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Using Medicaid Funds to Buy Qualified Health Plan Coverage for Medicaid Beneficiaries

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Introduction

On February 28th, 2013, *Politico* reported that Arkansas Governor Mike Beebe had received approval "to take federal Medicaid expansion money and use it to buy private health coverage for low-income residents through the state's insurance exchange." This Implementation Brief explains the legal basis for this decision, as well as the issues that can be expected to arise in using this approach to coverage.

Background

Section 1905(a) of the Social Security Act (42 U.S.C. §1396d(a)) has been part of the Medicaid statute since its 1965 enactment. This section, familiar to most people who work with Medicaid, defines what is meant by "medical assistance" by listing all of the categories of covered benefits.

What is less well-known is that a provision in §1905 dating to the mid-1980s permits states to use Medicaid to buy private health insurance for Medicaid beneficiaries.[1] Specifically, §1905[2] provides in pertinent part:

> The payment described in the first sentence [which defines the term "medical assistance"] may include expenditures for Medicare cost-sharing and for [Medicare] premiums . . . and [except in the case of elderly or disabled Medicare beneficiaries] *other insurance premiums for medical or any other type of remedial care or the cost thereof.*

A separate provision in the Medicaid statute, §1906A, requires states, under certain circumstances, to provide premium assistance subsidies in certain cases involving "qualified employer-sponsored coverage" in the case of Medicaid beneficiaries who are eligible for enrollment in such plans. This requirement is accompanied by a cost-effectiveness test. However, nothing in §1905 itself appears to limit payment of private health insurance premiums either to employer-sponsored plans or to situations in which it is cost-effective to buy private health insurance.

One might imagine that in the absence of an employer who contributes to the cost of coverage, the higher provider payment levels and administration and premium costs that characterize private health insurance would make private insurance *more* -- not *less* -- costly than Medicaid. Indeed, in its 2012 revised estimate of the impact of *NFIB v Sebelius* on federal spending under the Affordable Care Act, the Congressional Budget Office (CBO) concluded[3] that, were states to only partially cover the 2014 Medicaid

[1] Office of the Inspector General Medicaid Payment of Premiums for Employer Group Health Insurance (OEI-04-91-01050, May 1994).
[2] The definition of medical assistance itself in §1905 is one extremely long sentence spanning multiple pages of statutory text.
[3] CBO, Estimates of the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision http://www.cbo.gov/publication/43472 (accessed online March 5, 2013).

expansion group and move persons with incomes between 100% and 133% of the federal poverty level into an Exchange, the federal government would spend 50% more ($9,000 rather than $6,000) to provide the same level of coverage through tax subsidized private insurance plans.[4]

The CMS Ruling on Medicaid Premium Assistance for the Cost of QHP Coverage Medicaid Beneficiaries

In its December 10, 2012 FAQs on Exchanges, Market Reforms and Medicaid, CMS explained (Question 38) how, in fact, Medicaid can be used to pay private insurance premiums for Qualified Health Plan coverage purchased through the Exchange. CMS offered this model as a means of reducing the likelihood of health plan enrollment "churning" among lower income people as a result of income fluctuation:

> In both Medicaid and CHIP, premium assistance is authorized for group health coverage and, under some authorities, for health plans in the individual market, which, in 2014, would include qualified health plans available through the Exchange. . . The statutory authorities that permit use of [Medicaid or CHIP] funds to be used for premium assistance for health plans in the individual market, including qualified health plans in the Exchange, are section 1905(a) and 2105(c)(3) [the parallel CHIP authority]. . . . A state-based Exchange may be able to support such an option, and in states where a Federally Facilitated Exchange is operating, a state Medicaid or CHIP agency may be able to take this approach by making arrangements with qualified health plans to pay premiums for individuals. We will be working with states interested in this option to consider how the state Medicaid and CHIP agency can coordinate with the Exchange to establish and simplify premium assistance arrangements.[5]

CMS went on to elaborate further on this state option (which would not require a waiver) in Question 39. The agency noted that "states may be most interested in this option for families close to the top of the income limit,"[6] meaning that it appears to be encouraging states to be selective about the use of premium assistance. CMS also noted that premium assistance arrangements would be subject to "federal standards related to wrap around benefits, cost sharing, and cost effectiveness."

Despite the fact that the December 2012 FAQ mentions the cost effectiveness test, it does not indicate how cost-effectiveness will be demonstrated when Medicaid (or CHIP) financing is used to purchase coverage in the individual Exchange market, as opposed to the employer market, where a partnering sponsor exists. Nor does the FAQ elaborate on the other conditions that would apply to this state option. The 2012 FAQ is reflected in proposed 42 C.F.R. §435.1015 (78 Fed. Reg. 4594), which amplifies on the conditions under which FFP is available for premium assistance:

[4] CMS concluded in December 2012 that it lacked the authority to allow states to partially expand Medicaid and receive enhanced federal funding. See Update at http://www.healthreformgps.org/resources/update-cmss-frequently-asked-questions-on-market-reforms-and-medicaid-can-states-cover-less-than-all-newly-eligible-individuals-under-the-aca-2014-medicaid-eligibility-expansion-and/.
[5] CMS December 10 FAQ at p. 17.
[6] *Id*.

(a) FFP is available for payment of the costs of insurance premiums for an individual health plan on behalf of an individual who is eligible for Medicaid under this part, subject to the following conditions:

(1) The insurer is obligated to pay primary to Medicaid for all health care items and services for which the insurer is legally and contractually responsible under the individual health plan, as required under part 433 subpart D of this chapter;
(2) The agency furnishes all benefits for which the individual is covered under the State plan that are not available through the individual health plan;
(3) The individual does not incur any cost sharing charges in excess of any amounts imposed by the agency under subpart A of part 447; and
(4) The cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits for items and services covered under the Medicaid State plan, but not covered under the individual health plan, must be comparable to the cost of providing direct coverage under the State plan.

(b) A State may not require an individual who is eligible for services under the Medicaid State plan to enroll in premium assistance under this section as a condition of eligibility under this part.

In its guidance implementing the 2009 CHIPRA premium assistance amendments related to employer-sponsored coverage (on which the later ACA amendments build),[7] CMS clarified that the employer contribution serves as the proxy for cost-effectiveness. In the case of individual coverage however, there is no "partnering" sponsor akin to an employer to share the cost of coverage, since as CMS notes, premium subsidies are not available for Medicaid beneficiaries. The proposed rule appears to use a "comparability" test to determine cost-effectiveness but gives no range of what the agency considers "comparable."

The news accounts that describe HHS' approval of Arkansas' QHP purchasing proposal suggest that approval was given orally. There does not yet appear to be a detailed written explanation regarding how comparability will be measured in relation to cost-effectiveness, nor the steps states will be expected to take to ensure that premium assistance is voluntary, that Medicaid cost-sharing rules are adhered to, or that Medicaid's additional coverage obligations will be adhered to.

Issues

How many states will take the option and for which Medicaid beneficiary groups? As CMS notes in its December 2012 FAQ, purchasing a QHP for Medicaid beneficiaries may prove more effective in reducing health plan churning, as the basis of insurance affordability assistance switches between Medicaid and

[7] See CMS, State Health Official Letter 10-002, CHIPRA 2013, CHIPRA Premium Assistance Option. For a discussion of these amendments as well as analysis of the issues arising in the use of premium assistance options under Medicaid and CHIP, see Medicaid and CHIP Employer Sponsored Coverage Coordination Work Group: Report to the Secretary of Labor and the Secretary of Health and Human Services (August 2010) http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/downloads/WorkgroupPremiumAssistanceReportFinal.pdf (accessed online March 5, 2013).

advance premium tax credits for individuals and families at or near the 138% FPL transition point. QHP purchasing as a Medicaid benefit might also appeal to states interested in broadening the use of Medicaid to support market-based solutions to coverage of the poor. How many states will elect this option, and will they do so for all or only some non-Medicare-covered populations? For example, will they use the option for all low income, non-disabled adults and children whose eligibility is calculated according to MAGI? Only certain higher income populations? Only populations for whom the ACA's enhanced federal funding is available, since QHP coverage can be expected to be more costly?

What cost effectiveness test and what other conditions will apply to the use of Medicaid to purchase QHP enrollment? QHPs must cover all essential health benefits, but cost-sharing for the Exchange population would be higher than is the case under Medicaid. As CMS notes, adjustments to reflect Medicaid cost-sharing rules will be needed. How will these adjustments be made? In addition, Medicaid beneficiaries remain entitled to Medicaid coverage, even if a portion of that coverage is paid for through QHPs. How will CMS expect states to address additional coverage for Medicaid beneficiaries (in particular, children under 21 entitled to EPSDT benefits) that is not furnished as part of the QHP premium? How will Medicaid agencies be expected to coordinate Medicaid's more extensive coverage rules with participating QHPs? Where adult Medicaid beneficiaries are entitled to broader coverage than is available through their QHPs, how will this coordination of coverage be effectuated? How will CMS calculate whether the "comparable" test noted in its proposed rule will be met? Is a 50% greater premium "comparable"?

How will enrollment in premium assistance be made voluntary? The proposed rule provides that premium assistance is to be voluntary with beneficiaries. How will states be expected to carry out the informing and election process in order to ensure that beneficiaries understand the pros and cons of enrollment? On the "pro" side may be more stability in terms of coverage over time; on the "con" side may be changes in providers for beneficiaries who have been cared for through a Medicaid managed care entity or a fee-for-service arrangement, and whose primary care providers and specialists may not be part of a QHP network.

How will QHP issuers and their provider networks respond? Issuers of QHP products are in the process of readying their plans and networks for Exchange participation. How will issuers respond to the prospect of also enrolling Medicaid beneficiaries? How will their networks respond to the potential for Medicaid beneficiaries to also enroll in QHPs? Will issuers partner with Medicaid MCOs and thereby maintain separate products and networks for these populations while being able to charge higher prices reflecting the greater costs associated with private insurance coverage?

How will enrollment work in states that elect to purchase QHPs? Under CMS rules implementing the ACA, states can elect to have Exchanges screen and assess individuals for their Medicaid status but not to enroll them in coverage or in health plans. How might states align the eligibility determination and plan enrollment process in the event that they decide to buy QHP coverage for some or all beneficiaries? Will these states elect to allow the Exchanges to carry out the Medicaid eligibility determination and program (and QHP) enrollment process?

What will happen to Medicaid beneficiaries enrolled in QHPs whose incomes drops below thresholds determined by the state? CMS indicates that the QHP option may be most attractive for beneficiaries near the Medicaid/Exchange threshold? Will Medicaid beneficiaries whose incomes drop further as a result of, say, loss of employment, be required to disenroll from QHPs?