Health Advocate

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Medicaid Expansion Update: Premium Assistance and Demonstrations

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Key Resources

NHeLP Comments to Arkansas 1115 Waiver Application, available here.

NHeLP Comments to Iowa Wellness 1115 Demonstration Program, available here.

NHeLP Summary of HHS FAQs on Premium Assistance and the ACA, available here.

Coming in April's Health Advocate:

Estate Recovery and Medicaid

On January 1, 2014, twenty-five states (including DC) implemented a Medicaid expansion as authorized by the Affordable Care Act (ACA). However, two of those states did so through a variation never anticipated in the ACA. Arkansas and Iowa implemented Medicaid expansions using "premium assistance." Both states also relied on the Social Security Act's section 1115 demonstration authority to implement their premium assistance models. Below we introduce premium assistance and discuss the role of section 1115.

Premium Assistance: Key Protections at Risk

What is premium assistance?

Under a premium assistance model, the state uses Medicaid funds to purchase private coverage for a Medicaid enrollee. In other words, instead of directly paying for medical services or contracting with a managed care company to provide services, the state pays the premiums for a private insurance plan on behalf of an individual. The private insurance then provides the medical services.

Congress has considered and discussed premium assistance in the Medicaid Act and decided to authorize states to pay group or employment insurance premiums on behalf of certain employees (or their children). The Medicaid expansion premium assistance in Arkansas and Iowa is novel and different because it is implementing premium assistance that is not authorized by the Medicaid Act. The states will be paying premiums for individual market coverage in the Marketplace, unrelated to any group or employment coverage plan.

The most important thing to remember is that Medicaid enrollees who are put in premium assistance remain Medicaid enrollees, entitled to traditional Medicaid protections. This means the state must ensure that all Medicaid premium assistance enrollees still get protections like EPSDT for children (which requires coverage of all periodic screening and necessary services), Medicaid premium and cost-sharing protections, transportation for nonemergency medical care, the freedom to see any family planning provider of their choice, and full Medicaid appeals rights.

The way states accomplish this is by "wrapping around" coverage. For example, if the premium assistance private plan only covers $250 of a child's medically necessary

physical therapy, then the state Medicaid program must pay for the costs above $250 as required by EPSDT. As another example, if the plan's copay for the service is $15, but Medicaid's maximum allowable charge is $4, the state must step in and pay the $11 difference.

Does premium assistance make sense?

Premium assistance has a few possible benefits. It may help reduce churning, since individuals can keep the same insurance when they switch between Medicaid and the Marketplace. It might also simplify coverage for some families who have one member of the family in Medicaid and another member of the family in the Marketplace, by allowing both of them to enroll in the same plan.

However, the possible benefits may be negated by the problems of implementing premium assistance. Past experiences with Medicaid benefit packages has shown that states have trouble successfully wrapping around coverage. Even if the state designs a good system to wrap around coverage, there can be serious problems with individuals and providers understanding and accessing the wrapped services. Rather than a streamlined benefit, low-income individuals can be left holding a confusing coverage puzzle.

To date, premium assistance has also been a bad idea in Medicaid because it is more expensive. Medicaid coverage is less expensive than private coverage, so subsidizing coverage through Medicaid is a more efficient use of tax dollars than subsidizing that coverage through private insurance.

Even more importantly, premium assistance is not appropriate for Medicaid because it may represent an incremental step towards the dismantling of the Medicaid entitlement. Once Medicaid funding is just cash used to pay a private plan, it becomes easier for opponents of Medicaid to argue for the voucherization of the program. What distinguishes Medicaid are the defined protections and benefits, and premium assistance threatens that fundamental identity. Notably, Congress clarified the definition of Medicaid in the Affordable Care Act to make it clear to participating states that Medicaid is not just payment for services, but rather includes the responsibility to ensure coverage of the services themselves.

Premium assistance rules

Nonetheless, HHS has approved premium assistance in two states thus far, Arkansas and Iowa. The good news is that HHS has taken important steps to build on-paper protections into premium assistance. HHS issued guidance in March 2013 and regulations in July 2013 which place important limits on state use of premium assistance. There are at least two critical protections for consumers:

1. Both the guidance and regulation require states to wrap around coverage without fail, including services and cost-sharing. This means that a state cannot provide consumers with fewer benefits by using premium assistance.

2. The guidance (but not the regulation) requires that any demonstration using premium assistance will be limited to individuals in the Medicaid expansion (childless, non-disabled adults with incomes at or below approximately 138% of the poverty level) who have a benefits package that is "closely aligned" with the Marketplace benefits. This is important because it means that individuals with a benefit that is different from the Marketplace benefit, and which would thus require much more complex "wrap around," should not be enrolled in premium assistance—including people with disabilities, children with special health care needs, and older adults with chronic health conditions.

While these two protections do not solve all of the problems with premium assistance, they do help limit the damage. In the case of Arkansas, HHS faithfully applied these protections, and the Arkansas premium assistance Medicaid expansion is thus imperfect but not catastrophic. Given that section 1115 allows HHS to authorize states to conduct experiments of innovative demonstrations, the Arkansas model is probably an acceptable use of HHS' authority, and the harms may be less than the benefits of expanding Medicaid in Arkansas. Of course, the key to success in Arkansas will be the ability and willingness of HHS to monitor and enforce the limitations and consumer protections that exist on paper.

Unfortunately, things took a dramatically worse turn in the case of Iowa, the second state approved for premium assistance. HHS did not follow its own stated policy for premium assistance and instead granted Iowa section 1115 authority to violate the requirement to wrap around services in at least two crucial ways. First, although Medicaid does not permit premiums below 150% of the federal poverty level (FPL), Iowa was approved for premiums with termination for nonpayment down to 100% FPL. Second, Iowa was granted a waiver of the requirement to provide non-emergent medical transportation in 2014. Both of these policies contradict HHS' stated policy in guidance, and mean that consumers will receive less than they are entitled to under the law.

Section 1115 Demonstration Authority: Risking a Race-to-the-Bottom

Section 1115 authority

An important conclusion from the case of Iowa is: premium assistance alone, as implemented in Arkansas and subject to the protections in HHS guidance, is problematic but not facially disastrous. However, improper use of section 1115 demonstration authority can in fact turn a mole hill into a mountain, harming consumers, promoting a race-to-the-bottom in states, and threatening the future of Medicaid. Premium assistance plus careless use of section 1115 authority is a toxic mix.

Section 1115 authority allows HHS to test innovative demonstrations which promote the objectives of the Medicaid program. Unfortunately, HHS has in some cases allowed states to use this authority to try experiments which have no experimental value, and implement policies which hinder Medicaid's objectives. In the context of Medicaid expansion, HHS has granted three section 1115 demonstrations, two in a premium assistance model (Arkansas and Iowa) and one without premium assistance (Michigan). Premium assistance states seek section 1115 authority because under the law participation in premium assistance is optional for enrollees, so the states need the authority to "test" making it mandatory.

So far, so bad

The Arkansas model, as discussed, includes premium assistance but with important consumer protections built in. The Iowa model, in contrast, includes illegal waivers of the Medicaid prohibition on premiums between 100-150% FPL and the Medicaid requirement to provide for non-emergent transportation. To HHS' credit, HHS did deny numerous other illegal requests made by Iowa. In Michigan, HHS again allowed illegal premiums above 100% FPL and the use of a confusing system for monthly copayment billing.

As discussed above, the HHS approval regarding Iowa violated HHS' own stated policy on premium assistance. In both Iowa and Michigan, HHS' approvals are also an improper use of section 1115 authority. In both states, HHS approved waivers with no experimental value (premiums are well-established as a barrier to care for low income people and denying transportation will clearly harm access) and which contradict the objective of the Medicaid program, furnishing care to vulnerable individuals. Section 1115 proposals also must be "budget neutral," and premium assistance is more expensive than direct Medicaid services, so the Iowa approval is also questionable on that count.

Sadly, every concession made by HHS to one state becomes an invitation for the next state in line to ask for even more. In the wake of Iowa, Pennsylvania currently has a section 1115 application with twenty-four waiver requests, while some other states that already expanded are now considering reversing course on their expansions to pursue flexibilities granted in Iowa or Michigan. NHeLP has encouraged HHS to draw clear lines, based on a faithful application of the law, or else risk a race-to-the-bottom in which federal standards give way to state whim. It is also important to remember that the precedents set in the present – HHS' prioritization of discretion over law – will be the only restraint on less friendly administrations in the future.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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