from using Medicaid funds to subsidize purchase of individual plans because high administrative costs and poor coverage made the individual market unattractive. However, effective 2013, the ACA’s individual market reforms and new Marketplaces make individual plans more attractive, and Premium Assistance for individual plans easier to administer. As the Medicaid Expansion debate focused attention on the new Marketplaces as a coverage alternative, HHS issued new policy guidance on Premium Assistance in the individual market.

In December 2012, in a set of Frequently Asked Questions (FAQs) about Marketplaces, Market Reforms, and Medicaid, HHS indicated that it had concluded that Section 1905(a) of the Social Security Act provides statutory authority for states to use Medicaid funds for Premium Assistance for individual plans, including Marketplace plans. Most states and health policy experts were unaware or only vaguely aware of this long-standing provision. Nevertheless, according to a 2010 Government Accountability Office (GAO) report on Premium Assistance, six states had been using Section 1905(a)'s little-known statutory authority to subsidize Medicaid coverage in the individual market.

Section 1905(a)(29) authorizes state Medicaid programs to pay for “other insurance premiums for medical or any other type of remedial care or the cost thereof.” The provision is obscure, challenging to locate, and almost impossible
to decipher because of its tortured use of the English language. Nevertheless, CMS concluded that Section 1905(a) gives states authority to use Medicaid to pay private insurance premiums.

However, Section 1905(a) provides little guidance on the parameters for using Premium Assistance in the individual market generally or for new Marketplace plans in particular. The statute does not specify whether Section 1905(a) Premium Assistance is subject to the same or similar requirements as Section 1906 and Section 1906A Premium Assistance for employer-sponsored plans with regard to issues like voluntariness, wrap-around benefits, cost-sharing protections, and cost effectiveness. The lack of guidance persisted because HHS had never issued regulatory guidance for Section 1905(a). It was an orphaned provision.

In January 2013, a few months before Arkansas announced an agreement in principle with HHS on the use of Premium Assistance to purchase Marketplace plans, HHS issued proposed regulations for a state option to use Section 1905(a) Premium Assistance for individual plans. Final regulations were promulgated July 15, 2013. In the preamble to the final regulations HHS makes clear that

89 42 U.S.C. § 1396d(a)(29) reads:

[A]ny other medical care, and any other type of remedial care recognized under State law, specified by the Secretary, except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for Medicare cost-sharing and for premiums under part B of subchapter XVIII of this chapter for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapters I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of medical assistance solely because it is provided as a treatment service for alcoholism or drug dependency.

Id. (emphasis added).

90 See CMS 2012 FAQs, supra note 25, at 17.


92 Final Rule on Essential Health Benefits, Exchanges, and Eligibility for Medicaid and
its purpose in promulgating these regulations is “to support enrollment of individuals eligible for Medicaid in plans in the individual market, including enrollment in” Marketplace plans. In developing regulatory guidance for Section 1905(a) individual market Premium Assistance, HHS closely tracked the provisions in Sections 1906 and 1906A for employer-sponsored Premium Assistance that had evolved from experience over the last twenty years.

The preamble to the Section 1905(a) regulations emphasizes that under all state option Premium Assistance arrangements, including Section 1905(a), individuals remain Medicaid beneficiaries entitled to the full range of statutory protections. Medicaid-eligible individuals who obtain Marketplace plans through Section 1905(a) Premium Assistance are entitled to all Medicaid benefits and cost-sharing protections. States must assure that wrap-around services are available to the extent that Marketplace plans offer fewer benefits or more cost sharing than the state Medicaid plan.

Because Section 1905(a) does not make enrollment in individual market coverage a statutory condition for eligibility, HHS concluded that states do not have the option to require enrollment in Marketplace Premium Assistance as a condition for receiving Medicaid benefits. The regulations require that state option Premium Assistance for plans in the individual market be voluntary, and individuals must be given a choice of Medicaid via Premium Assistance or direct Medicaid coverage.

The regulations also impose a cost-effectiveness test for Section 1905(a) that is consistent with that used in Sections 1906 and 1906A. The costs of Premium Assistance for individual plans must be “comparable to the cost of providing direct coverage under the State plan,” taking into account not only premiums, but also wrap-around benefits, cost-sharing protections, and administrative costs.

In the preamble to the final regulations, HHS also noted that it would consider approving a “limited number” of Section 1115 demonstration waivers for Marketplace Premium Assistance, which could require mandatory enrollment in Marketplace plans. HHS specified that these demonstrations


93 Id. at 42,184.

94 Id. at 42,184, 42,186.

95 Id. at 42,303; see 42 C.F.R. § 435.1015 (2013).


97 Id. at 42,304; see 42 C.F.R. § 435.1015(b) (2013).


99 Id. at 42,304; see 42 C.F.R. § 435.1015(a)(4) (2013).

must meet the Section 1115 statutory requirement that they “further the objectives of the Medicaid program,” indicating it was interested in these demonstrations because they could help inform policy for new State Innovation Waivers created by the ACA and authorized to begin in 2017.101

In March 2013, HHS released a set of FAQs that outlines the standards it intends to use in evaluating applications for Section 1115 demonstration waivers for mandatory Marketplace Premium Assistance.102 The FAQs specify, yet again, that mandatory Marketplace Premium Assistance demonstration enrollees, like other Premium Assistance enrollees, remain Medicaid beneficiaries entitled to wrap-around services for Medicaid benefits and cost-sharing protections not provided by Marketplace plans.103 Those enrolled in mandatory Marketplace Premium Assistance demonstrations must be given a choice of at least two Marketplace plans.104 Such demonstrations must end no later than December 31, 2016—before the start date for State Innovation Waivers.105

The HHS guidance states that the agency will only consider approving mandatory Marketplace Premium Assistance demonstrations for individuals required to enroll in a Medicaid Alternative Benefit Plan (ABP) “whose benefits are closely aligned with benefits available on the Marketplace.”106 Limiting mandatory Marketplace Premium Assistance demonstrations to ABPs that are closely aligned with Marketplace plan benefits reduces the need for Medicaid wrap-around services. All Medicaid ABPs must cover certain services, like medically necessary transportation, EPSDT for those under age twenty-one, FQHC services, and out-of-network family planning that are not covered by Marketplace plans, these services should be relatively easy to provide via wrap-around arrangements. The HHS guidance also notes that limiting mandatory Marketplace Premium Assistance demonstration waivers to those required to enroll in ABPs prevents a large influx of medically frail and disabled Medicaid beneficiaries into the Marketplace that could adversely affect premiums for all Marketplace enrollees.107

Moreover, limiting mandatory Marketplace Premium Assistance demonstrations to individuals required to enroll in a Medicaid ABP closely aligned to the Marketplace means that HHS intends to approve only demonstrations that are limited to adults in the new Medicaid Expansion group who are not medically frail or have other special medical needs.108 Newly
eligible adults who are medically frail or have other special health needs are entitled to the option of enrolling in an ABP that covers all mandatory and optional services provided by the state plan, including nursing home and long term care services, benefits that do not align with those covered by Marketplace plans. Those who qualify as children, pregnant women, low-income parents, or based on disability are exempt from ABP coverage, being entitled to all benefits covered by the state plan.

The HHS guidance provides that the state must “[m]ake arrangements with the [Marketplace plans] to provide any necessary wrap-around benefits and cost sharing.”110 Apparently, the HHS guidance seeks to encourage demonstration waiver proposals in which wrap-around benefits and cost-sharing protections are provided by the private health plan through payment of a supplement premium or other mechanism. As HHS points out, this requirement should ensure that coverage is seamless, cost-sharing reductions are actually delivered, and there is accountability to ensure that beneficiaries receive the full Medicaid package to which they are entitled.111 However, it is also interesting that HHS declined to impose this as a regulatory requirement on states opting to use Section 1905(a)(29) for non-mandatory Premium Assistance.112

As with all demonstration waivers, mandatory Marketplace Premium Assistance demonstrations must “promote the objectives of the Medicaid program” and be budget neutral.113 For these demonstrations, HHS states it is willing to consider taking into account new factors that might reduce federal costs for the new Health Insurance Marketplaces, like cost savings from reduced churning between Medicaid and Premium Assistance and lower Marketplace premiums that might be created by the addition of new Premium Assistance enrollees into the Marketplace.114

HHS also advised states that the agency is particularly interested in demonstrations targeting those in the new adult group with income between 100% and 133% FPL, the group of those Medicaid Expansion eligible that originally prompted states’ interest.115 HHS’s rationale tracks the reasons that states and policy makers were attracted to Marketplace Premium Assistance originally: Medicaid allows for additional cost sharing for those above 100% FPL, this group is more likely to move between Medicaid and Marketplace

\footnotesize{
109 Id.
110 Id.
111 Id.
113 CMS 2013 FAQs, supra note 25, at 1–2.
114 Id. at 2.
115 Id.
}
plans, and this group is eligible for federal tax credits if the state does not expand Medicaid.\textsuperscript{116}

Through regulations and sub-regulatory guidance, HHS has invited states to use Medicaid for Marketplace Premium Assistance. States now have a clearly defined option available through which they may offer Premium Assistance for Marketplace plans as an alternative to direct Medicaid, as long as the coverage is cost effective and beneficiaries remain eligible for all Medicaid benefits and cost-sharing protections. HHS has also used sub-regulatory guidance to indicate the prerequisites for approval of demonstration waivers that require adults eligible for the Medicaid Expansion to participate in Marketplace Premium Assistance. With HHS's framework in mind, the question remains: how well does this comport with what is happening in Arkansas?

IV. Arkansas Revisited: The Arkansas Marketplace Demonstration Waiver

On February 28, 2013, Governor Mike Beebe announced that Arkansas had reached an "agreement in principle" with HHS to allow the State to cover adults newly eligible for the ACA's Medicaid Expansion by using Medicaid funds to purchase private plans offered through the State's new Health Insurance Marketplace.\textsuperscript{117} On March 26, 2013, the Arkansas legislature passed a Medicaid Expansion for adults conditioned on the State obtaining approval from HHS to use Marketplace Premium Assistance for "low-risk adults."\textsuperscript{118} On August 2, 2013, the State filed a demonstration waiver application with HHS seeking a waiver of Section 1905(a) to allow the State to implement mandatory Marketplace Premium Assistance for all Medicaid Expansion eligible adults who are not "medically frail" or have other exceptional medical circumstances.\textsuperscript{119} On September 27, 2013, HHS approved the demonstration waiver setting forth Special Terms and Conditions with which it must comply.\textsuperscript{120} Arkansas estimates that the demonstration, commonly referred to as the Private Option, will enroll 90% of those newly eligible for Medicaid in Marketplace plans and

\textsuperscript{116} Id.
\textsuperscript{120} Letter from Marilyn Tavenner to Andy Allison, supra note 2; Special Terms and Conditions, supra note 2.
nearly double the size of Arkansas's new Marketplace.\(^{121}\)

While Arkansas' authorizing legislation goes beyond what HHS indicated it is willing to approve via a Section 1115 demonstration waiver, the broad outlines of the Arkansas Marketplace Demonstration Waiver fairly closely track HHS’s guidance for mandatory Marketplace Premium Assistance demonstrations, at least for year one of the demonstration.\(^{122}\) Only Medicaid Expansion adults who are not medically frail or do not have other exceptional medical circumstances will be required to enroll in Marketplace plans.\(^{122}\) Marketplace enrollees will have a choice of at least two Marketplace plans.\(^{122}\) Medicaid ABPs will be closely aligned with Marketplace plan benefits, and Demonstration enrollees will be entitled, at least on paper, to almost all Medicaid benefits and all cost-sharing protections.\(^{122}\) According to Arkansas’s projections, using Marketplace plans will cost no more than direct Medicaid coverage.\(^{122}\) The demonstration is approved for three years, ending December 2016.\(^{122}\)

However, questions remain about what impact the Arkansas Marketplace demonstration will have on Arkansas’ new Marketplace, on those required to enroll in Marketplace Premium Assistance, and especially on beneficiaries who will continue to rely on traditional Medicaid. It is unclear whether the State’s budget projections are realistic and how HHS will evaluate the demonstration.

Moving into 2014, Arkansas presents an interesting, and in many ways enticing, landscape for the nation’s first mandatory Marketplace Premium Assistance demonstration. It is a small state with a population that tends to be older, sicker, and poorer than the nation as a whole.\(^{128}\) The private insurance

\(^{121}\) Arkansas Waiver Application, supra note 119, at 10, 17.


\(^{123}\) Special Terms and Conditions, supra note 2, at 8–9. Those who are medically frail or have other exceptional medical circumstances will be given the option to enroll in direct Medicaid with the state’s full scope of Medicaid benefits including long term care services and supports. \textit{Id.}; Arkansas Waiver Application, supra note 119, at 10.

\(^{124}\) Special Terms and Conditions, supra note 2, at 12; Arkansas Waiver Application, supra note 119, at 18.

\(^{125}\) Special Terms and Conditions, supra note 2, at 13; Arkansas Waiver Application, supra note 119, at 11–12, 15–16, 43–44. The State Medicaid agency will pay insurers’ premiums and cost-sharing subsidies using a payment system modeled after the system used to pay for federal premium tax credits. \textit{Id.} at 3, 26. The Demonstration application states that Arkansas intends to impose cost sharing on those with incomes between 50% and 100% FPL in year two, but it also acknowledges that the State will need an additional waiver to do so. \textit{Id.} at 15, 44.

\(^{126}\) See Arkansas Waiver Application, supra note 119.

\(^{127}\) \textit{Id.} at 1.

\(^{128}\) See The Henry J. Kaiser Fam. Found., Distribution of Total Population by Federal Poverty Level, \url{http://kff.org/other/state-indicator/distribution--by-fpl/} (last visited Nov. 14, 2013) (12\% of the Arkansas population lives under the national poverty level, compared to the
market has been neither vibrant nor competitive, with one insurance company dominating the market. The State's Medicaid program has the nation's stingiest eligibility limits for adults, disqualifying parents who earn more than 16% of the federal poverty line and declining to cover nondisabled adults without dependent children. More than one-quarter of working age adults in Arkansas are uninsured.

The State hopes that its mandatory Marketplace Premium Assistance demonstration will nearly double the size of the Marketplace, adding 225,000 relatively healthy adults, in an effort to attract more private insurers, increase competition, and ultimately bring down—rather than increase—premium costs in the Marketplace. However, it is not clear how realistic Arkansas projections are about the health status of newly eligible adults. Arkansas estimates that only 10% of adults eligible for the ACA Medicaid Expansion will be medically frail or have other exceptional medical circumstances excluding them from the mandatory Marketplace Demonstration. However, surveys consistently find that about 20% of the poor and near poor uninsured report being in poor to merely fair health; and HHS, in its waiver approval, reduced the estimated number of demonstration enrollees to 200,000, a figure more in line with the

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\[132\] See Arkansas Waiver Application, supra note 119, at 17 and 21 (noting that the demonstration adds 225,000 people to the Marketplace, nearly doubling its size).

\[133\] See id.

research data.\textsuperscript{135}

The State has designed the demonstration as a vehicle to entice new insurers into the Arkansas Marketplace by crafting it to allow Premium Assistance participants to enroll in any silver-level Marketplace plan, not just the two lowest-priced plans.\textsuperscript{136} All insurers who sell in the Arkansas Marketplace in 2014 will be able to compete for the estimated 200,000–225,000 Private Option enrollees.\textsuperscript{137} While the State has indicated that in future years it may more narrowly circumscribe which plans are eligible to participate in the Private Option (possibly limiting the choices to the two least costly plans), in 2014 Private Option enrollees can select any plan based upon the network and coverage, not the premium price, which will be paid by the State Medicaid agency.\textsuperscript{138} The State has also designed an auto-enrollment process for Private Option enrollees who fail to select a specific Marketplace plan, designed to help each Marketplace plan achieve a target minimum Private Option enrollment.\textsuperscript{139}

It is not clear how well the demonstration has succeeded in enticing new insurers to Arkansas: four insurers will be selling in the Arkansas Marketplace, with at least two that are new to the state.\textsuperscript{140} Of course, it is not clear yet how Arkansas’s premium pricing and plan designs will compare to other states. We also do not know whether the new insurers who have entered the Arkansas Marketplace also offer Medicaid managed care plans and whether those companies would be attracted to any state implementing the ACA Medicaid Expansion.

Another concern is how the demonstration’s “full choice” of plans will impact the overall cost of premiums in the new Marketplace: Private Option enrollees, as many as 200,000–250,000 people, have no immediate incentive to purchase less expensive plans and many may be auto-enrolled in higher priced plans as part of an effort to give all issuers a share of the Private Option enrollment. Moreover, for 2014, Marketplace premiums in Arkansas are already above the national average: $231 per month compared to a national average of

\begin{thebibliography}{99}
\bibitem{135} \textit{Special Terms and Conditions}, \textit{supra} note 2, at 1.
\bibitem{136} \textit{Id.}
\bibitem{137} \textit{See id.}
\bibitem{138} \textit{See id.} at 21–22. Out of pocket costs for enrollees will be the same for all plans. The State will require enrollees to pay the maximum cost sharing allowed by federal law. If the plan’s design requires higher or other cost sharing, the costs will be paid by the State Medicaid agency. \textit{Id.}
\bibitem{139} \textit{See id.} at 27.
\bibitem{140} \textit{See Andrew Demillo, Arkansas PPACA Exchange Attracts Four Carriers, LIFEHEALTHPRO} (June 5, 2013), http://www.lifehealthpro.com/2013/06/05/arkansas-ppaca-exchange-attracts-four-carriers. In addition to Arkansas Blue Cross Blue Shield, which has been the dominant insurer in Arkansas, Celtic Insurance Company, QualChoice of Arkansas, and a National Blue Cross Blue Shield multi-state plan will be selling through the Marketplace. \textit{Id. ASSISTANT SECY FOR PLANNING \& EVALUATION, U.S. DEPT OF HEALTH \& HUMAN SERVS., ASPE ISSUE BRIEF: HEALTH INSURANCE MARKETPLACE PREMIUMS FOR 2014, at 2 (2013) [hereinafter ASPE ISSUE BRIEF], available at http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/lb_premiumslandscape.pdf} (summarizing the options that will be available in the new Marketplaces).
$203 per month.  

The demonstration's "full choice" design also carries financial risks for enrollees, which could contribute to harmful churning as enrollees' incomes fluctuate moving them off Medicaid and into federal premium tax credit assistance. Premium tax credits are pegged to the cost of the second–lowest cost silver plan offered in the Marketplace in an effort to incentivize consumers to purchase lower cost plans. For example, a 35–year–old living in Little Rock, Arkansas earning $17,235 a year, 150% FPL, qualifies for a premium tax credit of $235 per month. With that credit her (or his) share of the premium for a silver plan ranges from $46 to $108 per month, depending on the plan.

In contrast, Private Option Medicaid enrollees, at least in year one of the demonstration, can pick any silver plan at no premium cost to them. Those who enroll in—or are auto–enrolled in—higher priced silver plans through the Medicaid Private Option, will likely suffer sticker shock if their earnings go up, they go off Medicaid, and move into the premium tax credit pricing structure. They may not be able or willing to pay their share of higher premiums to stay in their old Medicaid Private Option plan, and may end up churning between Marketplace plans as they move from Medicaid Private Option to premium tax credits. Without careful consumer education and full disclosure, Arkansas' "full choice" model could contribute to churning among plans and providers as people move between Medicaid and Marketplace plans.

The demonstration may also undermine the traditional Medicaid program that will continue to serve the most vulnerable: the aged, people with disabilities, children, very poor parents, pregnant women, and newly eligible medically frail adults. One of the State's reasons for using Marketplace Premium Assistance is its conclusion that Arkansas Medicaid provider network is at capacity, and unable to absorb all those newly eligible for the ACA Medicaid Expansion. Arkansas Medicaid physician payment rates are relatively high compared to

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141 ASPE Issue Brief, supra note 140, at 7–8 tbl.1 (reporting average for the thirty–six states using the federal Health Insurance Marketplace based on premiums for the individual policy of a 27–year–old).
142 See Fernandez & Gabe, supra note 15, at 10.
143 A bronze plan cost even less, between $0 and $35 per month, but those earnings below 250% FPL who purchase a silver plan also qualify for additional tax credits to reduce their cost sharing for deductibles, copayments, and cost of insurance. Thus, silver priced plans are the best value for those who qualify for cost–sharing help and the reason that the Arkansas Private Option uses silver plans. See generally Healthcare.gov, https://www.healthcare.gov/ (last visited Jan. 29, 2014) (providing premium and tax credit quotes).
144 The Arkansas Waiver Application notes that Arkansas has an "Any Willing Provider Law," which requires plans to accept into its network any provider willing to accept the plan rates and other contract terms. Arkansas Waiver Application, supra note 119, at 46. The State seems to assume this will mean that most plans will have extensive networks and few out-of-network providers. See, e.g., id. at 18. However, provider participation will depend upon reimbursement rates and other requirements. It cannot be assumed that all providers will participate in all plan networks.
145 Arkansas Waiver Application, supra note 119, at 3.
many states, but they are still lower than Medicare and commercial rates.\textsuperscript{146} While Arkansas physicians who participate in Medicaid are historically more likely to accept new Medicaid patients than participating physicians in other states, the new Marketplace plans may entice physicians to drop out of Medicaid or,\textsuperscript{147} at least, decline to accept new Medicaid patients. Arkansas’s proposed Private Option program is large enough that it could destabilize the traditional Medicaid program’s provider network, making it harder for those who continue to depend on it to find providers willing to accept their Medicaid cards, particularly if the new Marketplace plans pay commercial rates that are substantially higher than Medicaid fee-for-service rates.\textsuperscript{148}

Those enrolled in the Private Option may also have difficulty accessing the full scope of Medicaid benefits to which they are entitled. Arkansas is using the discretion given states by the ACA to design a Medicaid ABP that aligns closely with the essential health benefits offered by Marketplace plans, reducing the need for Medicaid wrap-around services.\textsuperscript{149} HHS’s Terms and Conditions for the waiver specify that the state’s traditional Medicaid fee-for-service program must provide wrap-around benefits for most ABP services not covered by Marketplace plans, specifically medically necessary transportation, EPSDT for those nineteen and twenty years old, and family planning services provided by out of network providers.\textsuperscript{150} Instead of being entitled to all FQHC services, HHS has granted a waiver providing that Private Option enrollees will only be guaranteed access to one Marketplace plan that includes at least one FQHC or Rural Health Clinic in its provider network.

In authorizing Arkansas’ Medicaid fee-for-service program to provide wrap-around services for Private Option enrollees, HHS retreated from its sub-regulatory guidance, which specified that wrap-around services would need to be provided by Marketplace plans. This means that Private Option enrollees are entitled to a limited scope of wrap-around services.

\textsuperscript{146} See id. at 3, 17; Decker, supra note 33, at 1183; The Henry J. Kaiser Fam. Found., Medicaid-to-Medicare Fee Index, http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/ (last visited Nov. 14, 2013) (Arkansas’s Medicaid-to-Medicare physician payment rate is 79% compared to a national average of 66%).

\textsuperscript{147} See Decker, supra note 33, at 1185.

\textsuperscript{148} The Budget Neutrality Worksheet that Arkansas submitted with its 1115 Waiver Application assumes Medicaid rates for the ACA Expansion group are the same as commercial rates. See Arkansas Waiver Application, supra note 119, at Budget Neutrality Spreadsheet. It is unclear, though, whether Arkansas is actually raising rates in its fee-for-service Medicaid program, and, if so, for which eligibility groups.

\textsuperscript{149} See Arkansas Waiver Application, supra note 119, at 11, 18–19, 42, 44–45. This alignment reduces the need for Medicaid wrap-around services such that the only wrap-around services that Private Option enrollees are entitled to are non-emergency transportation, EPSDT services for those ages 19 and 20, and family planning services provided by out of network providers. Arkansas figures that the costs for wrap-around services will be only $8.58 per month. Id. at 18, 22, 44–45. The State plans to provide wrap-around services through the Medicaid fee-for-service program and hopes it will be administratively feasible to provide one insurance card to access benefits through the private plan and fee for service Medicaid wrap-around services. Id. at 28.

\textsuperscript{150} Special Terms and Conditions, supra note 2, at 12–13.
enrollees will be issued two insurance cards, one for a Marketplace plan and the other for Medicaid, to access covered services. Two sources of coverage will make it more complicated for enrollees to navigate the system and again raises the issue that enrollees may miss out on wrap-around Medicaid benefits. Even more troublesome, the State has already indicated that Arkansas's fee-for-service program may not have the capacity to provide the wrap-around services that will be needed.

The demonstration also creates a substantial risk that those who are medically frail or who have other exceptional medical circumstances and need long term care and other services only provided by traditional Medicaid will be incorrectly enrolled in the Private Option rather than direct Medicaid. Arkansas plans to use a twelve-question online screening tool to identify those who are medically frail or have exceptional health needs and are thus not eligible for the Private Option. The screening tool will be administered as individuals apply for new health insurance, either through Medicaid or the Marketplace. Arkansas is contracting with highly respected researchers at the University of Michigan and the Agency for Healthcare Research and Quality to develop the questionnaire, but the protocol is still a work in process and, like any new protocol, is likely to misclassify people, especially during the first year of use.

It is also possible that Marketplace plans will try to push anyone who is Medicaid eligible with substantial medical needs, even those who do not meet the definition of medically frail and who do not need additional services covered by traditional Medicaid, into traditional Medicaid, in an effort to keep their Marketplace premiums competitive. Marketplace plans may try to cherry pick, enrolling only the healthiest and pushing as many Medicaid-eligible people as possible into traditional Medicaid. In this scenario, traditional Medicaid will function as a new high-risk pool, enrolling not only the most expensive

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151 Id. at 19–20.
152 See id. at 19.
153 See id. at 41 (explaining that the questionnaire is still being developed and the refinements likely to take place as the questionnaire is tested). The proposed screening tool, at least as described in the Arkansas Waiver Application, may also fail to comply with the federal law definition of those who are "medically frail." Id. (comparing the described algorithm which may be limited to those with the top 10% of costs with the regulatory definition of "medically frail," which includes a broad array of people with complex medical conditions and is not limited to those with the top 10% of costs). The Special Terms and Conditions for the Arkansas Waiver specify that Medicaid beneficiaries retain their Medicaid appeal rights that include, among other things, a right to appeal a factual finding that one is not medically frail. See Special Terms and Conditions, supra note 2, at 14 ("No waiver will be granted related to appeals."). This specification of appeal rights is significant because the Arkansas Demonstration Waiver Application provided that individuals would not be granted a right to a fair hearing to contest a finding that one was not medically frail but would have a right to "request a re-determination of whether they are medically frail at any time during the coverage year." Arkansas Waiver Application, supra note 119, at 41. HHS does not have authority under Section 115 to waive fair hearing due process rights guaranteed by the U.S. Constitution and federal Medicaid law that are designed to protect beneficiaries against factually inaccurate and harmful decisions. See Special Terms and Conditions, supra note 2, at 14.
medically frail patients, but all above-average users.

Particularly troubling is a concern that Arkansas's cost estimates are unrealistic, designed to support unsubstantiated claims of cost effectiveness and budget neutrality rather than a realistic estimate of what the Private Option is likely to cost compared to direct Medicaid. The State's actuaries apparently used the same formula to compute costs for a Medicaid Expansion using mandatory Marketplace Premium Assistance or traditional fee-for-service Medicaid, importing assumptions for each type of coverage that are simply unfounded for the other type of coverage. For traditional Medicaid, the actuarial formula assumes Medicaid will pay provider's commercial reimbursement rates rather than actual Medicaid or Medicare rates. The formula also assumes that traditional Medicaid will incur 20% administrative costs, adopting the medical loss ratio allowed for Marketplace plans, rather than the more typical 5% administrative costs reported by fee-for-service Medicaid programs like Arkansas's. On the Marketplace side, the actuarial formula computes costs based upon service utilization multiplied by commercial provider reimbursement rates, rather than using the premium and cost-sharing costs that will actually be charged to the state by Marketplace plans. While one might be sympathetic to HHS allowing Arkansas a little room on the cost estimates to encourage an important demonstration to move forward, budget neutrality and cost effectiveness calculations based upon such obviously flawed data are likely to create a baseline against which it is impossible to track whether the demonstration is cost effective or budget neutral compared to a traditional Medicaid expansion.

Ultimately, the most troublesome part of the waiver approval may be that HHS approved the demonstration before finalizing the details about how the demonstration will be evaluated, what data will be collected, how quality and access will be monitored, and what benchmarks will be used to judge how well or poorly this demonstration fares. The Special Terms and Conditions for the demonstration give Arkansas sixty days to submit a draft evaluation design. It specifies that the evaluation is to address cost effectiveness, access, quality, consumer satisfaction, and continuity of care, but leaves the details to be negotiated with the State, after implementation of the Private Option is

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154 See Arkansas Waiver Application, supra note 119, at 29 ("Because they could have been made eligible without a waiver, savings are not available. As a result, the projected enrollment and costs for the Private Option Beneficiaries are shown as identical in the without waiver and with waiver scenarios.").
155 See id.
156 Id.
157 See id. ("non-medical load (administration and profit/risk/contingencies)").
158 See id. ("Optumas applied the commercial reimbursement anticipated to be used on the Marketplace to the projected utilization . . .").
159 SPECIAL TERMS AND CONDITIONS, supra note 2, at 22-30.
Mandatory Marketplace Premium Assistance is an intriguing idea, but it presents substantial risks as well as potential benefits. Without good evaluative data—and an independent evaluator—there will be no way to determine how well, or poorly, Arkansas’s Private Option operates in practice and compares with traditional Medicaid coverage. Neither will it be possible to evaluate the true costs of using Marketplace plans rather than traditional Medicaid. Without adequate interim evaluations, enrollees in the Private Option and in traditional Medicaid may suffer from an experiment gone awry.

**Conclusion**

Arkansas' Private Option may be a game changer. It has already opened up a new avenue for expanding Medicaid that appears more politically acceptable to Republican lawmakers. The demonstration provides an opportunity to test important hypotheses about the relative cost, quality, and access to health care provided by the new Marketplaces and traditional Medicaid. As the experiment unfolds it can provide important new information about competition in the new Marketplaces, how to deliver services to those eligible for the ACA’s Medicaid Expansion for adults, and how to protect the nation’s most vulnerable—the aged, children, and people with disabilities—who remain eligible for traditional Medicaid.

However, questions remain about what impact the Arkansas demonstration will have on Arkansas’ new Marketplace, on those required to enroll in Marketplace Premium Assistance, and especially on the poorest beneficiaries who will continue to rely on traditional Medicaid. Also yet to be determined is whether HHS will allow Arkansas to expand the demonstration in years two and three of the waiver, beyond the parameters set forth by its sub–regulatory guidance, to enroll children and very low-income parents in mandatory Marketplace Premium Assistance and to impose additional cost sharing.

The post–NFIB federalism dance has just begun. Section 1115 gives the Secretary of HHS authority to waive certain sections of the Medicaid Act to test new approaches to program design that further the purposes of the Medicaid program. However, new approaches like mandatory Marketplace Premium Assistance must be subjected to rigorous, independent evaluation to determine how well they work and whether they do, in fact, provide quality, accessible, and affordable care.

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160 Id.