Premium Assistance in Medicaid. States have proposed using expansion funds to buy private coverage for Medicaid beneficiaries through the new health insurance exchanges.

**WHAT’S THE ISSUE?**

Nearly a year after the US Supreme Court’s June 2012 decision declaring the Affordable Care Act’s (ACA’s) Medicaid expansion optional, states continue to grapple with whether or not to pursue the option for newly eligible populations. Although the Medicaid expansion accounted for about half the total number of people projected to gain coverage under the ACA, many states to date have declined to expand Medicaid or are leaning toward rejecting the option because of cost and political concerns. But the long-term consequences of denying the Medicaid expansion, especially large coverage gaps for millions of low-income people, are also prompting some states to consider novel alternatives for extending Medicaid under the ACA.

One approach that has piqued states’ interest is using the additional federal funds as “premium assistance” for eligible Medicaid beneficiaries to purchase private coverage through the law’s new health insurance exchanges.

This middle ground or “private option” appears more politically tenable for states led by conservative lawmakers intent on moving more people into the private market. Proponents of the Medicaid premium assistance option also tout it as a potential path to lowering Medicaid spending, perhaps driving down private exchange costs over time and reducing the cyclical movement of beneficiaries between Medicaid and the exchanges based on their fluctuating incomes.

Skeptics of premium assistance contend the option is less attractive than first thought. States must show that the novel model is cost-effective compared to enrolling people in Medicaid. They must also ensure that the coverage provided through exchange plans is consistent with federal Medicaid requirements, including the scope of benefits provided and cost sharing. Another hurdle is that both states’ legislatures and the federal government have to approve states’ premium assistance plans.

This policy brief examines a range of policy issues surrounding premium assistance using Medicaid expansion funds and next steps for states.

**WHAT’S THE BACKGROUND?**

In June 2012 the Supreme Court upheld the constitutionality of the ACA’s individual insurance mandate requirement that people must have “minimum essential” health insurance coverage. New state-based health insurance exchanges (or “marketplaces”) will offer private coverage options to millions of Americans required to purchase such coverage unless they qualify for a specific exemption as stated in the law. Less expected was the court’s decision to strike down mandatory expansion of Medicaid coverage—part of the law’s two-prong approach, along with the
individual mandate, for substantially extending health insurance coverage nationwide. Since the Court’s ruling, states have carefully considered the many variables associated with expanding their Medicaid rolls and setting up and operating their exchange either independently or with federal support.

The exchanges are set to begin enrollment in October 2013, with coverage taking effect January 1, 2014. As of May 2013, 17 states and the District of Columbia will operate their own exchanges, and 7 states plan to operate state-federal partnership exchanges in which states may administer plan management functions, in-person consumer assistance functions, or both. The federal government will oversee other exchange functions. Another 27 states are not able or willing to establish a state-based exchange. They are planning to default to the federal government to operate all functions of their exchanges—a much larger number than the federal government originally anticipated.

To complement the major gains in coverage created by the state-based exchanges (projected to cover an estimated 25 million people by 2016), the federal government also expected states to expand Medicaid, covering up to an additional 16 million people. The ACA was written under the assumption that the Medicaid expansion would be universal, with all states expanding Medicaid to nearly all adults under age 65 with incomes below 133 percent of the federal poverty level, or about $22,350 for a family of four in 2011. For the first three years of the new expansion, 2014–2016, the federal government will pay 100 percent of the costs of covering newly eligible people. After 2016 the federal contribution will decrease over time to 90 percent by 2020. This contribution (called the Federal Medical Assistance Percentage, or FMAP) is greater than the federal contribution for traditional Medicaid, which usually ranges between 50 percent and 76 percent of the total Medicaid spending in each state.

The underlying Medicaid statute gives the federal Department of Health and Human Services (HHS) discretion to withhold federal Medicaid funds from states that do not comply with federal law. As a result, many state officials feared that after the ACA was enacted, their traditional Medicaid funding would be contingent on their accepting the program’s expansion in their state. This gave them no real choice, they said. Twenty-six states filed suit, claiming that this potential loss of funding was so great that it was unduly coercive. A majority on the Supreme Court agreed with the coercion argument, ruling in June 2012 that states declining the Medicaid expansion would lose only the new Medicaid expansion funding.

As of May 2013, 23 states as well as the District of Columbia have endorsed the Medicaid expansion and are participating. Another 19 states have declined to participate in the program, in great part because of political opposition to “Obamacare” (Exhibit 1). In Texas, which declined the expansion, 1.8 million people will be precluded from enrolling in Medicaid. The same number would be eligible for the Medicaid expansion in Florida, which is supported by the state’s governor but not its legislature. Of the remaining undecided eight states considering the expansion, six are leaning toward not participating, and two are leaning toward accepting the option. In three states that initially declined the expansion to varying degrees—Arkansas, Tennessee, and Indiana—lawmakers have begun to look for alternative solutions, given that millions of vulnerable and low-income Americans will remain uninsured. This has led them to reconsider their initial opposition and investigate other approaches to the Medicaid expansion.

Starting in 2017 states can also apply for innovation waivers, allowing them to conduct demonstration projects that replace Medicaid in the new private exchanges with various coverage alternatives. But some states do not want to wait until 2017 to test models they believe will provide better care at lower cost.

### WHAT’S THE PROPOSAL?

In February 2013 Arkansas initiated discussions with HHS about premium assistance options for Medicaid. Arkansas Democrats wanted the optional Medicaid expansion to help citizens not previously eligible for public coverage, but the state’s Republican-led state legislature did not. However, the legislature later endorsed, by a narrow majority, the premium assistance approach as a compromise, and Gov. Mike Beebe signed the bill into law in late April. It will assist between 200,000 and 250,000 residents in Arkansas who earn up to 138 percent of the poverty line, or just over $15,000 annually.

Although HHS endorsed Arkansas’s novel proposal to use Medicaid funds to buy private coverage in qualified health plans through the exchange in concept, it has yet to formally ap-
prove the plan. Other states, including Ohio, Tennessee, Florida, and Pennsylvania, also expressed keen interest in the premium assistance option. Some analysts saw the proposal as a “Medicaid game changer” that offered financial incentive for states to add more people and demonstrated the federal government’s commitment to offer states even more flexibility to run their programs.

A December 10, 2012, question-and-answer memo sent from HHS to the states noted, “Under Medicaid and CHIP statutory options, states can use federal and state Medicaid and CHIP funds to deliver Medicaid and CHIP coverage through the purchase of private health insurance.” In a follow-up March 29, 2013, clarifying memo, HHS explained more specifics for states pursuing the premium assistance mechanism:

First, HHS again made clear 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 they are “cost-effective.” In other words, the cost of covering Medicaid beneficiaries using the premium assistance approach must be comparable to the cost that Medicaid would otherwise pay for the same services. And that comparison must take into account the total cost of providing the required “full” Medicaid benefit package—that is the private plan premiums plus the cost of additional wrap-around coverage plus cost-sharing assistance.

Second, HHS reaffirmed its earlier announcement that premium assistance cannot be used for only a partial expansion of Medicaid. States that choose to use the enhanced federal matching funds for Medicaid expansion must extend eligibility to everyone in the new adult group (nearly anyone ages 19–65) earning up to 133 percent of the federal poverty level.

Third, HHS said that it would consider approving a “limited number” of demonstration waivers for states to use the new Medicaid funding as premium assistance to purchase plans available through the exchanges. The coverage is still required to be “cost-effective,” but HHS will consider “new factors introduced by the creation of [exchanges] and the expansion of Medicaid,” such as savings from reduced churning and increased competition.

Finally, HHS explained that all demonstrations must conclude by the end of 2016, because the purpose of granting these waivers is to help inform policy for the state innovation waivers that will begin in 2017.

In April, when signing the Medicaid expansion premium assistance option into law, Arkansas Governor Beebe said many premium assistance details must be worked out for each state applying: “Our work is just beginning. There’s a lot of i-dotting, t-crossing, and follow ups that have to occur.” Other states are continuing health care delivery option discussions with federal officials. Along with Arkansas, Tennessee’s governor also announced the state was reviewing the alternative model that would use federal funds to shift Medicaid eligible groups into private health plans. In April Indiana also submitted a waiver to HHS asking to expand coverage to eligible residents through the state’s Healthy Indiana Plan.

Overall, the decisions that states make this year on both the premium assistance option and the larger Medicaid expansion are not binding. The federal government indicated that states may elect to participate in the Medicaid expansions at any time in the future.

**WHAT’S THE DEBATE?**

With many states declining the Medicaid expansion, Arkansas’s premium assistance proposal attracted national attention as a way...
around staunch political opposition. Advocates of the model expressed early excitement about what they viewed as a truly transformative coverage development—one that also offered states substantial flexibility while potentially promoting competition in the marketplace.

Perhaps initially overlooked by some advocates of the premium assistance option, however, was that traditional Medicaid protections would continue to apply: It’s long-settled federal policy that people who are enrolled in private plans under premium assistance options need to receive Medicaid-level benefits and cost sharing. Reminded of these requirements by HHS, more criticism of the model emerged with analysts like Avik Roy arguing that the novel model is not premium assistance as advocated but rather “private sector window-dressing on a dysfunctional Medicaid program.” Although somewhat controversial from the start, the model may be attractive for states that can make it work by addressing program requirements.

**Cost:** Among the major concerns for expanding premium assistance is whether it will prove to be cost-effective on the individual market. As mentioned previously, Medicaid requires states’ private coverage purchases to be “cost-effective.” This will be shaped in the short run and over the long term, by factors like market rates in the exchanges—which may decrease with competition for new enrollees—as well as Medicaid’s reimbursement rates—which may increase to convince more providers to treat millions added to the program. The Congressional Budget Office determined that covering each recipient through an exchange will, on average, cost the federal government an additional $9,000 per year versus $6,000 through the regular Medicaid delivery system.

However, in an internal review by its Department of Human Services, Arkansas took into account factors that are unique to Arkansas and make premium assistance more affordable there than in other parts of the country. Its review reported that expanding Medicaid via exchanges would cost only 13–14 percent more than traditional Medicaid but possibly less under the theory that Medicaid would pay much higher rates to cover the newly eligible population. However, there are many competing proposals for Medicaid reform, including those to limit federal spending. (See the Health Policy Briefs published January 12, 2012, and April 18, 2013, for more information on Medicaid reform.)

It is unknown whether an expansion through the exchanges will cost both the federal government and states more over the long term because states will not begin chipping in funds to supplement the declining federal match for another three years. Because the federal government is paying 100 percent for the first three years, some states may not be as focused on this cost issue. At some point, a cost-effectiveness formula will need to be developed to assess the demonstration projects’ effectiveness.

Another cost concern relates to cost sharing. As per HHS’s March memo, the premium assistance option must ensure Medicaid protections around cost sharing: Federal rules allow states to impose cost sharing, such as copayments and deductibles, on people insured through Medicaid, but there are limits on these cost-sharing measures to make sure they don’t keep people from getting the services they need.

Program supporters view this requirement as a way to limit out-of-pocket spending by enrollees; critics believe historically low levels of cost sharing for deductibles and copays (sometimes only $5 for an emergency room visit under Medicaid) create an incentive for patients to seek unnecessary, wasteful treatment. They argue that imposing Medicaid’s traditional cost-sharing arrangements on private plans purchased through the exchanges will make it a lot harder for those plans to provide cost-effective coverage. Nevertheless, when it comes to cost sharing, the difference between Medicaid and private plans is substantial. For example, the average low-income adult’s annual out-of-pocket costs with private coverage were about seven times higher ($771 in 2006) than what Medicaid beneficiaries paid on average for the year ($106).

Proponents of premium assistance contend that Medicaid beneficiaries who move into exchange plans will see higher-quality coverage and care overall. Recent research, such as a 2010 study of more than 890,000 surgical operations, has shown that low-income people tend to have poorer health outcomes in Medicaid than under private coverage. However, other research, such as a February 2013 *Journal of General Internal Medicine* study, has suggested that private coverage does not always offer better coverage relative to Medicaid per-
performance, in part because it is hard to adjust for the effect of poverty on people’s health.

A recent Georgetown University Health Policy Institute study notes that the new exchanges will help drive quality improvement because the exchange can aggregate the purchasing power of individuals and small groups and extend system reforms beyond Medicaid. The ACA will also require all qualified health plans to implement quality improvement strategies and report on quality measures to improve health outcomes and patient safety and reduce health disparities and hospital readmissions.

It is often argued that Medicaid’s lower provider reimbursement rates make it harder for beneficiaries to find specialists and even primary care physicians. In a 2012 Health Affairs study, nearly one-third of physicians surveyed nationwide reported they were not accepting new Medicaid patients. A 2007 Health Affairs study on access to specialty care for patients receiving primary care from community health centers found that Medicaid recipients had significantly more difficulty accessing specialty care than privately insured patients.

An anticipated benefit of enrolling beneficiaries in the exchanges is that it eliminates any potential coverage gaps created when someone’s income rises and they become ineligible for Medicaid. Currently, many patients face gaps and variation in their coverage as changes in their income force them in and out of Medicaid and the private insurance market. This so-called churning can be harmful to beneficiaries who are often pushed from one clinician network to the next, depending on their coverage. A recent George Washington University report found that people who remained covered by Medicaid for a year paid on average $333 in monthly medical bills. Patients who remained covered for only six months paid on average $469 in monthly medical bills. Those enrolled for only one month paid even more: $625. Without continuity of coverage, patients are less likely to get the preventive care and chronic disease management they need to stay healthy and keep costs down.

If Medicaid beneficiaries can enroll in an exchange plan up front, they won’t have to move into a plan with a different provider network if their income rises. Supporters also hope that this approach will generate substantial administrative cost savings for states. Other analysts are unsure whether reducing churn would substantially reduce costs and whether testing such a hypothesis as part of a greater cost-effectiveness formula should be required of all premium assistance demonstration projects.

**Benefits:** Even if they use the Medicaid premium assistance approach, states are required to maintain Medicaid service protections including “wrap-around” coverage for services that private plans may not offer. Analysts say this condition makes the expansion option less appealing for states because it is difficult to administer. HHS has been actively working with states to find better options to solve the wrap-around dilemma, including the possibility of additional premium payments to exchange plans so that they simply add on the services to the traditional exchange package of benefits.

Critics also argue that requiring wrap-around services will lead to a set of exchange plans developed for Medicaid beneficiaries that are completely different and separate from those offered to everyone else purchasing coverage through the exchange.

**Additional Issues:** It is still not clear whether states are prepared to add thousands of Medicaid beneficiaries to exchanges that are already grappling with the influx of millions of Americans set to begin enrolling in October 2013. According to the Arkansas Times, the state will have to create a separate website to enroll the new premium assistance-eligible group. This could create potential confusion for enrollees who inadvertently register for the federal exchange portal but instead need to register through the private-option enrollment site. Eventually the two will be integrated. A further concern is costs related to building the enrollment infrastructure. Arkansas state officials expect the federal government to pay 90 percent of the administrative costs for enrollment, they say.

A final hurdle is that states’ legislatures and the federal government have to approve states’ premium assistance plans. Many states’ legislatures have spent months embroiled in heated debate about whether to accept the Medicaid expansion, and not all are reconsidering the debate even with the late-emerging premium assistance option. States can take on an expanded Medicaid any time starting January 1, 2014. However, on October 1, 2013, the exchanges will begin evaluating people’s eligibility for coverage. If states want to get the Medicaid expansion up and running on the...
same timeline, they have only a few months left.

State health officials in Arkansas are aiming to submit their premium assistance waiver request to HHS in June, and they anticipate an answer by October 1, when open enrollment begins for the exchanges.

**WHAT’S NEXT?**

It remains to be seen how many states will pursue the premium assistance approach to move their Medicaid rolls to the private exchanges. Although the option appeals greatly to conservative leaders looking to reduce the role of government in health care, many details must still be negotiated. 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 will see all of these benefits. Alternatively, the cost to an individual state may be higher than traditional Medicaid.

States will have to negotiate program changes individually with HHS. If Arkansas can figure out how to make premium assistance work, other states, such as Florida, Texas, Tennessee, and Pennsylvania, may attempt similar program modifications and follow suit.

**RESOURCES**


