Medicaid Expansion in Arkansas: The Art of the Deal

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Health Care Independence Program (HCIP)

- Emanated from 100 – 138% FPL discrepancy in ACA
- Alternative approach to Medicaid expansion (commonly called “Private Option”)
- Neither managed care nor traditional Medicaid coverage
- Use Medicaid funding through premium assistance to purchase private coverage through the Health Insurance Marketplace for those <139% FPL
- Majority of newly insured (~250,000) placed with private carriers; medically frail better served in traditional Medicaid
Percentage Uninsured by County, 2015

Competition Has Fallen

About 18 percent of people eligible for the Obamacare markets will live in counties with only one insurance carrier offering health plans next year.

Number of insurance carriers in the Obamacare markets

Source: McKinsey Center for U.S. Health System Reform
Obamacare Rates Are Rising

But there's a lot of variation. In some Arizona counties, prices for the most affordable midlevel plan are going up by 191 percent. In parts of Texas, premiums are going down by 30 percent.

2017 premium increase for lowest-cost silver plan

Note: There are two separate markets in Los Angeles County. We have shown rates for the market where more customers are enrolled.

Source: McKinsey Center for U.S. Health System Reform
Rural Hospital Closings in Surrounding States

Source: Adapted from the North Carolina Rural Health Research Program, “56 Rural Hospital Closures Map.” Accessed August 2015.
Arkansas Marketplace Enrollment

Private Option Enrollment by Age

Marketplace Enrollment without Private Option

Total Marketplace Enrollment

Private Option Enrollment by Age:
- 138% FPL and Under
- Over 138% FPL
- Combined

Marketplace Enrollment without Private Option:
- 138% FPL and Under
- Over 138% FPL
- Combined

Total Marketplace Enrollment:
- 138% FPL and Under
- Over 138% FPL
- Combined

18-44
45-65
Federal Equal Access Requirements

As required by federal rule, it would be unlikely that Arkansas could meet the equal access provision requiring state Medicaid provider payments to be

“consistent with efficiency, economy, and quality of care and ... sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

42 U.S.C. §1396a(a)(30)(A)
Research Questions Asked

1. What were differences across access, quality, and outcomes between those enrolled in Medicaid and those enrolled in commercial QHPs?

2. What were the differences in costs between Medicaid and premium assistance?

3. Under what inflationary scenarios would Medicaid costs exceed differential costs of utilizing premium assistance?
Evaluation Indicators

• **Access**
  – Geographic drive times between enrollees and provider(s)
  – Observed utilization
  – Self-reported experience

• **Clinical Care and Outcomes**
  – Consumer Assessment of Health Plans Survey (CAHPS)
  – Modified Healthcare Effectiveness Data and Information Set (HEDIS)
  – New York University Algorithm for Emergent/Non-Emergent ER use

• **Costs**
  – Paid premiums and cost-sharing reductions, paid claims, Medicaid supplemental payments.
  – Budgetary impact analysis on total Medicaid program
Arkansas 1115 Waiver Evaluation

- Study populations in Medicaid and QHPs
  - General Population
  - Individuals screened with self-reported utilization

- Study population(s) restricted to:
  - Newly covered individuals
  - Those with no limits to activities of daily living
  - Those with 6 months continuous enrollment

- Comparison Groups
  - Individuals screened for higher needs (Mcd vs QHP)
  - Individuals not screened (Mcd vs QHP)
## Research Design

<table>
<thead>
<tr>
<th>STUDY GROUP</th>
<th>General Population</th>
<th>Higher Needs (Screened)</th>
</tr>
</thead>
<tbody>
<tr>
<td>METHOD</td>
<td>Inverse Propensity Score Weighting</td>
<td>Regression Discontinuity</td>
</tr>
<tr>
<td></td>
<td>Medicaid</td>
<td>QHP</td>
</tr>
<tr>
<td>CLAIMS</td>
<td>N = 11,006</td>
<td>N = 69,499</td>
</tr>
<tr>
<td>CAHPS</td>
<td>N = 648</td>
<td>N = 895</td>
</tr>
</tbody>
</table>
## Year 1 Clinical Care Outcomes

<table>
<thead>
<tr>
<th>Preventive Health Care Indicators</th>
<th>Medicaid</th>
<th>QHP</th>
<th>Relative Difference (percent)</th>
<th>Statistical Difference (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving flu shot or spray (primary)</td>
<td>29.7%</td>
<td>31.1%</td>
<td>4.7%</td>
<td>0.450</td>
</tr>
<tr>
<td></td>
<td>38.5%</td>
<td>45.9%</td>
<td>19.2%</td>
<td>0.008</td>
</tr>
<tr>
<td>Received at least one eligible screening (secondary)</td>
<td>25.8%</td>
<td>29.6%</td>
<td>14.7%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>41.2%</td>
<td>66.0%</td>
<td>60.2%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Received all eligible screenings (secondary)</td>
<td>15.8%</td>
<td>16.8%</td>
<td>6.3%</td>
<td>0.020</td>
</tr>
<tr>
<td></td>
<td>20.3%</td>
<td>23.2%</td>
<td>14.3%</td>
<td>0.014</td>
</tr>
<tr>
<td>Diabetics with evidence of HbA1C assessment (tertiary)</td>
<td>73.0%</td>
<td>79.1%</td>
<td>8.4%</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>80.4%</td>
<td>84.8%</td>
<td>5.5%</td>
<td>0.046</td>
</tr>
<tr>
<td>Diabetics with evidence of LDL-c screening (tertiary)</td>
<td>67.4%</td>
<td>64.9%</td>
<td>-3.7%</td>
<td>0.247</td>
</tr>
<tr>
<td></td>
<td>69.5%</td>
<td>71.5%</td>
<td>2.9%</td>
<td>0.476</td>
</tr>
</tbody>
</table>
## Differences in Utilization of Emergency Room Services

<table>
<thead>
<tr>
<th>Emergency Room Visits per 12 Months (Claims)</th>
<th>Medicaid</th>
<th>QHP</th>
<th>Relative Difference (percent)</th>
<th>Statistical Difference (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Emergency Room Visits</td>
<td>1.034 (0.025)</td>
<td>0.898 (0.016)</td>
<td>-13.2%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td></td>
<td>1.521 (0.050)</td>
<td>0.749 (0.062)</td>
<td>-50.8%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Emergent Emergency Room Visits</td>
<td>0.149 (0.006)</td>
<td>0.331 (0.008)</td>
<td>122.1%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td></td>
<td>0.210 (0.012)</td>
<td>0.319 (0.039)</td>
<td>51.9%</td>
<td>0.002</td>
</tr>
<tr>
<td>Non-Emergent Emergency Room</td>
<td>0.494 (0.017)</td>
<td>0.207 (0.006)</td>
<td>-58.1%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td></td>
<td>0.679 (0.028)</td>
<td>0.247 (0.029)</td>
<td>-63.6%</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>
Interim Evaluation Summary of Key Findings

• Geographic access comparable

• Significant differences in reported and observed access in QHPs with improved:
  – Primary care availability
  – Specialty visits
  – Care when needed

• Observed differences in ER use:
  – More appropriate ER use in QHPs
  – Higher utilization rates in Medicaid
  – More non-emergent care delivered in ER for Medicaid

• Clinical outcomes improved in QHPs
Medicaid and Commercial Payer Price Differences for Outpatient Procedures by Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Weighted Medicaid Average Price</th>
<th>Weighted Commercial Average Price</th>
<th>Absolute Difference</th>
<th>Relative Difference (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician</td>
<td>$53.07</td>
<td>$100.67</td>
<td>$47.60</td>
<td>89.69%</td>
</tr>
<tr>
<td>Advanced Practice Nurses (APN)</td>
<td>$41.90</td>
<td>$68.19</td>
<td>$26.29</td>
<td>62.75%</td>
</tr>
<tr>
<td>Cardiologists</td>
<td>$61.49</td>
<td>$126.36</td>
<td>$64.87</td>
<td>105.49%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>$52.74</td>
<td>$109.72</td>
<td>$56.98</td>
<td>108.05%</td>
</tr>
<tr>
<td>Obstetrician / Gynecologist (OB/GYN)</td>
<td>$48.84</td>
<td>$92.72</td>
<td>$43.88</td>
<td>89.85%</td>
</tr>
<tr>
<td>Oncologist</td>
<td>$62.56</td>
<td>$120.35</td>
<td>$57.79</td>
<td>92.37%</td>
</tr>
<tr>
<td>Ophthalmologists</td>
<td>$44.47</td>
<td>$118.05</td>
<td>$73.58</td>
<td>165.46%</td>
</tr>
<tr>
<td>Orthopedists</td>
<td>$50.75</td>
<td>$98.23</td>
<td>$47.49</td>
<td>93.57%</td>
</tr>
<tr>
<td>Psychologists / Psychiatrists</td>
<td>$44.25</td>
<td>$91.92</td>
<td>$47.67</td>
<td>107.74%</td>
</tr>
</tbody>
</table>

Notes: Weighted Commercial and Medicaid Averages Prices were based on the most common CPT procedures billed for outpatient services. Only CPT procedures that were represented both in Commercial and Medicaid claims are included in the weighted averages. Relative difference percent calculated as (Commercial – Medicaid)/Medicaid x 100.
Budgetary Impact Analyses

• Observed Program Costs:
  – Medicaid: $272.01 PMPM
  – QHP: $485.05 PMPM (premium plus cost-sharing reduction)

• Inflationary scenarios for entire Medicaid program under traditional expansion
  (impact of ten-fold adult expansion)
  – Wage-sensitive payment rates
  – Major-medical service rates
  – Physician-only claims rates
Budget Neutrality Cut-Points Based on Impact Simulation of Price Pressure on Medicaid Program

14.5% increase in all Medicaid costs
24.7% increase in clinical claims costs
34.9% increase in physician claims costs

Simulated Increases in Payment Rates

Commercial PMPM | Medicaid PMPM
Political Observations: Need vs Reality

- Cost Sharing
- Premiums
- Benefit Incentives
- Lock-out periods
- Health Savings Accounts
- Work Requirements
- Retrospective eligibility restrictions
- Block grants – Global vs. Per-Capita
Health Independence Accounts:

- Individual accounts for those 100-138% FPL
  - Individuals required to contribute or generate a debt to the state (no collection mechanism)
    - 100-117% FPL $10/mo / 118-138% FPL $15/mo

- Payment resulted in state-funded cost-sharing protection for following month
  - Activation of account gained 2 months protection followed by payment expectations
  - State debits account only for failed payment

- State matches individual’s contribution up to $200 if timely payments / annual roll-over

- Funds available for premium payments upon exit
Outcomes: Economic Impact

- Premium payments for the ~7,000 individuals totaled $426,670
  - Median total $40 (IQR $15, $90): 4 months payments
  - Mean total $60 (Std Dev $141): 6 months payments

- Cost-sharing protections exceeded HIA payments by $50,172 ($476,843 – 426,670)

- Cost-avoidance (individual co-payment protections greater than monthly payments) was realized by 23.4% of participants

- Administrative costs to maintain program and accounts were ~$9M over 18 months
Conclusions:

• Introduction of “savings” accounts into Medicaid demonstrated limited participation

• Medicaid beneficiaries that are likely to participate in personal “savings” accounts are likely to be older, have more conditions, and previously hospitalizations

• Participating individuals demonstrated rational economic behavior with some achieving economic advantages

• Operational and fiscal costs of such efforts should be considered prior to implementation
Postlude:

• The Arkansas General Assembly terminated the Healthcare Independence Accounts in 2016 and replaced them with nominal monthly premiums.

• Individuals with account balances (n=2253) received program termination checks.

• No awareness of individuals directly utilizing account balances for private sector premium payments.
Thank you

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