



Medicaid  
Strategies

# Medicaid Premium Assistance The Arkansas Experience

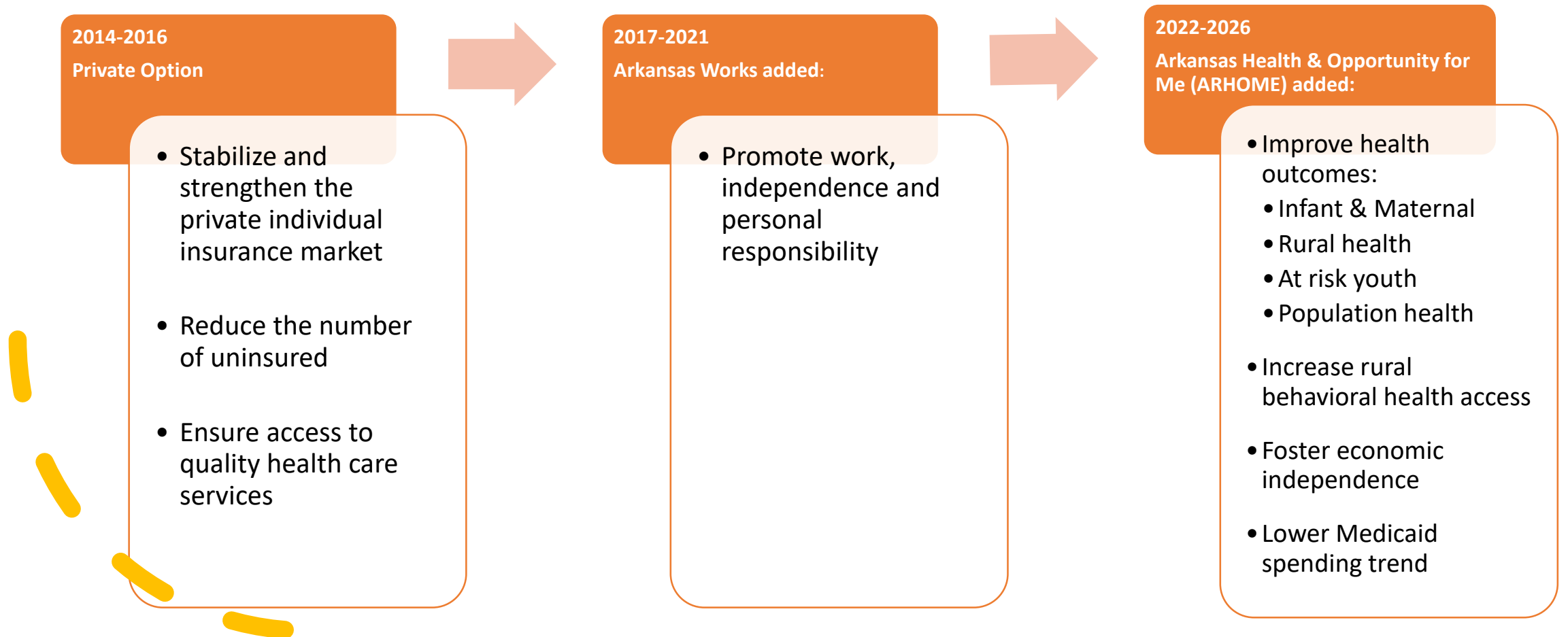
# The Arkansas Model – Integrate the Medicaid Population with the Private Insurance Marketplace

- States have the option, through **premium assistance**, to purchase private sector health insurance to cover Medicaid beneficiaries through either employer-sponsored group coverage or non-group (individual market) qualified health plans (QHPs).
- Since 2014, the **Arkansas premium assistance model** has used Medicaid dollars to purchase QHPs in the private insurance Marketplace under Section 1115 Demonstration Project (“waiver”) authority.
- Over 225,000 adults are thus integrated with the privately insured risk pool. By spreading the risk across a larger group of people who tend to be younger and healthier (33% less than 30 years old), Marketplace rates are lower and more stable than in other states.
- Providers are paid commercial rates negotiated with the private health plans, not Medicaid. Plans establish their own provider networks which must meet network adequacy set by the Arkansas Insurance Department (AID), not Medicaid.
- This flexibility capitalizes on the expertise and creativity of the private sector to attract providers, particularly specialists, and drive efficiencies.

# The Arkansas Model – Medicaid and the Insurance Department Jointly Administer the Program

- A yearly Memorandum of Understanding (MOU) between Medicaid, the Arkansas Insurance Department (AID), and each carrier facilitates annual payment rates and clarifies the plans eligible for premium assistance.
  - The Arkansas Health Insurance Marketplace is a Federal/State Partnership Marketplace within AID
- Currently, Medicaid will subsidize premiums only for plans priced within 10 percent of the second lowest silver plan in the market region. Medicaid pays the QHPs monthly for premiums and cost-sharing, excluding the individual enrollee's cost-sharing liability
- Eligibility is determined by Medicaid and individuals are notified by Medicaid that they are eligible for coverage through a QHP
  - A separate benefit is available for “medically frail”
- Individuals then choose their plan or are auto-assigned to a QHP and can change plans annually at open enrollment.
- The QHP then enrolls the beneficiary and treats them as an individual insurance market plan member

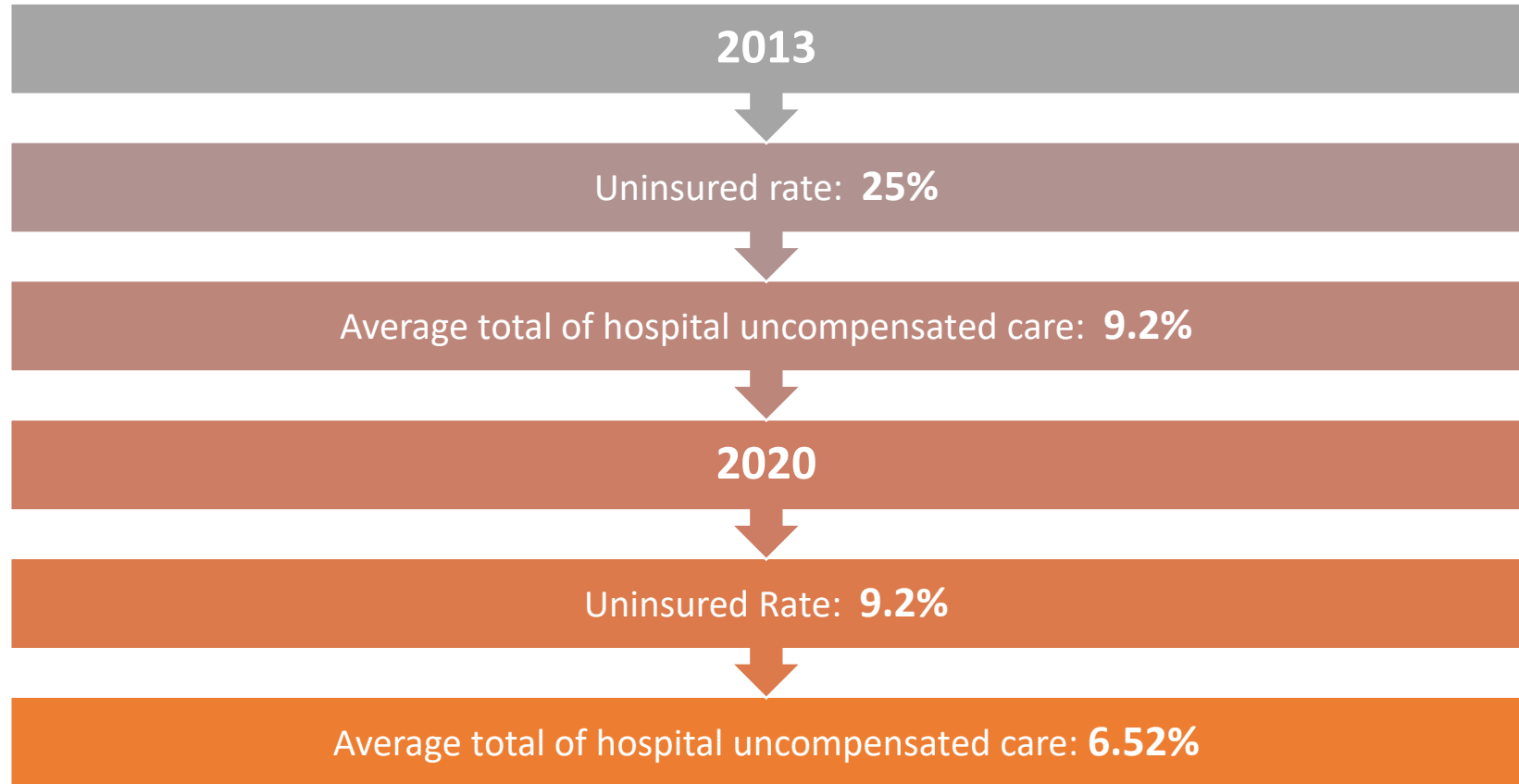
In 2014, Arkansas began purchasing private insurance through the Marketplace under 1115 Medicaid Waiver demonstration authority. Each iteration has added new goals and refinements.



Private Option  
Goal:

Reduce the number  
of uninsured

As the uninsured  
rate dropped,  
uncompensated  
care dropped



Uninsured visits dropped significantly in the first year:  
Inpatient: 48.7% drop  
Emergency room: 38.8% drop  
Outpatient clinics: 45.7% drop  
55% reduction in hospital uncompensated care losses.

Private Option  
Goal:  
Ensure Access  
to Quality  
Health Services

An initial concern was ensuring provider capacity to serve new Medicaid enrollees without increasing Medicaid rates statewide.

*Premium Assistance was designed to bring commercial rates into the program to ensure access to care and to stabilize the Medicaid provider network.*

**The 2018 “Private Option” Final Report found:**

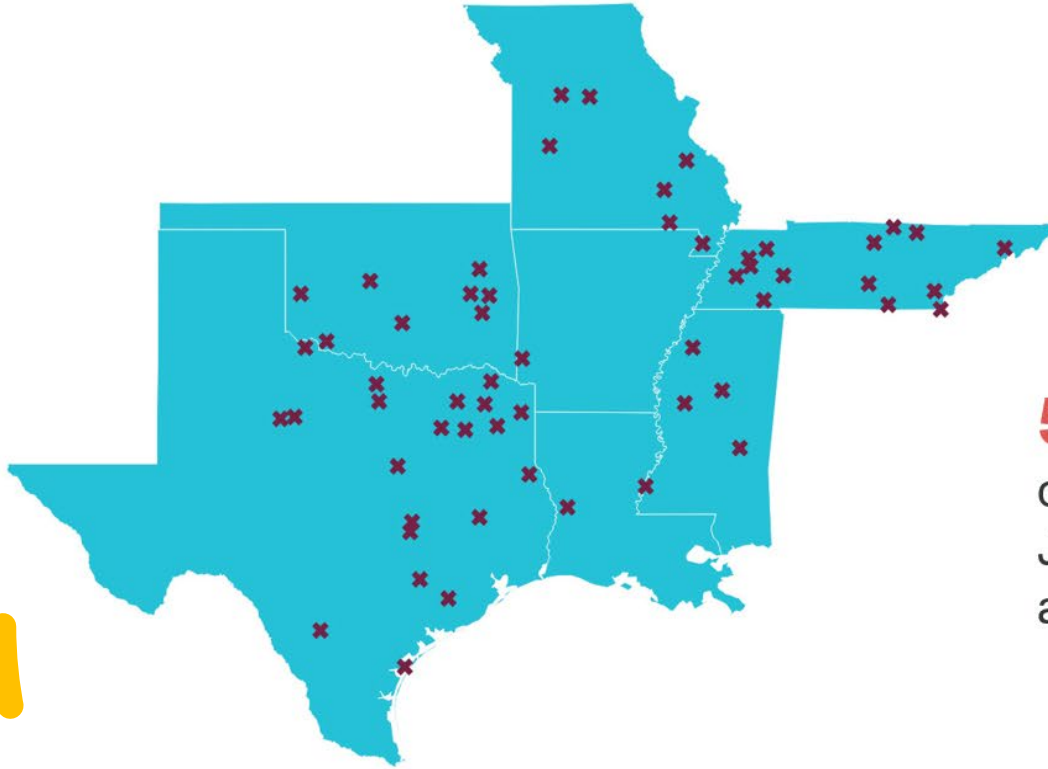
QHP rates consistently **exceeded** Medicaid rates

- Physician payment rates across outpatient services were 95% higher than Medicaid
- For inpatient hospital stays, QHP payment averaged \$12,270 per discharge compared to Medicaid payment of \$7,778 (a 53% difference)

QHP enrollees had **greater access** to primary and specialty care providers:

- Increased ability to get needed “care, tests, and treatment” and receive “an appointment for a check-up or routine care as soon as needed”
- Enrollees began receiving health care services more rapidly than those in the Medicaid program following enrollment

# ARKANSAS WORKS IMPACT ON RURAL HOSPITALS



**57** rural hospital closures, Jan. 2012–Jan. 2021 in Arkansas and neighboring states

## For all Arkansas hospitals:

- “Bad debt” decreased from over 5% to under 3%
- Average margin is now over 6%, better than the 4% national mean

<https://medica-musc.researchcommons.org/cgi/viewcontent.cgi?article=1767&context=theses> Figures 4, 5, and 6.

Source: Arkansas Center For Health Improvement 

Only **1** in Arkansas

# Private Option Goal:

Stabilize and  
strengthen the  
private  
individual  
insurance  
market

The 2024 Arkansas exchange premium for a 40-year old for the second lowest silver plan (a standard benchmark) is \$424. The comparable rates in surrounding states are as follows:

Alabama:	\$564
Georgia:	\$463
Louisiana:	\$563
Oklahoma:	\$508
Mississippi:	\$485
Missouri:	\$501
Tennessee:	\$501
Texas:	\$475

<https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>



Beyond Coverage:  
ARHOME builds on  
the strengths of  
private insurance  
and measures  
progress in health  
& economic  
outcomes

## ARHOME Goals

- 1) Improve health outcomes among Arkansans in:
  - Maternal and infant health
  - Rural health
  - Behavioral health
  - Chronic disease
- 2) Increase percentage of ARHOME population with incomes above 100% of Federal Poverty Level and increase percentage leaving the program due to higher income.
- 3) Slow the growth in state spending for the ARHOME population

### Monitoring and evaluation of goals

- A joint executive and legislative Health & Economic Outcomes Accountability Oversight Panel conducts quarterly reviews, sets annual health improvement targets, and monitors progress.
- An independent entity conducts a formal multi-year evaluation, as required by CMS

ARHOME  
Beyond Coverage:  
Maternal & Infant  
Health

**Over 1/3 of the babies born in Arkansas are born to moms in the premium assistance program**

- ARHOME targets those moms during their pregnancy and for up to 2.5 years after the baby is born to improve health outcomes for both the mom and child
  - Home visiting
  - Behavioral health
  - SDOH supports, including assistance with childcare, education, training & work
  - Chronic disease

Rural Penalty in Health Care: Excess deaths in rural compared to urban counties:

In 2004 -> 76.97 excess deaths per 100,000 population

In 2016 -> 134.70 excess deaths per 100,000 population

ARHOME  
Beyond Coverage:  
Targeting the  
Rural Penalty

41% of Arkansans lived in rural counties in 2019

ARHOME targets the “rural penalty” in healthcare by providing one-time and ongoing funds for rural hospitals

- New hospital employees to screen patients for SDOH needs and connect to services
- New hospital employees to serve as “coaches” for high needs patients, particularly with SMI or SUD - providing intensive case management and *assisting* enrollees with getting medical treatment and meeting health-related social needs
- New rural hospital ACU patient beds and services for individuals in mental health or substance use crisis

# ARHOME Beyond Coverage: At Risk Youth

Almost half of the enrollees are under 35 years of age. Many are in school or training programs and will move off Medicaid in the years ahead

ARHOME targets those young adults that, without intervention, are unlikely to move out of poverty and poor health.

- Formerly incarcerated
- Formerly in foster care
- Formerly in juvenile justice custody
- Most at risk of long-term Medicaid dependency and poor health
  - Those with very low income and no high school degree or GED and a chronic illness, including SMI/SUD.

ARHOME provides funds for hospitals to partner with community-based organizations to provide proven support models to young adults helping them address health-related social needs, including:

- safe and stable housing
- being effective parents
- long-term economic independence through work and education

# ARHOME Beyond Coverage: 1115 Waiver strengthens Medicaid Budget Controls

- **Financial risk shifts to QHPs with annual Budget Neutrality Payment Cap:**
  - Budget neutrality (BN) is set on a Per Member Per Month (PMPM) basis, with the PMPM fixed for each Demonstration Year in the waiver and the state at risk over the 5-year period.
  - The Department of Human Services (DHS) will not pay the QHPs in excess of the annual BN PMPM, transferring the risk to the QHPs.
- **New tools to meet spending targets:**
  - DHS can limit the number of individuals who are auto-assigned into the QHPs to meet spending targets. DHS used this budget control last year during the Public Health Emergency.
- **QHPs must pay rebates if they are below Medical Loss Ratio (MLR) requirements.**
- **Maximum cost-sharing for ARHOME population:**
  - Beginning 2023, individuals with income above 20% of the Federal Poverty Level (FPL) are required to pay copayments for services up to 5% of household income per quarter (maximum under federal rules).
  - The 5% limit is set by income bands (21%-40%; 41%-60%; 61-80%, etc.)
  - A person at 21% FPL could pay an annual amount of \$83.85 while a person at 121% FPL could pay as much as \$456.63.
  - Medicaid will not reimburse the QHPs for individual liability for cost-sharing.

# Questions

Thank you for your time!

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