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# Evidence from the Private Option: The Arkansas Experience

Bethany Maylone and Benjamin D. Sommers

## ABSTRACT

**Issue:** Arkansas was the first state to receive approval to expand Medicaid under the Affordable Care Act through a Section 1115 waiver. This approach, known as the "private option," uses Medicaid funds to purchase private health plans on the state's marketplace. It is intended to promote market competition, continuity of coverage, and greater access to care. **Goal:** To describe the key features of the private option and evaluate its impact on health care for low-income adults in the state after two years. **Methods:** Survey data from 2013–2015 that assessed health insurance coverage, access to care, utilization, and self-reported health among low-income adults in Arkansas compared to adults in two other states. **Key findings and conclusions:** Arkansas's private option improved access to primary care and prescription medications, reduced reliance on the emergency department, increased use of preventive care, and improved perceptions of quality and health among low-income adults in the state, compared to Texas, which did not expand Medicaid. Arkansas's benefits were similar to those observed in Kentucky's traditional Medicaid expansion. Churning in coverage remained a challenge for nearly a quarter of low-income adults each year.

## BACKGROUND

Arkansas was the first state to gain federal approval for expanding its Medicaid program to residents using premium assistance. This approach is also known as "the private option." As of November 2016, eight states—Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, New Hampshire, and Pennsylvania—have been granted authority to expand Medicaid via Section 1115 waivers.[1] Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), these waivers give states more freedom in testing new or alternative approaches in their Medicaid programs.

These waivers have included various features: enrollee premiums, increased cost-sharing, incentives for healthy behavior, reductions in nonemergency medical transportation, and premium assistance for private insurance in lieu of public coverage.[2] Some states have combined various elements from this list. For instance, using waivers, Iowa and Michigan implemented Medicaid premiums, but offered beneficiaries the opportunity to lower those premiums by completing a health risk assessment, wellness exam, and preventive health activities. Other states have linked premium



For more information about this brief, please contact:

Bethany Maylone, M.Ed.
Program Manager
Department of Health Policy and Management
Harvard T. H. Chan School of Public Health
bmaylone@hsph.harvard.edu

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nonpayment to disenrollment. For example, Indiana imposes fees when people do not pay premiums and prohibits individuals who miss a payment from reenrolling for six months.[3]

The model of using private insurance to cover low-income people instead of Medicaid was first implemented in Arkansas, but has garnered significant interest nationally. This issue brief explores the evidence to date on Arkansas's 1115 waiver program, which just completed its third year, as other states consider the option and Arkansas policymakers debate the future of the program.

## THE RATIONALE FOR THE ARKANSAS PROGRAM

Arkansas's Medicaid expansion waiver took effect January 1, 2014. It placed most newly eligible enrollees into private insurance plans via the state's marketplace. A small portion of beneficiaries who were deemed medically fragile (i.e., adults with chronic health conditions and complex medical needs) were placed in traditional Medicaid. Individuals eligible for the private option do not pay any premiums. Those with incomes below 100 percent of the federal poverty level ($11,880 in annual income for a single person) do not face cost-sharing at the point of care for covered services, while those with incomes above 100 percent of poverty face modest cost-sharing within federal limits. Out-of-pocket costs are capped annually so that they do not exceed 5 percent of a family's household income.[4]

Arkansas had several key goals in designing its expansion: create delivery system efficiencies, encourage carrier participation and enhance competition, and ensure continuity of care. Unlike many other states considering Medicaid expansion under the ACA, Arkansas did not have an established Medicaid managed care system and there were doubts as to whether its existing fee-for-service network of providers would be capable of withstanding a significant influx of newly eligible recipients.[5] These factors could have significantly hampered a traditional Medicaid expansion. By expanding coverage via private plans and leveraging private insurance markets, rather than traditional Medicaid expansion, advocates of this approach contended that Arkansas would be able to promote a more efficient system for insuring new enrollees with better access to high-quality providers.[6] In addition, by enrolling newly eligible individuals in private marketplace plans regardless of whether their incomes were above or below 138 percent of the federal poverty level, policymakers anticipated less churning—that is, fewer changes in coverage over time—under the private option than a traditional Medicaid expansion.[7]

Under the waiver, Arkansas's Medicaid program provided coverage to more than 250,000 new enrollees, contributing to a reduction in the state's uninsured rate from 27.5 percent in 2013 to 15.6 percent in 2015.[8] Our study aimed to evaluate the effects of the private option on coverage and access to care in Arkansas.

## FINDINGS FROM ARKANSAS'S PRIVATE OPTION

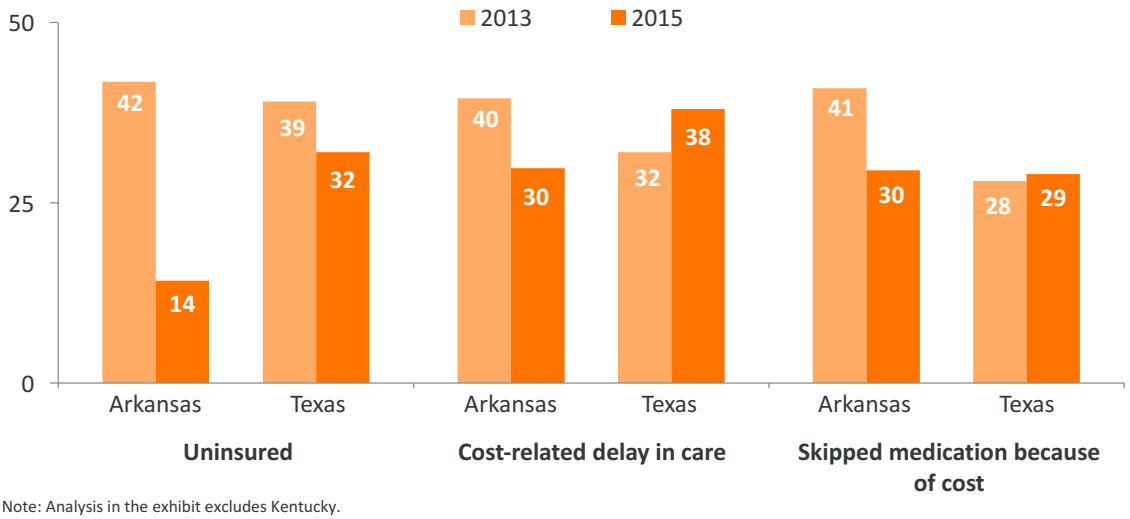
As part of a multiyear study supported by The Commonwealth Fund, our research team has been evaluating the experiences of low-income adults in Arkansas compared with their counterparts in Kentucky (which expanded Medicaid without a waiver) and Texas (which did not expand Medicaid). We conducted an annual survey of approximately 1,000 low-income adults in each state, beginning in 2013. Our findings show significant gains in both expansion approaches, compared to Texas, in terms of coverage, affordability of care, access to preventive care, and chronic disease management. Perhaps most important, we saw improvements in the perceived quality of care and overall health status.[9] Exhibits 1 and 2 show several of the key changes we saw in Arkansas compared to Texas.

However, we detected only a few small differences between Kentucky's Medicaid expansion and Arkansas's private option, other than the type of insurance obtained. Taken together, these results suggest that whether a state expands coverage makes a large difference in the lives of low-income adults, but whether it does so via public or private insurance is less consequential.

Exhibit 1

## Greater Gains in Coverage and Access for Low-Income Adults in Arkansas Compared to Texas

*Percent of low-income adults*



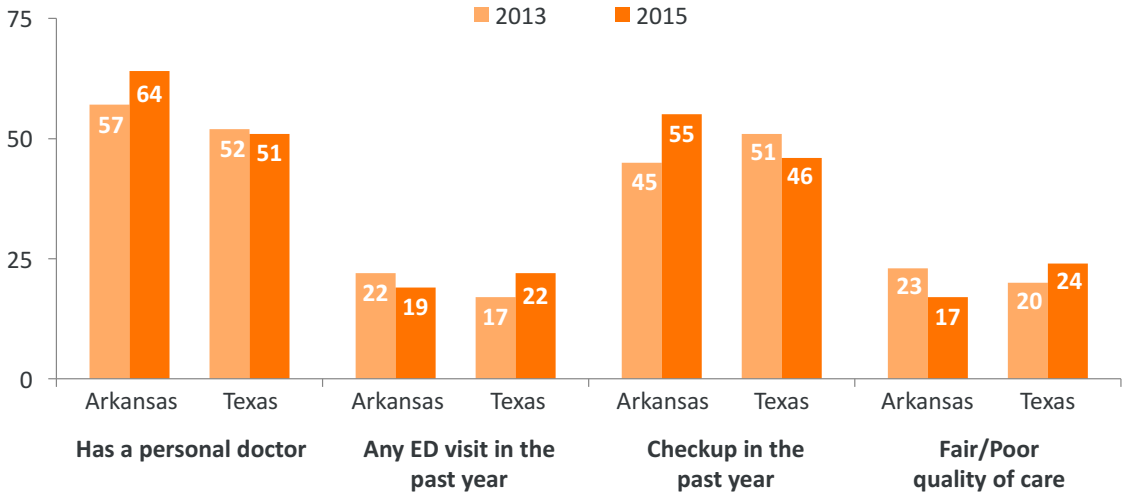

Note: Analysis in the exhibit excludes Kentucky.

Data: Authors' analysis of data from telephone surveys of 5,665 adults ages 19–64 with family incomes below 138 percent of the federal poverty level, November–December 2013 and November–December 2015.

Exhibit 2

## Improvements in Quality of Care for Low-Income Adults in Arkansas Compared to Texas

*Percent of low-income adults*




Note: Analysis in the exhibit excludes Kentucky.

Data: Authors' analysis of data from telephone surveys of 5,665 adults ages 19–64 with family incomes below 138 percent of the federal poverty level, November–December 2013 and November–December 2015.

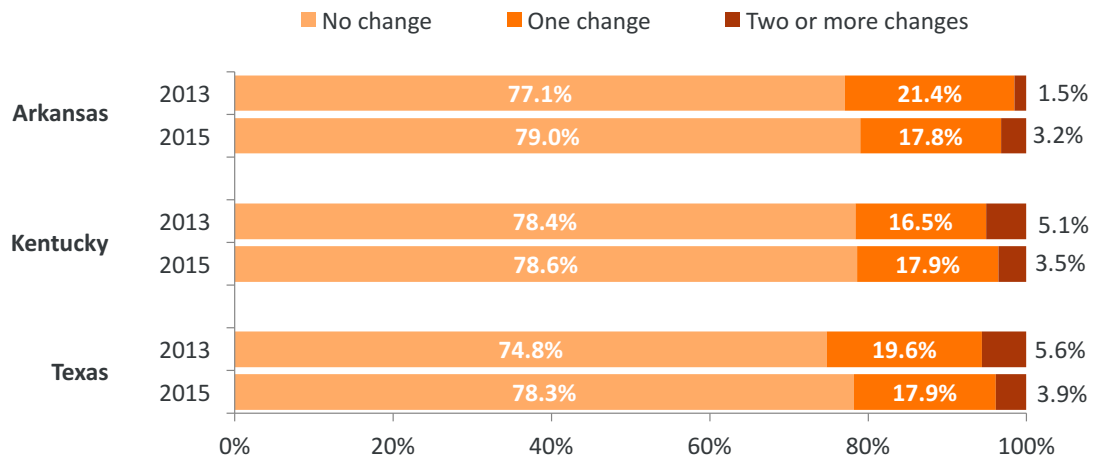
Another key consideration is the effect on churning. In this domain, our research shows less benefit than expected from Arkansas's approach. We found similar churning rates for low-income adults in all three states, roughly a quarter of low-income adults each year (Exhibit 3). Residents in Texas were more likely to drop coverage than those in Arkansas or Kentucky because they could not afford it, and the proportion in Texas who churned and had to change doctors was twice as large as in Arkansas.[10] Meanwhile, we found that adults in Arkansas were more likely than those in other states to have changed insurance because their old plan was no longer available. This likely relates to the fact that two of the original three issuers from 2014 in the Arkansas marketplace dropped out by 2015, though several new plans entered in their place.

Our most recent data, from a round of surveys completed in late 2016 after the election, show that low-income adults in Arkansas generally have positive attitudes toward the ACA. Of those reporting that the law has directly affected them, twice as many respondents in Arkansas said the law had helped them (32%) rather than hurt them (15%); meanwhile, in Texas, more respondents said the law had hurt them (22%) than helped them (15%).[11]

Exhibit 3

## Rates of Churning Are No Different in Arkansas Than They Are in Kentucky and Texas

*Frequency of health insurance coverage changes among low-income adults*




Note: "Change" refers to change in health insurance coverage during the previous 12 months.

Data: Authors' analysis of data from telephone surveys of 5,665 adults ages 19–64 with family incomes below 138 percent of the federal poverty level, November–December 2013 and November–December 2015.

## CONCLUSION

As federal policymakers debate the future of the ACA and Medicaid under the new administration, our research provides evidence that expanded health insurance in Arkansas has produced significant benefits for low-income adults. State leaders in Arkansas, including Republican governor Asa Hutchinson who was elected in 2015, are exploring how they might modify the program in the future.[12] Our findings suggest that the private option has been a successful approach that represents a pragmatic balance between the desire to expand coverage and a preference for private market-based solutions in health care. More broadly, our study indicates that a repeal of the ACA's coverage expansion could produce significant harm to low-income adults in Arkansas and likely in other states as well.

## NOTES

[1] Arizona expanded prior to receiving its waiver; Pennsylvania opted in 2015 to revert to a traditional expansion instead.

[2] S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?* (The Commonwealth Fund, May 2016); and S. Rosenbaum and C. Hurt, *How States Are Expanding Medicaid to Low-Income Adults Through Section 1115 Waiver Demonstrations* (The Commonwealth Fund, Dec. 2014).

[3] S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy?* (The Commonwealth Fund, May 2016).

[4] J. Guyer, N. Shine, M. Musumeci et al., *A Look at the Private Option in Arkansas* (Henry J. Kaiser Family Foundation, Aug. 2015).

[5] Ibid.

[6] Ibid.

[7] S. Rosenbaum and B. D. Sommers, "Using Medicaid to Buy Private Health Insurance—The Great New Experiment?" *New England Journal of Medicine,* July 4, 2013 369(1):7–9.

[8] Arkansas Center for Health Improvement, *Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration Waiver Interim Report* (Arkansas Center for Health Improvement, June 2016).

[9] B. D. Sommers, R. J. Blendon, E. J. Orav et al., "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *JAMA Internal Medicine,* published online Aug. 8, 2016.

[10] B. D. Sommers, R. A. Gourevitch, B. Maylone et al., "Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful for Many," *Health Affairs,* Oct. 2016 35(10):1816–24.

[11] B. D. Sommers and A. M. Epstein, "Red-State Medicaid Expansions—Achilles' Heel of ACA Repeal?" *New England Journal of Medicine,* published online Jan. 25, 2017.

[12] M. Evans, "Arkansas's Hutchinson Signs Medicaid Revamp But Hurdles Remain," *Washington Health Policy Week in Review,* The Commonwealth Fund Newsletter, April 11, 2016.

## About the Authors

Bethany Maylone, M.Ed., is a program manager in the Department of Health Policy and Management at the Harvard T. H. Chan School of Public Health. Her current projects include one which establishes an Engineering High Reliability Learning Lab (EHRLL) to enhance capacity for innovation and develops highly reliable systems that address communication and coordination challenges that pose patient safety risks at the intersection of primary and specialty care; an employee wellness study which analyzes the cost effectiveness, cost savings, and return on investment of a wellness program; and research on three southern states that have all taken different approaches to expanding Medicaid under the Affordable Care Act, and how those decisions have affected their low-income adults. Ms. Maylone holds a M.Ed. in higher education administration from Northeastern University and a B.A. in communications from Mercyhurst University.

Benjamin D. Sommers, M.D., Ph.D., is associate professor of health policy and economics in the Department of Health Policy and Management at the Harvard T. H. Chan School of Public Health. His main research interests are health policy for vulnerable populations, the uninsured, and the health care safety net. Dr. Sommers has received numerous awards for his research, including the Outstanding Dissertation Award, Alice Hersh New Investigator Award, and Article of the Year Award from AcademyHealth. He is a practicing primary care internist, and is also assistant professor of medicine at Brigham & Women's Hospital and Harvard Medical School. From 2011–2012 Dr. Sommers served as a senior advisor in the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, and served in a part-time advisory role from 2013 to 2016. His current research projects focus on barriers to health care access among low-income adults, Medicaid policy, and national health reform. Dr. Sommers received his medical degree from Harvard Medical School and his doctorate in health policy from Harvard University.

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