Arkansas’ Approach to the Medicaid Expansion: Premium Assistance

As New Hampshire considers the opportunity to accept millions of dollars in federal funds to reduce the number of people without insurance, some policy makers are looking at an experimental approach embraced by the state of Arkansas as it seeks to extend Medicaid to more of its low-income workers.

Under an approach known as “premium assistance,” Arkansas proposes to use federal funds to purchase private health insurance for newly-eligible Medicaid beneficiaries. While the Centers for Medicare and Medicaid Services (CMS) have yet to grant final approval to Arkansas’ approach, other states, including Ohio and Louisiana, are considering this option as well.

This paper explains the basic framework of Arkansas’ premium assistance proposal, examines the federal standards that will have to be met in order to implement such an approach, and explores some of the issues that must be weighed.

It also raises a few cautionary flags based on circumstances specific to New Hampshire.

- The high cost of private insurance in New Hampshire could make the Arkansas model more expensive here. New Hampshire faces some of the highest private market insurance rates in the nation and pays some of the lowest Medicaid reimbursement rates. Initial estimates from the state Department of Insurance confirm that individual private market claims costs are expected to be 20 percent higher than comparable Medicaid claims in 2014.1

- New Hampshire has signed contracts with private managed care companies as part of the Medicaid managed care initiative. Premium assistance would, at minimum, require New Hampshire to revise these contracts significantly, since they appear to promise coverage of the newly-eligible Medicaid recipients to the three MCOs.

These and other related challenges should be thoughtfully and carefully weighed. In short, premium assistance offers a novel approach to extending Medicaid to more people, but may not be well suited to New Hampshire circumstances.
Arkansas’ Plan

Under current law, states may use federal Medicaid funds to pay the premiums for private sector health insurance for eligible beneficiaries, an approach known as “premium assistance.” However, premium assistance has, until very recently, only been permissible when a Medicaid eligible adult has an offer of employer-sponsored insurance. In that instance, Medicaid may pay the employee’s contribution towards the premium and any employee cost-sharing. In early 2013, CMS issued a proposed rule that permits Medicaid to provide premium assistance in the absence of employer sponsored insurance in the individual market as well, paving the way for the Arkansas proposal.

Under Arkansas’ proposal, the state would use federal Medicaid funds to purchase private health insurance coverage for eligible adults. Arkansas would purchase insurance for these Medicaid beneficiaries from among the individual private insurance plans available through the Health Benefits Marketplace (the Marketplace), established under the ACA. The Medicaid program would pay insurance premiums and supplemental cost-sharing subsidies directly to the insurance carriers who issue the policies in the Marketplace. According to a March memo outlining the Arkansas premium assistance approach, “…eligible low-income adults would apply for health insurance in the health benefits Marketplace, and if their income is found to be [within Medicaid eligibility limits] premium assistance would come from the Medicaid program.”

Two groups of Medicaid beneficiaries would be mandated to participate in Arkansas’ premium assistance initiative. The first group would be adults newly eligible for Medicaid under the ACA: namely, anyone aged 19 through 64 with an income under 138 percent of the federal poverty level (FPL) who is not already eligible for Medicaid in Arkansas. The second group would be parents with incomes under 17 percent of the federal poverty level, who are currently eligible for Medicaid in Arkansas. These two groups would select coverage from a particular category of insurance plans offered within the Marketplace.

The Health Benefits Marketplace

The ACA requires the establishment of a Marketplace in every state. Marketplaces are the center pieces of private health insurance reforms in the ACA. A Marketplace will be a place where individuals and small businesses can shop for and secure health insurance coverage that has been certified as having all of the required categories of health insurance, known as Essential Health Benefits. The Marketplace will also be the only place where individuals and families with incomes between 100 and 400 percent of the federal poverty level (FPL) will be able to obtain subsidies from the federal government to help them pay for their health insurance. People with incomes between 100 and 250 percent of the FPL who are purchasing health insurance in a health benefits marketplace will also have access to some cost-sharing subsidies, which will decrease their out-of-pocket costs further.
Importantly, Arkansas must still request and receive permission from CMS to waive federal regulatory requirements before it can implement a mandatory approach to premium assistance.

**Premium Assistance Must Meet Federal Standards for Approval**

In order for any state to use premium assistance, it must satisfy a number of federal standards. In particular:

- **The state must continue to provide Medicaid beneficiaries all of the Medicaid benefits to which they are entitled, even if they are not offered by a private plan:** Any state seeking to employ premium assistance must provide all required Medicaid benefits to Medicaid beneficiaries in the premium assistance program even if they are unavailable through the private health plan. For example, newly-eligible Medicaid beneficiaries are entitled to non-emergency transportation, a benefit which may not be provided by private plans. Thus, states must have mechanisms to provide “wrap-around” coverage to the extent that benefits in private market plans are less than those in Medicaid.

- **Medicaid beneficiaries cannot be forced to bear additional costs:** Any state seeking to employ premium assistance cannot require individual Medicaid beneficiaries to pay cost-sharing in excess of Medicaid cost-sharing limitations established in federal law, unless a waiver is obtained. For instance, under current law, cost-sharing for a beneficiary with income between 100 and 150 percent of the FPL may not exceed 5 percent of family income. The analogous cost-sharing protection in the Marketplace would constitute approximately 20 percent of income for an individual who does not choose Medicaid coverage and has income at 100 percent FPL or 12 percent of income for an individual with income at 150 percent FPL. States will need to have mechanisms in place to wrap around the private Marketplace cost-sharing to the extent that cost-sharing requirements in private coverage are greater than those in Medicaid.

- **Premium assistance must be cost effective:** The cost of premium assistance coverage, including administrative expenditures and any wrap-around benefits, must be comparable to what the state’s Medicaid program would otherwise pay for the same services.

- **Premium assistance must be voluntary:** In general, a state cannot require an individual who is eligible for Medicaid to enroll in premium assistance as a condition of Medicaid eligibility in the absence of a waiver. That is, a Medicaid beneficiary must be provided an alternative to a private insurer, if he or she so desires.

*Cost-Effectiveness Standard May Be Difficult to Meet*

One key question is whether the purchase of coverage through the Marketplace will prove cost effective, since private market coverage is expected to be more expensive than Medicaid. A recent report by Milliman, a national actuarial consulting firm,
suggests that health care costs in a premium assistance program may be 20 to 40 percent greater than costs incurred through a Medicaid-operated program.x This gap in costs likely holds true in New Hampshire, a state that offers some of the lowest Medicaid reimbursement rates and that faces some of the highest private market insurance costs in the nation.xi In fact, initial estimates from New Hampshire’s Department of Insurance confirm that individual private market claims costs are expected to be 20 percent higher than comparable Medicaid claims in 2014.xii

Moreover, as discussed above, in order to comply with federal regulations, states employing premium assistance must ensure that Medicaid beneficiaries receive full Medicaid benefits and enjoy full cost-sharing protections, even if they are enrolled in a private health plan in the Marketplace. This, in turn, may mean additional costs for the state, since it must have the administrative capacity to provide benefits and cost-sharing subsidies to the private health plans if necessary.

CMS has not yet made clear how it will measure cost effectiveness. At present, the standard for cost effectiveness that applies to other Medicaid and CHIP premium assistance programs requires the state to establish that the cost of covering an individual is the same or less than covering the individual in the direct Medicaid or CHIP program.xiii Nevertheless, CMS has suggested it may take a relatively broad view of cost effectiveness going forward. For instance, recent guidance from the agency specifically contemplates using the projected savings associated with reducing administrative “churn” as well as efficiencies that may result from having additional enrollees in the Health Benefit Marketplaces as factors in determining comparability of cost in the context of obtaining a premium assistance waiver.xiv, xv Cost will also be informed by which Medicaid benefit design the state chooses for the newly-eligible Medicaid population.xvi

In short, New Hampshire would likely struggle to meet the cost-effectiveness test and would likely require significant flexibility from CMS to move forward. Even if the agency were to accept a twenty percent difference in cost as comparable, the state’s share of the cost will reflect that cost increase.

Cost-Sharing Standard Also Difficult to Satisfy

Cost sharing in the Marketplace, even with available cost-sharing subsidies, is unlikely to meet the Medicaid out-of-pocket limitations that will still apply to Medicaid beneficiaries. Under current law, states have some ability to impose cost-sharing in Medicaid, the precise limits of which vary according to enrollee eligibility category, income level, and type of service provided.xvii In general, the total aggregate amount of cost-sharing that may be imposed in Medicaid for all individuals in a family with income between 100 and 150 percent of the FPL may not exceed 5 percent of the family income.xviii In other words, out-of-pocket cost limitations could be approximately $574 to $861 per person in 2013 dollars. Moreover, states are required to track a Medicaid beneficiaries’ cost sharing in order to determine when the five percent aggregate maximum is reached.xix For an individual with similar income who does not choose to enroll in Medicaid, the out of pocket limits for a Marketplace plan in 2014 may be as much as $2,083 in 2013 dollars for an individual with income between 100
and 200 percent of the FPL. Thus, bridging the cost-sharing gap for Medicaid beneficiaries may be a significant factor when providing wrap coverage and is likely to add to the costs New Hampshire would experience if it were to pursue an approach similar to the one Arkansas hopes to use.

**CMS Will Not Permit Every State to Use Mandatory Premium Assistance and Will Do So Only for a Limited Time**

In order to pursue a mandatory premium assistance program, a state will need to receive permission from CMS via a waiver. It should be noted, though, that a state does not need a waiver to enact a voluntary premium assistance program. If New Hampshire wanted to permit Medicaid beneficiaries to choose premium assistance to be used with either employer-sponsored insurance or individual coverage it could do so.

CMS recently issued guidance relative to premium assistance and the waivers that may be sought to implement the ACA’s Medicaid expansion through this approach. CMS made clear that it will grant only a limited number of waivers relating to premium assistance; in other words, not every state that applies for such a waiver will necessarily be granted one. CMS also made it clear in its guidance that it will only consider waiver proposals that include the following elements:

1. the state must provide participating beneficiaries with the choice of at least two insurance products;

2. the state Medicaid agency has made arrangements with private marketplace insurance plans to provide wrap benefits and cost-sharing and to collect appropriate data to ensure that coverage is seamless and that there is accountability for any additional benefits or cost-sharing provided;

3. the state excludes from premium assistance any Medicaid beneficiaries who have more complex needs, such as people living with disabilities or people who are considered medically frail, and;

4. the pilot program must end by the end of calendar year 2016.

CMS has also made it clear that a premium assistance waiver may be well received if it limits participation in the premium assistance program to eligible adults with incomes between 100 and 133 percent of the FPL, because this is the segment of the Medicaid population most likely to fluctuate in and out of Medicaid eligibility due to income changes and thus may be best suited for being in a private market network. These baseline waiver parameters will be important to consider for any state exploring the premium assistance approach.

In pursuing a waiver a state can ostensibly seek to waive any component of federal law. It could ask for flexibility in satisfying any of the regulatory provisions that currently guide premium assistance. Still, states should proceed carefully because waivers may yield unanticipated results. For example, if cost-sharing protections are
waived, many Medicaid beneficiaries may find the cost-sharing unaffordable. Cost sharing, if set too high, can be a financial barrier to accessing care, especially for those with low income and significant health care needs. People may delay care or not seek it, which may result in adverse health outcomes.\textsuperscript{xiv} The disadvantage to the state of seeking increased cost sharing may be to create conditions that foster unmet medical need, which is counter to the health care reform efforts New Hampshire is pursuing through its Medicaid Care Management initiative.

Again, a state could attempt to move forward with a voluntary premium assistance program, thus avoiding the need for a waiver. However, doing so would mean the state could be exposed to wider cost volatility, because it would not be able to control how many Medicaid members would enroll in the premium assistance program. Conversely, the state may find it difficult to meet the cost-effectiveness standard without a waiver that would allow the state to mandate a fixed number of Medicaid beneficiaries into premium assistance.

**Premium Assistance Would Require Significant Restructuring of Medicaid Care Management Contracts**

In addition to meeting the preceding federal standards, New Hampshire would need to address the impact of premium assistance on its Medicaid Care Management initiative. In 2012, New Hampshire executed contracts to administer the Medicaid program through three managed care organizations (MCOs). Each of these contracts has a three-year term with each year representing a new phase of implementation. These contracts appear to promise the coverage of anyone newly eligible for Medicaid under the ACA in 2014 to the participating MCOs, should New Hampshire move forward with the expansion.\textsuperscript{xv} Premium assistance would, at minimum, require New Hampshire to revise these contracts significantly, since they currently appear to promise the coverage of the expansion population to the three MCOs.

There may be options for restructuring the contracts, however. For example:

- New Hampshire could seek to revise the existing contracts to require all three MCOs to offer federally-compliant alternative benefit plans within the health benefits Marketplace exclusively for Medicaid members.

  - On the negative side, the state could potentially establish a mechanism to enroll the Medicaid beneficiaries automatically into one of the three MCO Marketplace products to guarantee the MCOs the beneficiaries they were expecting to enroll. Guaranteeing this particular set of beneficiaries to particular insurance carriers may, however, diminish the competitive advantage of having any or all of the Marketplace insurance products compete to cover these additional lives.

  - On the positive side, having a health benefits plan that is solely for Medicaid beneficiaries in the Marketplace could potentially produce a Medicaid compliant cost-sharing and benefit design that could minimize or eliminate the
need for the state to provide wrap benefit coverage or cost-sharing protections because those features could theoretically be built into the product design offered by the MCOs.

- New Hampshire could also restructure the contracts to require the MCOs to offer a second insurance product in the Marketplace for people who have incomes too high to qualify for Medicaid, as a mechanism to minimize the disruption and the cost from churn. This would present an opportunity to introduce additional products into the Marketplace that are available to all members, which may be an advantage to the overall vigor of the Marketplace.

- New Hampshire could target participation in premium assistance products solely to eligible adults with incomes between 100 and 133 percent FPL. This is the sector of the Medicaid population most likely to fluctuate in and out of Medicaid eligibility due to income changes and thus may be best suited for being in a private market network. The remainder of the Medicaid expansion population with incomes below 100 percent FPL would remain in traditional or direct Medicaid, which would still be administered by the managed care organizations outside of the Marketplace.

- New Hampshire could permit eligible adults to choose from any products in the Marketplace. However, if it did so, it may lose its ability to reform and monitor the delivery of health care services that it has under the current Care Management contracts. Questions exist about whether Marketplace products offered to Medicaid populations would have to meet similar rate evaluation and data and quality reporting requirements as Medicaid managed care plans do in any event.

Of note, the premium assistance program in Arkansas is occurring in a Medicaid program with no participation by managed care organizations. In fact, Arkansas has very little managed care penetration in the commercial health insurance market either, with only 3.4 percent of the entire state population in an HMO product.

**The Impact of Premium Assistance on the Marketplace**

Having adults newly eligible for Medicaid covered in the Marketplace may have consequences for the rest of the products in it. Milliman questions whether premium assistance may result in higher premiums in the Marketplace, depending on how some risk adjustment tools used in the Marketplace are affected by including this population. These issues would largely turn on whether the Medicaid expansion population would be in a segregated Medicaid-only product. In any event these questions and scenarios need to be carefully explored in order to understand how having these additional lives in the Marketplace would affect the rest of the products offered.

More immediately, the deadline for insurance carriers in New Hampshire to submit data and applications to the state for insurance products to be offered in the Marketplace for 2014 is June 1. Consequently, undertaking these contract amendments or negotiations may be a practical difficulty for all of the MCOs unless
they have already submitted applications to offer Marketplace plans for coverage in 2014 or notified the state that they plan to do so.

New Hampshire may well obtain the private market efficiencies it seeks by continuing with the Care Management effort it has already initiated. The initial term of the contracts run through 2015. The state could take that time to complete the implementation of the Care Management system, while simultaneously evaluating the performance of the Marketplace. This would give the state much needed time to evaluate whether a Marketplace product for Medicaid beneficiaries is desirable for the state, Medicaid beneficiaries, or the participants in the Marketplace.

Conclusion

All of these complex questions warrant careful exploration. Before moving forward with premium assistance, New Hampshire would need to confirm what additional cost it may incur by using such a model. The state also would need to confirm what affect a premium assistance product would have on the Marketplace. Finally, New Hampshire would need to determine what changes would need to be made to the Care Management program already initiated within New Hampshire Medicaid. New Hampshire may be able to achieve private market efficiencies through its current Care Management initiative without using a premium assistance model. Ultimately, should policymakers wish to deploy premium assistance, they should do so only if it can be used without driving the state to incur additional costs, discouraging Medicaid beneficiaries from seeking needed care, or needlessly frustrating the goals of the Medicaid Care Management initiative.

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i Conversation with Tyler Brannen, Policy Analyst, New Hampshire Insurance Department, April 2013.
ii 42 USC §1396d(a)
iii 78 Fed. Reg. 4696 (§ 431.1015)
iv Arkansas private option CMS letter, 3-13-13, obtained via email on 4-10-13.
v Arkansas private option CMS letter, 3-13-13, obtained via email on 4-10-13; see also Arkansas legislation http://www.arkleg.state.ar.us/assembly/2013/2013R/Bills/HB1143.pdf
vi 42 CFR §435.1015
vii Even if a cost-sharing waiver is obtained, there is a high standard for receiving one, which appears to include these requirements: that the copayments are used to test a unique and previously untested use of copayments; be limited to a period of not more than 2 years; to provide benefits to the recipients reasonably expected to be equivalent to the risks to the recipients; be based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and be voluntary or make provision
for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation. Social Security Act §1916(f)

Social Security Act §1916(A)(e)

ACA §1402(c)(1)(A)(i) directs that people with incomes between 100 and 200 percent FPL who purchase health insurance through the Marketplace will have out of pocket limitations that are one third of the out-of-pocket maximum for health savings account compatible high-deductible health plans (HDPs). In 2013, that limit was $6,250, one third of which is $2,083.

"Considerations for Medicaid expansion through health insurance exchange coverage," Robert M. Damler, Kaitlyn Shaw, and Seema Verma, Milliman Health Care Reform Briefing Paper, April 2013, pp 2. Initial data from the New Hampshire Insurance Department indicates that private insurance claims cost would be at least twenty percent higher than Medicaid costs in the state.

See State Health Facts, Kaiser Family Foundation at http://kff.org/statedata/

Conversation with Tyler Brannen, Policy Analyst, New Hampshire Insurance Department, April 2013.


States must provide a "benchmark" Medicaid benefit to the newly eligible adult population. This benefit may be a slightly slimmed down Medicaid benefit that also covers the ten essential health benefits required in the private market and is compliant with mental health parity as required under federal law. This may mean the benefit is priced differently than the standard Medicaid benefit. However, it also means that multiple Medicaid benefit designs would have to be managed. Moreover, certain groups of Medicaid beneficiaries are entitled to standard Medicaid benefits and thus would have a differently priced plan if they were targeted for participation in premium assistance. The groups of Medicaid beneficiaries entitled to standard benefits are pregnant women, the blind and disabled, dual eligibles, terminally ill hospice patients, mandatory TANF parents and care takers, people with disabilities that impair ability in one or more activities of daily living, foster children, individuals who qualify for long-term care services because of their medical condition, individuals who qualify for spend down, and individuals who qualify for emergency care. CMS has indicated however, that many of these groups would not be welcome in a mandatory premium assistance program.

Cost sharing for individuals below 100 percent FPL was limited to a nominal amount of $3.80 for FY 2012 per service. For individuals with income between 100-150 percent FPL, it can be up to $7.60 per service. Proposed rules on cost sharing from January 2013 did not increase the aggregate cap, but did increase the amount of co-pay or co insurance a beneficiary may pay by a small amount. Social Security Act §1916A(e)

Charging premiums is prohibited in Medicaid for people with income below 150 percent FPL; only cost sharing within these income ranges is permitted. The norm within Medicaid, especially for beneficiaries with income below 100 percent FPL is for the cost sharing to be nominal, with maximum out of pocket costs for a particular service being no more than $3.80 under current regulations. Social Security Act §1916A(e). Proposed new regulations may increase this nominal amount slightly.

42 CFR §447.64.

ACA §1402(c)(1)(A)(i) directs that people with incomes between 100 and 200 percent FPL will have out of pocket limitations that are one third of the out-of-pocket maximum for health savings account compatible high-deductible health plans (HDPs). In 2013, that limit was $6,250, one third of which is $2,083.


Standards to waive some regulations are very high. See Note VII.

Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013, pp 6-10, Table 2.

At the time the contracts were executed, the US Supreme Court had not yet ruled on the Affordable Care Act and the Medicaid expansion was still mandatory for all states. See also, New Hampshire Medicaid Care Management Contract, Exhibit A. §8 Covered Populations and Services, §8.1 Covered Populations Matrix.
Ohio may be pursuing this style of waiver, also. CMS has made it clear that it does not want Medicaid beneficiaries who have the need for broad benefit designs to be in mandatory premium assistance programs. In New Hampshire people with disabilities or pregnant women may have income eligibility above these levels but would not be welcomed by CMS as participants in a premium assistance program. See Medicaid and the Affordable Care Act: Premium Assistance, FAQ, March 29, 2013, accessed at [http://medicaid.gov/FederalPolicyGuidance/Downloads/FAQ03-29-13-Premium-Assistance.pdf](http://medicaid.gov/FederalPolicyGuidance/Downloads/FAQ03-29-13-Premium-Assistance.pdf).


Arkansas does have two managed care programs, however: one provides non-emergent transportation to Medicaid members and the other uses a managed care model called primary care case management, in which care is coordinated by primary care providers in a fee for service setting without any MCO network or administration. Medicaid Managed Care Enrollment Summary Statistics as of July 1, 2011, CMS; National Summary of State Medicaid Managed Care Programs, CMS, as of July 2011.


xxvi Specifically, the reinsurance, risk corridors and risk adjustment provisions relative to the Exchange.