The Empty Promises of Arkansas’ Medicaid Private Option

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EXECUTIVE SUMMARY

The Arkansas Private Option, passed in 2013, is being held up by its in-state supporters as a market-oriented alternative to the Patient Protection and Affordable Care Act’s Medicaid expansion. As a result, many legislators in other states who may be opposed to Medicaid expansion are considering replicating Arkansas’ so-called Private Option in their own states.

Those legislators should be cautious. The Private Option is not the free-market alternative to Medicaid expansion its architects in the Arkansas Legislature hoped it would be. In fact, the Private Option is nothing more than Medicaid expansion by another name, and its passage was the result of a series of empty promises that, until now, have gone unchecked.

This report examines those empty promises—using supporters’ direct quotes from sources including media interviews, floor speeches and posts on social media—and rebuts them point by point.

1) EMPTY PROMISE: The Private Option is not part of ObamaCare.
   FACT: The Private Option implements key aspect of ObamaCare.

2) EMPTY PROMISE: The Private Option does not expand Medicaid.
   FACT: The Private Option is a traditional Medicaid expansion by another name, using Medicaid funding to provide Medicaid benefits.

3) EMPTY PROMISE: The Private Option encourages work and personal responsibility.
   FACT: The Private Option does not promote personal responsibility or “skin in the game.”

4) EMPTY PROMISE: The Private Option eliminates the disincentive to work.
   FACT: The Private Option creates a powerful disincentive to work.

5) EMPTY PROMISE: The Private Option is cheaper than traditional Medicaid expansion or no expansion.
   FACT: The Private Option’s alleged “savings” are built on faulty assumptions.

6) EMPTY PROMISE: The Private Option makes Arkansas’ health care costs more stable and predictable.
   FACT: Private Option costs will be unpredictable.

7) EMPTY PROMISE: The Private Option protects patients.
   FACT: The Private Option will hurt the most vulnerable.

8) EMPTY PROMISE: The Private Option is the Medicaid block grant Republicans always wanted.
   FACT: The Private Option is a new entitlement, not a block grant.

While many of the Arkansas politicians whose passed this so-called Private Option would have us believe their plan is a workaround that lets them take federal dollars without implementing a Medicaid expansion, the facts speak for themselves. The Arkansas Private Option is a wolf in sheep’s clothing — a Medicaid expansion program in disguise.
OVERVIEW

Under the Patient Protection and Affordable Care Act, commonly known as ObamaCare, state policymakers may choose to expand Medicaid eligibility to cover all individuals earning up to 138 percent of the federal poverty level. Although states are permitted to expand Medicaid eligibility in this way, the U.S. Supreme Court ruled in June 2012 that they are under no obligation to do so.¹

Across the country, half of the states have rejected ObamaCare’s Medicaid expansion.² Some states, fearing pushback from expanding a system already on the brink of collapse, have proposed “alternative” ways to expand Medicaid. But these “alternatives” are simply Medicaid expansion by another name.

Arkansas is perhaps the highest-profile case of Medicaid expansion through one of these so-called alternatives. Rather than expand Medicaid through the traditional fee-for-service system, Arkansas lawmakers approved an expansion of Medicaid eligibility through what they call the Private Option. Under Arkansas’ Private Option, the expansion population receives Medicaid benefits through plans offered on an ObamaCare insurance exchange.

Many of the promises made by lawmakers to secure support for Medicaid expansion have failed to materialize. As other states begin to investigate the Private Option as an alternative, it is important to understand those empty promises made by several high-ranking Arkansas officials.
EMPTY PROMISE: THE PRIVATE OPTION IS NOT PART OF OBAMACARE

FACT: THE PRIVATE OPTION IMPLEMENTS KEY ASPECTS OF OBAMACARE

Both before and after the Private Option vote, a number of Arkansas legislators promised their constituents that expanding Medicaid through the Private Option was not part of ObamaCare. The Speaker of the House of Representatives went so far as to suggest that voting for the Private Option was the same as voting against ObamaCare. Other Representatives actually insisted that rejecting Medicaid expansion “implemented” ObamaCare, but expanding Medicaid through the Private Option “fights” it.

Senator Jason Rapert
If you have to get “multiple waivers” to utilize the Arkansas Private Option, it is NOT ObamaCare.
Source: Twitter

Representative Sheilla Lampkin
As most of us have said repeatedly, this is not “ObamaCare.”
Source: Monticello Live

Senator David Sanders
The Private Option will be authorized under 1115 waiver authority, NOT the Affordable Care Act.
Source: Twitter

Representative Davy Carter
A vote for the Private Option in Arkansas is a vote against ObamaCare.
Source: Talk Business Arkansas

Representative Charlie Collins
ObamaCare comes 2014, we must fight it & Private Option does that.
Source: Twitter
Such statements demonstrate a fundamental misunderstanding of the nature of ObamaCare. The agreement Arkansas made with the Obama administration expressly states the Private Option expands Medicaid coverage to all groups made eligible by Sec. 1902(a)(10)(A)(i)(VIII) of the Social Security Act. This section was added by Title II of ObamaCare.

Medicaid expansion is perhaps the single most important aspect of ObamaCare. More than three-quarters of the individuals the White House projects to gain coverage under ObamaCare in 2014 are expected to do so through Medicaid. This is not a short-term expectation. Once fully implemented, most of the individuals that the U.S. Department of Health and Human Services expects to gain coverage under ObamaCare will do so through the Medicaid expansion.

To insist, as many Arkansas officials have, that implementing one of ObamaCare's most critical provisions actually "fights" ObamaCare is so absurd that one cannot help but wonder if those officials truly understand the nature of ObamaCare.

EMPTY PROMISE: THE ARKANSAS PRIVATE OPTION DOES NOT EXPAND MEDICAID

FACT: THE PRIVATE OPTION IS A TRADITIONAL MEDICAID EXPANSION BY ANOTHER NAME, USING MEDICAID FUNDING TO PROVIDE MEDICAID BENEFITS

Perhaps even less believable than the insistence that Arkansas' Private Option is wholly unrelated to ObamaCare is the promise that the Private Option does not actually expand Medicaid eligibility.

Senator Jon Woods
There are many bloggers, reporters, journalists, commentators, elected officials and special interest groups who are trying to claim that we are expanding Medicaid in Arkansas. Nothing could be further from the truth.

Source: Facebook

Senator Jason Rapert
Private Option alternative is not Medicaid expansion

Source: Twitter

Some lawmakers have even claimed that expanding Medicaid through the Private Option would actually reduce the number of people enrolled in the program. Many insisted that Medicaid expansion through the Private Option would reduce Medicaid enrollment by roughly 35 percent. Others claimed that under the Private Option, no "working-age adult" would be enrolled in Medicaid.
Representative Charlie Collins
ObamaCare do nothing expands rolls further, while Private Option reduces them by 35%
Source: Twitter

Representative John Burris
AR plan has no working age adult in Medicaid.
Source: Twitter

Representative Charlie Collins
AR plan is focused on reforming AND dramatically reducing Medicaid
Source: Twitter

It is a truly impressive feat to be able to expand eligibility to hundreds of thousands of able-bodied, working-age adults and simultaneously reduce Medicaid enrollment by 35 percent. So how did Arkansas manage to perform this Herculean feat? It didn’t.

When Arkansas officials insist they are reducing Medicaid enrollment, they are engaging in a clever bit of wordplay. In truth, they are simply planning to move some of the people currently receiving Medicaid benefits under the traditional fee-for-service system over to the Private Option, where those Medicaid recipients would receive their benefits through qualified ObamaCare health exchange plans, instead.¹⁹-²¹

Senator Jason Rapert
It takes thousands off existing Medicaid rolls, steers people into private insurance instead of the giveaway Medicaid program that teaches dependence.
Source: Facebook

Senator David Sanders
What it is is the Private Option and it gets people off Medicaid and it gets them onto private insurance and gives them some skin in the game and encourages some personal responsibility.
Source: Arkansas News

Senator Jon Woods
With this method, the Arkansas Medicaid program is likely to get smaller because SB 1020 will transfer low-income families’ health coverage from Medicaid to a private insurance carrier.
Source: Facebook
PRIVATE OPTION ENROLLEES RECEIVE ALL MEDICAID BENEFITS, WHICH IS PAID FOR WITH MEDICAID FUNDING

One must wonder how Arkansas lawmakers can tell their constituents that individuals receiving Medicaid benefits through the Private Option are not enrolled in Medicaid. The Private Option operates under Title XIX of the Social Security Act, the title reserved for the Medicaid program. Unless explicitly waived by the terms of the agreement with the Obama administration, the Private Option must comply with “all requirements of the Medicaid program” that are laid out by law, regulation or policy.

Private Option enrollees will receive full Medicaid benefits, with traditional fee-for-service Medicaid coverage for all benefits not covered by the qualified ObamaCare exchange plans. It is no surprise, then, that the federal government has said explicitly that Private Option enrollees “remain Medicaid beneficiaries” and that they will be “entitled to all benefits and cost-sharing protections” available under the traditional Medicaid program.

Put simply, Private Option enrollees are recognized by the federal government as Medicaid beneficiaries. They receive all Medicaid benefits and those benefits are delivered through the Medicaid program and paid for with Medicaid funding. And yet, Arkansas lawmakers claim these individuals are not truly enrolled in Medicaid.

By this standard, Medicaid patients receiving benefits through managed care organizations—as they do in Florida and Kansas, for example—are not actually enrolled in Medicaid. After all, these individuals receive their Medicaid benefits through private health plans, rather than the traditional fee-for-service system. Nationally, such a mistaken view ignores three-quarters of all Medicaid enrollees, or 42 million people, who receive Medicaid benefits through managed care.

When Private Option enrollees are properly viewed as Medicaid enrollees as the federal government does, the Private Option actually increases Medicaid enrollment by 40 percent or more.

The false claim that the Private Option decreases Medicaid enrollment is based on the premise that, at some point in the future, Arkansas will shift Medicaid enrollees currently receiving fee-for-service benefits into the Private Option.

But the agreement with the federal government does not permit Arkansas to shift anyone from the traditional fee-for-service program to the Private Option, at least for the first year. Only individuals made eligible for Medicaid under ObamaCare can receive benefits through the Private Option.

If Arkansas wishes to expand its Private Option to include Medicaid enrollees currently receiving fee-for-service benefits, it must seek an amendment to the federally-approved waiver agreement. If Arkansas pursues such an amendment, it is subject to federal approval at the discretion of the Secretary of the U.S. Department of Health and Human Services. That is certainly not a “done deal.” Even if Arkansas wants to shift its current Medicaid population into the Private Option, nothing compels the federal government to allow Arkansas to do so. In fact, Arkansas lacks the leverage to even negotiate such a change. The federal government may have been willing to accept Arkansas’ Private Option for three years so state officials would embrace ObamaCare’s Medicaid expansion, but shifting the state’s current Medicaid population into the Private Option is another matter entirely.
EMPTY PROMISE: THE PRIVATE OPTION ENCOURAGES WORK AND PERSONAL RESPONSIBILITY

FACT: THE PRIVATE OPTION DOES NOT PROMOTE PERSONAL RESPONSIBILITY OR “SKIN IN THE GAME”

A number of Arkansas lawmakers promised the Private Option would encourage personal responsibility because it allegedly gives patients “skin the game” through significant cost-sharing requirements. This was supposedly in contrast to the fee-for-service Medicaid program, described as a “giveaway” program that “teaches dependence” to enrollees. In fact, the legislation itself describes a primary purpose of the Private Option is to “strengthen personal responsibility through cost-sharing” for enrollees. Some leading proponents of the plan even went so far as to say that Private Option enrollees would have higher cost-sharing than individuals in the ObamaCare exchange.

Senator Jason Rapert
It takes thousands off existing Medicaid rolls, steers people into private insurance instead of the giveaway Medicaid program that teaches dependence.
Source: Facebook

Senator David Sanders
What it is is the Private Option and it gets people off Medicaid and it gets them onto private insurance and gives them some skin in the game and encourages some personal responsibility.
Source: Arkansas News

Senator David Sanders
Medicaid cost-sharing rules will not apply.
Source: Twitter

Representative Sheilla Lampkin
They will pay co-pays, and possibly other cost-sharing amounts, just like most of the rest of us pay for medical treatments.
Source: Monticello Live

Representative John Burris
You have so much more flexibility and cost-sharing in that Private Option exchange than you do under Medicaid.
Source: Arkansas House of Representatives
Senator David Sanders

It is the 1115 waiver that allows us to operate outside of the Medicaid rules, to waive the cost-sharing rules

*Source: Arkansas House of Representatives*

But according to the state’s agreement with the federal government, Private Option enrollees will pay no part of their premiums. Although the qualified health plans available under the Private Option do have deductibles of a few thousand dollars, the Medicaid program pays those deductible as wrap-around coverage.

Enrollees will pay no deductible, while any copays actually imposed in the Private Option must comply with federal cost-sharing requirements for all Medicaid patients. Under federal law, these amounts are generally capped at nominal levels, based on the state’s payment for services. For individuals above the federal poverty line, this cost-sharing is generally also capped at 10 percent of the cost of service and total cost-sharing is capped at five percent of a family’s monthly or quarterly income.

**Medicaid caps copayments at nominal amounts**

<table>
<thead>
<tr>
<th>State payment for service</th>
<th>Maximum copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.00 or less</td>
<td>$0.65</td>
</tr>
<tr>
<td>$10.01 to $25.00</td>
<td>$1.30</td>
</tr>
<tr>
<td>$25.01 to $50.00</td>
<td>$2.60</td>
</tr>
<tr>
<td>$50.01 or more</td>
<td>$3.90</td>
</tr>
</tbody>
</table>

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

In its agreement with the federal government, the Private Option provides even less “skin in the game” than Medicaid rules allow. Enrollees with incomes below the federal poverty line, as well as enrollees who are American Indians, will pay no cost-sharing whatsoever under the Private Option in at least the first full year. For those with incomes above the poverty line, cost-sharing will be capped at five percent of the federal poverty line. According to estimates produced by the Urban Institute, this means roughly 77 percent of the Private Option enrollees will have absolutely no cost-sharing.

Even the group that will pay cost-sharing will have less “skin in the game” than if the state had not expanded Medicaid whatsoever. Private Option enrollees will pay absolutely no premiums, regardless of which plans they choose. If Arkansas had not expanded Medicaid, a 37-year-old individual right above the poverty line would pay $230 per year in premiums for the second-cheapest Silver plan. But if that individual picked some of the more expensive plans that are covered by the Private Option, he or she could pay as much as $2,956 per year.

If that same individual earned just under 138 percent of the federal poverty level, he or she would pay $522 per year in premiums for the second-cheapest Silver plan. But if that individual picked some of the more expensive plans that are covered by the Private Option, he or she could pay as much as $3,248 in premiums per year.

Individuals in this group have their out-of-pocket costs capped at roughly $604 per year under the Private Option. But if Arkansas had not expanded Medicaid through the Private Option, the cap on annual out-of-pocket costs for this group would have been between $754 and $2,117 per year.
Private Option enrollees will have less skin-in-the-game than similar groups in non-expansion states

Difference in annual premiums and out-of-pocket costs for a 37-year-old selecting any Silver plan, with and without the Private Option Medicaid expansion

<table>
<thead>
<tr>
<th></th>
<th>Income</th>
<th>Annual Premiums</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Medicaid expansion</td>
<td>100% FPL</td>
<td>Up to $2,956</td>
<td>$754 - $2,117</td>
</tr>
<tr>
<td></td>
<td>138% FPL</td>
<td>Up to $3,248</td>
<td>$754 - $2,117</td>
</tr>
<tr>
<td>Private Option Medicaid expansion</td>
<td>100% FPL</td>
<td>$0</td>
<td>$604</td>
</tr>
<tr>
<td></td>
<td>138% FPL</td>
<td>$0</td>
<td>$604</td>
</tr>
</tbody>
</table>

Source: Foundation for Government Accountability

Arkansas policymakers have said that they intend to pursue a waiver in future years to apply more cost-sharing to individuals between 50 percent and 100 percent of the federal poverty level. It is unclear what that cost-sharing will look like. Regardless, any cost sharing must generally still meet federal rules. Perhaps more importantly, however, is the fact that this plan for higher cost-sharing has not been—and may never be—approved by the federal government.
EMPTY PROMISE: THE PRIVATE OPTION ELIMINATES MEDICAID’S DISINCENTIVES TO WORK

FACT: THE PRIVATE OPTION CREATES A POWERFUL DISINCENTIVE TO WORK

Another empty promise made by Private Option supporters is that, unlike traditional Medicaid, the Private Option will not create a disincentive to work.\textsuperscript{62} Supporters argue that the different cost-sharing requirements for individuals in poverty and individuals above the poverty level help alleviate any concerns that Private Option enrollees will face a large marginal tax—in the form of reduced benefits—when they work and earn more money.\textsuperscript{63-65}

Representative John Burris
You don’t have people not progressing themselves through society, getting higher wages and things of that nature because you don’t cross a threshold where you lose more benefits that whatever wage increase you receive.

Source: Arkansas House of Representatives

Senator David Sanders
No disincentive to work, but the more they earn, the more they pay.

Source: YouTube

Representative John Burris
You will never reach a cliff where getting a raise will push you over, where it costs you less to stay where you are.

Source: YouTube

Senator David Sanders
Encourage work by fundamentally ending the decades old social welfare trap’s disincentive for work.

Source: Twitter

Instead of the sliding scale of cost-sharing its architects envisioned, there are two major tax cliffs within the Private Option. The first cliff occurs when an individual moves from just below the poverty line to just above it. An individual below the poverty line pays no premiums and no cost-sharing in the Private Option.\textsuperscript{66-67} But if the same individual earns one dollar more, he or she is suddenly subject to cost-sharing requirements that can add up to $604 per year.\textsuperscript{68}

The second, larger cliff occurs at the top of Private Option eligibility, when income exceeds 138 percent of the federal poverty level and wrap-around benefits no longer apply.\textsuperscript{69} An individual earning slightly under 138 percent of the federal poverty level pays no premiums and has an out-of-pocket spending cap of $604 per year.\textsuperscript{70} But if that same individual earns one dollar more, he or she must pay $522 per year in premiums.\textsuperscript{71-72} The cap on his or her annual out-of-pocket costs would also increase to between $754 and $2,117 per year.\textsuperscript{73} Depending on how much medical care the individual uses, he or she could end up paying between $672 and $2,035 simply by earning one extra dollar.\textsuperscript{74} That individual could end up paying thousands more if he or she selected some of the more expensive plans that are covered by the Private Option.

Despite the higher costs owed for earning just one extra dollar, the individual would not receive any additional benefits. He or she would keep the same qualified ObamaCare exchange plan obtained under the Private Option, but would lose the additional wrap-around Medicaid benefits. Because Private Option enrollees will not have the kind of “skin in the game” envisioned by proponents, enrollees will have a powerful incentive to reduce their work hours in order to avoid this new tax cliff.
The Private Option creates a large tax cliff for enrollees

Difference in annual premiums and out-of-pocket costs for individuals selecting the second-cheapest Silver plan in the Private Option and in the ObamaCare exchange

<table>
<thead>
<tr>
<th>Program Eligibility</th>
<th>Income</th>
<th>Required annual premiums</th>
<th>Annual out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$15,856</td>
<td>$0</td>
<td>$604</td>
</tr>
<tr>
<td>Exchanges</td>
<td>$15,857</td>
<td>$522</td>
<td>$754 - $2,117</td>
</tr>
</tbody>
</table>

Source: Foundation for Government Accountability

Other states expanding Medicaid have experienced this disincentive to work firsthand. Researchers at Emory University and the University of Colorado investigated the impact of expanding Medicaid in states that have previously expanded eligibility to able-bodied working adults.75 Those researchers found that full-time employment among the new Medicaid population declined by more than eight percent after expansion.76 They also found that the share of this group who did not work at all increased by nearly 11 percent.77 This is particularly troubling, given the fact that full-time employment moves people off of government dependence and into self-sufficiency.

EMPTY PROMISE: THE PRIVATE OPTION IS CHEAPER THAN TYPICAL MEDICAID EXPANSION OR NO EXPANSION

FACT: THE PRIVATE OPTION’S ALLEGED “SAVINGS” ARE BUILT ON FAULTY ASSUMPTIONS

Some lawmakers promised the Private Option would be cheaper than expanding Medicaid through the fee-for-service program and also cheaper than not expanding Medicaid whatsoever.78 Proponents argued the Private Option was the “most cost-effective” option on the table.79 Although the state hired a consultant to prove that the Private Option was less expensive than doing nothing, the results are based on faulty assumptions, an unexplained methodology and misleading data manipulation.

Senator Jason Rapert
Independent, peer review analysis, showed that pursuing the Private Option costs the state’s taxpayers less than Medicaid Expansion and doing nothing, while countering the harmful effects of ObamaCare.

Source: Facebook

NEWS

Representative Mark Biviano
And we need to look at the very best way in our states in our country that we can implement this law to be most cost effective as possible.

Source: Arkansas House of Representatives
THE PRIVATE OPTION’S ACTUARIAL ANALYSIS ASSUMES A WOODWORK EFFECT NOT GROUNDED IN REALITY

The first major problem can be found in the consultants’ assumptions about individuals currently eligible for Medicaid who have not yet enrolled. According to the state’s consultants, choosing not to expand Medicaid would encourage more people currently eligible for benefits to enroll in the program.

According to their estimates, if Arkansas had forgone the Medicaid expansion, it could have expected more than 55,000 individuals currently eligible for Medicaid to ultimately sign up. But those same estimates predict that expanding Medicaid eligibility will actually cause fewer people to seek Medicaid coverage, predicting just 40,000 individuals currently eligible for Medicaid eventually signing up. This is known as a woodwork effect. According to state estimates, this difference alone is worth nearly $800 million during the next decade.

The report released to the public provides no explanation for why it assumes this woodwork effect will be larger if the state does not expand Medicaid. But expanding eligibility for government insurance programs has historically increased the woodwork effect, not decreased it. Even pro-ObamaCare advocacy groups and states accepting the optional Medicaid expansion acknowledge that expanding eligibility will surely cause more currently eligible individuals to sign up for Medicaid than would sign up absent the expansion.

The estimates further assume that if Arkansas did not expand Medicaid, the individuals who are currently eligible who would sign up would be far more expensive to cover than they would be if Arkansas expanded. The estimates assume that the woodwork population would cost roughly 36 percent more to cover if the state chose not to expand Medicaid than if it expanded eligibility. The consultants then assumed this group would cost even less in the Private Option, despite the fact that only newly-eligible individuals are enrolled in the Private Option under the current terms of the federal waiver.

Once again, the consultants provide no evidence to support these assumptions. These two assumptions account for $1.6 billion of the promised ten-year “savings” created by expanding Medicaid eligibility, nearly $500 million of which are state funds. This represents approximately three-quarters of the alleged “savings” the consultants estimated Arkansas would reap by expanding Medicaid through the Private Option.
THE PRIVATE OPTION IMPLIES A QUESTIONABLE DEFINITION OF BUDGET NEUTRALITY

Arkansas’ flawed savings projections continue. As part of the federal waiver, Arkansas had to demonstrate that the Private Option would not cost the federal government more money than expanding Medicaid eligibility through its current fee-for-service system.94

The waiver request estimates that the Private Option will cost approximately $5,666 per person in 2014.95 Documents prepared by state officials a few months prior predicted this same population would cost approximately $3,900 per person to cover through a traditional Medicaid expansion in 2014.96 This 45 percent cost differential between Medicaid coverage and coverage through qualified ObamaCare exchange health plans is similar to national estimates produced by the Congressional Budget Office.97 In fact, even after winning federal approval, state officials have admitted to reporters that expanding Medicaid through the Private Option was more expensive than expanding through Old Medicaid, meaning the program will not truly be budget neutral.98

So, how did the state win federal approval, when its own estimates show the Private Option would be more costly? It assumed that traditional Medicaid expansion would require it to increase reimbursement rates by roughly 24 percent, the difference between current Medicaid rates and reimbursement rates paid by qualified health plans.99-100

Arkansas has no plans to increase reimbursement rates for its current fee-for-service population. In fact, at the same time the state was discussing Medicaid expansion, it was talking about cutting reimbursement rates in order to reduce the state’s Medicaid deficit.101

This is unsurprising. In 2003, Arkansas paid doctors and hospitals approximately 95 percent of what Medicare paid.102 By 2008, reimbursement rates had fallen to 89 percent of what Medicare pays.103 And by 2012, the rates had fallen even further behind, with Arkansas’ Medicaid program now paying just 79 percent of what Medicare pays.104

Despite these facts, Arkansas used these faulty projections and simply assumed the Private Option would cost exactly the same as expanding Medicaid through its fee-for-service system. This clever accounting allowed the state to appear to meet the budget neutrality requirement.105 Arkansas never provided evidence that the Private Option would be budget neutral, but it appears that the U.S. Department of Health and Human Services was willing to accept the mere assumption of budget neutrality as good enough for government work.

This is not the first time the federal government approved waivers with no concern for the budget neutrality requirement set by federal law. The Government Accountability Office has frequently criticized HHS for approving waivers that added costs to federal taxpayers.106 It has recommended Congress provide more oversight and force HHS to improve its budget neutrality process.107 Given how far the state has strayed from acceptable methods of fiscal projections in determining budget neutrality, Arkansas officials should expect congressional leaders to raise concerns and questions over this particular waiver in the coming months.

Although most other Section 1115 waivers are approved for five-year periods, the federal government granted Arkansas approval to run the Private Option for just three years.108-109 Given the major budget neutrality problems noted above, it would not be surprising if the Private Option were denied a renewal after the initial three-year period, particularly given the complete discretion exercised by the federal government in approving or renewing the waiver.

In fact, in its agreement with Arkansas, the federal government made explicitly clear that it retained the right to amend or withdraw its agreement with Arkansas at any time, including during the first three years, regardless of whether Arkansas is upholding its end of the agreement or not.110 Although the federal government accepted Arkansas’ unrealistic estimates in exchange for getting the state to expand Medicaid eligibility, when those projections prove false the real costs may prove fatal to budget neutrality and long-term federal approval.
THE PRIVATE OPTION IS UNLIKELY TO REDUCE OBAMACARE EXCHANGE SUBSIDIES OR LOWER PREMIUMS

Another part of Arkansas’ budget neutrality argument is that the federal government will save up to $700 million that would otherwise be spent on individuals receiving subsidies in the ObamaCare insurance exchange.111 Under federal law, individuals earning between 100 percent and 400 percent of the federal poverty level could be eligible for subsidies to buy insurance on the exchange.112 The Private Option, on the other hand, covers individuals earning up to 138 percent of the federal poverty level.113 If an individual is eligible for the Private Option, they lose eligibility for federal subsidies in the exchange.114 This ultimately means the individuals earning between 100 and 138 percent of the federal poverty level will no longer qualify for federal ObamaCare exchange subsidies.

Arkansas counts this as savings to the federal government in order to meet the budget neutrality agreement. Of course, given that Private Option coverage is more expansive and requires less cost-sharing than exchange coverage, the federal government will likely end up paying more for this population than it otherwise would. It is not until the federal government begins shifting some of those costs to the state that it could count those savings. At that point, the federal government would only be saving money because what was once a cost borne entirely by the federal government would now be shared with state taxpayers.

Another component of Arkansas’ budget neutrality argument is that adding more people to the exchange will lower premiums, both for the Private Option and for exchange enrollees.115 This was designed to prop up the ObamaCare exchange by ensuring enough people enrolled in qualified ObamaCare exchange plans that the exchange pool would not collapse. State officials estimated that the Private Option would help lower exchange premiums by roughly five percent.116 This is based on the assumption that adding 250,000 new people into the exchange will help drive down premiums.117

But once again, this assumption—which is crucial to the long-term health of the program—is difficult to defend. Simply adding more people to the exchange’s risk pools will not necessarily drive down premiums. The makeup of who is added to the risk pool is far more important than simply the number of people added. For example, adding the 4,000 individuals in Arkansas’ high risk pool are unlikely to bring down premiums, given that they cost more than five times as much as the average individual in the non-group market.118

The Medicaid expansion population’s likelihood of being in fair or poor health is nearly twice as high as the uninsured who may be eligible to buy insurance through the Arkansas ObamaCare exchange.

Arkansas officials predict that the Medicaid expansion population will be healthier, in general, than the exchange population, which they believe will reduce premiums.119 But individuals potentially eligible for the Private Option have worse self-reported health than individuals currently in the non-group insurance market. Just five percent of individuals in Arkansas’ non-group market report that they are in fair or poor health.120

For comparison, nearly 20 percent of the uninsured expected to gain coverage through Arkansas’ Medicaid expansion report that they are in fair or poor health.121 The Medicaid expansion population’s likelihood of being in fair or poor health is nearly twice as high as the uninsured who may be eligible to buy insurance through the Arkansas ObamaCare exchange.122 Even if you skim the least healthy five percent to 10 percent out of the Private Option and put them into Old Medicaid, as Arkansas plans to do, Private Option enrollees are likely to have worse health than the potential exchange enrollees.
Experiences with Medicaid expansions illustrate this point. States that have previously expanded Medicaid coverage to childless adults have found they are significantly more expensive to cover than low-income parents, largely because they are older and sicker. The expansion population is also more likely to have more intensive mental health needs, helping drive up premiums further. They are ten percent more likely to have a serious mental illness or serious psychological distress than potential exchange enrollees.

The average premium increases in Arkansas’ non-group market make it difficult to believe the Private Option has reduced premiums. In 2013, Arkansas had among the lowest premiums in the nation in the individual market. But the premiums for buying coverage in Arkansas’ exchange are among the highest in the nation. Given these facts, it is hard to accept the promises of Private Option proponents of lower premiums on the exchanges as anything but empty.

**EMPTY PROMISE: THE PRIVATE OPTION MAKES ARKANSAS’ HEALTH CARE COSTS STABLE AND PREDICTABLE**

**FACT: PRIVATE OPTION COSTS WILL BE UNPREDICTABLE**

Some lawmakers promised that the Private Option is needed in order to “bend the cost curve” and create a more predictable budget. The Private Option was sold as a way to do what was fiscally responsible, stabilize the Arkansas state budget, tamp down costs and create a program that was sustainable. But the simple fact is that the Private Option will create more budget uncertainty than ever before.

*Representative John Edwards*

We have an opportunity to take Arkansas and catapult it into a leadership position on doing what’s right, doing what’s sound, doing what’s fiscally responsible in health care.

*Source: Arkansas House of Representatives*

*Representative John Burris*

I think it stabilizes our health care system and our state budget.

*Source: Arkansas House of Representatives*

*Senator Jonathan Dismang*

I do believe we have a plan here that will help tamp down costs.

*Source: Arkansas House of Representatives*

*Representative John Burris*

This bill creates a health care system in our state that is sustainable

*Source: Arkansas House of Representatives*

**NEWS**

*Senator Jonathan Dismang*

The Arkansas act reduces existing government bureaucracy and creates a more predictable budgeting process.

*Source: Talk Business Arkansas*
PRIVATE OPTION ENROLLEES CAN CHOOSE ANY SILVER PLAN AT NO COST

Premiums for Private Option enrollees will vary widely by age, geographic area, smoking status and which plans enrollees select. The state is divided into seven different rating areas, with plans and premiums varying by area.¹³³

Arkansas is divided into seven different rating regions

Geographic rating areas in Arkansas

![Geographic rating areas in Arkansas](image)

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

The number of participating insurers in each region ranges from a high of three to a low of just one.¹³⁴⁻¹³⁵ Private Option enrollees in nearly a third of Arkansas’ counties will be able to pick plans from just one single insurer.¹³⁶ Approximately half of individuals with incomes below 138 percent of the federal poverty level will be able to select plans from just one or two insurers.¹³⁷ Fewer competing insurers inevitably lead to higher prices.

Premiums vary widely by region in Arkansas’ Private Option

Median monthly Silver plan premium for a non-smoking 37 year old, by rating area

<table>
<thead>
<tr>
<th>Rating Area</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating Area 1</td>
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<tr>
<td>Rating Area 2</td>
<td>$277.92</td>
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<tr>
<td>Rating Area 3</td>
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<tr>
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<td>Rating Area 5</td>
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<td>Rating Area 6</td>
<td>$296.60</td>
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<tr>
<td>Rating Area 7</td>
<td>$334.24</td>
</tr>
<tr>
<td>Statewide Average</td>
<td>$317.27</td>
</tr>
</tbody>
</table>

Source: U.S. Department of Health and Human Services
Enrollees picking plans with absolutely no price sensitivity will also contribute to higher, unpredictable costs. Private Option enrollees can choose among all the Silver plans offered in their geographic region with no premiums.\(^{138}\)

These enrollees will have no incentive to choose lower cost options, particularly given the fact that many plans reduce provider networks in order to bring premiums down. Those plans with wider provider networks are likely to have the highest costs. Private Option enrollees are likely to be attracted to these higher-cost options.

In many regions, this cost difference will be large. For non-smokers, the cost difference will range from a low of just six percent in some regions to a staggering 58 percent in others.\(^{139}\) When combined with regional cost differences, it becomes even worse. For example, the highest-cost plan for non-smokers in the area surrounding Bentonville in northwest Arkansas is 66 percent more expensive than the lowest-cost plan in the area surrounding Fort Smith in west-central Arkansas.\(^{140}\)

**Premiums vary widely by plan choice in Arkansas’ Private Option**

*Lowest and highest annual premium for a 37-year-old, by rating area*

![Premiums vary widely by plan choice in Arkansas’ Private Option](image)

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

The cost differences for smokers are even higher. In some regions, the difference between the lowest-cost and highest-cost plans is nearly 90 percent.\(^{141}\) After accounting for differences between regions, the differences are magnified even further. For example, the highest-cost plan in the area surrounding Bentonville in northwest Arkansas is nearly twice the cost of the lowest-cost plan in the area surrounding Fort Smith in west-central Arkansas.\(^{142}\) Given the fact that low-income adults, the very group targeted by the Private Option, are the most likely group to be smokers, these differences become all the more important.\(^{143}\)

Nationally, adults living below the poverty line are 1.6 times as likely as other adults to be smokers.\(^{144}\) Men, who are expected to make up most of the Private Option enrollees, are also far more likely to smoke.\(^{145}\) Smoking in Arkansas and other southern states is also significantly higher than the national average, meaning state officials should expect to pay significantly higher premiums than the non-smoker base rates for Private Option enrollees.\(^{146}\)
THE PRIVATE OPTION PAYS FOR UNPREDICTABLE COST-SHARING SUBSIDIES

But Arkansas is not simply paying premiums. Typically, Silver plans pay an average of 70 percent of the costs for enrolled members. The remaining 30 percent is made up through deductibles, coinsurance, copays and other cost sharing requirements. But, as noted earlier, most Private Option enrollees will pay no cost sharing at all, with very limited cost-sharing for the remaining enrollees subject to nominal copays. The state will pay insurers an additional subsidy in order to cover the additional costs of deductibles, coinsurance, copays or other cost sharing normally required by the plans.

According to federal estimates, the average Silver plan enrollee is expected to use nearly $4,800 in medical care each year. This means that, on average, Silver plans are expected to cover slightly more than $3,300 in medical expenses, leaving nearly $1,500 to cover out-of-pocket. These estimates may even be low for Private Option enrollees, as more than a quarter of the individuals in the federal sample are children, who typically have lower health care costs on average than the adults eligible for the Private Option.

On top of the premiums paid on behalf of Private Option enrollees, the state will be responsible for hundreds of millions of dollars in cost-sharing reduction subsidies each year.

EMPTY PROMISE: THE PRIVATE OPTION PROTECTS PATIENTS

FACT: THE PRIVATE OPTION WILL HURT THE MOST VULNERABLE

A number of Arkansas lawmakers promised that expanding Medicaid eligibility was necessary to protect the most vulnerable. Some lawmakers said the expansion would make 250,000 elderly individuals, children and “those working but can’t quite afford insurance” qualify for Medicaid. The governor and other legislators said the Medicaid expansion population was composed of hardworking families who could not afford to purchase insurance on their own.

Senator Paul Bookout
Basically having a private insurance plan that those individuals which equals about 250,000 in Arkansas and include elderly, children and those working but cant quite afford insurance, but they do qualify for Medicaid.

Governor Mike Beebe
Today’s House vote on the Arkansas private option is a hard-fought victory for the working people of Arkansas.

Representative Greg Leding
Most of the 250K Arkansans who stand to benefit from the private option are hard-working individuals.
Far from protecting the most vulnerable, the Private Option actually puts them at risk. It is important to remember who actually qualifies for the Private Option. The Private Option’s Medicaid expansion does not cover the elderly, individuals with disabilities or even poor children—groups most frequently considered among the most vulnerable.\(^\text{158}\)

According to the terms of the agreement made with the federal government, the Private Option simply expands eligibility to able-bodied, working-age adults.\(^\text{159}\) Nearly three-quarters of these able-bodied adults have no dependent children.\(^\text{160}\) Worse yet, the U.S. Department of Justice estimates that more than 35 percent of these new potential Medicaid enrollees have previous involvement in the criminal justice system, having spent time in jail or prison.\(^\text{161}\)

Nor are most of the individuals eligible for the Private Option full-time workers. Nearly half of potential Private Option enrollees do not work at all, compared to less than a quarter who are full-time, year-round workers.\(^\text{162}\)

**Few potential Private Option enrollees are full-time, year-round workers**

Uninsured Arkansans earning less than 138\% FPL, by work experience

Non-disabled adults without children have never been considered among the most vulnerable citizens. They have generally been ineligible for other types of taxpayer-funded welfare, including cash assistance and long-term food stamps. It is no surprise, then, that the majority of Americans oppose giving non-cash assistance, such as food stamps and Medicaid benefits, to able-bodied, working-age adults, especially those with no dependent children.\(^\text{163}\)

The Private Option creates an entirely new class of individuals eligible for Medicaid benefits. This redirects limited state and federal resources away from the elderly, from children and from disabled individuals in order to fund Medicaid coverage for working-age, able-bodied adults.

Arkansas’ most vulnerable citizens are already struggling in a Medicaid safety net that is broken. Care is frequently fragmented, access to quality care is often low and health outcomes remain poor. This is all the more troubling given Arkansas’ severe medical provider shortage. According to federal data, Arkansas has a primary care doctor shortage in 54 of its 75 counties.\(^\text{164}\)

As state officials told the federal government, Arkansas’ existing network of Medicaid providers is already at capacity.\(^\text{165}\) Covering an additional 250,000 individuals will inevitably make access problems even worse, as it greatly increases demand while doing nothing to increase the supply of providers. The Private Option will force the most vulnerable to compete with 250,000 new, able-bodied adults for fewer and fewer available appointments with physicians.
State officials argue that because the qualified ObamaCare exchange plans offer higher reimbursement rates than Medicaid, Private Option enrollees will have better access to care than they would within the fee-for-service system. But this creates financial incentives for Medical providers to treat the new working-age adults covered through the Private Option, rather than the most vulnerable served through traditional Medicaid. This is particularly worrisome, given the fact that Arkansas has no plans to increase provider reimbursement in the traditional program and may even reduce those rates below where they are today. As a result, the Private Option is expected to create even larger access barriers for the elderly, individuals with disabilities and low-income children. Rather than protecting the most vulnerable, the Private Option prioritizes able-bodied adults over the truly vulnerable patients relying on the traditional Medicaid safety net.

**EMPTY PROMISE: THE PRIVATE OPTION IS THE MEDICAID BLOCK GRANT REPUBLICANS ALWAYS WANTED**

**FACT: THE PRIVATE OPTION IS A NEW ENTITLEMENT, NOT A BLOCK GRANT**

Some lawmakers in Arkansas promised that the Private Option is the equivalent of a block grant. It remains unclear however, how creating a new entitlement for able-bodied, working-age adults is akin to receiving a block grant for Medicaid.

**Senator Jason Rapert**

In short, the GOP Private Option is essentially what we all say we want—Medicaid Block Grant funding to allow states to innovate for their own populations—we are getting the option to innovate without getting the full power of the purse.

*Source: Facebook*

**Senator David Sanders**

Andy Allison, once a CMS waiver reviewer, agrees that the Private Option functions like a block grant.

*Source: Twitter*

As with other entitlements, the Private Option operates under an open-ended funding scheme. Because Private Option benefits are available to an unlimited number of eligible individuals, each new enrollee will result in additional Medicaid funding. But under a block grant funding scheme, states receive a fixed sum of federal funding, usually accompanied by flexibility to use those funds in order to meet broad goals of the program.

One popular example of block grants can be found in cash assistance welfare. Prior to 1996, cash assistance programs generally operated as an open-ended entitlement through the Aid to Families with Dependent Children (AFDC) program. But as part of President Clinton’s bipartisan welfare reforms, AFDC funding was converted to a block grant to states through the Temporary Assistance for Needy Families (TANF) program. Under TANF, the federal government provides states with a fixed sum of funding and grants them flexibility in program design in order to meet broad policy objectives.

By definition, a block grant would require the state to receive a fixed amount of funding in exchange for meeting certain policy objectives. But this is not how the Private Option works. Rather than receive a fixed pool of money, Arkansas will continue to receive Medicaid’s normal open-ended entitlement funding for the Private Option. Equating a block grant to creating a new entitlement demonstrates a fundamental misunderstanding of the flexibility a block grant creates, as well as the immense burden that creating a new entitlement will ultimately place on Arkansas.
CONCLUSION

Arkansas policymakers worked with the federal government to expand a Medicaid program already on the brink of collapse. Many of the promises made by lawmakers to secure support for Medicaid expansion have failed to materialize.

Now that the policy objectives of those promises have failed to materialize, Arkansas officials should move to repeal and defund its Medicaid expansion. At the same time, legislators in states that are exploring the Private Option as an alternative must understand these empty promises of Medicaid reform.

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 the Private Option. Lawmakers should instead focus their efforts on fixing the program with a proven pro-patient, pro-taxpayer solution so that the health care safety net truly works for the most vulnerable. Sadly, the Private Option does the opposite.
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47. Ibid.
49. Ibid.
50. Ibid.
54. Author’s calculations based upon an individual earning just above 100 percent of the federal poverty level. The applicable taxpayer percentage is capped at roughly 2 percent of household income for the second-cheapest Silver plan.
55. Author’s calculations based upon an individual earning just above 100 percent of the federal poverty level. The applicable taxpayer percentage is capped at roughly 3.3 percent of household income for the second-cheapest Silver plan, but the subsidy only equals the difference between the applicable taxpayer percentage and the cost of the second-cheapest Silver plan. Individuals selecting more expensive plans must make up the difference.
56. Author’s calculations based upon an individual earning just under 138 percent of the federal poverty level. The applicable taxpayer percentage is capped at roughly 3.3 percent of household income for the second-cheapest Silver plan.
57. Author’s calculations based upon an individual earning just under 138 percent of the federal poverty level. The applicable taxpayer percentage is capped at roughly 3.3 percent of household income for the second-cheapest Silver plan, but the subsidy only equals the difference between the applicable taxpayer percentage and the cost of the second-cheapest Silver plan. Individuals selecting more expensive plans must make up the difference.
Individuals between 100 percent and 150 percent of the federal poverty level qualify for cost-sharing reductions to bring Silver plans up to an actuarial value of 94 percent, which lower their deductible and total overall out-of-pocket costs. This means that, on average, the plan will pay 94 percent of qualified medical expenses, although individuals may pay more or less than the average in a given year. The statute caps total out-of-pocket spending for this group at $2,117 per year. See, e.g., Bernadette Fernandez and Thomas Gabe, “Health insurance premium credits in the Patient Protection and Affordable Care Act,” Congressional Research Service (2013), http://dl.dropboxusercontent.com/s/bxcm64vc9/94i137.pdf.


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States that opt into the Medicaid expansion must also apply a five percent disregard to income, effectively raising eligibility to 138 percent of the federal poverty level.


Author’s calculations based upon an individual earning just above 138 percent of the federal poverty level. The applicable taxpayer percentage is capped at roughly 3.3 percent of household income for the second-cheapest Silver plan. The individual could pay more or less than this amount, depending on which plan he or she chooses.

Individuals between 100 percent and 150 percent of the federal poverty level qualify for cost-sharing reductions to bring Silver plans up to an actuarial value of 94 percent, which lower their deductible and total overall out-of-pocket costs. This means that, on average, the plan will pay 94 percent of qualified medical expenses, although individuals may pay more or less than the average in a given year. The statute caps total out-of-pocket spending for this group at $2,117 per year. See, e.g., Bernadette Fernandez and Thomas Gabe, “Health insurance premium credits in the Patient Protection and Affordable Care Act,” Congressional Research Service (2013), http://dl.dropboxusercontent.com/s/bxcm64vc9/94i137.pdf.

An individual could purchase a Bronze plan, which would reduce annual premiums for someone at 138 percent of the federal poverty level to zero for all individuals aged 21 or older. However, Bronze plans are not eligible for cost-sharing subsidies, meaning the actuarial value of the cheaper plan would be reduced to 60 percent from 94 percent, leading to higher out-of-pocket costs.


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APPENDIX

EIGHT EMPTY PROMISES OF THE ARKANSAS PRIVATE OPTION

1) EMPTY PROMISE: THE PRIVATE OPTION IS NOT PART OF OBAMACARE.
FACT: THE PRIVATE OPTION IMPLEMENTS KEY ASPECT OF OBAMACARE.
Medicaid expansion is perhaps the single most important aspect of ObamaCare. Once fully implemented, most of the individuals the U.S. Department of Health and Human Services (HHS) expects to gain coverage under ObamaCare will do so through Medicaid expansion. The agreement Arkansas made with the Obama administration explicitly states that the Private Option expands Medicaid coverage to all groups made eligible through Title II of ObamaCare.

2) EMPTY PROMISE: THE PRIVATE OPTION DOES NOT EXPAND MEDICAID.
FACT: THE PRIVATE OPTION IS A TRADITIONAL MEDICAID EXPANSION BY ANOTHER NAME, USING MEDICAID FUNDING TO PROVIDE MEDICAID BENEFITS.
Private Option enrollees receive all Medicaid benefits and those benefits are delivered through the Medicaid program and are paid for with Medicaid funding. Using Private Option supporters’ view, Medicaid patients receiving benefits through managed care organizations are also not actually enrolled in Medicaid since their Medicaid benefits are delivered through private health plans. Nationally, this characterization would dismiss three-quarters of all Medicaid enrollees, or 42 million people, who receive benefits through managed care. When Private Option enrollees are properly viewed as Medicaid enrollees—as the federal government does—the Private Option actually increases Medicaid enrollment in Arkansas by 40 percent or more.

3) EMPTY PROMISE: THE PRIVATE OPTION ENCOURAGES WORK AND PERSONAL RESPONSIBILITY.
FACT: THE PRIVATE OPTION DOES NOT PROMOTE PERSONAL RESPONSIBILITY OR "SKIN IN THE GAME."
Private Option enrollees will pay no part of their premiums or deductibles, while any copayments must comply with minimal cost sharing that Medicaid allows. In fact, the Private Option provides even less “skin in the game” than traditional Medicaid or the ObamaCare exchanges, as enrollees below the poverty line will pay no cost sharing at all in at least the first full year. For everyone else, cost sharing will be capped at five percent of the federal poverty line. Traditional Medicaid, on the other hand, caps cost sharing at five percent of family income.

4) EMPTY PROMISE: THE PRIVATE OPTION ELIMINATES THE DISINCENTIVE TO WORK.
FACT: THE PRIVATE OPTION CREATES A POWERFUL DISINCENTIVE TO WORK.
Supporters argue that different cost-sharing requirements allow individuals to move up the income ladder and out of poverty. But instead of the sliding scale of cost sharing its architects envisioned, there are two major tax cliffs within the Private Option. The first occurs when individuals move from just below the poverty line to above it, where they could pay $604 per year in cost sharing. The second, larger cliff occurs at the top of Private Option eligibility, when individuals no longer qualify for Medicaid but want to keep their private plan—where they could pay up to $2,035 more. Researchers at Emory University and the University of Colorado found that in other states that expanded Medicaid to able-bodied, childless adults, full-time employment decreased by eight percent and the share who didn’t work at all grew by 11 percent.

5) EMPTY PROMISE: THE PRIVATE OPTION IS CHEAPER THAN TRADITIONAL MEDICAID EXPANSION OR NO EXPANSION.
FACT: THE PRIVATE OPTION’S AllegED “SAVINGS” ARE BUILT ON FAULTY ASSUMPTIONS.
A FLAWED WOODWORK EFFECT
According to the state’s consultants, if Arkansas did not expand Medicaid more currently-eligible people would sign up for the program and that the Private Option would discourage these people from signing up. (Historically, expanding eligibility
for government insurance programs brings more people out of the woodwork, not less.) The estimates further assume that if Arkansas did not expand Medicaid, these “woodwork” individuals would be far more expensive to cover than they would be under the Private Option. These claims represent approximately three-quarters of the Private Option’s alleged “savings.”

**IT’S NOT REALLY “BUDGET NEUTRAL”**

Arkansas’ own estimates show that the Private Option would be more costly than expanding traditional Medicaid. So how did the state win federal approval? It assumed that traditional Medicaid expansion would require it to increase reimbursement rates by roughly 24 percent, the difference between current Medicaid rates and reimbursement rates paid by plans in the Private Option. This clever accounting allowed the state to appear to meet budget neutrality requirements.

**THE PRIVATE OPTION IS UNLIKELY TO REDUCE OBAMACARE EXCHANGE SUBSIDIES OR LOWER PREMIUMS**

The Private Option covers a portion of the population (between 100-138% FPL) slated to receive ObamaCare exchange subsidies. Since Arkansas will pick up some of the tab, they count this as “savings” for the ObamaCare exchanges, even though Private Option plans will likely be more expensive because of generous Medicaid benefits and nominal Medicaid cost-sharing. Arkansas also estimated that the Private Option would lower exchange premiums by making the insurance pool bigger. But Private Option enrollees are likely to be sicker and more expensive to cover, so premiums will go up, not down.

**6) EMPTY PROMISE: THE PRIVATE OPTION MAKES ARKANSAS’ HEALTH CARE COSTS MORE STABLE AND PREDICTABLE.**

**FACT: PRIVATE OPTION COSTS WILL BE UNPREDICTABLE.**

**PRIVATE OPTION ENROLLEES CAN CHOOSE ANY SILVER PLAN AT NO COST**

The number of participating insurers in each region ranges from a high of three to a low of just one. Approximately half of individuals with incomes below 138 percent of the federal poverty level will be able to select plans from just one or two insurers. Fewer competing insurers inevitably lead to higher prices. In some regions, the price difference between the cheapest and most expensive plans is nearly 90 percent. Enrollees picking plans with absolutely no price sensitivity will contribute to higher, unpredictable costs.

**PRIVATE OPTION COST-SHARING SUBSIDIES WILL BE UNPREDICTABLE**

Under the Private Option, enrollees can pick any ObamaCare exchange Silver plan, which will pay an average of 70 percent of health care costs. In addition to paying 100 percent of Silver plan premiums, Arkansas must also pay the bulk of the other 30 percent of health care costs in the form of deductibles, coinsurance, copays and other cost sharing.

**7) EMPTY PROMISE: THE PRIVATE OPTION PROTECTS PATIENTS.**

**FACT: THE PRIVATE OPTION WILL HURT THE MOST VULNERABLE.**

Supporters argue the Private Option will extend coverage to the most vulnerable. But the Private Option simply expands Medicaid to able-bodied, working-age adults. Nearly three-fourths of potential Private Option enrollees have no children. Nearly half of potential Private Option enrollees do not work at all and less than one-fourth of them are full-time, year-round workers. Rather than protecting the most vulnerable, the Private Option prioritizes able-bodied adults over the truly vulnerable patients relying on the traditional Medicaid safety net.

**8) EMPTY PROMISE: THE PRIVATE OPTION IS THE MEDICAID BLOCK GRANT REPUBLICANS ALWAYS WANTED.**

**FACT: THE PRIVATE OPTION IS A NEW ENTITLEMENT, NOT A BLOCK GRANT.**

A block grant is a fixed amount of federal funds accompanied by flexibility to use those funds to meet the broad goals of the program. But as with other entitlements, the Private Option operates under an open-ended funding scheme. Because Private Option benefits are available to an unlimited number of eligible individuals, each new enrollee will result in additional Medicaid funding. Equating a block grant to creating a new entitlement demonstrates a fundamental misunderstanding of the flexibility a block grant creates, as well as the immense burden that creating a new entitlement will ultimately place on Arkansas.