Arkansas’ Private Option Medicaid expansion is putting state taxpayers on the hook for millions in cost overruns

ObamaCare advocates repeatedly promise that Medicaid expansion is fully funded by the federal government, at least through 2016. Advocates repeated this promise for the Arkansas “Private Option” Medicaid expansion, which sought to use Medicaid funding to deliver Medicaid benefits to a new class of working-age, able-bodied adults through private ObamaCare exchange plans.

But under terms of the Private Option federal waiver signed by Governor Beebe, state taxpayers could soon be on the hook for any cost overruns. The special terms and conditions of the Private Option waiver feature monthly per-person caps on federal spending for each of the next three years.¹ A common feature of Medicaid waivers, these caps are meant to protect the federal taxpayer if the Private Option ends up being more expensive than previously estimated.

Under the terms of the waiver, the state taxpayer is responsible for all costs which exceed these per-enrollee caps. At the end of the waiver period, the federal government will calculate how much Arkansas spent on the Private Option Medicaid expansion and compare it to the annual budget caps agreed to in the waiver. Any amounts over those caps must then be repaid to the federal government from state tax dollars.
Just two months into the program, costs have been far above the state’s initial projections. When the Private Option originally passed, consultants for the Arkansas Department of Human Services projected that the program would cost $437 per person per month in 2014. But the Division of Legislative Audit reports that the Private Option had an average monthly cost of $476.59 per person in January alone. By February, the Department of Human Services reported average monthly costs had increased to $483.15 per person.

**THE PRIVATE OPTION MEDICAID EXPANSION ALREADY COSTS MORE THAN INITIAL PROJECTIONS**

Average monthly per-person costs for the Private Option in 2014

![Cost Comparison Chart]

Although the state built a little wiggle room into the cap it negotiated with the federal government, the Private Option began to exceed the monthly per-enrollee cap of $477.63 in February, the second full month of the program. The waiver does provide the state an opportunity to ask for an adjustment to this cap, but this would require additional federal approval and is supposed to only be granted for mistakes in participation rates and similar factors. If February’s cost overruns continue, state taxpayers could be on the hook for millions of dollars in 2014 alone under the current terms of the waiver. If costs continue to escalate throughout the year, the
state could face much higher cost overruns than these conservative estimates suggest.

These cost overruns would depend on how many individuals eventually enroll in the program. By February 2014, more than 100,000 individuals had signed up for the Private Option Medicaid expansion. Enrollment is expected to grow to roughly 250,000 individuals by 2015. The table below presents potential cost overruns, based upon different enrollment scenarios.

### STATE TAXPAYERS COULD BE LIABLE FOR MILLIONS OF DOLLARS IN 2014 FOR PRIVATE OPTION COST OVERRUNS

*Potential 2014 cost overruns based on average per-person costs in February, by potential average monthly enrollment*

<table>
<thead>
<tr>
<th>Average monthly enrollment</th>
<th>Potential cost overruns</th>
</tr>
</thead>
<tbody>
<tr>
<td>100,000</td>
<td>$6.6 million</td>
</tr>
<tr>
<td>125,000</td>
<td>$8.3 million</td>
</tr>
<tr>
<td>150,000</td>
<td>$9.9 million</td>
</tr>
<tr>
<td>175,000</td>
<td>$11.6 million</td>
</tr>
<tr>
<td>200,000</td>
<td>$13.2 million</td>
</tr>
<tr>
<td>225,000</td>
<td>$14.9 million</td>
</tr>
<tr>
<td>250,000</td>
<td>$16.6 million</td>
</tr>
</tbody>
</table>

*Source: Foundation for Government Accountability*

Given the inherent unpredictability in the Private Option’s design, it is likely Arkansas will continue to exceed this cap in the coming months and years. Unlike Medicaid managed care reforms, for example, the state does not set multi-year contracts through competitive bidding under the Private Option. Instead, the state pays premiums and additional subsidies to cover deductibles, coinsurance, copayments and other out-of-pocket costs. Simply put, the state has no real negotiating leverage with the plans to control costs and absolutely no predictability of future premium increases. It is the worst of both worlds for state taxpayers – total financial responsibility to cover all cost overruns and no authority to control premiums and other costs. For the federal government, it is the best scenario – a federal per-person cap on what is typically an open-ended entitlement and complete federal control for what is typically a state-run Medicaid program.
The fact that enrollees can pick any Silver exchange plan at no cost to themselves creates even more unpredictability for the state. In some regions, the difference between the lowest-cost plan and the most expensive plan is nearly 90 percent. In Fayetteville, for example, the least-expensive Silver plan available to a 37-year-old costs roughly $3,200 per year in premiums. But the most expensive plan costs more than $6,000 per year in premiums. Private Option enrollees have no incentive to pick those lower-cost options.

**WIDE VARIATIONS IN PLAN PREMIUMS CREATE BUDGET UNCERTAINTY**

*Lowest and highest annual Silver plan premiums for 37-year-old, by rating area*

<table>
<thead>
<tr>
<th>Rating Area</th>
<th>Lowest-cost</th>
<th>Highest-cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide average</td>
<td>$3,281</td>
<td>$5,117</td>
</tr>
<tr>
<td>Rating Area 1</td>
<td>$3,414</td>
<td>$5,217</td>
</tr>
<tr>
<td>Rating Area 2</td>
<td>$3,170</td>
<td>$5,492</td>
</tr>
<tr>
<td>Rating Area 3</td>
<td>$3,206</td>
<td>$6,070</td>
</tr>
<tr>
<td>Rating Area 4</td>
<td>$3,150</td>
<td>$4,993</td>
</tr>
<tr>
<td>Rating Area 5</td>
<td>$3,588</td>
<td>$3,381</td>
</tr>
<tr>
<td>Rating Area 6</td>
<td>$3,623</td>
<td>$3,414</td>
</tr>
<tr>
<td>Rating Area 7</td>
<td>$3,055</td>
<td>$5,444</td>
</tr>
</tbody>
</table>

*Source: U.S. Department of Health and Human Services*

The federal ObamaCare exchange sought to discourage this kind of behavior for non-Private Option enrollees by pegging federal subsidies to the second-cheapest plan. If individuals want a more expensive plan, they must pay the difference. That’s how it works in non-Medicaid expansion states – enrollees who choose a more expensive plan above the benchmark plan must pay the difference of the higher premium. That’s a real incentive for the individual to be frugal.

Arkansas’ Private Option eliminates this skin-in-the-game requirement. Private Option enrollees can pick any Silver plan at no cost. And the state taxpayer is on the
hook if that enrollee’s choice is more expensive than the federal cap. Unlike Medicaid enrollees in other states, Arkansas’ Private Option puts state taxpayers are on the hook for the expensive choices of Medicaid enrollees.\textsuperscript{14-15}

Arkansas taxpayers should expect this uncertainty to increase as more and more enrollees begin to pick their own plans. Under the Private Option, enrollees who do not select their own plan initially are automatically assigned to the lowest-cost plans, depending on market share and capacity of insurers in their region.\textsuperscript{16} Private Option enrollees then have 30 days to change plans.\textsuperscript{17}

Early estimates show that only 20 percent to 25 percent of Private Option enrollees had actively selected a plan, with the remaining 75 percent to 80 percent of enrollees being automatically assigned to plans for the first month.\textsuperscript{18} This automatic assignment rate should be expected to decline, as most states with Medicaid managed care programs report automatic assignment rates of 20 percent of less.\textsuperscript{19}

The fact that Arkansas’ Private Option is already over budget in its second month, with so few people actively picking plans, shows what a financial disaster Arkansas state taxpayers could be in for as enrollees start picking more expensive plans.

Once Private Option enrollees begin selecting their own plans, many will likely select the most expensive options, which typically have broader physician and other provider networks and more expansive drug formularies. This will drive up costs for the Private Option even further, putting state taxpayers at significant financial risk for a program that was supposed to be funded completely with federal money.

Worse, under terms of the waiver signed by Governor Beebe, the federal cap will only grow by 4.7 percent annually.\textsuperscript{20} The state, in its waiver request, predicted costs to rise by roughly 5 percent per year.\textsuperscript{21} When the Private Option originally passed, the state’s consultants predicted costs would increase by roughly 6.5 percent annually.\textsuperscript{22} Actuaries at the U.S. Department of Health and Human Services predict costs in the individual health insurance market will rise by roughly 6 percent per person during the next three years.\textsuperscript{23}

Not only has Arkansas exceeded the initial cap in February, but if the costs grow even a few percentage points faster than the waiver allows, state taxpayers will be forced to repay the federal government hundreds of millions of dollars.

Rather than creating budget stability that Private Option supporters touted, Arkansas’ Medicaid expansion is a vortex of more budget uncertainty than ever
before and more uncertainty than in any other state, especially those states who did not adopt ObamaCare’s Medicaid expansion.

This massive unpredictability is just one of many reasons Arkansas officials should immediately act to repeal and defund its ObamaCare Medicaid Private Option expansion.24-25

At the same time, governors and legislators in states that are exploring the Private Option as an alternative way to expand Medicaid must understand the uncertainty it creates.

States can and should reform their existing Medicaid programs. States such as Florida, Kansas and Louisiana have led the way on true reform. But Medicaid reform does not require creating a new entitlement for working-age, able-bodied adults without children, which is the main policy objective of ObamaCare and the Private Option. Lawmakers should instead focus their efforts on fixing the Medicaid program with a proven pro-patient, pro-taxpayer solution to make the program work right for the most vulnerable. Sadly, the Private Option does the opposite.
REFERENCES


4 According to the Arkansas Department of Human Services, the state paid $33,774,673 to Private Option insurers on behalf of 69,905 enrollees during February, for an average of $483.15 per person.


6 Ibid.

7 As of February 22, 2014, more than 127,000 individuals had been deemed eligible for the Private Option Medicaid expansion, with nearly 94,000 individuals completing the enrollment process and nearly 12,000 individuals being diverted to the traditional Medicaid program as “medically frail” enrollees. See, e.g., David Ramsey, “Latest enrollment figures from DHS: 127,000 have gained coverage under the Private Option,” Arkansas Times (2014), http://www.arktimes.com/ArkansasBlog/archives/2014/02/26/latest-enrollment-figures-from-dhs-127000-have-gained-coverage-under-the-private-option.


11 Ibid.

12 Ibid.


17 Ibid.

18 Ibid.


