Medicaid and the Affordable Care Act: Premium Assistance
March 2013

1. Is Arkansas seeking a partial expansion of Medicaid, with individuals above the poverty threshold getting tax credits for private qualified health plans (QHPs) in Health Insurance Marketplaces (Exchanges) and those with income below the poverty threshold receiving Medicaid?

No. As stated in the past, the Affordable Care Act does not provide for a phased-in or partial expansion. 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. Arkansas has initiated discussions about "premium assistance" options for Medicaid beneficiaries; partial expansion is not part of these discussions.

2. What is premium assistance in Medicaid?

The Medicaid statute provides several options for states to pay premiums for adults and children to purchase coverage through private group health plans, and in some case individual plans; in most cases, the statute conditions such arrangements on a determination that they are "cost effective." Cost effective generally means that Medicaid's premium payment to private plans plus the cost of additional services and cost sharing assistance that would be required would be comparable to what it would otherwise pay for the same services. Similar provisions also apply in the Children's Health Insurance Program (CHIP).

Under all these arrangements, beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections. States must have mechanisms in place to "wrap-around" private coverage to the extent that benefits are less and cost sharing requirements are greater than those in Medicaid. In addition under the statutory options in the individual market beneficiaries must be able to choose an alternative to private insurance to receive Medicaid benefits.

A state may pursue premium assistance as a state plan option without a waiver.

3. Would the Department of Health and Human Services (HHS) consider premium assistance demonstrations for the individual market?

Some states have expressed interest in section 1115 demonstrations to provide premium assistance for the purchase of QHPs in the Exchange. Under section 1115 of the Social Security Act, the Secretary may approve demonstration projects that she determines promote the objectives of the Medicaid program. HHS will consider approving a limited number of premium assistance demonstrations since their results would inform policy for the State Innovation Waivers that start in 2017. As with all such demonstrations, HHS will evaluate each proposal that is submitted and consider it on a case by case basis relative to this standard.

With regard to premium assistance demonstrations, HHS will consider states' ideas on cost effectiveness that include new factors introduced by the creation of Health Insurance Marketplaces and the expansion of Medicaid. For example, states may quantify savings from reduced churning (people moving between Medicaid and Exchanges as a result of fluctuating incomes) and increased competition in Marketplaces given the additional enrollees due to premium assistance. As with all demonstration proposals, the actuarial, economic, and budget justification (including budget neutrality) would need to be reviewed and, if approved, the program and budgetary impact would need to be carefully monitored and evaluated.

To ensure that the demonstrations further the objectives of the program and provide information in a timely way, HHS will only consider proposals that:

- Provide beneficiaries with a choice of at least two qualified health plans (QHPs).

- Make arrangements with the QHPs to provide any necessary wrap around benefits and cost sharing along with appropriate data; this would be done within the context of premium assistance, for example through a supplemental premium. This ensures that coverage is seamless, that cost sharing reductions are effectively delivered and that there is accountability for the payments made.

- Are limited to individuals whose benefits are closely aligned with the benefits available on the Marketplace, that is, individuals in the new Medicaid adult group who must enroll in benchmark coverage and are not described in SSA 1937(a)(2)(B)(an example of a population that is described in SSA 1937(a)(2)(B) is the medically frail). Marketplace plans were not designed to offer broader benefits and could experience unexpected adverse selection due to enrollment of groups that are described in SSA 1937(a)(2)(B).

- End no later than December 31, 2016. Starting in 2017, State Innovation Waiver authority begins which could allow a range of State-designed initiatives.

In addition, a state may increase the opportunity for a successful demonstration by choosing to target within the new adult group individuals with income between 100 and 133 percent of FPL. Medicaid allows for additional cost-sharing flexibility for populations with incomes above 100 percent of FPL; this population is more likely to be subject to churning and would be eligible for advance premium tax credits and Marketplace coverage if a state did not expand Medicaid to 133 percent of FPL.