



Continuing with the Same Issuer in Transitions Between Medicaid and the Marketplace: Premium Assistance Models in Arkansas, Iowa, and New Hampshire

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Executive summary

Many low-income adults experience fluctuations in income and household composition that affect their eligibility for Medicaid versus Marketplace subsidies, causing churning between public and private coverage. Smoothing these coverage transitions was one objective of section 1115 demonstrations in Arkansas, Iowa, and New Hampshire, which expanded Medicaid coverage to beneficiaries with incomes up to 133 percent of the federal poverty level¹ and offered premium assistance to support new beneficiaries' enrollment in qualified health plans (QHPs) based on those available in the Federally Facilitated Marketplace. Beneficiaries who transition between coverage types are more likely to be able to stay enrolled with the same issuer and keep the same providers when the same issuer offers plans in both settings in a given state. To examine the potential for continuity of coverage across settings, we used information on issuer participation to assess the overlap between Marketplace and premium assistance issuers, as well as the overlap between issuers offering Medicaid managed care plans and QHPs in the states that served as comparisons to the demonstration states.

Arkansas and New Hampshire both require issuers who participate in the Marketplace to also participate in premium assistance; there is complete overlap in issuers participating in both settings in those states. There was less overlap in

Iowa, where participation in premium assistance was optional for Marketplace issuers when the state's premium assistance program was operational in 2014 and 2015. The complete issuer overlap in Arkansas and New Hampshire increases the potential for beneficiaries to stay enrolled with the same issuer as they experience changes in eligibility for Medicaid expansion or Marketplace subsidies. This degree of overlap seems unlikely to exist in the absence of state intervention—either through regulation or incentives—given Iowa's experience and the limited overlap between Marketplace and Medicaid managed care plans that we observed in most states.

Though our focus was on understanding premium assistance as a tool to smooth coverage transitions, we also note that fluctuations in Marketplace participation can create obstacles to continuity of coverage over time. Marketplace issuers must apply to offer coverage and be certified as QHPs on an annual basis, thus annual entries and exits may require both Marketplace and premium assistance beneficiaries to change issuers from one year to the next.

Likewise, our analyses highlight challenges in bridging Medicaid managed care and Marketplace coverage (with or without premium assistance as an intermediate step). States can enter into multi-year contracts with managed care organizations to provide coverage for Medicaid beneficiaries, a contrast to the annual Marketplace process. Given these distinct regulatory

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 premium assistance programs have required multiple beneficiary protections, such as limits on total cost-sharing, access to certain mandatory benefits, and rights to fair hearings.

environments, it is unsurprising that we found more changes from 2014 to 2017 among Marketplace issuers than among Medicaid managed care issuers in the states we examined. If states are interested in continuity of enrollment with the same issuer for Medicaid populations other than those enrolled in premium assistance, they might consider regulations or incentives to improve issuer overlap between the Marketplace and Medicaid managed care, and to improve the stability of Marketplace issuers.

Introduction

Three states—Arkansas, Iowa, and New Hampshire—expanded Medicaid and used section 1115 demonstration authority to support new beneficiaries' enrollment in qualified health plans (QHPs) based on those available in the Federally Facilitated Marketplace.² Premium assistance demonstrations allow states to pay the insurance premiums for non-disabled adults under age 65 with household incomes up to and including 133 percent of the federal poverty level (FPL). Beneficiaries eligible for these demonstrations are required to enroll in QHPs as long as they are not medically frail and can choose between two or more QHP issuers. Arkansas and Iowa implemented premium assistance demonstrations in January 2014, and New Hampshire began its premium assistance demonstration in January 2016.³ Arkansas and New Hampshire continue to operate their demonstrations, whereas Iowa suspended its premium assistance program in December 2015.

States choose to implement premium assistance demonstrations in part because they believe enrolling adults in QHPs offers advantages over traditional Medicaid coverage. For example, if adults lose Medicaid eligibility and transition to the Marketplace, their coverage and provider relationships might be less disrupted if the same issuer offers plans in both settings (Rosenbaum and Sommers 2013). Smoother transitions could benefit the substantial proportion of low-income adults who experience changes in their health insurance coverage each year—recent studies of low-income adults in three states have estimated this proportion to be around 20 to 25 percent (Sommers et al. 2016; Maylone and Sommers 2017).

In this brief, part of an ongoing series designed to assess how states implemented their demonstrations, we first summarize the key features of the three premium assistance demonstrations. Focusing on the years 2014 - 2017, we then discuss (1) the degree of overlap between premium assistance and Marketplace issuers in the three demonstration states, and the degree of overlap between Medicaid managed care (MMC) and Marketplace issuers in both demonstration and comparison states; (2) changes in Marketplace issuer participation over time; and (3) changes in MMC issuer participation over time. Throughout, we discuss how issuer participation supports

the potential for continuity of coverage when beneficiaries switch between coverage sources, and whether regulations or incentives may be needed to encourage broader participation by issuers in different settings to support the goal of issuer and provider continuity.

To conduct these analyses, we compiled lists of issuers in the demonstration states that participated in premium assistance, along with lists of issuers in all demonstration and comparison states that offered coverage via MMC or the Marketplace. We included Kentucky, Indiana, Michigan, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Washington, and West Virginia as comparison states.⁴ These states, which have served as comparisons for other aspects of the national section 1115 demonstration evaluation,⁵ were similar to the demonstration states in two important respects: each expanded Medicaid to include adults with incomes up to 133 percent FPL in 2014 or 2015, and each had historically low income eligibility thresholds for adults before the expansion. We categorized comparison states by market size, and focused our assessment of issuer participation by comparing New Mexico, West Virginia, and North Dakota to New Hampshire (small markets), and by comparing Kentucky, Nevada, and Oregon to Arkansas and Iowa (medium markets).⁶

How are states implementing premium assistance?

States with premium assistance demonstrations supporting enrollment in QHPs cover the premium payments to QHP issuers and cost-sharing for eligible adults. Beneficiaries access most of their care through provider networks maintained by the QHPs, and can also access mandatory “wraparound” benefits through Medicaid providers who are reimbursed on a fee-for-service basis (Bradley and Colby 2017). Premium assistance states offer the following wraparound benefits: non-emergency medical transportation (in Arkansas and New Hampshire), family planning services from out-of-network providers, and Early and Periodic Screening, Diagnostic, and Treatment services for 19- and 20-year-olds.

Arkansas. Arkansas implemented its premium assistance program in January 2014 under the Health Care Independence Program (Private Option) demonstration. The state extended its demonstration for the period spanning 2017 through 2021 under the name Arkansas Works. There were no significant changes to premium assistance with the implementation of Arkansas Works in 2017. Enrollment in Arkansas' premium assistance program is mandatory for expansion adults with incomes through 133 percent of the FPL with the exception of those who are medically frail, American Indians or Alaska Natives, or pregnant. All issuers who offer QHPs in the Marketplace offer plans that qualify for the premium assistance program, as required by the Arkansas Insurance Department.

Iowa. Iowa's premium assistance demonstration, Marketplace Choice, operated between January 2014 and December 2015. Enrollment in Marketplace Choice was mandatory for adults with incomes from above 100 percent of the FPL up to 133 percent, other than those who were medically frail, American Indians, or Alaska Natives. Those with access to cost-effective employer-sponsored insurance were not eligible. The Iowa Insurance Division allowed issuers to make their own decisions about whether to take on the risk of participating in premium assistance because regulators did not want the state to be liable for issuer insolvency (Bradley and Wagnerman 2017). Only two Marketplace issuers participated in premium assistance in the first year of the demonstration. One of these became insolvent in late 2014 and the other stopped accepting new Medicaid beneficiaries in 2015, effectively ending the premium assistance demonstration. The state received approval in January 2016 to modify eligibility for its other 1115 demonstration, the Iowa Wellness Plan, to include the population formerly enrolled in premium assistance.

New Hampshire. New Hampshire implemented its Premium Assistance Program as part of the New Hampshire Health Protection Program demonstration, with coverage in QHPs beginning in January 2016. Enrollment in the Premium Assistance Program is mandatory for adults with incomes through 133 percent of the FPL, except for those who are medically frail. American Indians, Alaska Natives, and pregnant women can opt out of premium assistance and into traditional Medicaid coverage. The state planned to exclude individuals with access to cost-effective employer-sponsored insurance from the demonstration, but did not implement this exclusion because so few eligible adults had offers of such insurance. All issuers that offer QHPs in the Marketplace offer plans that qualify for the Premium Assistance Program, as required by the New Hampshire Insurance department.

How much overlap exists between Medicaid and Marketplace issuers?

Premium assistance issuers and Marketplace issuers.

Arkansas and New Hampshire have complete overlap between Medicaid premium assistance and Marketplace issuers, whereas Iowa had less overlap. As noted, the Arkansas and New Hampshire insurance departments require issuers that offer QHPs in the Marketplace to also offer plans that qualify

for the premium assistance program. As a result, beneficiaries who cycle between premium assistance and Marketplace plans have a higher likelihood of staying with the same issuer in those states. Iowa did not have this requirement; only two of its four Marketplace issuers in 2014 and one of its three Marketplace issuers in 2015 offered both Marketplace and premium assistance plans (Table 1). The fact that several of Iowa's Marketplace issuers opted out of participating in premium assistance suggests that high overlap, which supports greater continuity of enrollment with an issuer, may only be achievable through active state intervention—either through regulation or incentives. Determining whether participation requirements are necessary may depend on the size of the state and Marketplace participation trends.

MMC issuers and Marketplace issuers. None of the states we examined require Marketplace issuers to also offer MMC plans, or vice versa. New Hampshire did not have any issuers offering plans in both the Marketplace and MMC settings. One issuer in Iowa offered both Marketplace and MMC plans in 2016 when Iowa transitioned all demonstration enrollees into Medicaid managed care; however, the issuer dropped out in 2017 (Table 1). Arkansas does not contract with managed care plans for its Medicaid program. Two of the three small-market comparison states had no or very little overlap in issuers. In the third small-market comparison state, three out of six issuers offering either MMC or Marketplace plans participated in both markets from 2015 to 2016, and two out of six participated in both markets in 2017. Among medium-market comparison states, between one and four issuers participated in both settings, representing 5 to 44 percent of all Marketplace and MMC issuers, depending on the state.

We note that overlap between Marketplace and MMC issuers was consistently higher in Michigan than in any other state we considered (39 to 67 percent across 2014 to 2017), and Michigan had no requirements in place that would predict this outcome. Relatively high existing overlap suggests a strong potential foundation for the premium assistance program that Michigan is adding to its section 1115 demonstration in 2018. If issuers currently participating in MMC and the Marketplace also decide to participate in Medicaid premium assistance, many beneficiaries could have continuity of enrollment with the same issuer across all three plan types—MMC plans, premium assistance, and subsidized Marketplace coverage.

Table 1. Number of overlapping issuers and percentage of overlapping issuers out of all participating issuers, by state, 2014–2017

States	2014 N (%)	2015 N (%)	2016 N (%)	2017 N (%)
Small markets (<150K potential Marketplace enrollees)				
Demonstration states				
New Hampshire				
Premium assistance and Marketplace issuers	n.a.	n.a.	5 (100)	4 (100)
MMC and Marketplace issuers	0 (0)	0 (0)	0 (0)	0 (0)
Comparison states (MMC and Marketplace issuers)				
New Mexico	1 (20)	3 (50)	3 (50)	2 (33)
North Dakota	1 (33)	1 (33)	1 (33)	1 (33)
West Virginia	0 (0)	0 (0)	0 (0)	0 (0)
Medium markets (200–300K potential Marketplace enrollees)				
Demonstration states				
Arkansas				
Premium assistance and Marketplace issuers	3 (100)	4 (100)	5 (100)	4 (100)
MMC and Marketplace issuers	n.a.	n.a.	n.a.	n.a.
Iowa				
Premium assistance and Marketplace issuers	2 (50)	1 (33)	n.a.	n.a.
MMC and Marketplace issuers	0 (0)	0 (0)	1 (14)	0 (0)
Comparison states (MMC and Marketplace issuers)				
Kentucky	2 (33)	3 (43)	4 (44)	2 (33)
Nevada	1 (20)	1 (17)	1 (20)	1 (20)
Oregon	2 (8)	2 (8)	2 (9)	1 (5)
Large markets (>450K potential Marketplace enrollees)				
Comparison states (MMC and Marketplace issuers)				
Indiana	3 (30)	3 (12)	3 (12)	3 (21)
Michigan	7 (39)	10 (56)	10 (67)	7 (50)
Ohio	4 (29)	5 (31)	6 (38)	4 (31)
Pennsylvania	5 (19)	5 (12)	4 (11)	2 (13)
Washington	3 (21)	4 (33)	4 (33)	3 (27)

Source: Mathematica analysis of Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight Service Area Public Use Files, 2014–2017; 2014 and 2015 CMS Medicaid Managed Care Enrollment and Program Characteristics; 2016–2017 National Committee for Quality Assurance Medicaid Health Insurance Plan Rating; 2014–2017 Oregon Health System Transformation CCO Performance Metrics Reports; Iowa 1115 Demonstration Waiver Marketplace Choice quarterly monitoring reports; and Kaiser Family Foundation's "2016 Medicaid MCOs and Their Parent Firms." For the states that did not use healthcare.gov for their Marketplace, issuer information was gathered from state exchange websites, press releases, and reports as of May 3, 2017.

Notes: For the premium assistance and Marketplace overlap percentages, we use the total number of unique Marketplace and premium assistance issuers as the denominator. For the MMC and Marketplace overlap percentages, we use the total number of unique Marketplace and MMC issuers as the denominator. Among states included in our analysis, the number of unique issuers ranges from 4 to 7 in states with small markets; 5 to 25 in states with medium markets; and 10 to 37 in states with large markets.

Issuers must offer plan(s) for the entire year to be included as a participating issuer for that year.

Market sizes were categorized according to the number of potential 2015 Marketplace enrollees for each state, as reported by the Kaiser Family Foundation (2016).

The CMS PUF files did not include information on whether certain issuers in North Dakota only offered off-exchange stand-alone dental plans. We used information from the Kaiser Family Foundation (2017) to confirm the number of issuers offering health plans on the Marketplace, excluding those not identified by Kaiser to ensure consistent exclusion of stand-alone dental plans across states.

The managed care organizations counted for Oregon are coordinated care organizations.

Arkansas does not have MMC. Iowa's premium assistance program, Marketplace Choice, closed on December 31, 2015. New Hampshire's premium assistance program did not begin until 2016.

MMC = Medicaid managed care; n.a. = not applicable.

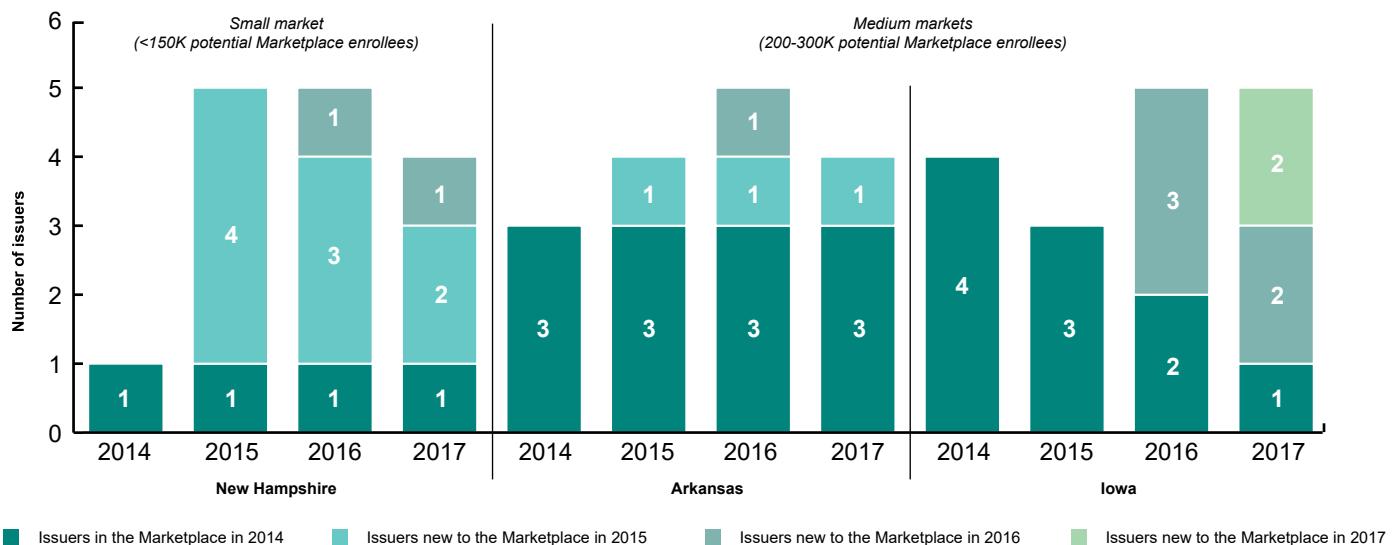
How did the number and composition of Marketplace issuers change over time?

The aggregate issuer overlap statistics we present in Table 1 mask changes in individual issuer participation in the Marketplace that can affect whether premium assistance beneficiaries remain enrolled with the same issuer from one year to the next, even if they do not experience eligibility changes. For this reason, we also examine changes in individual issuer participation in the Marketplace over time (Figure 1). The three demonstration states had distinct patterns. Iowa's Marketplace has been the most volatile. Three to five issuers participated each year, but only one of the four initial issuers in 2014 continued to participate by 2017. New Hampshire's Marketplace only had one issuer in 2014 and added four more in 2015—all but one of which continued to offer plans in 2016 when the premium assistance demonstration began. An additional issuer that joined New Hampshire's Marketplace in 2015 withdrew in 2017. Arkansas's Marketplace included three issuers at the time its premium assistance

demonstration began in 2014, and had a net increase of one issuer in 2015 and one in 2016. The issuer that joined in 2016 did not offer plans in 2017.

Because all Marketplace issuers are required to offer premium assistance plans to Medicaid beneficiaries in Arkansas and New Hampshire, changes in issuers' Marketplace participation over time could affect demonstration beneficiaries in ways that could be positive, negative, or neutral. For example, more issuers in the Marketplace could mean more plan choices for premium assistance enrollees. In contrast, when issuers leave the Marketplace, premium assistance enrollees may need to change their plans and providers. However, if the issuers that remain in the Marketplace over time cover the majority of enrollees, the effects of Marketplace changes will be limited for most enrollees. For example, in New Hampshire, Ambetter's continued participation is consequential, as it accounts for nearly half of all premium assistance enrollees. In contrast, Community Health Options enrolled less than 6 percent of premium assistance beneficiaries, and its withdrawal would therefore have more limited impacts (NH Department of Health and Human Services Medicaid Services 2016a, 2016b, 2017).

Figure 1. Changes in Marketplace issuers in demonstration states, 2014–2017

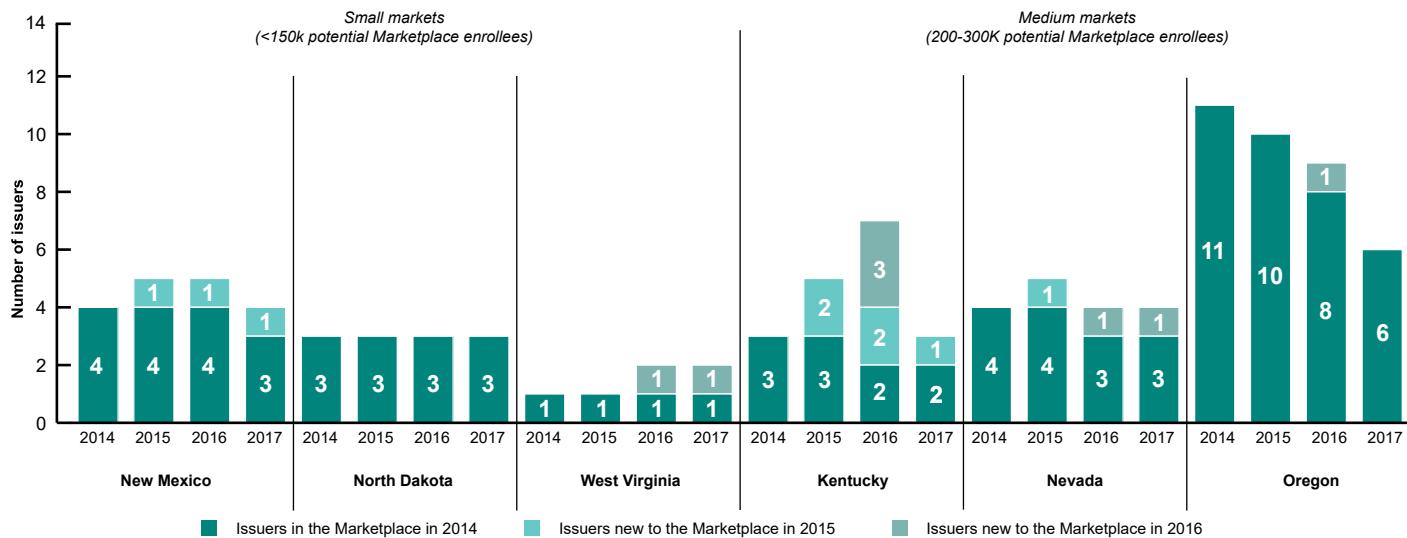


Source: Mathematica analysis of CMS Center for Consumer Information & Insurance Oversight Service Area public use files, 2014–2017.

Notes: Issuers must offer plan(s) for the entire year to be included as a participating issuer for that year.

Market sizes were categorized according to the number of potential 2015 Marketplace enrollees for each state, as reported by the Kaiser Family Foundation (KFF 2016).

Figure 2. Changes in Marketplace issuers in comparison states, 2014–2017



Source: Mathematica analysis of CMS Center for Consumer Information & Insurance Oversight Service Area public use files, 2014–2017. For the states that did not use healthcare.gov for their Marketplace, issuer information was gathered from state exchange websites, press releases, and reports as of May 3, 2017.

Notes: Issuers must offer plan(s) for the entire year to be included as a participating issuer for that year.

The CMS PUF files did not include information on whether certain issuers in North Dakota only offered off-exchange stand-alone dental plans. We used information from Kaiser Family Foundation (2017) to confirm the number of issuers offering health plans on the Marketplace, excluding those not identified by Kaiser to ensure consistent exclusion of stand-alone dental plans across states.

Market sizes were categorized according to the number of potential 2015 Marketplace enrollees for each state, as reported by the Kaiser Family Foundation (2016).

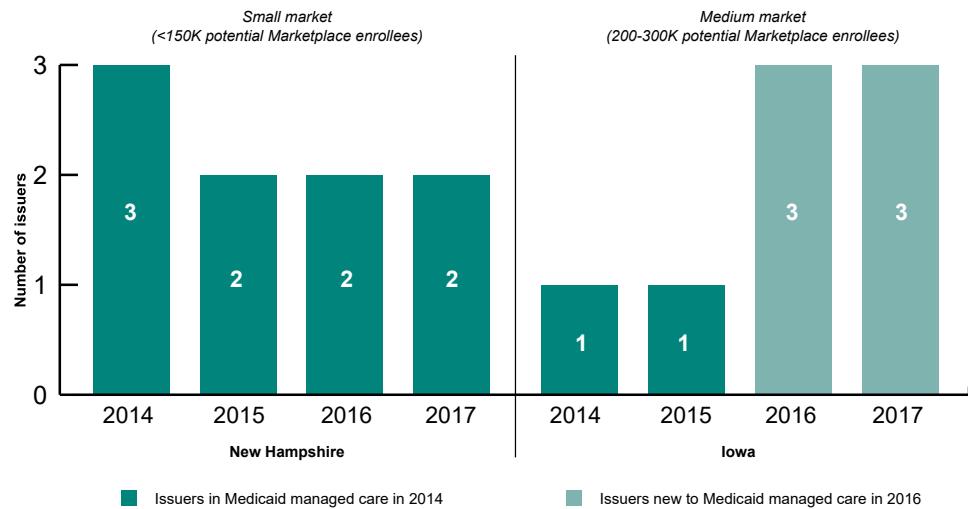
Comparison states experienced some fluctuations in Marketplace issuers between 2014 and 2017, but the majority of issuers continued to participate throughout this period in most states. Figure 2 presents issuer participation data for small- and medium-market states because they are most directly comparable to demonstration states. Fluctuations were largest in Kentucky and Oregon.

How did the number and composition of MMC issuers change over time?

Two demonstration states—Iowa and New Hampshire—had three or fewer MMC issuers in each year of the analysis period. The number of MMC issuers in Iowa increased from one in 2014

and 2015 to three in 2016, with turnover in 2016 as Iowa shifted from fee-for-service Medicaid to the IA Health Link managed care program on April 1, 2016, awarding contracts to three issuers to administer the program until 2019 (Iowa Department of Human Services 2017). In early 2016, Iowa moved remaining premium assistance beneficiaries to the Iowa Wellness Plan, and subsequently transitioned its entire Medicaid program to managed care in April 2016. New Hampshire's MMC market experienced fewer changes in participation. It included three issuers in 2014; one issuer left in 2015 but the two remaining issuers continued to offer MMC plans from 2015 to 2017 (Figure 3). Arkansas does not contract with managed care plans for its Medicaid program.

Figure 3. Changes in Medicaid managed care issuers in demonstration states, 2014–2017



Source: Mathematica analysis of 2014 and 2015 CMS Medicaid Managed Care Enrollment and Program Characteristics; 2016–2017 National Committee for Quality Assurance Medicaid Health Insurance Plan Rating; and Kaiser Family Foundation’s “2016 Medicaid MCOs and their Parent Firms.”

Notes: Issuers must offer plan(s) for the entire year to be included as a participating issuer for that year.

Sources used for 2014–2015 and 2016–2017 are based on different information. The 2014–2015 data are based on information provided by state officials and the 2016–2017 data are based on issuer reports.

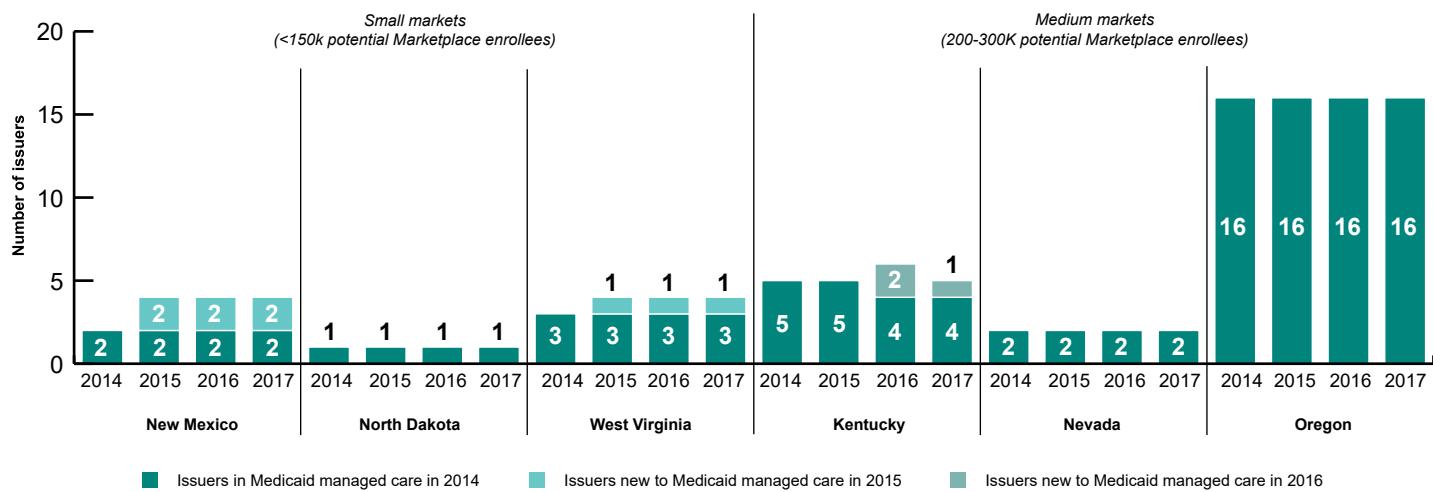
Market sizes were categorized according to the number of potential 2015 Marketplace enrollees for each state, as reported by the Kaiser Family Foundation (2016).

Arkansas does not contract with managed care plans for its Medicaid program.

As expected, MMC issuer participation remained relatively stable among most of the comparison states. States often select MMC plans through competitive bidding and establish multi-year contracts (Bailit Health Purchasing 2017). In contrast, Marketplace issuers must recertify QHPs annually in order to

offer them in the next plan year (CMS 2015). As a result, there is generally less change in MMC issuer participation than among Marketplace issuers. From 2014 to 2017, the comparison states either experienced few or no changes in the number of MMC issuers (Figure 4).

Figure 4. Changes in Medicaid managed care issuers in comparison states, 2014–2017



Source: Mathematica analysis of 2014 and 2015 CMS Medicaid Managed Care Enrollment and Program Characteristics; 2016–2017 National Committee for Quality Assurance Medicaid Health Insurance Plan Rating; 2014, 2015, and 2016 Oregon Health System Transformation CCO Performance Metrics Reports; CCO Oregon's "Resources: Coordinated Care Organization"; and Kaiser Family Foundation's "2016 Medicaid MCOs and their Parent Firms."

Notes: Issuers must offer plan(s) for the entire year to be included as a participating issuer for that year.

Sources used for 2014–2015 and 2016–2017 are based on different information. The 2014–2015 data are based on information provided by state officials and the 2016–2017 data are based on issuer reports.

The managed care organizations counted for Oregon are coordinated care organizations (CCOs). We used Oregon Health System Transformation CCO Performance Metrics Reports to calculate the number of issuers in Oregon because sources used for other states did not include all participating CCOs.

Market sizes were categorized according to the number of potential 2015 Marketplace enrollees for each state, as reported by the Kaiser Family Foundation (2016).

Limitations

We did not systematically examine issuers by market share, so overlap among multiple small issuers may affect fewer enrollees than overlap for one large issuer. Certain issuers participating in both Marketplace and MMC settings have large shares of the individual insurance market. For example, Kentucky had 33 percent overlap among issuers in 2014, reflecting the fact that two issuers offered both Marketplace and MMC plans out of six unique issuers participating in the Marketplace and Medicaid managed care. One of these issuers was Anthem, which covered 51 percent of the individual market in 2014 (Kaiser Family Foundation n.d.). To the extent that individual market share is representative of an issuer's share of other markets, large issuers may cover a high proportion of both the MMC and Marketplace populations in each state.

In addition, some issuers offer plans only in certain parts of a state, and we did not examine issuer participation in geographic areas smaller than the state. Thus, even in states with significant issuer overlap, residents in certain areas may not have the option of staying enrolled with the same issuer. For example, Arkansas's state-based interim evaluation reports differences in the number of issuers by region. Differences by region in the number of issuers offering coverage diminished over the

demonstration period as more issuers began to offer coverage. In 2014, only three out of seven market regions in Arkansas had more than two participating issuers. By 2016, all seven market regions had at least five issuers offering coverage (Arkansas Center for Health Improvement 2016).

Finally, we used a variety of sources to identify issuers because no single source contained the information we needed for every year in the study. We also found differences between sources. For example, the CMS Medicaid Managed Care Enrollment and Program Characteristics source included a more comprehensive list of MMC issuers for 2014 and 2015 than the National Committee for Quality Assurance (NCQA) source did. Because the CMS data are not available for 2016 and 2017, the number of issuers we list for each state in 2016 and 2017 may not reflect all participating issuers. We attempted to minimize this limitation in the 2016 data by comparing the list of NCQA issuers with a list generated by Kaiser Family Foundation for 2016 only. We also compared the information from the CMS Center for Consumer Information & Insurance Oversight Service Area Public Use Files: 2014–2017 with a Kaiser Family Foundation report (2017) and found that the number of Marketplace issuers differed for some states. The CMS data generally include more issuers than the number reported by Kaiser Family Foundation, which are based on state insurance filings.⁷

Discussion

This issue brief provides early evidence on the potential of premium assistance demonstrations to smooth coverage transitions when Medicaid beneficiaries experience eligibility changes. Demonstration states that require Marketplace issuers to also offer QHPs to the premium assistance population have complete overlap in participating issuers, increasing the potential for continued enrollment with the same issuer over time. Iowa, where participation in the premium assistance program was optional for Marketplace issuers, had much less overlap. This suggests that other states interested in pursuing Marketplace-focused premium assistance may want to consider how requirements or incentives that promote issuer participation in both settings would impact their program.

We note that even if beneficiaries maintain coverage with the same issuer when experiencing eligibility changes, their ability to maintain continuous relationships with the same provider depends on whether the plans offered to Marketplace and Medicaid beneficiaries have comparable provider networks (McQueen 2013). If the plans offered by issuers in each setting differ in their provider networks, a high degree of issuer overlap will not necessarily translate into continuity in provider relationships as beneficiaries change coverage sources.

Though our primary focus was on understanding premium assistance as a tool to smooth coverage transitions, this issue brief also highlights challenges introduced by fluctuations in Marketplace participation. Although issuer overlap within each state in a given year may promote continuity for beneficiaries who experience changes in eligibility during the year, Marketplace entries and exits require beneficiaries to change plans from one year to the next. These transitions could be by choice as new options arise, or by requirement if beneficiaries' current plans exit the Marketplace.

Likewise, if states have a high degree of change in Marketplace issuer participation in each year, we would expect the overlap

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.

between Marketplace and MMC issuers to fluctuate. If states are interested in continuity of issuer enrollment for Medicaid populations other than those enrolled in premium assistance, they might consider whether requirements or incentives would improve overlap between the Marketplace and MMC. For example, states might consider whether overlap would increase if state departments of insurance encourage Marketplace issuers to either have an existing contract as an MMC organization or to bid for a contract during the state's next procurement cycle. We note that there is substantial overlap between Marketplace and MMC in Michigan without explicit requirements, so it may also be possible to achieve overlap through other mechanisms, depending on issuer participation trends and local market forces.

METHODS AND DATA SOURCES

Descriptive information about Section 1115 demonstrations and lists of issuers that offered premium assistance plans are based on Mathematica's analysis of documents pertaining to the demonstration 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–Q4; 2016 Q1–Q3; 2014 and 2016 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–Q4; 2016 Q1–Q2; 2014 annual report. Memorandum of Understanding Between Iowa Department of Human Services and Coventry Health Care of Iowa, February 28, 2014.
- Iowa 1115 Demonstration Waiver Marketplace Choice quarterly monitoring reports.
- New Hampshire Special Terms and Conditions, Approval Period: March 4, 2015–December 31, 2018. Section 1115 demonstration monitoring reports: 2016 Q1–Q3; 2016 annual report. Memorandum of Understanding between the State of New Hampshire and “Issuer,” October 12, 2015.

Lists of Marketplace issuers from 2014 to 2017 for demonstration and comparison states with a Federally Facilitated Marketplace were compiled from the following sources:

- CMS Center for Consumer Information & Insurance Oversight Service Area Public Use Files: 2014–2017.
- CMS Plan Finder Data: 2014 Quarter 3; 2016 Quarter 2.

Lists of Marketplace issuers for states with a state-based Marketplace were compiled from enrollment reports, exchange websites, a report to a state legislative committee, and a health insurance exchange directory, as noted below:

- Kentucky: State-Level Field Network Study of the Implementation of the Affordable Care Act, 2014; Kentucky Health Benefit Exchange website; Kaiser Family Foundation’s Number of Issuers Participating in the Individual Health Insurance Marketplaces: 2014–2017.
- Nevada: Atlantic Information Services, Inc., Average 2014 Individual Premium Rates Per Tier, Per State, for Health Plans Participating in Public Exchanges; Commonwealth Fund Insurer Participation in State-Based Marketplaces in 2016: A Closer Look.
- Oregon: Oregon Health Insurance Marketplace: Report to the Joint Interim Committee on Ways and Means and Interim Senate and House Committees on Health Care, 2015; Commonwealth Fund Insurer Participation in State-Based Marketplaces in 2016: A Closer Look.
- Washington: Washington Health Benefit Exchange Health Coverage Enrollment Reports: October 2014, September 2015, open enrollment; Washington State Health Insurance Market Analysis; Kaiser Family Foundation Number of Issuers Participating in the Individual Health Insurance Marketplaces: 2014–2017.

Lists of Medicaid issuers were compiled using the sources listed below.

- CMS Medicaid Managed Care Enrollment and Program Characteristics: 2014 and 2015
- National Committee for Quality Assurance List of Health Insurance Plan Ratings for Medicaid: 2016–2017
- Kaiser Family Foundation’s list of 2016 Medicaid Managed Care Organizations and their Parent Firms
- Oregon Health System Transformation CCO Performance Metrics Reports: 2014–2016
- CCO Oregon. “Resources: Coordinated Care Organizations”. Available at <https://www.ccooregon.org/resources/ccos/>. Accessed January 9, 2018.

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Endnotes

¹ The Affordable Care Act established a 5 percent income disregard that increases the effective income limit from 133 to 138 percent of the federal poverty level.

² Throughout this issue brief, 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.

³ 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.

⁴ Although Indiana and Michigan expanded Medicaid coverage as part of their 1115 demonstrations, neither state had implemented premium assistance during the period covered by this analysis.

⁵ For more information on the section 1115 national evaluation, see the evaluation design plan (Irvin et al. 2015), available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf>.

⁶ For more information on the sources we used for this issue brief, please see the Methods and Data Sources box.

⁷ The CMS Center for Consumer Information & Insurance Oversight Service Area Public Use Files for 2014 – 2017 contain data submitted by health insurance issuers during the plan certification process. Data from plans that did not complete the certification process for display on HealthCare.gov or that were withdrawn from the certification process are excluded from the Public Use Files. In some cases, Public Use Files listed more issuers than other sources, such as Kaiser Family Foundation (2017), because the Public Use Files list some parent and subsidiary companies as separate issuers whereas other sources excluded these issuers.