State Health Reform Assistance Network
Charting the Road to Coverage

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Purchasing Coverage for Medicaid Beneficiaries in the Exchange: A Review of the Premium Assistance Option

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In January 22, 2013 draft regulations, the Centers for Medicare and Medicaid Services (CMS) proposed to allow states to use Medicaid/CHIP funding to purchase coverage for Medicaid/CHIP eligible beneficiaries in the individual market, including coverage through Qualified Health Plans (QHPs) in Exchanges.[1] As CMS recognizes in the preamble to the draft regulations, there are several circumstances where a state might want to use "premium assistance" to purchase coverage for Medicaid-eligible adults in the Exchange.

First, premium assistance enables individuals to stay with the same health plan and same provider network as their income fluctuates above and below Medicaid eligibility levels. A wealth of research regarding "churning" (the cycle of losing and regaining means-tested insurance coverage due to income changes) has documented the economic, social and health costs of churning. Premium assistance breathes real life into the Affordable Care Act's (ACA) promise of a seamless continuum of insurance affordability programs (IAPs) for individuals with incomes below 400 percent of the Federal Poverty Level (FPL) who will experience frequent income changes that impact IAP eligibility.[2]

Second, premium assistance provides Medicaid beneficiaries the same access to providers as privately insured patients, precisely what federal Medicaid law requires.[3] And, it ensures that those providers are paid the same whether they serve an individual whose income is $14,000 a year and enrolled in Medicaid or $16,000 a year and enrolled in a QHP. Cost-shifting among payers should be reduced and potentially even eliminated.

Third, premium assistance enables "whole family" coverage whereby children who are eligible for Medicaid or CHIP can, through premium assistance, enroll in the same health plans as their parents who are eligible for tax credits through QHPs. Finally, it facilitates multi-payer payment and delivery system reform, enabling Medicaid and the Exchange to drive quality and performance initiatives across government and private insurance products.

Since release of the proposed rule, several states have expressed interest in premium assistance to purchase coverage for Medicaid-eligible adults in the Exchange. This brief will examine some of the legal, policy and operational issues states will need to consider in pursuing this approach. Of necessity, the discussion is at a high level as many of the details of the program are still evolving.

[1] 78 Fed. Reg. 4594 (Jan. 22, 2013)

[1] Benjamin D. Sommers & Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs*, 30, no. 2 (2011): 228-236.

[1] Social Security Act § 1902(a)(30)(A)

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Background

Premium assistance is not a new concept in Medicaid. States have had long-standing authority under Section 1906 of the Social Security Act to use Medicaid premium assistance to wrap around employer coverage for an employed individual who is also eligible for Medicaid. That is, the Medicaid program may cover some or all premium and cost-sharing obligations of an individual's employer-based coverage, as well as any additional benefits covered under the state's Medicaid program. In 2009, the premium assistance option was extended to the Children's Health Insurance Program (CHIP).[4] To date, states have made only limited use of premium assistance; however, the opportunity to use premium assistance to purchase coverage through Insurance Exchanges has spurred new state interest in the program.

Premium assistance is a Medicaid program; enrollees retain their rights as Medicaid beneficiaries under federal Medicaid law. States must provide enrollees with all the benefits to which an individual is entitled under Medicaid, and ensure that cost-sharing does not exceed federal Medicaid rules. States will also have to demonstrate that the cost of purchasing private coverage (including administrative costs and any cost-sharing or benefit wraps) is comparable to the cost of providing direct coverage under their Medicaid plans. Premium assistance offers considerable benefits; the challenge comes in meshing the legal, policy and operational imperatives of the public and private markets. Several of the most important issues States will need to address are discussed below.

Covered Benefits

As a first step, a state considering premium assistance for Medicaid beneficiaries to enroll in QHPs must compare the benefit package offered by the QHP to the alternative benefit plan (ABP) to be offered to the group of non-disabled adults under the age of 65 that is newly established under ACA.[5] The new adult group must receive an ABP. States may offer the ABP to all Medicaid beneficiaries, with certain populations eligible to opt out into the "standard" or full Medicaid benefit package in the state plan.[6]

Like QHPs (but unlike standard Medicaid benefits), the ABP must include the 10 categories of essential health benefits (EHBs) defined in the ACA and implementing regulation.[7] Thus, at the outset, there will be considerable overlap between the QHP benefit package and the ABP benefit package. The ABP must also include non-emergency transportation, Early Periodic Screening Detection and Treatment (EPSDT) (for 19 and 20 year olds), family planning services and FQHC/RHC services.[8] Benefits that are missing from the QHP will either have to be waived by CMS or provided by the state Medicaid agency as wrap around benefits. Non-emergency medical transportation and EPSDT services (most notably dental and vision services) for 19 and 20 year olds will almost certainly fall into this wrap around category.

Coverage Effectuation

Coverage start dates are different in Medicaid than in the Exchange, and states will have to consider how to provide Medicaid coverage for the period of time—potentially up to five weeks—between the determination of Medicaid eligibility and QHP enrollment. The requirement that Medicaid coverage apply three months retroactively will likewise apply to premium assistance programs. In both instances, states may be required to cover beneficiaries in their fee-for-service programs until QHP enrollments become effective.

Cost-Sharing

Section 1916 of the Social Security Act and the implementing regulations describe the cost-sharing rules applicable to all Medicaid beneficiaries. Absent a waiver, premiums are not permitted for individuals with incomes below 150 percent of the FPL and total cost-sharing may not exceed five percent of family income. States using premium assistance to purchase coverage for Medicaid eligible beneficiaries through QHPs, will have to wrap around the QHP premium and design QHP products that meet Medicaid cost-sharing requirements (most likely these standard product designs would be at the highest value silver-level variation with a 94 percent actuarial value) or wrap around the QHP cost-sharing to bring it down to levels permissible under federal Medicaid law.

Cost Effectiveness

Proposed regulations require states seeking to use premium assistance in the individual market to demonstrate that the costs of premium assistance is comparable to the cost of coverage through the Medicaid state plan.[9] There are many factors that impact this evaluation, and these factors are state-specific. The starting point is an evaluation of the cost to Medicaid of providing each of the services in the ABP, taking into account all relevant reimbursement including supplemental payments made to providers. Thereafter, the state must compare QHP coverage through the Exchange with its Medicaid coverage model (fee-for-service, Primary Care Case Management, Medicaid managed care), considering whether and what efficiencies may be achieved through QHP coverage. For example, Arkansas calculated a five percent savings related to moving

[4] Social Security Act § 1906 A (enacted in Pub. L. No. 111-3). For a full review of the premium assistance options in Medicaid and CHIP, see Kaiser Commission on Medicaid and the Uninsured, *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act*, March 2013.

[5] Affordable Care Act § 2001.

[6] See Social Security Act § 1937.

[7] Affordable Care Act § 2001(c).

[8] See SSA § 1937(1)(A)(ii), 42 C.F.R. § 440.345 (requiring coverage of EPSDT); 42 C.F.R. § 440.390 (requiring coverage of non-emergency medical transportation); SSA § 1937(4); 42 C.F.R. § 440.365 (requiring coverage of FQHC/RHC services).

[9] 78 Fed. Reg. at 4696 (proposing 42 C.F.R. § 435.1015).

Medicaid beneficiaries from its fee-for-service program to health plans in the Exchange. Additional savings were estimated related to price competition driven by moving 250,000 Medicaid beneficiaries into the private market in Arkansas, thus doubling the size of the Exchange.[10] Several other factors relevant to the price comparison are: whether Medicaid would otherwise be required to increase its provider rates in order to assure adequate provider capacity absent premium assistance; savings related to administering the ABP through QHPs rather than establishing an additional Medicaid benefit package and modifying operations and systems to administer a bifurcated benefit; savings related to a decrease in beneficiary churning; and finally, future savings related to cross payer reforms facilitated by the integration of Medicaid into private coverage.

Ultimately, states will need CMS guidance as to the application of the comparability standard and how much cost variation is acceptable.

Operational Issues

Purchasing Medicaid coverage through the Exchange and QHPs allows states to provide private and public coverage in one unified system, taking full advantage of the continuum of coverage contemplated by the ACA. However, as the rules of the respective markets do not align perfectly, a number of operational issues must be addressed to assure that goals of a unified system are achieved. Among the issues that will need to be addressed are the following:

- ***Mandatory Enrollment*** – Will states be able to require Medicaid beneficiaries to secure coverage through QHPs in the Exchange through a state plan amendment or only through a waiver? Our analysis suggests that states may mandate premium assistance;[11] however, states may need to secure a freedom of choice waiver under Section 1915(b) of the Social Security Act to the extent the QHP uses a closed provider network.

- ***Risk Pooling*** – It would appear that Medicaid enrollees in QHPs will be in the individual market risk pool and the ACA's risk stabilization programs, including risk adjustment, risk corridors and reinsurance, will apply.

- ***Plan Shopping and Enrollment*** – Central to a large scale premium assistance program is the ability of Medicaid beneficiaries to shop and enroll into QHPs (or a subset thereof) on the Exchange. (Indeed, some states with expansive Medicaid managed care programs are similarly considering using the Exchange shopping and enrollment functionality for these programs.) How and when will Exchanges, including the Federally Facilitated Exchange (FFE), be able to accommodate this additional functionality? If necessary, what are the interim solutions that can be adopted for 2014?

- ***Flow of Funds to QHPs*** – State will pay QHP premiums and cost-sharing wraps for Medicaid beneficiaries in premium assistance programs. Systems will need to be established to notify the state Medicaid agency that an enrollment has occurred and enable the state to pay the premium to the selected QHP.

- ***Benefit Wraps*** – As noted above, states will need to establish a mechanism to provide any benefits that are not included in the QHP. This could be done through the Medicaid fee-for-service system or through the QHP as a "rider."

- ***Notices*** – States will need to notify Medicaid beneficiaries receiving ABP benefits through QHPs in the Exchange of the circumstances under which they would be entitled to opt into standard Medicaid. States will also need to provide notice to premium assistance enrollees of their right to access any Medicaid benefits provided outside the QHP.

- ***Coverage Appeals*** – There is general alignment in informal appeals, both internal and external, across Medicaid and QHPs; however, Medicaid beneficiaries will retain their right to request a fair hearing to challenge a particular coverage decision.

Conclusion

Premium assistance holds the promise of continuity of coverage and care for low and modest income consumers, placing Medicaid squarely in to the continuum of coverage in the individual insurance market and leveraging the purchasing power of the state and the Exchange to improve health and contain costs. However, successful implementation requires states, in partnership with the federal government, to address significant policy, legal and operational issues.

[10] *See* David Ramsey, "DHS: extra cost to feds of Arkansas 'private option' will be little to none," *Arkansas Times*, Arkansas Blog (March 18, 2013) *available* at http://arktimes.com/arkansas/blogs/Post?basename=dhs-extra-cost-to-feds-of-arkansas-private-option-will-be-little-to-none&day=18&id=ArkansasBlog&month=03&year=2013.

[10] The proposed regulations, however, do not permit mandatory premium assistance and if the rules remain unchanged, a state would need a waiver to implement a mandatory program.