

Expanding Medicaid Using Premium Assistance, or the “Private Option,” to Buy Health Insurance



States can use premium assistance to cover their Medicaid expansion populations, which involves buying policies for enrollees from plans in the new health insurance marketplaces in lieu of providing coverage directly.

As states consider this option, advocates need to understand what premium assistance is, how it can be used to expand Medicaid, and how to get involved if their state is considering this approach.

States have the option of using premium assistance to provide coverage to their Medicaid expansion populations.¹ Generally, premium assistance refers to when a state’s Medicaid program buys private coverage for some segment of its Medicaid population instead of providing Medicaid directly. If a state wants to use premium assistance specifically for the Medicaid expansion, often referred to as the “private option,” its Medicaid program would buy policies for Medicaid enrollees from plans operating in the state’s new health insurance marketplace in lieu of providing direct coverage.

Premium assistance is not new to Medicaid, but making it the way that the Medicaid expansion population gets coverage could broaden its use considerably.² As states start looking at this option, it is important that advocates understand what premium assistance is, how it can be used for the Medicaid expansion population, and how to get involved if their state is seriously considering this approach.

Medicaid Premium Assistance: What It Is and How It’s Been Used

Premium assistance has been an option in Medicaid for a long time, but up until now, premium assistance programs have been comparatively small.

How is premium assistance different from regular Medicaid?

State Medicaid programs usually provide enrollees with “direct coverage.” That’s where the state pays doctors, hospitals, and other health care providers directly, or it directly contracts with managed care plans to provide health care services to

Medicaid enrollees. In a premium assistance program, the state purchases policies from private plans to cover Medicaid enrollees. The people getting coverage are still considered Medicaid beneficiaries, so Medicaid program requirements still apply.

About Medicaid Enrollees

People who are enrolled in Medicaid but who get their health insurance through private plans are still Medicaid enrollees. That means that they are entitled to full Medicaid benefits, they have the same limits on out-of-pocket costs as traditional Medicaid, and they have the benefit of other Medicaid protections.

How much is premium assistance used in Medicaid today?

Most states have at least one premium assistance program, but these programs don't cover many Medicaid enrollees.³ They represent only about 1 percent of all Medicaid spending.⁴ Most of these programs help pay for job-based coverage for Medicaid enrollees whose workplaces offer health insurance.⁵ States also have the option of buying coverage for Medicaid enrollees in the individual market, but only a small number of states have programs that do so.⁶

What have state experiences with premium assistance programs been like?

Data collection on Medicaid premium assistance programs has been spotty and inconsistent. That and the fact that different programs cover different populations make it difficult to draw firm conclusions about how well the programs are working.⁷ Reporting

on program costs has also been spotty, and different states use different approaches to calculate those costs. That's made it hard to determine whether these programs cost more than coverage through traditional Medicaid.⁸ In addition, because most of these programs are small, it's nearly impossible to tease out any lessons learned that might work on a larger scale, such as a program for a state's entire Medicaid expansion population.

What has increased interest in using premium assistance?

Right now, there isn't an organized market for individual insurance policies. In addition, policies sold in the individual market are hard to find, often have meager coverage, and can be very expensive. These factors have made using the individual market a poor way for states to provide coverage.

As a result, states that have been interested in using premium assistance have been largely limited to subsidizing employer coverage for people in Medicaid. That will change in 2014, when the Affordable Care Act's new state health insurance marketplaces (also known as exchanges) are fully operational. These marketplaces will present the first opportunity people will have to buy individual policies in a structured, regulated arena.

Plans that are sold in the new marketplaces will have to offer coverage that meets minimum requirements.⁹ And because more people will be buying coverage in these marketplaces, the policies purchased there will be more affordable than they are in the individual market that exists today. This means that there will be a new opportunity for states to purchase individual policies for Medicaid enrollees.

Why would a state want to use premium assistance instead of traditional Medicaid for the Medicaid expansion?

There could be a lot of reasons. In some states, the governor or legislature might be politically or philosophically opposed to expanding traditional Medicaid. In those states, premium assistance might be the only way to move the Medicaid expansion forward. Also, some governors or legislators might look at premium assistance as a way to let people keep the same health coverage if their income fluctuates and they move in and out of Medicaid eligibility. In those situations, it could improve continuity of care.

Premium Assistance and the Medicaid Expansion: Guidelines from CMS

In March 2013, the Centers for Medicare and Medicaid Services (CMS) issued a series of questions and answers that offer some guidance for states that are interested in using premium assistance to cover their Medicaid expansion populations.¹⁰ The information in this section is based on that document.

Are there different approaches states can take to using premium assistance for their expansion populations?

CMS outlined two approaches states can use to set up premium assistance programs for their Medicaid expansion:

1. A state plan amendment
2. A demonstration waiver under Section 1115 of the Social Security Act¹¹

Both options require states to get approval from CMS, but the first option is administratively simpler. To pursue the state plan option, a state has to file an amendment to its Medicaid plan with CMS, and the program must still meet all current Medicaid requirements. Alternatively, a state can apply to CMS for a Section 1115 waiver that lets it bypass certain Medicaid requirements. This approach gives states more flexibility to design unique programs, but the approval process is more involved, and it includes opportunities for public comment. CMS has indicated that it will approve only a limited number of premium assistance Section 1115 waivers for the Medicaid expansion.

What's required if a state wants to set up a premium assistance program using the state plan option?

CMS outlined several requirements in its March Q&A:

- The program cannot be mandatory for anyone, including those who are newly eligible for Medicaid. Enrollees have to be given a choice between private coverage and coverage through Medicaid.
- The state has to make sure that the Medicaid enrollees who select a private plan have access to all the benefits they would have if they were covered directly through Medicaid. States may have to make arrangements to provide additional services, or “wrap-around coverage,” for any Medicaid services the private plan does not cover.
- Enrollees’ cost-sharing cannot be more than it would be if they were covered directly through Medicaid. If the private plan’s cost-sharing is higher than Medicaid’s, the state will have to cover the difference.

- The cost of the premium assistance program to the federal government, including administrative expenses and any wrap-around coverage or cost-sharing assistance, must be comparable to what it would be if the services were provided through Medicaid directly.

How can a Section 1115 waiver program be different from one that uses the state plan option?

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the authority to approve pilot or demonstration programs to evaluate different approaches to delivering care in order to further the goals of the Medicaid program. The secretary has the authority to waive a wide range of Medicaid requirements for these demonstrations, and programs can therefore be very different from one another. For example, Section 1115 waiver programs do not have to be statewide, and they can target specific populations.

States' waiver requests will vary, and each application will reflect its state's priorities. However, it is likely that states will use Section 1115 waivers to make premium assistance mandatory for much of their Medicaid expansion population. States may also submit waivers to request to use premium assistance for only a portion of their expansion populations, like people with incomes above the poverty level.

CMS has indicated that it will consider only Section 1115 waivers that meet certain requirements (see the next section).

What's required if a state wants to set up a premium assistance program using the Section 1115 waiver option?

CMS has said that, in order for it to consider a state's application, the program proposed must meet the following criteria:

- The program can be mandatory only for the sub-set of the Medicaid expansion population that is required to enroll in a Medicaid alternative benefit plan. States do not have to offer their Medicaid expansion populations the same benefits package that the states have for their existing Medicaid programs—they can offer a more limited package, called an alternative benefit plan.

Certain people in the expansion group who have high medical needs cannot be required to enroll in the alternative benefit plan—they must be given the option to enroll in traditional Medicaid.¹² This “exempt” group includes people who are blind or who have a disability, patients who are terminally ill and receiving hospice care, medically frail enrollees, women who are pregnant, and people who are also entitled to benefits under Medicare (also known as dual eligibles). Just as these individuals cannot be required to enroll in the alternative benefit plan, they cannot be required to enroll in a Section 1115 waiver program for premium assistance.

- Program enrollees must have access to the same benefits and cost-sharing protections as they would have if they were enrolled directly in Medicaid. If necessary, the state

must arrange to have the health plans provide wrap-around coverage and not charge enrollees more than would be allowed in Medicaid.

- The state must offer a choice of at least two “qualified health plans”—the plans that meet Affordable Care Act standards and that have been approved to operate in the state’s new health insurance marketplace.
- Programs must be budget neutral to the federal government. Budget calculations are based on historic Medicaid costs

and cost projections.¹³ For these waiver applications, CMS has said that it will consider new factors in the budget calculations based on the overall changes in the state’s health care system that will be taking place in 2014. As an example of system changes, CMS noted the potential savings that might result from keeping enrollees in the same health plans as their incomes change and they move between Medicaid and marketplace coverage.¹⁴

- All waivers that are approved will expire on December 31, 2016.

Key Elements of the State Plan Option and Section 1115 Waivers

State Plan Option	Section 1115 Waiver
<p>Premium assistance for the Medicaid expansion group must:</p> <ul style="list-style-type: none"> ■ Be optional ■ Have cost-sharing no greater than what enrollees would pay in traditional Medicaid ■ Ensure enrollee access to all Medicaid benefits ■ Cost the federal government comparable to coverage through traditional Medicaid 	<p>To be considered by CMS, Section 1115 waiver proposals must:</p> <ul style="list-style-type: none"> ■ Limit any mandatory enrollment to Medicaid beneficiaries who are required to enroll in an alternative benefit plan ■ Have cost-sharing that’s within Medicaid limits ■ Ensure enrollees have access to all the Medicaid services to which they are entitled ■ Give Medicaid enrollees a choice of at least two qualified health plans ■ Be budget neutral, meaning the cost to the federal government is no higher than it would be without the waiver ■ End by or before December 31, 2016 <p><i>Consideration does not guarantee approval. CMS has said that it will approve only a limited number of Section 1115 premium assistance waivers.</i></p>

Can a state operate multiple premium assistance programs at one time?

Yes. For example, a state might use a Section 1115 waiver to set up a mandatory premium assistance program for enrollees with incomes between 100 and 138 percent of poverty (\$19,530 to \$26,950 for a family of three in 2013) and also use a state plan amendment to establish a voluntary premium assistance program for everyone else in its Medicaid expansion population.

Why will the new Section 1115 waivers be approved only until the end of 2016?

Section 1115 waivers are typically approved for five years. The approval time for these new waivers is shorter because, in 2017, states will be able to apply for what are called State Innovation Waivers. Those waivers, which are new under the Affordable Care Act, will allow states to change requirements related to the new health insurance marketplaces, as well as to Medicaid.¹⁵ The thought is that the lessons learned from the premium assistance waivers will be incorporated into broader state innovation waivers.

How many waivers will CMS approve?

CMS has not set a specific limit, but it has said that the number it approves will be limited.



What Advocates Should Be Thinking About

- Opposing or supporting the use of premium assistance
- What to look for in program design
- Opportunities to get engaged

Pros, Cons, and the Role for Advocates

Advocates can influence how their states shape any premium assistance proposals. They should take full advantage of the opportunities to weigh in.

Should advocates oppose proposals to use premium assistance for the Medicaid expansion?

The issue of using premium assistance does raise some concerns, and advocates should evaluate such proposals carefully. However, in some states, it may be the only politically feasible path to getting health coverage for low-income residents.

While a premium assistance program may not be ideal, it is certainly better than not expanding coverage at all. Advocates will have to evaluate each state's proposal to ensure that the programs actually provide a way for

low-income residents to get the coverage and care they need. That means making sure that the programs are set up to make cost-sharing protections and wrap-around benefits easily available to Medicaid enrollees.

Are there potential upsides to using premium assistance for the Medicaid expansion?

Yes. For example, premium assistance programs might help reduce “churning.” Medicaid enrollees, particularly those at the upper end of Medicaid eligibility, frequently experience fluctuations in income. As their incomes change, they may move between being eligible for Medicaid and being eligible for premium tax credits to help purchase coverage in the new health insurance marketplaces. A premium assistance program could allow individuals to stay in the same plan and keep the same doctors even if their income and eligibility change. This could reduce the disruptions in care that happen when people have to change health plans.

Premium assistance could also be a way for all family members to be in the same health plan, even if the source of coverage is not the same for all family members. For example, if children have CHIP coverage and their parents have marketplace coverage with tax credits, all family members could be in the same premium assistance plan.

Finally, plans sold in a state’s marketplace may have more participating providers than the state’s Medicaid program. If so, premium assistance programs could give enrollees more options for providers.

What are some of the things to look for in program design?

There are a lot of factors advocates should consider in program design. One of the most important factors is making sure that people will be able to use the coverage they have. First and foremost, plans have to be affordable. For example, if a plan typically has higher cost-sharing than Medicaid, there should be a system in place to make sure that Medicaid enrollees will be charged only Medicaid cost-sharing; that they know ahead of time that they won’t have to pay more even though they’re in a private plan; and that there is an easy, real-time way to resolve any cost-sharing questions at the point of service.

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States should also establish robust educational programs so Medicaid enrollees understand their benefits and their out-of-pocket obligations.

In addition, states should have good data collection processes in place, as these are critical to measuring program performance. Premium assistance programs should be set up from the start to collect data on Medicaid enrollees’ access to care, service use, health outcomes, satisfaction, and cost.

What are the opportunities for advocates to get engaged?

When the idea of premium assistance starts to gain traction in a state legislature or governor’s office, advocates should weigh in during the negotiations that shape the bill. If a state follows a path that requires a Section 1115 waiver, which will include any state that wants to make premium assistance mandatory, advocates should work with the state office that’s developing the waiver proposal to make sure it includes key consumer protections.

After the initial waiver proposal is developed, there will be opportunities for public comment. The Affordable Care Act requires that states have a meaningful public comment period before submitting a Section

1115 waiver application to CMS. Once the application is submitted, there are additional opportunities for public comment. This notice and comment process is outlined in detail in Families USA’s *How the Affordable Care Act Makes the Section 1115 Waiver Process More Transparent: An Advocate’s Guide*.¹⁶ Advocates should make sure they take full advantage of all the opportunities built into this process.

Once a premium assistance program is in place, there’s a continuing role for advocates in making sure that the program is working for Medicaid enrollees. These programs may become part of larger state innovation waivers in future years, so it is important to understand whether they are working and if not, what needs to change.

States can use premium assistance to provide coverage to their Medicaid expansion populations, and advocates should get engaged as soon as their state starts considering this approach to make sure that the program is set up to truly work for people in Medicaid.

Conclusion

States have had the option of using premium assistance as a way to provide Medicaid coverage for many years, but until now, most programs have been quite small. The opening of the new health insurance marketplaces in 2014 will give states a way to use premium assistance in Medicaid on a much larger scale. Some states are starting to look at it as a way to cover their Medicaid expansion populations.

Using premium assistance on such a broad scale raises some concerns, but in some states, it may be the only way to move the Medicaid expansion forward. CMS has laid out requirements for premium assistance programs. Among these, states must ensure that enrollees have access to Medicaid benefits and cost-sharing protections, and the programs cannot be mandatory for all members of the expansion group. Advocates need to make sure that state programs meet CMS requirements, both on paper and in practice, and that they incorporate additional consumer protections. In states that are considering this approach, advocates should get engaged early and stay engaged throughout program design and implementation to make sure the program works for people in Medicaid.

Endnotes

¹ The Centers for Medicare and Medicaid Services (CMS) has addressed this in two public documents. In its December 10, 2012, publication, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, questions 38 and 39 addressed premium assistance in Medicaid. That publication is available online at <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>. In March 2013, CMS issued a more detailed series of questions and answers on premium assistance under the heading *Medicaid and the Affordable Care Act: Premium Assistance*, which is available online at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

² In 2009 (the latest year for which data are available), 39 states had premium assistance programs. More than half of these programs had fewer than 1,000 enrollees. The largest program had 30,000 enrollees. U.S. Government Accountability Office, letter to Senators Max Baucus and Charles Grassley, and Representatives Henry Waxman and Joe Barton, *Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs*, GAO-10-258R, January 19, 2010, available online at <http://www.gao.gov/assets/100/96518.pdf>.

³ Ibid.

⁴ Joan Alker, *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act* (Washington: Kaiser Commission on Medicaid and the Uninsured, March 2013), available online at <http://www.kff.org/medicaid/upload/8422.pdf>.

⁵ Section 1906 of the Medicaid statute allows states to purchase group coverage for people in Medicaid. These programs must meet certain requirements, one of which is that coverage must be cost-effective, meaning it cannot cost more than coverage in traditional Medicaid.

⁶ Section 1905(a) of the Medicaid statute includes “payment of insurance premiums for medical care” under the definition of medical assistance. In 2009, the Government Accountability Office found that a small number of states operated programs under this authority. It is important to note that this section of the Medicaid statute excludes seniors and people with disabilities from premium assistance programs.

⁷ Joan Alker, *op. cit.*

⁸ Generally, private insurance costs more than Medicaid coverage. Leighton Ku, *Medicaid Expansion Using Private Plans: The Role of Premium Assistance and Cost Sharing*, Health Reform GPS, available online at <http://www.healthreformgps.org/wp-content/uploads/ku-premium-assistance1.pdf>.

⁹ Plans that are sold in the new health insurance marketplaces will have to offer coverage that includes, at a minimum, the essential health benefits that are specified in the Affordable Care Act. Section 1302 of the law outlines 10 general coverage categories that must be included in essential health benefits: ambulatory care; emergency services; hospitalization; prescription drug coverage; laboratory services; preventive and wellness services and chronic disease management; mental health and substance use disorder services, including behavioral health treatment; rehabilitative and habilitative services and devices; maternity and newborn care; and pediatric services, including oral and vision care.

¹⁰ See CMS’s March 2013 Q&A under the heading *Medicaid and the Affordable Care Act: Premium Assistance*, available online at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

¹¹ For a discussion of state plan amendments and waivers and the approval process for both, see Families USA, *State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs* (Washington: Families USA, June 2012), available online at <http://familiesusa2.org/assets/pdfs/medicaid/State-Plan-Amendments-and-Waivers.pdf>.

¹² Section 1937(a)(2)(B) of the Social Security Act lists the groups that cannot be required to enroll in Medicaid alternative benefit plans. That list includes, but is not limited to, people who are eligible for Medicaid because they are blind or have a disability, the medically frail, people with special medical needs, and people who qualify for long-term care services. These individuals should be identified through the Medicaid application process.

¹³ Families USA, *op. cit.*

¹⁴ See CMS’s March 2013 Q&A, *op. cit.*

¹⁵ Section 1332 of the Affordable Care Act allows states to request “innovation waivers” beginning in 2017 to pursue their own strategies for expanding health coverage. States could ask to waive any of the following sections of the law: provision of exchanges (health insurance marketplaces), cost-sharing and premium assistance, the responsibility of employers to provide coverage, and the responsibility of individuals to maintain coverage. To be approved, a “waiver for state innovation” must provide coverage that is at least as comprehensive as the coverage that would be provided under the Affordable Care Act, that is at least as available and affordable as coverage under the Affordable Care Act, that covers at least as many people as would be covered under the Affordable Care Act, and that costs no more than coverage under the Affordable Care Act.

¹⁶ Families USA, *How the Affordable Care Act Makes the Section 1115 Waiver Process More Transparent: An Advocate’s Guide* (Washington: Families USA, April 2012), available online at <http://familiesusa2.org/assets/pdfs/medicaid/Section-1115-Waiver-Process.pdf>.

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This publication was written by:

Dee Mahan, Director, Medicaid Advocacy

**The following Families USA staff contributed
to the preparation of this publication:**

Ingrid VanTuinen, Deputy Director, Publications

Carla Uriona, Director of Publications

Nancy Magill, Senior Graphic Designer

1201 New York Avenue NW, Suite 1100
Washington, DC 20005

202-628-3030 • info@familiesusa.org
www.FamiliesUSA.org

www.facebook.com/FamiliesUSA
[@FamiliesUSA](https://www.facebook.com/FamiliesUSA)

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