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UNDER THE MICROSCOPE

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PREMIUM ASSISTANCE: THE "PRIVATE OPTION" MEDICAID EXPANSION ALTERNATIVE

ISSUE.

We have just passed the third anniversary of the Affordable Care Act; it's almost a year since the Supreme Court's decision upholding the law, and we've got but 6 months before key program elements go into effect. Yet, a number of states continue to debate whether to pursue the ACA's Medicaid expansion option for newly eligible populations. As a reminder, Medicaid expansion broadens program coverage to include individuals with incomes of up to 138% of the Federal poverty level (around $22,350 for a family of four). And, to ensure access to quality, cost-effective, affordable health insurance, the ACA requires insurers, including Medicaid, to cover a comprehensive package of items and services—Essential Health Benefits—spanning 10 categories: (1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) *Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7)Rehabilitative and habilitative services and devices; (8)* Laboratory services; (9) *Preventive and wellness services and chronic disease management*; and (10) Pediatric services, including oral and vision care. To be certified and offered through the state health insurance marketplaces, insurers (including those in the individual and small group markets) must cover these benefits by 2014. All state Medicaid plans, too, must cover these categories by that date. and the coverage must be "equitable" across the categories.

Despite these requirements, the incentives for expansion, nonetheless, represent a remarkably good deal for the states. In the first 3 years, the federal government will pay 100% of the costs of covering newly eligible individuals. After that, the federal share will drop to 90% on a permanent basis; a state's 10% match is considerably lower than current matching requirements for today's beneficiaries. According to some estimates, ACA-related Medicaid spending of around 2.8% above current rates will be more than offset by savings to states of some $101 billion between 2014 and 2019. It's a potential real windfall for many states, since, under the traditional state-Federal Medicaid partnership, they only get a Federal payment of between 50-75% of total costs.

Notwithstanding the high Federal contribution, not all states are moving forward with Medicaid expansion. While 23 states (and the District of Columbia) are moving forward with Medicaid expansion, 19 have declined to participate primarily due to a combination of cost and political concerns. Of the remaining eight, six are leaning toward nixing Medicaid expansion; the other two are likely to adopt expansion. But among a handful of states that initially rejected expansion, the potential loss of significant federal dollars, coupled with longer-term consequences—e.g., large gaps in coverage for millions of low-income people—have given rise to creative thinking, yielding some novel alternatives to the ACA's statutory Medicaid expansion. They don't want to wait until 2017 to apply to HHS for innovation waivers designed to enable them to conduct demonstration projects that test coverage alternatives to Medicaid in the new health insurance marketplaces. Rather, they want to implement their alternative programs as substitutes for Medicaid

expansion right now, enabling them to collect the 100% Federal funding.

One approach gaining traction in largely conservative states involves using Federal Medicaid expansion dollars to provide "premium assistance" to newly eligible Medicaid beneficiaries, enabling them to purchase private coverage through the ACA's health insurance marketplaces. To its proponents, this "private option" is a middle ground, a way to have one's cake and eat it, too. A state can reap the benefit of 100% Federal Medicaid expansion funding and, at the same time, promote the private sector and 'personal choice.' Some argue premium assistance can curb excessive Medicaid spending. Others argue that any cost-efficiencies likely would be offset by the costs to private insurers of including the range of EHBs demanded by the ACA.

Answers are likely to come as the result of recently enacted premium assistance plans that have become law in both Iowa and Arkansas. The two programs are not identical; both will require HHS waiver approval to become practice; and both are the subject of this issue of *Under the Microscope.*

ANALYSIS.

As the issue of premium assistance has moved forward over the past 6 months, HHS has established some parameters under which proposed 'private option" programs may move forward as alternative routes to expanded Medicaid coverage under the ACA. In a March 29, 2013, memo, HHS clarified that:

- States have long been allowed to pay premiums for adults and children to purchase coverage through private group health plans (and, in some cases, individual plans), as long as the private plans are cost-effective. That is, the cost and scope of benefits provided under a private option must be comparable to the full benefit package available and paid for under standard Medicaid.
- States must extend eligibility to *everyone* earning up to 138% of the federal poverty level. They may not cherry-pick age brackets to include or exclude from coverage.
- HHS will consider a "limited number" of *demonstration waivers* that enable specific states to use Medicaid expansion funding as premium assistance to purchase plans available through the exchanges. Such demonstrations would be required to end by the start of 2017 and demonstrate their cost effectiveness (including savings related to such issues as reduced churning and increased competition).

With the HHS guidance as prelude, we now explore Iowa and Arkansas, the two states in the forefront of the premium assistance movement. In both cases, the green light to move this option forward was given by the legislature and signed into law by the governor. However, there are marked differences –particularly in Iowa, where a number of additional, potentially burdensome, requirements are placed on the new beneficiaries themselves. And remember, nothing can move forward without HHS approval of a formally submitted waiver from each state's Medicaid authority.

ARKANSAS.

In February, Arkansas entered into discussions with HHS about the potential implementation of a premium assistance alternative to traditional Medicaid for newly eligible beneficiaries under the ACA's Medicaid expansion provision. As the result of those discussions, HHS spelled out a number of specific parameters that must be met for Arkansas to successfully gain a waiver for the alternative. Specifically:

- Partial expansion to some, but not all, of the new beneficiaries in the 100-138% of federal poverty is not possible, whether by class of person or income level.
- A premium assistance option must meet the current "cost-effectiveness" criteria required under the Medicaid statute and provide the full range of benefits and cost-sharing protections available under traditional Medicaid—including, so-called "wrap around" coverage to bolster private coverage that has fewer benefits and greater out-of-pocket costs than Medicaid.

- HHS will consider approving waivers for only a limited number of premium assistance demonstrations, and only through the end of 2016, with the understanding that the outcomes will inform policy for state innovation waivers beginning in 2017.

The effort was undertaken in an effort to find a work-around to a fractured State government that might not accept Medicaid expansion as proposed in the ACA. Some legislators—primarily Democrats—supported the notion of Medicaid expansion for people from 100-138% of the federal poverty level. However, the majority in the Republican-controlled legislature did not. Thanks to the work by the Governor, the legislature enacted a compromise by a narrow margin: a premium assistance approach that will pay private insurers to cover as many as 250,000 Arkansas residents newly eligible for public coverage as the result of Medicaid expansion. The measure was signed into law by the Governor in April, resulting in further rounds of discussions with HHS about securing a State waiver to make the premium assistance program a reality.

While HHS gave a nod in principle to Arkansas' proposal to use Medicaid funds to buy private coverage in qualified health plans through the State's health insurance marketplace, the Department has yet to approve the plan formally. In part, that's because Arkansas must now submit a formal waiver request. The aim is to secure approval before the end of August.

IOWA.

With a split legislature – a Democrat-controlled Senate and Republican-controlled House—enactment of full ACA Medicaid expansion never stood a chance. Both the Governor and House objected to the scope of the expansion, and feared the federal share might be dropped, leaving the State with the added expense. In contrast, the Senate supported bringing people from 100-138% of the federal poverty level – many people with behavioral disorders—under the Medicaid program. The impasse was broken through a brokered compromise approved on the last day of the legislative session. The outcome, the Iowa Health and Wellness Plan, now signed into law by Governor Branstad (R), is expected to provide coverage for about 150,000 additional Iowans.

According to one of the compromise brokers, the Iowa Health and Wellness Plan has been described as "full Medicaid expansion with a twist." Under the plan, if approved by the Centers for Medicare and Medicaid Services (CMS), Iowans with incomes at or below 100 percent of poverty will be enrolled in Medicaid with a benefit package similar to that offered to state employees. Those with incomes between 100 and 138% of the federal poverty level (about a third of those 150,000 newly eligible individuals) will be enrolled in a premium assistance program. Medicaid will pay premiums for these individuals directly to insurers that offer coverage through the health insurance marketplace.

The Iowa measure requires that, beginning in year 2, beneficiaries with incomes between 50-138% of the federal poverty level will be required to contribute to their insurance premiums. [Thus, people now on standard Medicaid will be paying a premium for the first time.] According to Governor Branstad's office, the premium payment will be required *instead of* standard Medicaid copays and will be determined using an income-associated sliding scale. To curb excessive costs and abuse of emergency room services, beneficiaries who use ED services will be charged a nominal copayment. And, in lieu of the full current Medicaid benefit package, benefits under the Iowa Health and Wellness Plan will look more like those available to state employees, with the addition of mental health and dental benefits to meet Essential Health Benefit requirements. Additionally, the plan requires all Medicaid beneficiaries to join an Accountable Care Organization that provides integrated service delivery. The "Medicare expansion with a twist" concept comes in the form of a "personal responsibility" clause, seen by some as rather pernicious and clearly separates it from Arkansas' premium assistance proposal. Beginning in year 2, under this provision, called "My Health Rewards," insurance premiums can be waived for individuals who participate in certain health and wellness activities. We can only assume this refers to such things as exercise, not

smoking, reducing obesity, refraining from drugs and excessive alcohol use, lowering cholesterol levels, etc. We do not know whether and which specific "healthy activities" will be identified, what yardstick will be used against which to measure progress, or even who will make the annual determinations for each beneficiary with income between 50-138% of poverty.

What we do know is that the Iowa Health and Wellness Plan has a clear idea about how to safeguard itself against additional Medicaid costs in the years ahead. The new law protects State coffers against a feared reduction of federal Medicaid expansion contributions below the 90% level established under the ACA by requiring hospitals to cover the first 5% of Medicaid expansion costs below that level. And we also know that the Iowa plan, like the Arkansas plan, will require a waiver from HHS. To date, none has been forthcoming. Stay tuned.

NEXT STEPS.

Along with Arkansas and Iowa, a number of other states are considering the premium assistance option. For example, Tennessee's governor announced the state is reviewing this alternative model as a way to use federal dollars to shift Medicaid-eligible groups into private health plans. A few months ago, Indiana asked HHS for a waiver to expand coverage to eligible residents through the state's Healthy Indiana Plan. Ohio has similar plans, as do a number of other states.

Clearly, this private option is an appealing option for conservatives who rail at the idea of Washington-based programs and want to "get government out" of health care. But whether it works as a viable alternative to Medicaid and the ACA remains in question. Advocates of the option speculate that exchanges may offer more efficient cost sharing, greater competition, reduced fraud, less churning, higher reimbursement rates, and better provider networks.

However, not all of the states choosing premium assistance are likely to see all of these benefits. In fact, the cost to an individual state may be higher than traditional Medicaid. People enrolled in private plans using premium assistance options in lieu of traditional Medicaid still must receive Medicaid-level benefits, including wraparound coverage for services that private plans may not offer. Thus, in Iowa, the costs will rise when the State must upgrade current benefits available through both traditional Medicaid and by private insurers to include currently excluded essential health benefits such as community-based behavioral health care. Equally, man-hours and costs will rise, perhaps substantially, when implementation of the Iowa Health and Wellness program demands creation of at least three separate programs, mechanisms and rosters for the different categories of beneficiaries:

1. Traditional Medicaid beneficiaries (those under 50% of the federal poverty level) who will pay no premiums;
2. Premium assistance beneficiaries (50-138% of federal poverty level) insured through the State's health insurance marketplace who will pay premiums based on a sliding scale. And, beginning in the second year, two subsets of this group – one that pays no premiums thanks to healthy behaviors, and another for those who will pay premiums for not meeting health and wellness requirements.
3. Other individuals being insured through the State's health insurance marketplace mechanism.

Whether dollars will be saved or not, nothing will move forward in Iowa, Arkansas or elsewhere without HHS approval. Whatever does move forward can do so only as short-term demonstration programs that must show cost-effectiveness and be completed by the end of 2016. And HHS will not approve any private-option waiver that fails to include fewer covered services than required under the ACA and Medicaid as essential health benefits.

Thus, much remains to be resolved, including how many states will now pursue the premium assistance approach. And remember, a state's decisions this year, whether on the premium

assistance option or the broader Medicaid expansion itself, are not binding. According to HHS, states may elect to participate in the Medicaid expansions at any time in the future. Thus, if Iowa and Arkansas succeed in their efforts, then other conservative jurisdictions now considering the option—among them, Florida, Pennsylvania, Texas and Tennessee, among others—may jump at the opportunity.

Our role at this point is to be vigilant and ready to take action to ensure that the ACA's aim – health care access and coverage for people at greatest risk, such as those we serve – is achieved. Our role at this point is to ensure that as many of our low-income consumers as possible who now lack health coverage gain access to it through the ACA's Medicaid expansion and health insurance exchanges, no matter how they are structured, no matter by whom they are managed. And our role at this time is to work together to ensure that the mission of the ACA is achieved. After all, as Emerson said, "health is our first wealth." Let's all work together—and encourage others to do as as well—to grasp the opportunity to enrich our nation with health as envisioned in the ACA.

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