



Premium Assistance Demonstrations: The Challenges of Interagency and Public/Private Coordination

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Executive Summary

Three states—Arkansas, Iowa, and New Hampshire—expanded their Medicaid programs using section 1115 demonstration authority to test a new approach to providing premium assistance to people with low incomes. These states designed and implemented demonstrations that support Medicaid beneficiaries' purchase of coverage from qualified health plans (QHPs) based on those available in the Federally Facilitated Marketplace. Effective design and implementation of Marketplace premium assistance programs requires a high degree of interagency and public/private coordination. During the planning and implementation phases, state Medicaid agencies, insurance departments, and insurance carriers held frequent discussions to understand differences in the regulatory environments of Medicaid and commercial health plans and to create operating agreements that specify their respective responsibilities. Implementation issues arose in the areas of rate-setting, benefits and benefit coordination, cost-sharing, benefit appeals, data-sharing, and guaranteed issue regulations. States formalized many of the agreements that resolved these issues in memoranda of understanding between Medicaid agencies and insurance carriers.

Understanding the implementation process and the challenges that arise is important not only for states that are interested in this

type of premium assistance but also for evaluators, who should account for key program features when designing comparison groups and interpreting results. For example, any examination of beneficiaries' access to care and health outcomes in these premium assistance programs should account for the specific enrollment processes for medically frail individuals and pregnant women, which differ from those for other Medicaid-eligible adults in QHPs. In addition, the implementation process also illuminates data issues that may constrain evaluators' ability to assess these programs. Enhanced data-sharing systems and more comprehensive data agreements may make it easier for Medicaid agencies and carriers to work together and would facilitate accurate assessments of demonstration performance.

Introduction

Three states—Arkansas, Iowa, and New Hampshire—have used section 1115 authority to expand their Medicaid programs, designing demonstrations that support beneficiaries' purchase of qualified health plans (QHPs) based on those available in the Federally Facilitated Marketplace. Known as premium assistance demonstrations, these programs allow states to cover the insurance premiums for non-disabled adults under age 65 whose household incomes are up to and include 133 percent of the federal poverty level.¹ Beneficiaries eligible for these demonstrations are required to enroll in QHPs as long as

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some of these new approaches being tested under 1115 authority draw on established practices in commercial health insurance, such as cost-sharing at levels that exceed Medicaid limits and financial incentives for pursuing healthy behaviors. Other new approaches involve partnerships with private-sector entities, such as issuers that offer qualified health plans. However, Medicaid beneficiaries have lower incomes and poorer health status than most privately insured individuals and Medicaid expansion demonstrations have required multiple beneficiary protections, such as limits on total cost-sharing, access to certain mandatory benefits, and rights to fair hearings.

they are not medically frail and have a choice of two or more QHP carriers. Arkansas and Iowa implemented premium assistance demonstrations in January 2014, and New Hampshire began its premium assistance demonstration in January 2016.² Arkansas and New Hampshire continue to operate their demonstrations, whereas Iowa suspended its program in December 2015. In this issue brief, we discuss the implementation experiences of all three states.³

States choose to implement premium assistance because they believe these demonstrations offer advantages over traditional Medicaid coverage. For example, premium assistance may increase continuity of coverage and provider relationships for adults who lose Medicaid eligibility when their income rises, if they are able to maintain coverage with the same Marketplace carrier and provider networks are comparable across insurance products offered by that carrier. Premium assistance may also help smooth coverage transitions to non-Marketplace plans (for example if a beneficiary gains access to employer-sponsored insurance) by familiarizing Medicaid beneficiaries with the features of private coverage, such as provider networks that differ from those in Medicaid. Although these are potential advantages, implementing premium assistance requires a significant amount of coordination across agencies and between public and private entities. State Medicaid agencies, insurance departments, and QHP carriers must forge new working relationships so they can make decisions about how to operate the program, resolve differences in the regulatory environments of Medicaid and commercial insurance, and address the concerns of two federal partners within the Centers for Medicare & Medicaid Services: the Center for Medicaid & CHIP Services and the Center for Consumer Information and Insurance Oversight. All three states highlighted in this brief had to resolve these challenges in relatively short time frames.

In addition, the three demonstration states had little experience to draw on, given significant differences between Marketplace-focused premium assistance and other public/private health insurance arrangements. For example, although some state Medicaid agencies, including New Hampshire, have worked with commercial carriers to establish risk-based Medicaid managed care, the managed care contracting process allows Medicaid agencies to retain control over operational details and oversight. In contrast, some of the oversight of premium assistance demonstrations falls under the authority of state insurance departments, which manage regulatory functions such as QHP certification and benefit appeals. Likewise, Marketplace-focused premium assistance requires significantly more public/private and interagency cooperation than other premium assistance programs, such as the Health Insurance Premium Payment (HIPP) program, require. Separately from their premium assistance demonstrations for non-disabled adults, Arkansas,

New Hampshire, and Iowa each operate a HIPP program to support Medicaid beneficiaries' enrollment in employer-sponsored plans.⁴ However, commercial carriers design employer-sponsored plans to meet the needs and preferences of employed groups rather than those of Medicaid-eligible adults, which may influence the provider networks and cost-sharing structures they establish. For example, employers may prioritize the inclusion of certain providers—either those in demand by their employees, or, in an effort to manage plan costs, those with whom lower rates have been negotiated or those that deliver high-quality outcomes relative to their costs. Commercial carriers and employers have relatively little incentive to consider factors like accessibility via public transportation or co-location of social service providers when designing their plans' networks, though these features may be important for Medicaid beneficiaries. In contrast, Marketplace premium assistance requires carriers, insurance departments, and Medicaid agencies to work together to create designated QHPs that meet the needs of large numbers of Medicaid beneficiaries while maintaining the plans' viability in competitive markets.⁵

How did states approach the challenge of establishing Medicaid premium assistance?

The intensive coordination required to establish Marketplace-focused premium assistance in Arkansas, Iowa, and New Hampshire compelled Medicaid agencies and insurance departments to establish open lines of communication early in the planning process. Before they submitted applications to the Centers for Medicare & Medicaid Services (CMS) to conduct section 1115 demonstrations, agency officials in all three states began talking about the implications of such demonstrations during state-level debates about how and whether to expand Medicaid under the Affordable Care Act. Premium assistance implementation required state agencies to work together more closely and communicate more frequently than they typically do. New Hampshire and Iowa officials noted that these interagency conversations were made easier by the agencies' equal status in state executive branches and their common purpose in achieving their respective governors' health reform goals.

Although the first conversations about the broad parameters of premium assistance programs took place between Medicaid agencies and insurance departments, QHP carriers later joined in negotiations over operational details. Frequent communication was necessary to understand the significant differences in the business practices and regulatory environments of Medicaid and commercial insurance companies. One state official noted that Medicaid agencies and QHP carriers did not realize how different their assumptions were about each other's regulatory environment until they had their first planning meetings.

Because insurance department officials are both knowledgeable about commercial insurance and familiar to QHP carriers, insurance departments frequently served as facilitators and “translators” as Medicaid agencies and carriers worked to resolve their operational or regulatory differences. For example, the New Hampshire Insurance Department helped to explain carriers’ questions and concerns about Medicaid regulations governing beneficiary cost-sharing,⁶ because commercial insurance deals with cost-sharing in a very different way. Arkansas and New Hampshire also relied on outside parties to help them plan and execute their demonstrations. In Arkansas, the state’s demonstration evaluator, the Arkansas Center for Health Improvement (ACHI), played a critical role in supporting collaboration and identifying policy and operational solutions. ACHI continues to facilitate regular meetings. New Hampshire planning meetings often included two consultants with significant experience in Medicaid, Manatt and Public Consulting Group, which helped the state work through issues such as the effect of premium assistance on the regulatory environment for QHPs. Over time, Medicaid agencies and QHP carriers began to communicate more directly and openly with each other about how to design programs that met the rules and regulations applicable to Medicaid and commercial insurance.

As the three states developed their approaches to operating the premium assistance demonstrations, they formalized Medicaid and carrier responsibilities in memoranda of understanding (MOUs). Iowa and New Hampshire developed MOUs between their respective Medicaid agencies and each participating QHP carrier. Arkansas developed a three-way MOU that included the Arkansas Insurance Department. Arkansas and New Hampshire standardized MOU language across carriers, and Iowa developed slightly different language for each of its two participating carriers. In addition to the Medicaid/carrier MOUs, both Arkansas and New Hampshire developed shorter MOUs between Medicaid and insurance departments to clarify agency roles; these focus mainly on the benefit appeals process.

What are the main roles of state agencies?

State insurance departments. States that have chosen to operate State-Partnership Marketplaces or State-Based Marketplaces carry out plan management functions, including QHP certification and carrier oversight. All three states highlighted in this issue brief are plan management states. As such, insurance departments maintained their central role as QHP regulators before, during, and after the implementation of premium assistance.⁷ Insurance department officials described this role as a balance between enforcing carriers’ compliance with federal and state requirements and ensuring solvency and a vibrant

market. Rate review is one of the many insurance department responsibilities that serve both these goals. For example, an Iowa official articulated the need to ensure that rates both reflected the risk involved in covering recently uninsured adults and were actuarially justifiable, not discriminatory. However, insurance departments do not set rates, and officials in all three states noted that they were obliged to clarify this for Medicaid agencies during the planning process because Medicaid agencies set rates for Medicaid managed care plans. Plan certification is another important regulatory function in establishing premium assistance. After carriers developed proposals for QHPs, insurance departments certified that the plans met all pertinent regulatory requirements, such as the benefits required for “silver” plans in the Marketplace. The insurance departments in Arkansas and New Hampshire also enforced a requirement that any carrier participating in the Marketplace must also participate in the premium assistance demonstration.

State Medicaid agencies. One of Medicaid’s main responsibilities in implementing premium assistance is to select the criteria for QHPs that beneficiaries can choose from once insurance departments have certified the plans. In selecting these criteria, the agencies focus on determining whether the QHPs meet rate-setting and benefits requirements, which vary depending on the state. For example, the Arkansas Medicaid agency amended its QHP purchasing guidelines for plan year 2016 by specifying that in a given service area, the agency will only purchase the lowest-cost essential health benefit (EHB)-only silver plan, the second-lowest-cost EHB-only silver plan, and any other carrier’s lowest-cost EHB-only silver plan that falls within 10 percent of the second-lowest-cost plan.⁸ In contrast, New Hampshire avoided setting a firm cutoff for relative premium prices to allay carriers’ concerns about setting rates that reflect the risks inherent in covering this population. Specifically, the Medicaid agency signaled that a QHP may not be considered cost-effective if its premium price “approaches” a 20-percent difference from the median premium of other QHPs reviewed in each county, although the final determination depends on the characteristics of other plans in the county.

Another major responsibility for Medicaid agencies is to include mandatory Medicaid benefits in their program design and protect beneficiaries from out-of-pocket expenses that exceed Medicaid limits, both in the aggregate and for specific services.⁹ However, because carriers maintain their authority over benefit design as long as they meet regulatory requirements for QHPs, and because Medicaid agencies have no legal authority to compel carriers to meet Medicaid requirements, Medicaid agencies have met this responsibility by developing wraparound benefits and cost-sharing protections.^{10,11} In the next section of this brief, we provide specific examples of issues that arose during the negotiations over benefits and cost sharing, and how states resolved them.

Shared roles in the implementation process. Both Medicaid agencies and insurance departments conducted carrier outreach and education, although they did so with varying degrees of intensity in the three demonstration states. Although insurance departments typically made the initial contact with carriers, insurance department officials in two states noted that they emphasized education over recruitment. In Iowa, where participating in premium assistance was optional for carriers in the Marketplace, Iowa Insurance Division officials considered it important for carriers to make their own decisions about whether to take on the risk of participating in premium assistance, because they did not want the state to be liable for any carrier insolvency. In New Hampshire, where participation in premium assistance is mandatory for carriers in the Marketplace, New Hampshire Insurance Department officials concentrated on offering carriers information on premium assistance, and not on advocating for the program.

In each state, the insurance department and Medicaid agency have also shared the responsibility of communicating with CMS to clarify federal expectations for demonstration operations. One example of a cross-agency issue that state agencies sought to clarify with federal partners was the process for beneficiary appeals, which we discuss in detail in the next section. Finally, Medicaid agencies and insurance departments collaborate on enrollment processes. For example, the Arkansas Medicaid agency and insurance department worked closely together to implement an enrollment portal that allows beneficiaries to select QHPs after beneficiaries are determined by Medicaid to be eligible for premium assistance.

How were the most challenging policy issues addressed?

As the demonstrations were being planned and implemented, policy issues arose in the areas of rate-setting, benefits and benefit coordination, cost-sharing, benefit appeals, data-sharing, and guaranteed issue regulations. States formalized many of the agreements that resolved these issues in their MOUs. In Table 1, we summarize the features of the MOUs between state Medicaid agencies and participating carriers. For Arkansas and Iowa, the most recent MOUs at the time this research was conducted in February 2016 reflected issues that arose after the 2014 implementation, during the course of demonstration operations. Although New Hampshire's MOU included only those operational agreements made in the first year of implementation planning, it covered a wider range of topics. The omission of a particular topic in an MOU does not necessarily indicate that the state is out of compliance with Medicaid regulations or demonstration conditions.

Rates. In all three states, carriers wanted to account for beneficiaries' tobacco use in their rates. Doing so is not typical practice in Medicaid, though it is permissible for Marketplace plans to charge tobacco users up to 50 percent more on their

premiums than what they charge non-users of tobacco.¹² In Arkansas, the Medicaid agency resolved this conflict in the first year of the demonstration by agreeing to pay carriers higher premiums (retroactively, to the original date of the policy) as long as the carriers could produce evidence of tobacco use. The Medicaid agencies and carriers in Iowa and New Hampshire codified in MOUs their decision to use smoking as a rating factor. The Medicaid agencies also agreed to make potential tobacco-related payment increases during their year-end cost reconciliation with carriers. More generally, carriers were also concerned about setting rates that would reflect the risk involved in covering adults who were newly eligible for Medicaid. For this reason, carriers in New Hampshire requested utilization data from the Bridge Program to inform their rate-setting. The Bridge Program was a temporary Medicaid program that covered adults before the launch of premium assistance. The Medicaid agency did not share these data, because officials believed the data were likely to reflect service use by beneficiaries who were recently uninsured, and would not reliably predict subsequent utilization under premium assistance.

In Arkansas, another rate-setting issue surfaced after implementation. Specifically, carriers assumed that pregnant women and women who became pregnant while enrolled in QHPs would transition out of premium assistance because low-income pregnant women are entitled to Medicaid coverage for pregnancy-related services. Carriers therefore did not account for pregnancy when they were developing their premium rates.¹³ The Medicaid agency considered such transitions optional, rather than automatic or required. A similar issue arose when a number of pregnant women enrolled in QHPs after the state sent a postcard to beneficiaries of the Supplemental Nutrition Assistance Program; the postcard advertised an opportunity to enroll in premium assistance without completing a full application. The Medicaid agency ultimately resolved the carriers' concerns about pregnancy costs by providing them with supplemental payments.

Benefits and benefit coordination. State officials in Arkansas, Iowa, and New Hampshire collaborated with carriers to address the challenge of aligning QHP and Medicaid benefits. In Iowa, the two state agencies and QHP carriers agreed to use the 100 percent actuarial value (AV) plan already developed for the American Indian/Alaska Native population as a model because it better matched the mental health benefits that are normally available under Medicaid. However, carriers did not include dental or transportation benefits in their plan designs, because they believed it would cost too much to develop provider networks for those services. Iowa Medicaid created a separate dental plan in collaboration with Delta Dental, which resolved the lack of dental networks in QHPs. Iowa separately received permission from CMS to eliminate coverage of non-emergency medical transportation altogether for both premium assistance

beneficiaries and other adults in the expansion group. The New Hampshire Insurance Department worked with carriers in that state to align QHP benefits with the substance abuse and mental health benefits available in Medicaid.

State officials also had to work out several conflicts between the different practices of Medicaid and commercial insurance. For example, Medicaid typically covers the cost of hospital stays if patients are determined to be eligible for Medicaid after admission, but QHP carriers in Arkansas were unwilling to cover hospital costs for individuals who were determined to be eligible for premium assistance after their hospital stays began. Arkansas Medicaid ultimately agreed to pay for the costs of such hospital stays on a fee-for-service basis. In New Hampshire, the Medicaid agency and carriers realized the need to coordinate benefits for newborn babies whose mothers were enrolled in premium assistance. Under state insurance law, QHPs must provide 31 days of newborn coverage, which is essentially a benefit to the mother. However, because children are not part of the Medicaid expansion, this law led to confusion among carriers about whether newborns should receive benefits under the mother's QHP, a separate policy, or Medicaid. The state and carriers agreed that newborn babies would receive coverage under the mother's QHP for 31 days, after which they can be enrolled in a Medicaid managed care plan.

Cost sharing. Arkansas and New Hampshire worked to assure the availability of 94 percent AV plans that include co-payments and co-insurance for beneficiaries whose incomes are above the poverty line. Both New Hampshire Medicaid and the New Hampshire Insurance Department characterized the negotiations over cost sharing as a major implementation challenge. Specifically, carriers found it difficult to design cost sharing that both fit within the 94 percent AV calculation and also met Medicaid guidelines.⁶ After several design modifications, carriers and the Medicaid agency agreed that Medicaid would pay the cost of a \$350 deductible. A second policy challenge around cost sharing arose because Medicaid regulations prevent the use of co-payments for certain services for which cost sharing is common practice in commercial insurance, such as emergent visits to emergency departments. This issue also arose in Arkansas. During the first year of Arkansas' premium assistance program, carriers charged a \$20 co-pay for all emergency room visits, in contrast with the special terms and conditions of Arkansas' demonstration. The state eliminated the co-pay in the second demonstration year to bring QHP cost sharing into alignment with Medicaid rules.

A different implementation challenge related to cost-sharing was the need to develop systems to track total out-of-pocket spending by beneficiaries to ensure it does not exceed the required limit of 5 percent of household income. New Hampshire Medicaid officials described the difficulty of tracking this under

premium assistance, because Medicaid is not immediately aware of what services beneficiaries obtain or what they pay out of pocket. Carriers agreed to create a cost-sharing tracking system that leveraged their existing systems, which use claims incurred to track quarterly out-of-pocket spending. The new tracking system assumes that all beneficiaries making copays have incomes at the poverty line, even if their actual income is higher. This allows the carriers to use the same out-of-pocket cap for all beneficiaries. Arkansas, in contrast, contracted with a third-party administrator in the second year of the demonstration to implement beneficiary accounts called Independence Accounts. (The state closed the Independence Accounts in June 2016.) The third-party administrator tracked accrued cost-sharing for beneficiaries with incomes above the federal poverty line by asking beneficiaries to swipe their Independence Account membership cards at the point of service. Monthly Independence Account contributions also counted towards the cost-sharing cap. As in New Hampshire, the tracking system in Arkansas assumed that all beneficiaries have incomes at 100 percent FPL and set the cap accordingly.

Appeals process. State officials in Arkansas, Iowa, and New Hampshire all reported that developing a benefit appeals process was another major challenge as they implemented premium assistance demonstrations, mainly because federal Medicaid law requires Medicaid agencies to serve as an appeal venue in addition to the commercial appeals process. In Arkansas, the first state to negotiate an appeals process with CMS, beneficiaries first appeal coverage decisions to the Arkansas Insurance Department. Each month, the Department submits a report to the Medicaid agency that details benefit complaints and how they were resolved by the Department. Appeals to these decisions go to the Medicaid agency as the last stop in the process. In New Hampshire and Iowa (while the demonstration was operational), premium assistance beneficiaries appeal coverage decisions to QHP carriers. If beneficiaries exhaust their appeals options under commercial coverage, the Medicaid agency must arrange for a fair hearing at the state level. State officials in Arkansas and Iowa, the two states with significant implementation experience, asserted that no coverage appeal had yet come to the Medicaid agencies.

Data-sharing. Arkansas Medicaid officials described the process of developing a data-sharing agreement to support the demonstration evaluation as the single most challenging negotiation with carriers. CMS requires that the state evaluate the premium assistance program as a condition of the demonstration, but QHP carriers were reluctant to disclose the necessary beneficiary data, citing concerns based on the Health Insurance Portability and Accountability Act (HIPAA). Carriers ultimately agreed to share their claims data with the state's evaluator, the Arkansas Center for Health Improvement. The state formalized this agreement using MOU language that

specifies the carriers' obligations to share data with the Arkansas Insurance Department "or its designee." Other data sharing discussions concerned the issue of whether carriers would agree to share information about beneficiary address changes with Medicaid agencies. Arkansas and New Hampshire developed MOU language to clarify carriers' obligations to notify the state of beneficiary address changes because Medicaid eligibility systems require current addresses. In Iowa, data-sharing conversations focused on information technology. Iowa Medicaid Enterprise staff and carrier staff met weekly to discuss data transfer methods and ultimately agreed to use Medicaid's standard electronic file formats for enrollment, claims, and payment. Iowa also developed MOU language specifying confidentiality and data exchange obligations.

A different set of data-sharing issues surfaced after implementation and enrollment began in Arkansas and Iowa. QHP carriers in Arkansas wanted the Medicaid agency to give them more information about eligibility terminations and let them know about terminations in advance. The Medicaid agency felt it would violate HIPAA to share termination reasons with carriers, which meant carriers could not answer questions about terminations when beneficiaries called to ask why they were disenrolled. Carriers in Arkansas also wanted Medicaid to share beneficiaries' phone numbers and email addresses, but the staff at the state's Medicaid agency believed that HIPAA only allowed them to share mailing addresses.

Sharing data related to medically frail determinations turned out to be another significant operational issue. In Arkansas and Iowa

(while the demonstration was operational), Medicaid agencies make the final determinations of medical frailty, but carriers can identify individuals who may be medically frail, and recommend that the state Medicaid agency assess these individuals so they can be transitioned to traditional Medicaid mid-year. Carriers in Arkansas initially identified a small number of beneficiaries as medically frail and notified the Medicaid agency. However, Medicaid could not confirm these determinations because the carriers were not comfortable sharing medical information with the state. Carriers in Arkansas later decided to abandon their efforts to identify beneficiaries who may be medically frail after they enroll in QHPs. The Medicaid agency continues to use a health needs assessment to prospectively identify medically frail individuals at enrollment and annually thereafter.

Terminating enrollment. In Arkansas, a conflict emerged between commercial coverage termination dates, which are governed by guaranteed issue regulation, and the way Medicaid handles terminations. The Medicaid agency's position was that carriers should reimburse Medicaid for half the premium amount if a beneficiary's eligibility was terminated in the middle of the month. Because commercial coverage cannot lapse until the end of the month (due to guaranteed issue regulations), commercial insurers are required to make claims payments for any services a beneficiary receives throughout the entire month. Arkansas' 2015 MOU described specific circumstances under which carriers must reimburse Medicaid premiums due to mid-month terminations, and the state planned to seek further resolution with CMS.

Table 1. Selected topics covered in 2014-2015 Medicaid/carrier MOUs

	MOU features ^a	Arkansas	Iowa	New Hampshire
Enrollment	Medicaid makes final determination of medical frailty; carriers can help identify individuals who may be medically frail	X	X	
	Beneficiaries self-attest to being medically frail			X
	Medicaid is responsible for medical expenses from the date that individuals are determined eligible for coverage until the effective date of their QHP enrollment	X		X
	Terminations are effective the first day of the following month, regardless of when in the month a beneficiary is terminated	X		X
	Limited circumstances under which beneficiaries can be terminated mid-month instead of on the first day of the following month	X		
	Carrier notifies Medicaid of beneficiaries' address changes	X		X ^b
	Medicaid conducts outreach to beneficiaries about their right to wraparound benefits			X
	Medicaid agency and carriers work together to ensure beneficiaries receive clear and consistent information about their access to wraparound benefits			X
Compensation paid to carriers	Carrier compensation includes premiums plus cost-sharing reduction (CSR) payments	X	X	X
	Carriers may use tobacco use as a rating factor		X	X
	Carriers may not issue invoices for premiums or cost-sharing to beneficiaries			X
	Medicaid pays deductible as part of CSR calculation			X
	Medicaid is not responsible for cost sharing for services that are not essential health benefits or are not included in Alternative Benefit Plan			X
	Carriers can ask Medicaid to adjust cost-sharing payments if payments appear to be significantly different than payment amount at reconciliation			X

(continued)

	MOU features ^a	Arkansas	Iowa	New Hampshire
	Medicaid issues formal monthly payment reports to carriers; carriers review and submit variances for reconciliation by Medicaid; adjustment payments are made quarterly			X
	Maximum out-of-pocket cost sharing is 5% of a beneficiary's income per quarter; Medicaid and carrier will agree on process to track cost sharing			X
	Carriers will calculate medical loss ratio payments, notify state, and send payment in accordance with federal law	X		X
Appeals	Beneficiaries have the same rights to internal and external review processes that QHPs provide to other QHP/Marketplace enrollees	X	X	X
	Medicaid agency provides a fair hearing under certain circumstances			X
Data-sharing	Carriers report claims data to state (or its designee)	X	X	X
	Enrollment, access, expenditures or utilization data will be reported, or reported on an "as needed basis" by carrier to state (or its designee)	X	X	X ^c
	Carriers will send Medicaid requested healthy behaviors data		X	
	Carriers will provide information required to support an application for transfer out of QHP based upon determination of medical need	X		
	Carriers will provide any other data that the state identifies as necessary to implement, monitor or evaluate premium assistance	X		
	Carriers and Medicaid agree to confidentiality and secure data exchange obligations		X	
Other	Carriers may not assign its obligations to another entity without consent from Medicaid agency and state insurance department	X		X
	State has sole right to determine cost effectiveness of any QHP and to limit regional offering or terminate QHPs based on cost-effectiveness			X
	In-network providers will not bill beneficiaries, except for permitted cost-sharing	X		X
	Carriers will maintain records related to the MOU during the term of the MOU and for a certain period of time following termination of the MOU	X		X
	Carriers will provide "reasonable access" to records related to the MOU to Medicaid, the state insurance department, and CMS	X		X
	Notices from carriers to beneficiaries on rights and benefits covered by the QHP are subject to regulation by the insurance department and CMS			X
	Medicaid will be responsible for providing all Medicaid-specific notices to beneficiaries			X

Sources: Mathematica analysis of:

Memorandum of Understanding between Arkansas Department of Human Services and the Arkansas Insurance Department, January 15, 2014.

Memorandum of Understanding between Iowa Department of Human Services and Coventry Health Care of Iowa, February 28, 2014.

Memorandum of Understanding between the State of Arkansas and Arkansas Blue Cross Blue Shield ("Issuer"), April 22, 2015.

Memorandum of Understanding between the State of New Hampshire and "Issuer," October 12, 2015.

Note: MOUs for Arkansas and New Hampshire have the same language for all carriers.

^a The omission of a particular topic in an MOU does not necessarily indicate that the state is out of compliance with Medicaid regulations or demonstration conditions.

^b Carrier will make "reasonable effort" to notify Medicaid of beneficiaries' address changes.

^c Carriers must provide Medicaid with an extract of their submissions to the New Hampshire all-payer claims database, the Comprehensive Health Information System.

CSR = cost-sharing reduction; MOU = memorandum of understanding; QHP = qualified health plan.

Lessons learned from premium assistance implementation and implications for evaluation efforts

Premium assistance demonstrations have the potential to provide valuable evidence about the advantages and challenges of expanding Medicaid by making it possible for beneficiaries to enroll in QHPs. These demonstrations combine standardized, affordable QHP benefits with important beneficiary protections that are not available in the commercial market, such as the option to move to direct Medicaid coverage after being determined medically frail, and access to the Medicaid agency during the appeals process.¹⁴ Moving forward, it will be important to track whether

premium assistance demonstrations achieve outcomes that are better than or comparable to outcomes achieved through direct Medicaid coverage, including beneficiaries' access to care, health outcomes, and take-up rates, as well as total Medicaid spending. The upcoming national evaluation of section 1115 demonstrations will include such comparisons (Irvin et al. 2015).¹⁵

Arkansas, Iowa, and New Hampshire established programs that operate within a complex and sometimes inconsistent set of regulations that govern both Medicaid and commercial insurance; their experiences in navigating this terrain may help other states that are planning to implement premium assistance in the future—including Michigan, which has been approved to incorporate a premium assistance component in its demonstration beginning

in 2018. These demonstrations also hold larger lessons for interagency and cross-sector efforts to improve coverage and access to care. In particular, the experiences of these three states highlight the need for frequent and open communication and flexible approaches to solving operational problems. They also highlight opportunities to align regulations governing Medicaid and commercial health insurance.

Understanding the implementation process is also important for both state-based and federal evaluators, because they should account for implementation status when designing comparisons and interpreting results. For example, any examination of beneficiary access to care and health outcomes in Arkansas' premium assistance program should consider how medically frail individuals and pregnant women are enrolled along with other Medicaid-eligible adults in QHPs because of the way Arkansas implemented its program.

In addition, the implementation process illuminates the importance of data sharing issues for both evaluation and program implementation success. Successfully creating data-sharing agreements between carriers and Medicaid agencies has been a key implementation challenge in all three demonstration states. Insufficiently connected or automated data systems, as well as interpretations of HIPAA that limit data-sharing, can cause operational difficulties for both carriers and Medicaid agencies, and may impede access to data that are needed for evaluations of demonstration performance. Enhanced data-sharing systems and more comprehensive agreements may make it easier for

Medicaid agencies and carriers to work together and to protect low-income beneficiaries from inadvertent harms by quickly identifying factors such as high medical needs, address changes, or total cost-sharing accrued.

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports will inform an interim outcomes evaluation in 2017 and a final evaluation report in 2019.

METHODS AND DATA SOURCES

The Information in this issue brief is based on Mathematica's analysis of section 1115 demonstration documents for Arkansas, Iowa, and New Hampshire, as listed below.

- Arkansas Special Terms and Conditions, Approval Period: September 27, 2013–December 31, 2016; as amended January 1, 2015. Section 1115 demonstration monitoring reports: 2014 Q1–Q4; 2015 Q1–Q2; 2014 annual report. Memorandum of Understanding between the State of Arkansas and Arkansas Blue Cross Blue Shield ("Issuer"), April 22, 2015. Memorandum of Understanding between Arkansas Department of Human Services and the Arkansas Insurance Department, January 15, 2014.
- Iowa Marketplace Choice Plan Special Terms and Conditions, Approval Period: January 1, 2014–December 31, 2016; as amended July 31, 2015. Section 1115 demonstration monitoring reports: 2014 Q1–Q4; 2015 Q1–Q3; 2014 annual report. Memorandum of Understanding between Iowa Department of Human Services and Coventry Health Care of Iowa, February 28, 2014.
- New Hampshire Special Terms and Conditions, Approval Period: March 4, 2015–December 31, 2018. Memorandum of Understanding between the State of New Hampshire and "Issuer," October 12, 2015.

In January and February 2016, we also conducted key informant interviews in all three states with officials at state Medicaid agencies and insurance departments. A lead interviewer and a note taker were present at each interview.

Endnotes

¹ The Affordable Care Act established a five percent income disregard that increases the effective income limit from 133 to 138 percent of the federal poverty level.

² Michigan received approval in December 2015 to amend its demonstration to include a premium assistance program. The premium assistance phase of the demonstration is scheduled to begin in April 2018.

³ Iowa's premium assistance demonstration was effectively closed on December 31, 2015, although the state retained its authority to operate the program through December 2016. One of Iowa's two participating QHP carriers became insolvent in late 2014 and the other stopped accepting new Medicaid beneficiaries in 2015. The state received approval in January 2016 to modify eligibility for the other component of its 1115 demonstration, the Iowa Wellness Plan, to include the population formerly enrolled in premium assistance.

⁴ Section 1906 of the Social Security Act authorizes the Health Insurance Premium Payment (HIPP) program, through which states pay Medicaid-eligible employees' share of employer-sponsored insurance (ESI) premiums when ESI is available and cost-effective. Iowa also uses authority in section 1905(a) of the Social Security Act to support the purchase of private group or non-group health coverage by Medicaid beneficiaries.

⁵ Throughout this document, we use the terms "qualified health plan" and "QHP" to denote the plans that Medicaid beneficiaries can enroll in under premium assistance demonstrations. These premium assistance QHPs are technically off-Marketplace products that are exact duplicates of Marketplace QHPs, except for their higher actuarial value (94 or 100 percent). Medicaid beneficiaries cannot buy regular QHPs in the Marketplace, and consumers who are not Medicaid beneficiaries may not apply tax credits to obtain the QHP lookalikes that are available through the Medicaid premium assistance programs.

⁶ For example, Medicaid does not allow copayments for emergency services, family planning services, or pregnancy-related services. Copayments are limited to nominal or minimal amounts for most other services. For example, copayments are \$4 for outpatient services, \$4 for preferred drugs, \$8 for non-preferred drugs, and \$75 for inpatient services, including hospital stays. See <https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html>

⁷ Arkansas operates a type of State-based Marketplace called a State-based Marketplace-Federal Platform, in which the state relies on the Federally-facilitated Marketplace IT platform but otherwise performs all Marketplace functions. Iowa and New Hampshire are State-Partnership Marketplaces. See <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁸ The Essential Health Benefits categories, set forth in 42 U.S. Code § 18022, include ambulatory services; emergency

services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The law does not specify which benefits QHPs must provide in each category, although it requires that the scope of benefits must be equal to that of a typical employer plan. For more information on Essential Health Benefits see <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html>

⁹ Federal regulations set forth in 42 CFR § 447.78 limit aggregate out-of-pocket Medicaid expenses—including premiums and cost-sharing—to five percent of income, calculated on a quarterly or monthly basis. See <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec447-78.pdf>

¹⁰ For more information on wraparound benefits in premium assistance demonstrations, see Bradley, Katharine and Maggie Colby, "Wraparound Benefits in Premium Assistance Demonstrations." Issue brief submitted to the Centers for Medicare & Medicaid Services. Cambridge, MA: Mathematica Policy Research, September 2017.

¹¹ States with premium assistance demonstrations must cover the insurance premium payments and other cost-sharing that exceeds the 5-percent limit (see note 8 above). States provide cost-sharing protections in several ways, including by designating high "actuarial value" plans that have low levels of cost-sharing, by developing systems to track beneficiaries' total out-of-pocket expenses, and by making cost-sharing reduction payments to carriers.

¹² Allowable rating practices based on tobacco use are set forth in 42 U.S. Code § 300gg. For more information on the provisions of the Affordable Care Act that relate to tobacco use, see http://www.integration.samhsa.gov/health-wellness/How_the_Affordable_Care_Act_Affects_Tobacco_Use_and_Control.pdf

¹³ It should be noted that the issue of accounting for pregnant women in rate-setting for adults made eligible under the Affordable Care Act is not limited to premium assistance states.

¹⁴ At the time of our interviews with state officials in early 2016, no benefit appeals by premium assistance beneficiaries had been escalated to the Medicaid agency or to a state fair hearing in Arkansas or Iowa (New Hampshire had only recently implemented its premium assistance program).

¹⁵ For more information on the national evaluation, see Irvin, Carol V., Debra Lipson, Carey Appold, Maggie Colby, Katharine Bradley, Jessica Heeringa, Jenna Libersky, Vivian Byrd, and Julia Baller. "Medicaid 1115 Demonstration Evaluation Design Plan." Final report to the Centers for Medicare & Medicaid Services. Cambridge, MA: Mathematica Policy Research, May 2015. The design plan is available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf>