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Premium Assistance FAQ Summary

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On March 29, 2013, HHS issued a Frequently Asked Questions document (FAQ) addressing some of the questions swirling around Arkansas' and other states' interest in implementing Medicaid expansion by paying premiums to purchase private insurance (called premium assistance). Summarized below, the FAQ addresses some of beneficiary advocates' major concerns while raising some new questions.

1. No partial expansion. Rumors were circulating that HHS was going to allow states to implement only partial Medicaid expansions using premium assistance. A previous transmittal from CMS had said partial expansion using enhanced federal funds is not authorized by the Affordable Care Act. See CMS, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid* (Dec. 10, 2012) (FAQ #26). The March 26th FAQ reaffirms this: "States that wish to take advantage of the enhanced federal matching funds for newly eligible individuals must extend eligibility to 133% of the federal poverty level (FPL) by adopting the new adult group." FAQ #1.

2 Full Medicaid protections. Most importantly, the FAQ clarifies that premium assistance programs would still have to meet the requirements of Medicaid law: "Under all these arrangements, beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections." FAQ #2. Thus, Medicaid beneficiaries remain entitled to all required Medicaid services and Medicaid's cost-sharing limits. In addition, the FAQ clarifies that individuals must be able to choose a Medicaid alternative to the premium assistance plan. And, premium assistance must be cost-effective compared to what Medicaid would otherwise pay. While most welcome, this aspect of the FAQ raises a number of questions, including: How will the wrap-around mechanism work in real time to ensure that individuals receive necessary services with reasonable promptness? How will the mechanism work in real time to ensure that individuals pay only the Medicaid-permitted copayments at the doctor's office or pharmacy? How will the mechanism work to ensure Medicaid due process protections for notice and opportunity for a prior termination/reduction hearing are maintained?

3 Limited number of section 1115 demonstrations. The FAQ clarifies that states can conduct premium assistance directly through their state plan but also discusses § 1115 demonstrations. HHS is open to approving only a limited number of demonstrations that must adhere to the following requirements: (1) beneficiary choice of at least two plans, (2) wrap-around of Medicaid benefits and cost-sharing requirements particularly for those with incomes below 100% FPL, (3) limiting premium assistance to individuals whose benefits are "closely aligned" with those available on the Marketplace, namely those in the new adult group (and not, for example, medically fragile individuals), and (4) an end date of December 31, 2016. HHS suggests that states would be more likely to obtain approval by targeting their demonstrations to adults in the 100-138% FPL group. This makes sense because lower income populations tend to need more benefits than those on the Marketplace and also because the key rationale for premium assistance—that it avoids churning as individuals move among coverage due to income fluctuations—is much less likely in lower income populations. Some second-level questions that the FAQ raises include: How will HHS ensure that these projects are truly testing "experimental, pilot or demonstration" ideas as opposed to large-scale Medicaid policy shifts with no real experimental value? How will the FAQ ensure that states' cost sharing requests do not create barriers to care and result in individuals requiring most costly services? How will HHS assure that the transparency requirements for section 1115 project reviews are adhered to in this context? What types of provisions will HHS be willing to waive, and will HHS try to push the legal limits of what section 1115 can waive?

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