

Medicaid Marketplace Premium Assistance

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State Health Reform Assistance Network Charting the Road to Coverage

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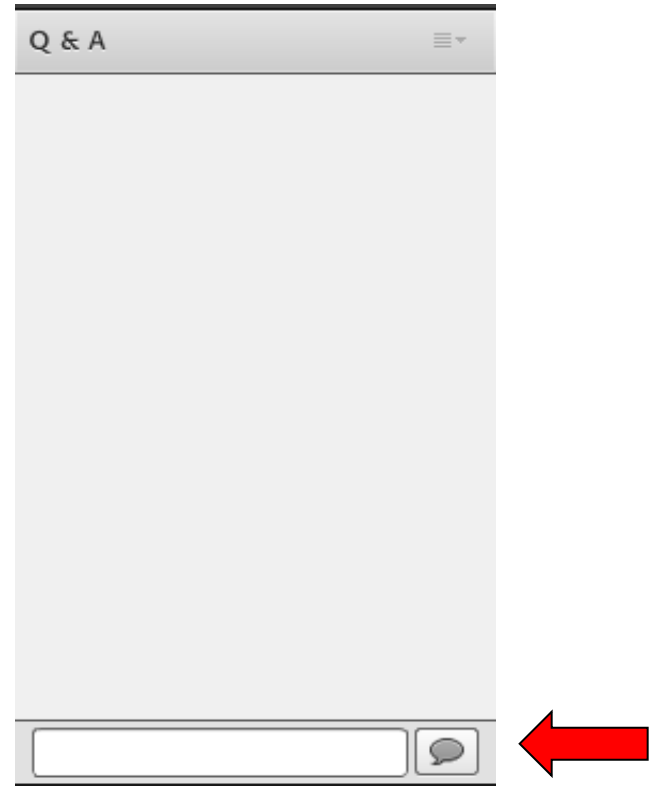
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The following presentation provides an overview of Medicaid Marketplace Premium Assistance and outlines the authorization vehicles through which a state may establish this program. Additionally, it details the federal requirements for and operational implications of implementation with respect to: eligibility for the program, benefits and network adequacy, premiums and cost-sharing, shopping and enrollment, cost effectiveness, appeals and interagency cooperation.

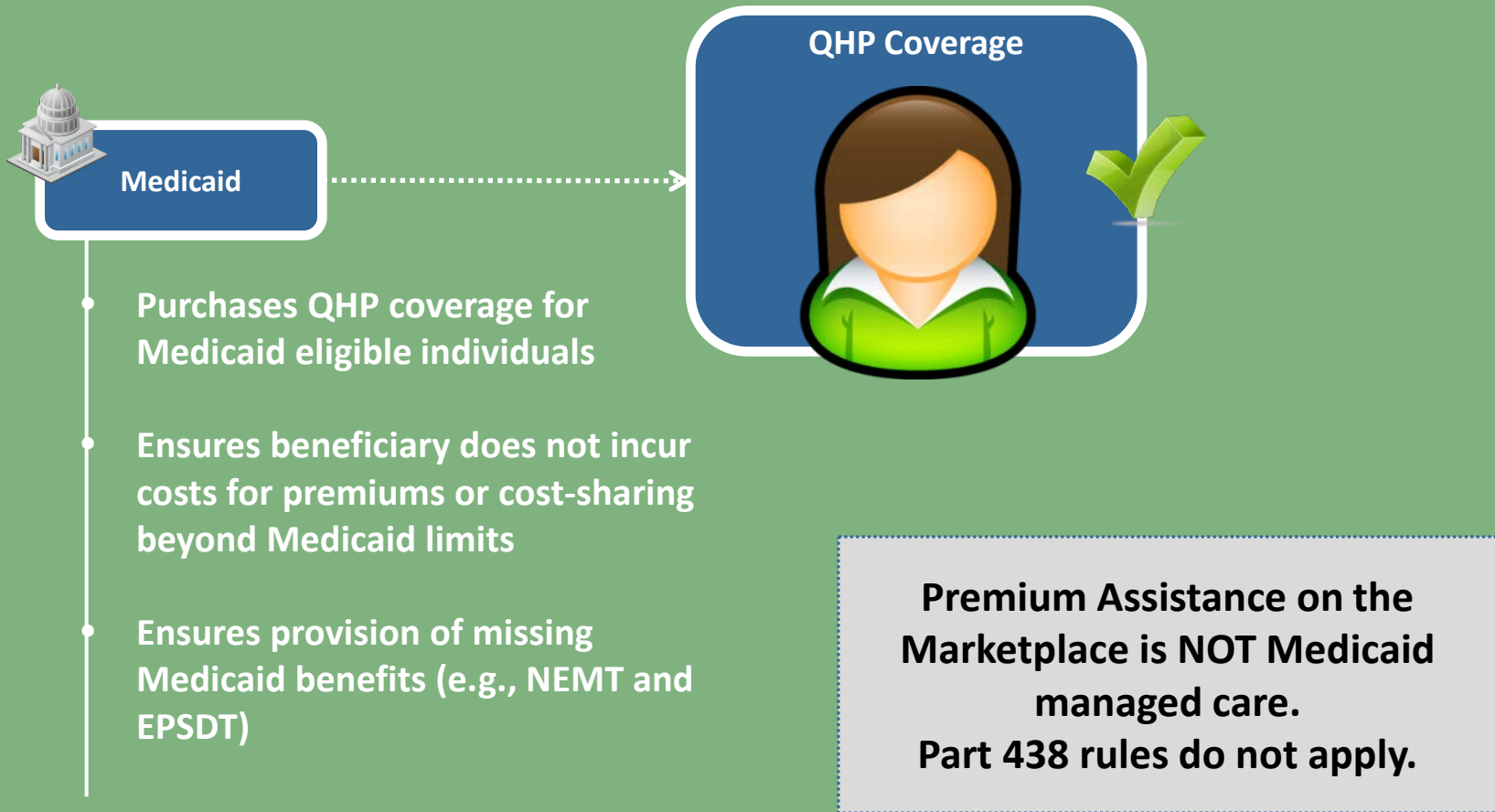
As of publication of this presentation, the Centers for Medicare and Medicaid Services has approved two states' – Arkansas and Iowa – Medicaid Marketplace Premium Assistance programs, authorized through 1115 waivers, which enable these states to purchase coverage for some or all new adults through qualified health plans (QHPs) on the Marketplace. A number of additional states have expressed interest in this approach.

Agenda

- **Medicaid Marketplace Premium Assistance Overview**
- **Federal Requirements and Operational Implications**
- **Looking Ahead**

Medicaid Marketplace Premium Assistance Overview

Premium Assistance on the Marketplace



Reasons States Have Pursued Marketplace Premium Assistance

- Enables continuity of coverage and care as individuals' and families' income fluctuates
- Enables comparable access to providers for state residents, regardless of income
- May encourage Marketplace competition
 - Increased size of the individual market may attract more plans
 - Increased competition may drive down Marketplace premiums
- Increases alignment of regulation and oversight across government and private markets
- Enhances stability of risk pool through increasing potential enrollees
- Provides opportunity to test hypothesized improvements to quality and outcomes

Challenges States May Face with Marketplace Premium Assistance

- Administratively complex for states to operationalize
- Different considerations for states with Medicaid managed care
- Must be cost effective
- Must meet budget neutrality (if in 1115 waiver)

Cost Effectiveness Requirement

The cost of providing coverage through premium assistance (including QHP premiums, cost-sharing above Medicaid permissible limits, coverage of additional services and administrative expenditures) must be comparable to the cost of providing direct coverage under the State Plan.

Budget Neutrality in a Waiver

States must determine that a Demonstration will not cost the federal government more than what would have been spent absent the Demonstration

Sources: Medicaid and the Affordable Care Act: Premium Assistance. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>

CMS Guidance for Marketplace Premium Assistance Waiver

An 1115 Waiver is required to make Marketplace Premium Assistance mandatory. HHS will only consider proposals for mandatory premium assistance demonstrations that:

- Provide beneficiaries with a choice of at least two QHPs
- Wrap any cost sharing and benefits inconsistent with Medicaid rules
- Protect rights of medically frail and tribal populations
- Demonstrate cost effectiveness & budget neutrality

Cost Effectiveness in a Waiver

HHS will consider alternative cost effectiveness tests that consider, among other factors:

- Savings from reduced churn between Medicaid and the Marketplace
- Economic benefits of increased competition on the Marketplace
- Improved access
- Improved patient outcomes
- Benefits of family coverage under one product

Sources: Medicaid and the Affordable Care Act: Premium Assistance. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>

Budget Neutrality: GAO Reports

It is standard practice for CMS to require states to meet budget neutrality in Demonstration proposals; however, budget neutrality is not defined in statute or regulation, which allows for significant CMS discretion

The Government Accountability Office (GAO) has often critiqued CMS' assessment of budget neutrality in GAO reports, including recently regarding the Arkansas Private Option Demonstration

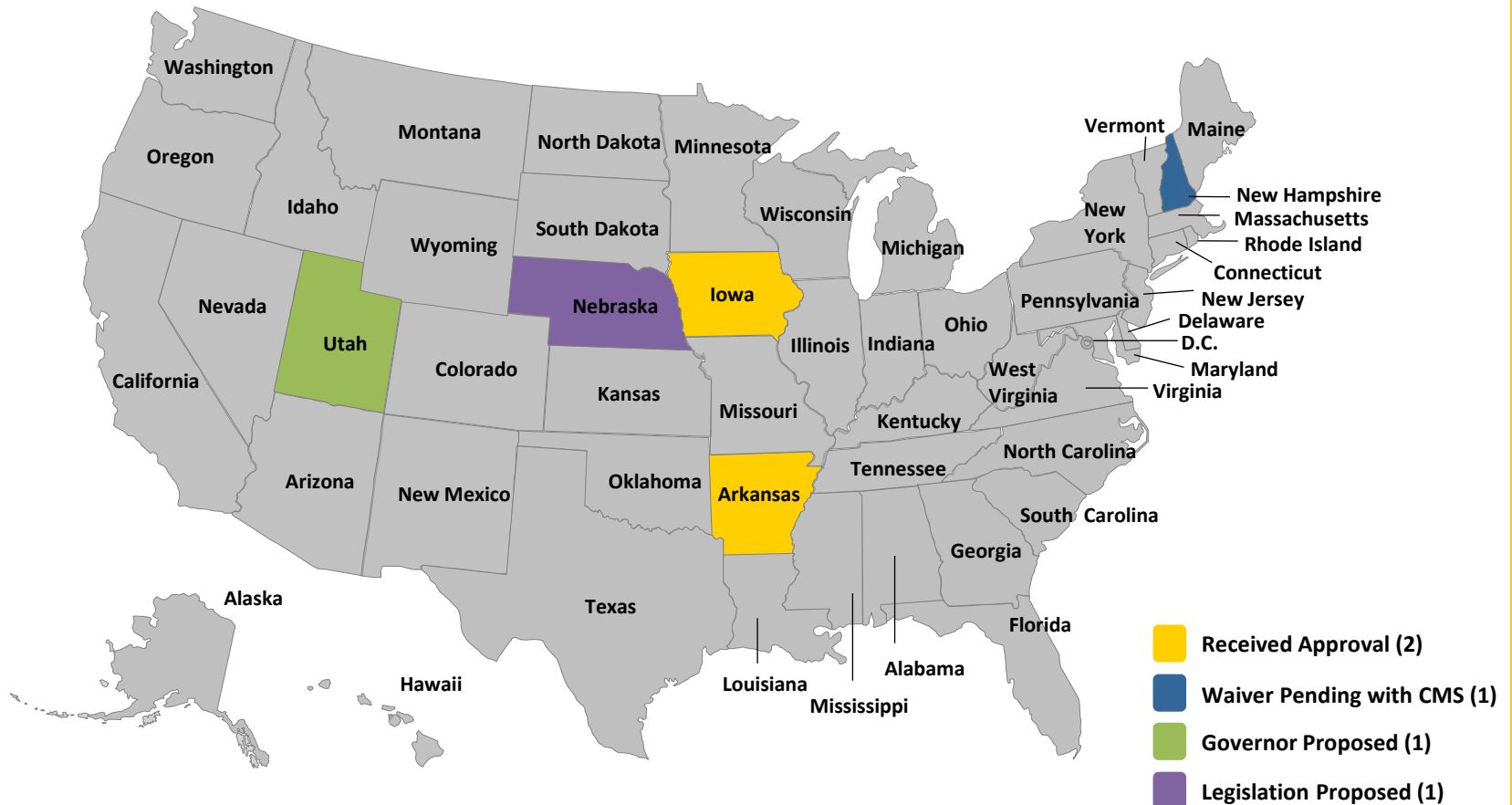
GAO Findings on Budget Neutrality in the Arkansas Private Option Demonstration

- **The GAO** concluded HHS did not ensure budget neutrality because, among other things it assumed that the hypothetical “without waiver costs” were based on the higher payment amounts the state assumed it would have to make to providers if it expanded under traditional Medicaid, without supporting data.
- According to GAO this resulted in a spending limit that was \$778 million higher than it would have been if HHS had used unadjusted historical data.

HHS & Arkansas Responses to Report

- **HHS** response:
 - Arkansas used the most reasonable and documented cost assumptions considering the “dramatic and unique” increase in adult Medicaid enrollment
 - GAO’s calculations only used a subset of data that HHS uses to determine appropriate estimates and did not account for major program changes
- **Arkansas** response:
 - Governor’s spokesperson: "This was a report developed without contact with anyone on the ground in Arkansas. That \$778 million is very abstract...If you're going to build the infrastructure to serve 200,000 more people, you're going to have increased costs. ... Not all costs are continuing costs."
 - Department of Human Services spokesperson: "Historically, clients across the country have had difficulties getting access to physicians willing to take Medicaid because of the low payment rates. It's unreasonable to assume we could add hundreds of thousands of clients to the traditional program and not have had to raise rates."

Approved and Pending Marketplace Premium Assistance Programs



Federal Requirements and Operational Implications

Marketplace Premium Assistance Issue Areas



Eligibility & Target Population



Benefits & Network Adequacy



Premiums & Cost-Sharing



Shopping & Enrollment



Interagency Cooperation

Eligibility & Target Population

Legal Requirements and HHS Guidance

Eligibility Requirements:

- No program requirements beyond standard Medicaid/CHIP eligibility rules
- Comparability applies (program must be applied to all Medicaid/CHIP beneficiaries, absent a waiver)

Target Population for Mandatory Programs:

- Will only consider mandatory program proposals limited to individuals whose Medicaid benefits are closely aligned with those available on the Marketplace

Sources: Medicaid and the Affordable Care Act: Premium Assistance. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

Eligibility & Target Population: Examples



ARKANSAS:

All newly eligible adults:

- Childless adults aged 19-64: 0-138% FPL
- Parents aged 19-64: > 17% FPL

Medically frail individuals are excluded



IOWA:

Newly eligible adults aged 19-64:
>100-138% FPL

Medically frail individuals are excluded



Benefits & Network Adequacy

Benefits & Network Adequacy: Legal Requirements and HHS Guidance

Align Benefits

- Premium assistance enrollees remain Medicaid beneficiaries entitled to all Medicaid benefits
- Benefits not covered under QHP must be wrapped
 - Non-emergency medical transportation (NEMT) *Waived for year 1 in Iowa*
 - For 19 and 20 year old new adults, EPSDT benefits (e.g., vision, dental)

Network Adequacy

- QHPs' network adequacy is a condition of certification regulated by state insurance departments
- For premium assistance, the state must ensure that Medicaid/CHIP enrollees also have access to required Medicaid/CHIP providers:
 - FQHCs/RHCs at Prospective Payment System (PPS) rates
 - I/T/U providers
 - Family planning providers, including out-of-network

Align Pharmacy

- State must align Medicaid and QHP prior authorization and formulary requirements. Medicaid beneficiaries are entitled to barbiturates and benzodiazepines, which may not be covered in the QHP

Rebates

- The availability of rebates depends on the mechanism the state uses to align cost-sharing with Medicaid standards. If the state pays the pharmacy directly as a secondary payer, the rebate will apply. If the state pays the plan to reduce the cost sharing for the prescription drug, the rebate would not apply.

Sources: Medicaid and the Affordable Care Act: Premium Assistance.
<http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>; ACA Sec. 1302; 78 Fed Reg 42184

Benefits & Network Adequacy: Examples



ARKANSAS:

Did not request any benefit waivers for 2014

Wrap benefits (EPSDT and non-emergency transportation) provided by FFS Medicaid

Limited to QHP formulary

Prior authorization within 72 instead of 24 hours, but prescribed pharmaceutical provided in the interim in the event of an emergency



IOWA:

Received a one-year waiver of NEMT

Wrapped EPSDT benefits provided by FFS Medicaid

Limited to QHP formulary

Prior authorization within 72 instead of 24 hours, but prescribed pharmaceutical provided in the interim in the event of an emergency



Premium & Cost-Sharing Assistance

Premiums & Cost-Sharing: Key Legal Requirements and HHS Guidance

- All Medicaid premium and cost-sharing requirements apply to enrollees in Medicaid Marketplace Premium Assistance programs
- Cost-sharing in high-value Silver qualified health plans (94% actuarial value) may be aligned with Medicaid cost-sharing rules if Medicaid covers the plan's deductible
 - Arkansas (approved) and New Hampshire (pending) use this approach

See Appendix for full Medicaid premium and cost-sharing requirements

Sources: SSA 1916A; 42 CFR 447.64; SSA 1916; 42 CFR 457.520; 42 CFR 457.560; Medicaid and the Affordable Care Act: Premium Assistance.
<http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>

Shopping and Enrollment

Legal Requirements and HHS Guidance

Plan Selection

- If in mandatory program, enrollees must have a choice of at least two QHPs
- Plan enrollment currently cannot take place through the Federally-facilitated Marketplace

Enrollment Periods

- If in mandatory program, enrollment must be permitted at any time (may not be limited to Marketplace open enrollment and special enrollment periods)
- State must provide coverage between date of application and enrollment in QHP

Retroactive Coverage

- Enrollees are eligible for three months retroactive Medicaid coverage from the date of application

Sources: SSA 1902(a)(34); Medicaid and the Affordable Care Act: Premium Assistance.
<http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>; 78 Fed Reg 42184

Interagency Cooperation

Legal Requirements and Operational Considerations

Federal Requirements

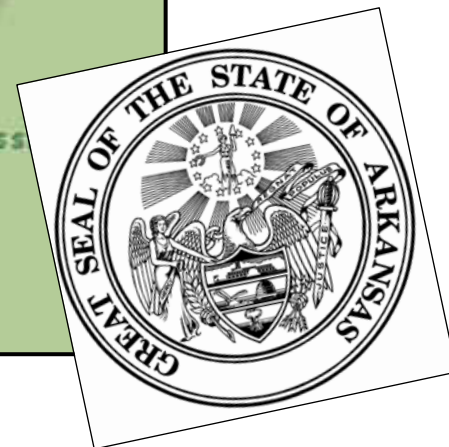
- Medicaid is the “single state agency” and remains fully accountable for ensuring compliance with and oversight of Medicaid requirements
- If Medicaid agency delegates any responsibility to a state insurance agency, an Intergovernmental Cooperation Act Waiver is required.* A Memorandum of Understanding (MOU) may be required.

Operational Considerations

- Potential MOUs between and among:
 - Medicaid agency
 - Insurance agency
 - Exchange (if applicable)
 - QHPs

**If the state's Department of Insurance is the Exchange, waiver is not required*

Arkansas's Marketplace Premium Assistance Program

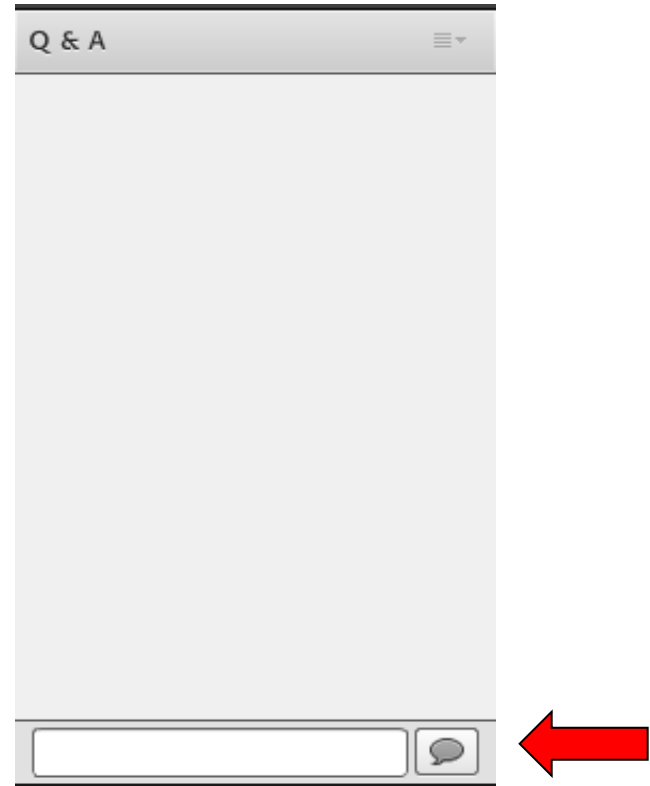


Discussion

Submitting Questions

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Thank You!

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Appendix

Premium Assistance Regulatory Timeline

Social Security Act Section 1905(a) authorizes states to use premium assistance to purchase private coverage in the individual market with Medicaid funds

Jan. 22,
2013

Mar. 29

July 15

Sept. 27

Dec. 10,
2013

HHS releases proposed rule in [78 Fed Reg 4624](#) regarding using Medicaid & CHIP funds for Marketplace premium assistance

HHS releases [FAQ](#) "Medicaid and the Affordable Care Act: Premium Assistance" outlining Marketplace premium assistance waiver guidance

HHS releases Final Rule in [78 Fed Reg 42184](#), integrating Final Rule into [42 CFR 435.1015](#)

CMS [approves](#) Arkansas Private Option Waiver

CMS [approves](#) Iowa Marketplace Choice Plan Waiver

Right click and select "Open Hyperlink" to access materials online

Authorization for Marketplace Premium Assistance: SSA 1905(a)

SSA § 1905(a): Definition of Medical Assistance

Authorizes states to use Medicaid dollars for “other insurance premiums for medical or any other type of remedial care or the cost thereof”

42 CFR 435.1015

- Authorizes FFP for “payment of the costs of insurance premiums on behalf of an eligible individual for a health plan offered in the individual market”
- Requires states to provide Medicaid benefits not covered through the individual health plan
- Requires states to ensure Medicaid beneficiaries do not incur cost sharing charges in excess of Medicaid limits
- Requires program to be cost-effective relative to what the state would have spent, including administrative expenditures, to provide comparable coverage through Medicaid
- Requires program to be voluntary (absent a waiver)

Sources: SSA 1905; Medicaid and the Affordable Care Act: Premium Assistance. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>; 42 CFR 435.1015

Authorization for Marketplace Premium Assistance: Waiver

Waiver Option

A waiver is required if the state wants to:

Establish a mandatory premium assistance program

Modify benefits or cost-sharing, but:

- States must provide benchmark coverage to the new adult group to be eligible for the enhanced federal match
- Special statutory limits on waiving cost-sharing requirements exist

Extend the coverage model to a subset of Medicaid eligible individuals (comparability)

Use an alternative cost effectiveness test

Sources: Medicaid and the Affordable Care Act: Premium Assistance. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>; 42 CFR 435.1015; 78 Fed Reg 42184

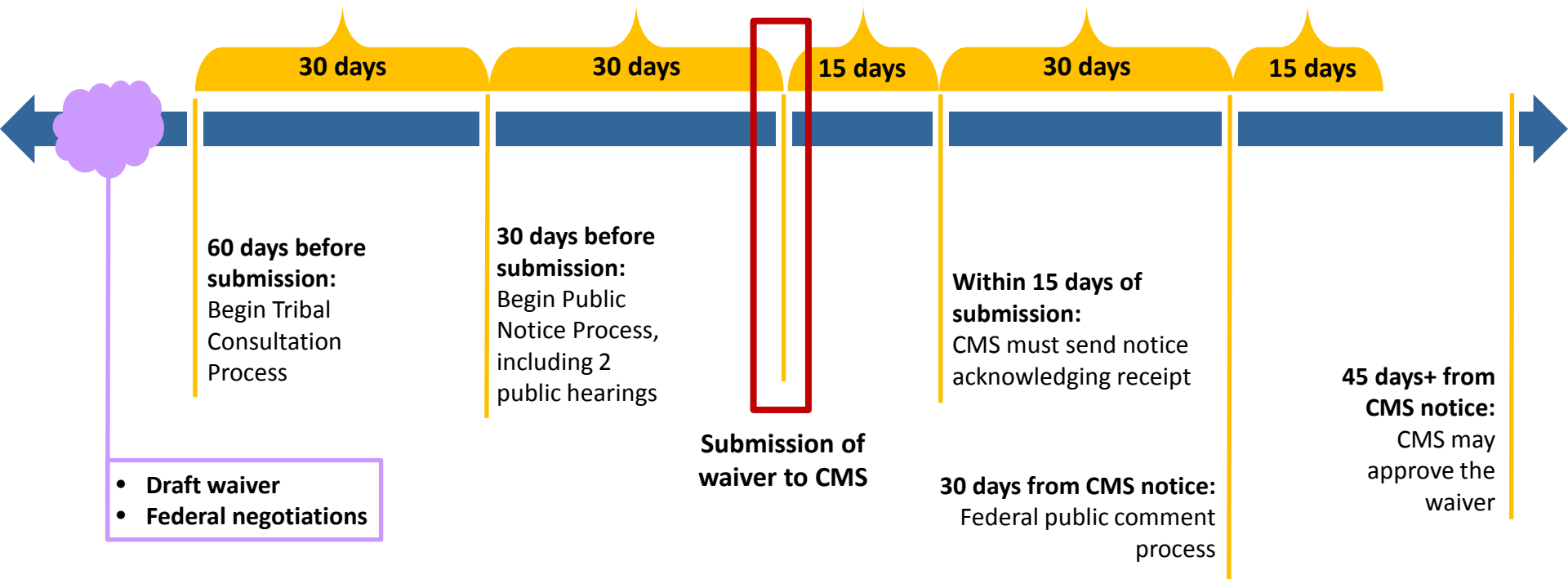
Medicaid Premium & Cost-Sharing Rules

	< 100% FPL	100% - 149% FPL	≥ 150% FPL
<i>Maximum Allowable Medicaid Premiums and Cost-Sharing</i>			
Aggregate Cost-Sharing Cap	5% household income	5% household income	5% household income
Premiums	Not allowed	Not allowed	Permitted, subject to aggregate cap
<i>Maximum Service-Related Co-pays/Co-Insurance</i>			
Outpatient services	\$4	10% of cost the agency pays	20% of cost the agency pays
Non-emergency ER	\$8	\$8	No limit
Rx Drugs	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: 20% of cost the agency pays
Institutional	\$75 per stay	10% of total cost the agency pays for the entire stay	20% of total cost the agency pays for the entire stay



- Specific services are exempt from cost-sharing, including emergency services, family planning and pregnancy-related services
- Specific populations are exempt from cost-sharing requirements (e.g., pregnant women, spend-down beneficiaries, and individuals receiving hospice). However, exempt individuals may be charged cost-sharing for non-preferred drugs and non-emergency use of the emergency room
- Services may not be denied for individuals who fail to make co-payments if their income <100% FPL; services may be denied for those with incomes >100% FPL
- If non-preferred drugs are medically necessary, preferred drug cost sharing applies
- Aggregate cost-sharing (inclusive of premiums) imposed on family with income <150% FPL may not exceed 5% of family income on a monthly or quarterly basis.
- States are required to track an individual's cost sharing contributions in order to determine when the 5% aggregate maximum is reached, if reasonable risk that beneficiary could reach the aggregate cap

Sources: SSA § 1916 and 1916A

1115 Waiver Submission & Decision Timeline



Approved State Marketplace Premium Assistance Programs

	Populations Covered	Benefit Variations	Premiums	Cost-Sharing	Healthy Behavior Incentives
Arkansas 	<ul style="list-style-type: none"> Newly eligible adults with incomes 0-138% FPL Medically frail excluded 	No coverage of non-emergency use of the ER	No	Yes <ul style="list-style-type: none"> Individuals with incomes 100-138% FPL only Applied to wide range of services 	No
Iowa 	<ul style="list-style-type: none"> Newly eligible adults with incomes 100-138% FPL who do not have access to cost effective ESI Medically frail excluded 	Non-emergency medical transportation waived for one year	Yes <p><i>100-138% FPL:</i></p> <ul style="list-style-type: none"> Up to \$10/month May be terminated for failure to pay for 90 days and do not request hardship waiver <p><i>50-100% FPL:</i></p> <ul style="list-style-type: none"> Up to \$5/month Payment not a condition of eligibility 	Yes <ul style="list-style-type: none"> Individuals with income 0-138% FPL Limited to \$8 co-payment for non-emergency use of the ER 	Yes <ul style="list-style-type: none"> May reduce premium obligations