



Coverage Expansion Learning Collaborative

Medicaid QHP Premium Assistance

September X, 2014

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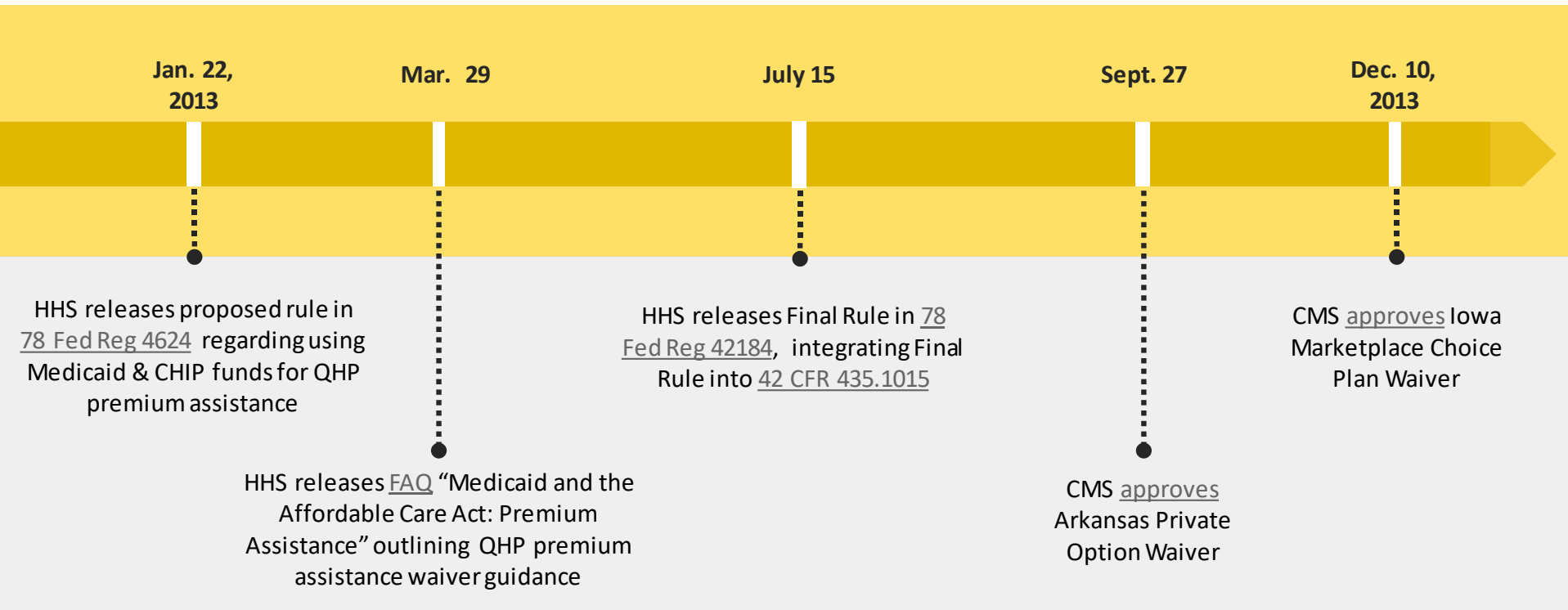
Agenda

- **Marketplace Premium Assistance Overview**
- **Authorization Vehicles for Marketplace Premium Assistance**
- **Federal Requirements and Operational Implications**
- **Discussion**

Marketplace Premium Assistance Overview

Premium Assistance Regulatory Timeline

Social Security Act Section 1905(a) authorizes states to use premium assistance to purchase private coverage in the individual market with Medicaid funds



States are Using a Range of Delivery Models for Medicaid

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Premium Assistance for Qualified Health Plans (QHPs). Enables states to purchase coverage for some or all new adults through qualified health plans on the Marketplace



Premium Assistance for Employer Sponsored Insurance (ESI). States may require Medicaid-eligible enrollees with access to ESI to take up that coverage, with Medicaid covering the employee premiums, excess cost sharing and missing benefits



Medicaid Managed Care. States with robust Medicaid Managed Care programs are using these private plans to deliver services to expansion adults.

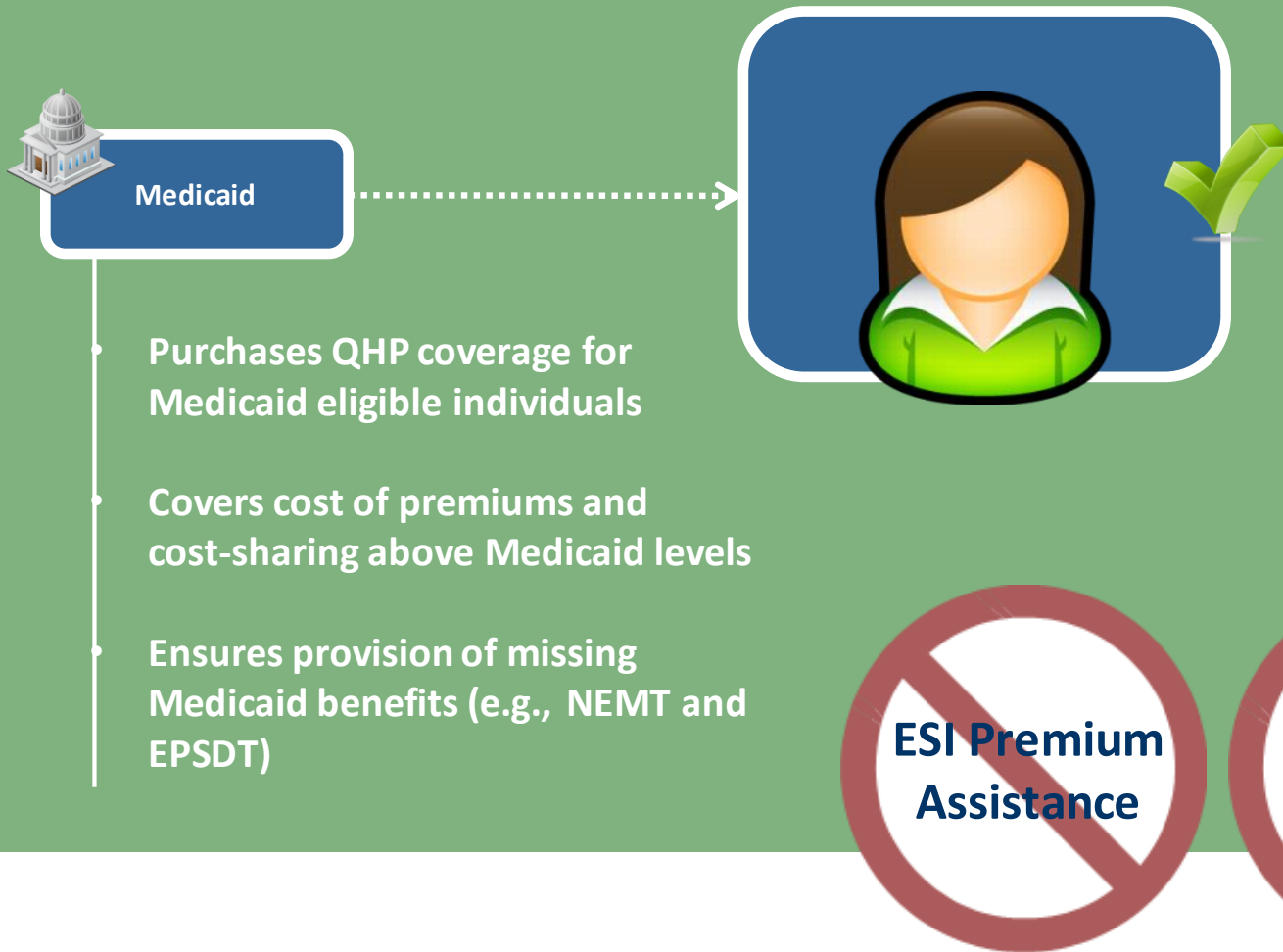


Provider-Led Accountable Care Models. Both expansion and non-expansion states are pursuing reforms that require providers to assume responsibility for the cost and quality of care delivered to Medicaid enrollees

Delivery Model Options Are Not Mutually Exclusive

- States may implement more than one model simultaneously or may implement different models for different populations or in different geographic regions
- States may sequence implementation of delivery models

Premium Assistance on the Marketplace



Reasons States Have Pursued QHP Premium Assistance

- Enables continuity of coverage and care as individuals' and families' income fluctuates
- Enables comparable access to providers for all state residents in the individual market, regardless of income
- May encourage Marketplace competition
 - Increased size of the individual market may attract more plans
 - Increased competition may drive down Marketplace premiums
- Aligns regulation and oversight across government and private markets
- Enhances stability of risk pool through increasing potential enrollees
- Provides opportunity to test hypothesized improvements to quality and outcomes

Challenges States May Face with QHP Premium Assistance

- Administratively complex for states to operationalize
- Different considerations for states with Medicaid managed care
- Requires an 1115 Waiver if state's goal is to make the program mandatory
- Voluntary and mandatory programs must demonstrate cost effectiveness

Authorization Vehicles for Marketplace Premium Assistance

Authorization for QHP Premium Assistance: SSA 1905(a)

SSA § 1905(a): Definition of Medical Assistance

Authorizes states to use Medicaid dollars for “other insurance premiums for medical or any other type of remedial care or the cost thereof”

42 CFR 435.1015

- Authorizes FFP for “payment of the costs of insurance premiums on behalf of an eligible individual for a health plan offered in the individual market”
- Requires states to provide Medicaid benefits not covered through the individual health plan
- Requires states to ensure Medicaid beneficiaries do not incur cost sharing charges in excess of Medicaid limits
- Requires program to be cost-effective relative to what the state would have spent, including administrative expenditures, to provide comparable coverage through Medicaid
- Requires program to be voluntary (absent a waiver)

Waiver Option

A waiver is required if the state wants to:

- Establish a mandatory premium assistance program
- Modify benefits or cost-sharing
- Extend the coverage model to a subset of Medicaid eligible individuals (comparability)
- Use alternative cost effectiveness test

Waiver Guidance

HHS will only consider proposals for 1115 premium assistance demonstrations that:

- Provide beneficiaries with a choice of at least two QHPs
- Wrap any cost sharing and benefits necessary with seamless coverage, accountability for payments and effective cost-sharing reductions
- Protect rights of medically frail and tribal populations
- Demonstrate cost effectiveness & budget neutrality

Federal Requirements and Operational Implications

QHP Premium Assistance Issue Areas



Eligibility & Target Population



Benefits & Network Adequacy



Premiums & Cost-Sharing



Shopping & Enrollment



Cost Effectiveness



Appeals



Interagency Cooperation

Eligibility & Target Population

Legal Requirements and HHS Guidance

Eligibility Requirements:

- No program requirements beyond standard Medicaid/CHIP eligibility rules
- Comparability applies (program must be applied to all Medicaid/CHIP beneficiaries, absent a waiver)

Target Population for Mandatory Programs:

- Will only consider mandatory program proposals limited to individuals whose Medicaid benefits are closely aligned with those available on the Marketplace
 - Unlikely to consider populations such as:
 - Medically frail
 - Children
 - Low-income parents

Eligibility & Target Population: Examples



ARKANSAS:

All newly eligible adults:

- Childless adults aged 19-64: 0-138% FPL
- Parents aged 19-64: > 17% FPL

Medically frail individuals are excluded



IOWA:

Newly eligible adults aged 19-64:
>100-138% FPL

Medically frail individuals are exempt

Newly eligible adults <=100% FPL not enrolled
through Premium Assistance program



Benefits & Network Adequacy

Benefits & Network Adequacy: Legal Requirements and HHS Guidance

Align Benefits

- Premium assistance enrollees remain Medicaid beneficiaries entitled to all Medicaid benefits
- Benefits not covered under QHP must be wrapped
 - Non-emergency medical transportation (NEMT) *Waived for year 1 in Iowa*
 - For 19 and 20 year old new adults, some EPSDT benefits (e.g., vision, dental)

Align Pharmacy

- State must align Medicaid and QHP prior authorization requirements
 - Medicaid requires a 24 hour turnaround for pharmacy prior authorization requests, and that individuals be able to receive a 72-hour emergency supply of drugs while a prior authorization request is pending.
- States must also align Medicaid and QHP formularies. Medicaid beneficiaries are entitled to barbiturates and benzodiazepines, which may not be covered in the QHP

Rebates

- The availability of rebates depends on the mechanism the state uses to align cost-sharing with Medicaid standards. If the state wraps per prescription filled, the rebate applies. If the state deploys cost-sharing reductions, the rebate does not apply.

Network Adequacy

- QHPs' network adequacy is a condition of certification regulated by state insurance departments
- For premium assistance, the state must ensure that Medicaid/CHIP enrollees also have access to required Medicaid/CHIP providers:
 - FQHCs/RHCs at Prospective Payment System (PPS) rates
 - I/T/U providers
 - Family planning providers, including out-of-network

The "New Adult" Population receives the **ALTERNATIVE BENEFIT LAN (ABP)**

- 10 Essential Health Benefits
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 and 20 year olds
- Non-emergency medical transportation
- In-network Federally Qualified Health Centers
- Free access to family planning services and providers

Benefits & Network Adequacy: Examples

CMS to decide whether to include non-emergency use of ER bullet



ARKANSAS:

Did not request any benefit waivers for 2014

No coverage of non-emergency use of the ER

Wrap benefits provided by FFS Medicaid

Limited to QHP formulary

Prior authorization within 72 instead of 24 hours, but prescribed pharmaceutical provided in the interim in the event of an emergency



IOWA:

Received a one-year waiver of NEMT

Wrapped EPSDT benefits provided by FFS Medicaid

Limited to QHP formulary

Prior authorization within 72 instead of 24 hours, but prescribed pharmaceutical provided in the interim in the event of an emergency



Premiums & Cost-Sharing: Key Legal Requirements and HHS Guidance

Premiums

- Enrollees with incomes < 150% FPL may not be charged premiums (unless state receives a waiver)
 - Premiums and cost sharing are subject to the 5% aggregate cap

See Appendix for full Medicaid premium and cost-sharing requirements

Cost-Sharing

- Cost sharing must comply with Medicaid requirements (unless state receives a waiver)
 - *Note: Special statutory limits on waiving cost-sharing requirements exist*
- **Aggregate cost sharing (inclusive of premiums) imposed on family with income < 150% FPL may not exceed 5% of family income on a monthly or quarterly basis**
- States are required to track an individual's cost sharing contributions in order to determine when the 5% aggregate maximum is reached, if reasonable risk that beneficiary could reach the aggregate cap

Premiums & Cost-Sharing: Examples



ARKANSAS:

No premiums

Cost-sharing for a range of services for individuals 100-138% FPL; consistent with Medicaid requirements



IOWA:

Premiums up to \$10/month for individuals 100-138% FPL, waived for first year of enrollment; may be condition of eligibility; may be waived with hardship exemption

Cost-sharing limited to \$8 co-payment for non-emergency use of the ER for individuals 100-138% FPL



Premiums up to \$10/month for individuals 50-100% FPL, waived for first year of enrollment; not a condition of eligibility; non-payment may result in collectible debt.

This population is not enrolled through QHP premium assistance program.

Legal Requirements and HHS Guidance

Plan Selection

- If in mandatory program, enrollees must have a choice of at least two QHPs

Enrollment Periods

- If in mandatory program, enrollment must be permitted at any time (may not be limited to Marketplace open enrollment and special enrollment periods)
- State must provide coverage between date of application and enrollment in QHP

Retroactive Coverage

- Enrollees are eligible for three months retroactive Medicaid coverage from the date of application

Shopping and Enrollment: Key Issues

Key Operational Considerations:

- How will the state effectuate retroactive coverage?
- How will the state effectuate coverage between date of application and QHP enrollment?
- Which QHPs will Medicaid beneficiaries be able to enroll in?
 - All Silver-level QHPs?
 - High-value Silver-level QHPs? *Both Arkansas and Iowa permit enrollment only in high-value Silver-level QHPs*
 - Based on quality or other state priorities?
- How will the state effectuate shopping and enrollment in the available QHPs?
- How much time will individuals be given to select a QHP before they are auto-assigned?
- What will the auto-assignment methodology be?
 - Equally across plans?
 - Based on state priorities?

Legal Requirements and HHS Guidance

Cost Effectiveness Requirement

The cost of providing coverage through premium assistance (including QHP premiums, cost-sharing above Medicaid permissible limits, coverage of additional services and administrative expenditures) must be comparable to the cost of providing direct coverage under the State Plan

Cost Effectiveness in a Waiver

HHS will consider alternative cost effectiveness tests that consider, among others:

- Savings from reduced churning between Medicaid and the Marketplace
- The economic benefits of increased competition on the Marketplace
- Improved access
- Improved patient outcomes
- Benefits of families being covered under one product

Legal Requirements and HHS Guidance

- Medicaid beneficiaries have a constitutional right* to a “Medicaid fair hearing”
- Commercial appeals processes used by QHPs may not align with the Medicaid fair hearing requirements in 4 key areas:
 - Right to cross-examine
 - Right to testify / appear on your own behalf
 - Aid continuing (i.e., accessing “continued benefits” during appeal process)
 - Time frames for appeal processes, including decisions **For discussion: Government agency requirement?**
- States may use the QHP appeals process in a Medicaid premium assistance program, to the extent it complies with, or may be supplemented to assure, provision of rights listed above

Legal Requirements and Operational Considerations

Federal Requirements

- Medicaid is the “single state agency” and remains fully accountable for ensuring compliance with Medicaid requirements
- If Medicaid agency delegates any responsibility to a state insurance agency, an Intergovernmental Cooperation Act Waiver is required and a Memorandum of Understanding (MOU) may be required

Operational Considerations

- Potential MOUs between and among:
 - Medicaid agency
 - Insurance agency
 - Exchange board (if applicable)
 - QHPs

Thank You!

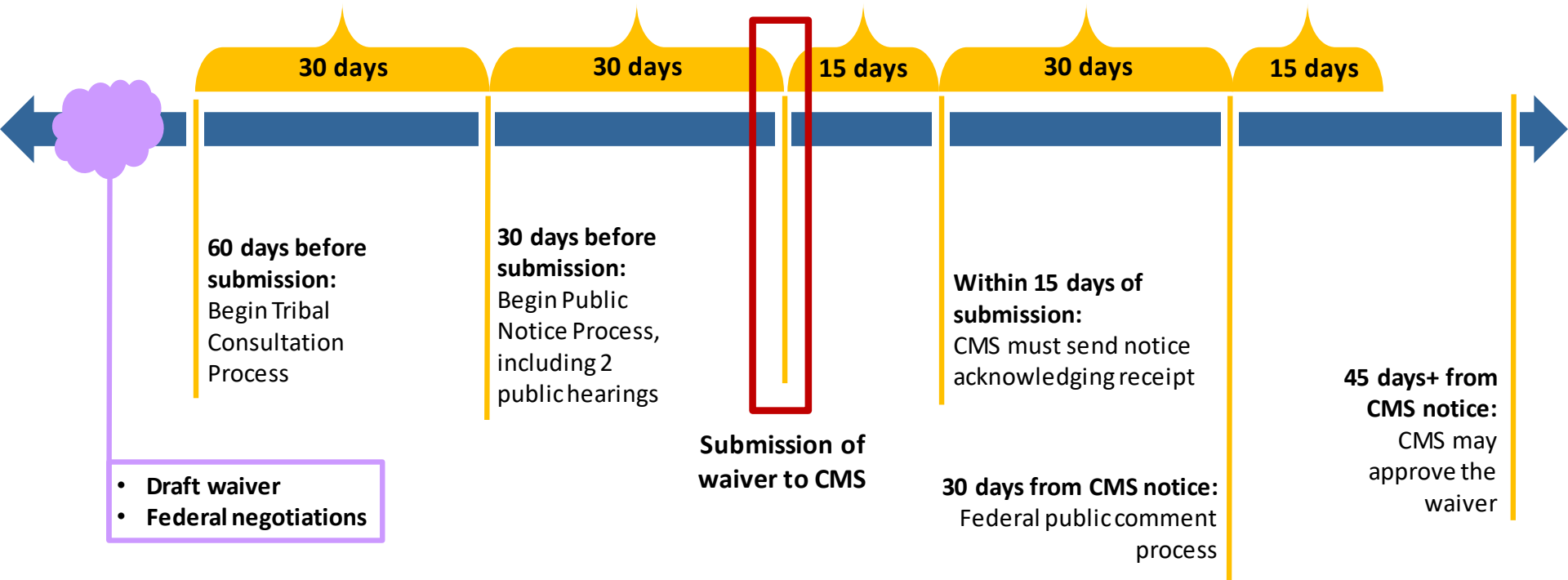
Appendix

Medicaid Premium & Cost-Sharing Rules



| | < 100% FPL | 100% - 149% FPL | ≥ 150% FPL |
|---|--------------------------------------|---|--|
| <i>Maximum Allowable Medicaid Premiums and Cost Sharing</i> | | | |
| Aggregate Cost-Sharing Cap | 5% household income | 5% household income | 5% household income |
| Premiums | Not allowed | Not allowed | Permitted, subject to aggregate cap |
| <i>Maximum Service Related Co pays/Co Insurance</i> | | | |
| Outpatient services | \$4 | 10% of cost the agency pays | 20% of cost the agency pays |
| Non-emergency ER | \$8 | \$8 | No limit |
| Rx Drugs | Preferred: \$4 Non-Preferred: \$8 | Preferred: \$4 Non-Preferred: \$8 | Preferred: \$4 Non-Preferred: 20% of cost the agency pays |
| Institutional | \$75 per stay | 10% of total cost the agency pays for the entire stay | 20% of total cost the agency pays for the entire stay |

- Specific services are exempt from cost-sharing, including emergency services, family planning and pregnancy-related services
- Specific populations are exempt from cost-sharing requirements (e.g., pregnant women, spend-down beneficiaries, and individuals receiving hospice). However, exempt individuals may be charged cost-sharing for non-preferred drugs and non-emergency use of the emergency room
- Services may not be denied for individuals who fail to make co-payments if their income <100% FPL; services may be denied for those with incomes >100% FPL
- If non-preferred drugs are medically necessary, preferred drug cost sharing applies

1115 Waiver Submission & Decision Timeline



Approved State QHP Premium Assistance Programs

| | Populations Covered | Benefit Variations | Premiums | Cost-Sharing | Healthy Behavior Incentives |
|--|--|--|--|--|--|
| Arkansas  | <ul style="list-style-type: none"> Newly eligible adults with incomes 0-138% FPL Medically frail excluded | No coverage of non-emergency use of the ER | No | Yes <ul style="list-style-type: none"> Individuals with incomes 100-138% FPL only Applied to wide range of services Consistent with Medicaid requirements | No |
| Iowa  | <ul style="list-style-type: none"> Newly eligible adults with incomes 100-138% FPL who do not have access to cost effective ESI Medically frail exempt | Non-emergency medical transportation waived for one year | Yes <ul style="list-style-type: none"> Up to \$10/month for 100-138% FPL May be terminated for failure to pay for 90 days and do not request hardship waiver | Yes <ul style="list-style-type: none"> Individuals with income 0-138% FPL Limited to \$8 co-payment for non-emergency use of the ER | Yes <ul style="list-style-type: none"> May reduce premium obligations |