

Considerations for Medicaid expansion through health insurance exchange coverage

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Arkansas has approached the Centers for Medicare and Medicaid Services (CMS) and proposed to implement Medicaid expansion by using Medicaid dollars to provide premium subsidies so that eligible individuals can purchase coverage in the exchange. The Arkansas plan has received a conceptual go-ahead from CMS. Other states, including Tennessee and Ohio, have also expressed interest in the premium assistance option; however, little information is known about the details of these plans. This paper seeks to lay out the key policy and financial considerations for a state contemplating such an approach.

PREMIUM ASSISTANCE IN MEDICAID

Under current Medicaid rules, states may use Medicaid funds to provide premium assistance to enroll Medicaid-eligible individuals into employer-sponsored coverage. The coverage must meet the cost-effectiveness standard and provide wraparound benefits to be funded by the Medicaid agency. This means that the cost of the premium payment, administration, and any wraparound services must not be greater than the estimated cost of covering individuals through Medicaid.

In a proposed rule published in January 2013,¹ CMS allows Medicaid to provide premium assistance for coverage in the individual market in addition to group plans. As with premium assistance for group coverage, the coverage must be determined to be cost-effective, wraparound services must be provided, and cost sharing has to meet the applicable Medicaid requirements. Additionally, the proposed regulation states that individuals who are eligible for services via the state plan may not be required to enroll in the premium assistance option as a condition of their eligibility.

EXCHANGES

In 2014, exchanges will offer a forum for individuals between 100% and 400% of the federal poverty level (FPL) to access subsidized health insurance coverage. These individuals will be required to pay a certain percentage of their incomes toward health insurance premiums. The remaining premiums will be subsidized. Individuals who are eligible for Medicaid are not eligible for premium tax credits or cost-sharing subsidies in the exchanges. In addition to premium subsidies, individuals between 100% and 250% of FPL will also have access to cost-sharing subsidies that will decrease the amount of cost sharing present in their health plans. These

subsidies will reduce the cost of maintaining coverage and receiving care for individuals in these income groups; however, the cost-sharing reductions do not currently meet the Medicaid out-of-pocket maximum limit of 5% of monthly or quarterly income in total cost sharing. Additionally, health plans offered on the exchange will provide essential health benefits (EHBs), which lack certain required Medicaid benefits such as nonemergency transportation and early and periodic screening, diagnostic, and treatment (EPSDT) services.

Per current CMS guidance, to enroll Medicaid-eligible individuals in exchange plans the Medicaid agency would have to assure that the coverage was cost-effective, that Medicaid cost-sharing limitations were met, and that wraparound services were provided for all benefits required by Medicaid that are not present in the commercial market coverage options. Premium assistance can be implemented without a waiver, provided these conditions are met and the enrollee is not required to enroll in the commercial market coverage as a condition of eligibility.² Waivers may be sought for programs that require enrollment into commercial coverage or seek flexibility in one or more of these requirements.

ARKANSAS

As mentioned above, Arkansas has approached CMS and proposed using Medicaid funding to enroll individuals eligible for the Medicaid expansion in exchange products.³ Individuals would apply to the exchange in a way similar to those seeking premium tax credits, but their subsidies would be paid by Medicaid. The 100% federal matching rate for the first three years will be used to fund the individual's premiums and cost-sharing subsidies. Payments for premium assistance and cost-sharing reductions will be paid directly from Medicaid to the qualified health plans on the exchange. Plans eligible to enroll Medicaid recipients will be required to take part in the Arkansas Health Care Payment Improvement Initiative.

Under this plan, Arkansas estimates an additional 215,000 individuals would be enrolled in commercial market plans offered on exchanges. This additional enrollment is projected to increase competition and the contracting power of health plans and help to decrease per-enrollee cost through economies of scale. Arkansas projections estimate that buy-in to an exchange plan would cost \$366 per member per month (PMPM) and that this cost is

1 Proposed 42 CFR 435.1015
2 Proposed 42 CFR 435.1015(b)
3 Cost-sharing reductions are only available in *silver-level* plans on the exchange.

comparable to the expected cost of covering this group through a Medicaid program.

Current projections developed by Arkansas show that the premium assistance proposal would be cost-neutral to the alternative of covering these individuals on Medicaid, and would at maximum increase costs by 15% over Medicaid coverage. This 15% increase over current Medicaid coverage could be overstated since it does not take into account increases in provider rates that may need to occur to assure network adequacy if the Medicaid program were expanded. Additionally, Arkansas puts forth the argument that increased competition due to the 215,000 additional lives in the exchange will save the federal government on subsidies for the remainder of the exchange population because cost decreases that may result due to increased competition should be market-wide.

Arkansas expects that implementing this proposal will create efficiencies and lower administrative costs associated with expanding Medicaid, reduce the number of individuals in current Medicaid categories, decrease cross-subsidies between the private market and Medicaid, and vastly reduce concerns around churning between Medicaid and exchange coverage. Providing coverage through private plans may also help to ensure access to networks due to enhanced provider reimbursement and may yield savings by capitalizing on the commercial cost-sharing and incentive structure. The details of the plan are still under development. While premium assistance programs may be implemented through the state plan without a waiver, an 1115 waiver may be necessary depending on the ultimate program design for the Arkansas Premium Assistance Program.

HHS RESPONSE

The U.S. Department of Health and Human Services (HHS) has indicated that, as a test of effectiveness, it will consider approving a limited number of proposals to cover Medicaid beneficiaries through commercial market plans. HHS will only consider approving proposals that meet the following criteria:

- Provide beneficiaries with a choice of at least two qualified health plans
- Make arrangements with QHPs to provide:
 - Wraparound benefits
 - Meet Medicaid cost-sharing requirements
 - Provide appropriate data
- Limit the eligibility to individuals in the new adult group who must enroll in a benchmark or benchmark equivalent plan
- Be time-limited to December 2016, as state innovation waivers become an option in 2017

- Additional consideration will be given for demonstrations that only target a subset of the population, i.e., those between 100% and 138% of FPL, for enrollment in private health plans

HHS has indicated it will consider states' ideas on cost-effectiveness that include new factors introduced through the market-wide changes in 2014. These factors may include savings from reduced churning and increased competition. States may propose additional factors for consideration.

FINANCIAL CONSIDERATIONS

The following outlines several financial considerations with the proposal to utilize the healthcare exchanges for the Medicaid expansion populations.

- Provider reimbursement: Given that provider reimbursement may be higher in the exchange than for traditional Medicaid, the overall healthcare costs will be higher in the exchange than a Medicaid program for the same benefit design.
 - Medicaid provider reimbursement varies on a state-by-state basis. However, Medicaid reimbursement traditionally has been 20%+ less than Medicare reimbursement and 40%+ less than commercial reimbursement rates. Given the price differential alone, the exchange healthcare costs would be expected to be 40% to 65% greater than Medicaid in a competitive environment, potentially more if there were limited insurers on the exchange.
- Medical loss ratio: The individual medical loss ratio requirement is 80%. Most individual carriers will be able to meet this requirement, unless the health insurance carrier has a favorable year. With the expanded benefits that are required to be covered, the administrative costs will not change dramatically. Most plans should meet the 80% medical loss ratio without significant changes in operations. Further, in a review of more than 140 Medicaid health plans throughout the United States, the national average medical loss ratio in 2011 was reported as 85.5%, which is greater than the 80% medical loss ratio requirement in the exchanges.⁴
- Demand for services: With higher coverage rates (i.e., lower uninsured populations), there will be anticipated increase in the demand for services. Providers may become more selective in the number of patients with lower reimbursement rates accepted, resulting in a need for higher reimbursement.
- Cost comparison: Based on a high-level analysis for a single state Medicaid agency, it appears that the health care costs in a premium assistance program may be 20% to 40% greater than costs incurred through a Medicaid-operated program. This is highly dependent on the reimbursement level assumed to be paid to providers.

⁴ Palmer, J. and Pettit, C. (July 2012). *Medicaid risk-based managed care: Analysis of financial results for 2011*. Milliman research report.

- Three Rs of the exchange: The exchange model has three cost stabilizing programs known as the three Rs: reinsurance, risk corridors, and risk sharing.
 - Reinsurance: The federal government has established a national reinsurance rate that will be paid by all self-insured and fully insured commercial health insurance carriers. The reinsurance will be provided for the individual health insurance market. The national rate has been established for calendar year 2014 at \$63 per member per year. The question is that, if the Medicaid expansion population is placed into the exchange, will the reinsurance program apply to the Medicaid expansion population? If so, then the reinsurance member pool grows and the amount available on a per-life basis decreases. This will increase the premium rates for all others that will be participating in the exchange. The reinsurance program is a three-year program.
 - Risk corridors: The federal government has established a risk corridor program. It has established corridors that protect against losses for individual health insurance carriers in the exchanges. Again, will the Medicaid expansion population in the exchange be eligible for the risk corridor program? As with the reinsurance program, the risk corridor program is a three-year program.
 - Risk adjustment: The risk adjustment provision is the only permanent program of the three Rs. The risk adjustment provision transfers money from the health insurance carriers with lower morbidity to those with higher morbidity. The risk adjustment provision is for all non-grandfathered individual health insurance and small group health insurance, both inside and outside of the exchange. Again, the question becomes, will the Medicaid expansion population be included in the risk adjustment program? As discussed below, the Medicaid expansion population will have higher morbidity than those in the exchange above 100% of FPL or 138% of FPL. By including the Medicaid expansion population in the risk adjustment program, the health plans with higher Medicaid expansion enrollment may receive more payments from the health plans with the higher-income populations.
- Relative morbidity: There is a generally observed morbidity difference between populations by federal poverty level. The morbidity difference between those with incomes below 138% of FPL may be 15% to 25% greater than those with incomes in the range of 138% to 300% of FPL, which is the expected range of individuals who will be participating in the exchanges. With the higher morbidity population enrolling in the exchange, the exchange premium will need to be higher. The higher premiums will be paid for by either the other exchange beneficiaries or by the federal government through higher subsidies.
- Other Medicaid issues:
 - Pharmacy rebates: If Medicaid expansion occurs by providing premium assistance for commercial health insurance products, will the state Medicaid program still be able to receive pharmacy rebates? This is a significant cost savings in the Medicaid program and creates more of a financial gap between the exchange-related products and Medicaid health plans.
 - Incarcerated population: In many states, it is anticipated that the incarcerated population will be Medicaid-eligible under an expansion during any short-term hospitalizations. How would the state handle this population under an expansion that utilizes a premium assistance program?
 - Actuarial soundness criteria: Will the exchange-related products offered for Medicaid populations require certification as actuarially sound under the federal regulations related to Medicaid managed care plans?
 - Medicaid monitoring: Will the exchange-related products be required to meet reporting requirements similar to Medicaid managed care plans? State Medicaid agencies are required to assure access to care, monitoring Healthcare Effectiveness Data and Information Set (HEDIS) measures, collecting encounter data, etc. Will these provisions be required under a premium assistance program?
 - Cost-sharing subsidies: In the exchanges, individuals between 100% and 250% of FPL are eligible for cost-sharing subsidies if enrolled in a silver benefit plan. The cost-sharing subsidies will be paid directly by the federal government to the health insurance carriers. It is not anticipated that the health insurance carriers will be at risk for the cost-sharing subsidy. However, under the proposal, it is expected that the cost-sharing portion will be covered through wrap-around payments by the state Medicaid agency. This will either need to occur through fixed at-risk capitation payments or reconciliation on a fee-for-service basis.

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