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Medicaid Premium Assistance Programs: What Information is Available About Benefit and Cost-Sharing Wrap-Around Coverage?

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Executive Summary

States have long used Medicaid funds as premium assistance to purchase private health insurance for beneficiaries as an alternative to providing coverage directly through the state Medicaid program. States using premium assistance generally must provide wrap-around benefits and cost-sharing protections so that Medicaid beneficiaries receiving private coverage will not have access to fewer benefits or pay higher out-of-pocket costs when private coverage fails to meet Medicaid's level of coverage or is more expensive. Some states seeking alternative ways to implement the Affordable Care Act's (ACA) Medicaid expansion have been interested in expanding Medicaid premium assistance programs and adopting new models to purchase individual market coverage. These initiatives can be informed by an understanding of how pre-ACA premium assistance programs are working, particularly regarding wrap-around benefits and cost-sharing protections.

This issue brief examines states' approaches to administering wrap-around benefits and cost-sharing in long-standing Medicaid premium assistance programs and the information available to beneficiaries about how to access these program features. We present findings based on our survey in 2014 of eight states (AL, LA, NV, RI, TX, UT, VT, and WI) that previously had reported spending dedicated to premium assistance wrap-around benefits to collect updated data and ascertain what states considering premium assistance in the Medicaid expansion context could learn about wrap-around benefits and cost-sharing based on long-standing premium assistance programs. We supplement our analysis by examining these states' written materials designed to inform beneficiaries about premium assistance coverage and end with a discussion of post-ACA premium assistance programs.

Little data are available about spending on wrap-around benefits in state premium assistance programs. Key findings from the 8 states include the following:

- States serve relatively small numbers of people in premium assistance programs that pre-date the ACA's Medicaid expansion, and to the extent that limited data are available, spending on wrap-around benefits as a percent of total premium assistance program spending varies considerably among states.

- Few states report how much is spent on wrap-around benefits and cost-sharing protections in their premium assistance programs which makes it difficult to assess the extent to which beneficiaries are accessing those benefits and whether premium assistance programs are cost-effective.
- The clarity of states' written materials explaining how beneficiaries can access wrap-around benefits varies.
- States' written materials do not always clearly convey the availability of wrap-around EPSDT services for children.
- States have different policies for administering wrap-around cost-sharing protections, with most protecting beneficiaries from paying excess cost-sharing upfront. However, wrap-around cost sharing protections in examined states are available only if beneficiaries receive services from a provider who is both in their private insurance plan network and also accepts Medicaid. Beneficiaries may not be aware of this limitation, and it may further restrict provider options rather than expanding them.

As states' interest in Medicaid premium assistance models continues, further research is needed to examine the beneficiary experience in these programs. This is especially true for access to wrap-around benefits and cost sharing protections, as little data presently is available in this area. Premium assistance approaches could have political and practical advantages for enrollees, and implementation of new programs in the context of alternative Medicaid expansions, can be informed by states' experiences with long-standing programs. At the same time, wrap-around benefits add a layer of complexity for beneficiaries, providers, and states in premium assistance programs. Explaining how the wrap-around works is a challenge, especially when broad benefits that may not be fully included in private coverage, like EPSDT, are involved. Given the complex nature of these programs and variation in state implementation, the extent to which enrollees have access to the full Medicaid benefit package and cost-sharing protections is an area for continued study.

In addition, to the extent that Medicaid beneficiaries enrolled in premium assistance programs do not have access to wrap-around cost sharing protections unless they see Medicaid providers, beneficiaries are not receiving one of the key advantages often cited by proponents of premium assistance – access to a wider network of providers. Educational materials provided to beneficiaries do not always clearly explain the availability of wrap-around benefits and cost sharing protections, particularly EPSDT, and varied considerably in the states we examined. As more states consider premium assistance models to serve greater numbers of beneficiaries, the need to understand how to best administer wrap-around benefits and cost-sharing protections is of growing importance.

Introduction

For many years, states have used Medicaid funding to purchase private health insurance for Medicaid beneficiaries as an alternative to providing coverage directly through the state Medicaid program. This approach, known as premium assistance, typically has been used to help people eligible for Medicaid afford the premiums for employer-sponsored insurance and has been a relatively small component of state Medicaid program enrollment prior to the Affordable Care Act (ACA). Since 2014, some states seeking alternative ways to implement the ACA's Medicaid expansion have been interested in expanding Medicaid premium assistance programs to cover more beneficiaries and adopting new models to purchase coverage in the individual market.¹ These initiatives can be informed by an understanding of how pre-ACA premium assistance programs are working, particularly regarding so-called “wrap-around” benefits and cost-sharing protections, which states generally must provide to supplement the private coverage and make it comparable to Medicaid.

This issue brief examines states' approaches to administering wrap-around benefits and cost-sharing in long-standing Medicaid premium assistance programs and the information available to beneficiaries about how to access these program features. We sought to collect updated data and ascertain what states considering premium assistance in the Medicaid expansion context could learn about wrap-around benefits and cost-sharing based on long-standing premium assistance programs. We present findings based on data from our survey in 2014 of eight states that had previously reported spending dedicated to premium assistance wrap-around benefits. The states include Alabama, Louisiana, Nevada, Rhode Island, Texas, Utah, Vermont, and Wisconsin. We identified these states because they had reported such spending in 2009 in a Government Accountability Office (GAO) report.² Of the 45 premium assistance programs in 37 states in the GAO report, nine states reported spending for wrap-around benefits. Of these, we excluded Virginia because its premium assistance program is limited to CHIP beneficiaries and only provides wrap-around benefits for immunizations. Since our survey, Vermont has discontinued its program, and Louisiana recently announced that it intends to discontinue its program as of December 1, 2015.

We supplement our analysis by examining these states' written materials designed to inform beneficiaries about premium assistance coverage. We asked state officials to share these materials and accessed others online at the states' websites. We did not receive written beneficiary materials from Vermont, and were unable to access materials online as its program was discontinued in 2014; we did receive a limited response to our survey on some of the spending questions. The brief ends with a discussion of post-ACA premium assistance programs.

Background

MEDICAID PREMIUM ASSISTANCE OPTIONS

State options to use premium assistance to purchase private coverage for Medicaid beneficiaries predate the ACA.³ The most common form of Medicaid premium assistance is the use of Section 1906 authority to purchase private group insurance with Medicaid dollars, authorized in 1990.⁴ These programs are commonly referred to as Health Insurance Premium Payment (HIPP) programs. If premium assistance for group coverage is deemed cost-effective by the state, relative to the cost of providing Medicaid coverage directly, beneficiaries may be required to enroll in Section 1906 premium assistance programs. While these programs can be implemented

through a state plan amendment, some states operate premium assistance programs with similar features through Section 1115 demonstration authority. Because relatively few Medicaid beneficiaries have access to employer-sponsored or other private group health insurance, these premium assistance programs have remained small.⁵

In addition to subsidizing group coverage, the Centers for Medicare and Medicaid Services (CMS) has used Section 1905(a) to authorize Medicaid premium assistance for individual market coverage.⁶ Prior to the ACA, Medicaid beneficiaries' access to individual market coverage was limited because the cost was often unaffordable, and insurers could deny coverage based on pre-existing medical conditions. The creation of the Marketplaces under the ACA has generated new interest among some states in using Medicaid as premium assistance for individual market coverage, and in 2013, CMS released regulations and guidance for such programs.⁷ Enrollment in Section 1905(a) premium assistance programs is voluntary, unless the state obtains Section 1115 demonstration authority from CMS to make enrollment mandatory; in such cases, states must offer beneficiaries a choice of at least two health plans.⁸

WRAP-AROUND BENEFITS AND COST-SHARING IN MEDICAID PREMIUM ASSISTANCE

Medicaid serves people with low incomes and who often have greater health care needs relative to other populations. In light of these characteristics, federal Medicaid law contains minimum benefit standards and maximum cost-sharing limitations. Private insurance typically offers fewer benefits than Medicaid does.⁹ Certain Medicaid services, most notably non-emergency medical transportation, usually are not covered by private insurance, and some private plans may have more restrictive limits on prescription drugs and other services, such as physical therapy, than are available to adults under Medicaid. In addition, private coverage for children is almost certainly less extensive than Medicaid as Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires states to cover any services "necessary. . . to correct or ameliorate. . . physical and mental illnesses or conditions. . ."¹⁰ A service that is not covered by private insurance is likely unattainable for people with low-incomes if it is not available through the Medicaid benefit package and therefore must be paid out-of-pocket. Medicaid also limits beneficiaries' cost-sharing obligations to nominal amounts for adults with income below the federal poverty level and generally prohibits cost-sharing for children,¹¹ while private insurance is likely to have cost-sharing obligations in excess of Medicaid limits. For people with low incomes, a body of research has established that cost-sharing creates a barrier to accessing needed services.¹²

Given the characteristics of the Medicaid-eligible population, federal law generally requires states using premium assistance to provide wrap-around benefits and cost-sharing protections so that Medicaid beneficiaries receiving private coverage will not have access to fewer benefits or pay higher out-of-pocket costs when private coverage fails to meet Medicaid's level of coverage or is more expensive.¹³ States need waiver authority from CMS to limit wrap-around benefits and cost-sharing protections. A small number of pre-ACA premium assistance programs operate under such waivers; these programs may have expanded coverage to populations who were otherwise ineligible for Medicaid and include fewer benefits and/or higher cost-sharing. As of 2014, the ACA provides authority for states to cover nearly all adults without a waiver as full Medicaid beneficiaries with enhanced federal matching funds.

Consistent with the ACA's coverage expansion, CMS's 2013 regulations governing individual market premium assistance specify that beneficiaries must be provided with the same benefits and cost sharing protections that they would have had under traditional Medicaid.¹⁴ The preamble to the regulations confirms that "[u]nder all premium assistance arrangements, Medicaid and CHIP-eligible individuals remain Medicaid or CHIP beneficiaries and continue to be entitled to all Medicaid/CHIP benefits and cost sharing protections."¹⁵ Additional guidance issued in light of state interest in alternative Medicaid expansions using Marketplace premium assistance requires states to provide wrap-around benefits and cost sharing protections to "ensure that coverage is seamless [and] that cost-sharing reductions are effectively delivered."¹⁶ CMS's regulations and guidance do not prescribe the specific methods that states must use but rather confirm that "states have the flexibility to determine how best to meet these cost-sharing and benefit responsibilities."¹⁷

The costs of providing wrap-around benefits and cost-sharing protections must be included when determining whether Medicaid premium assistance programs are cost-effective.¹⁸ States generally cannot use premium assistance unless the cost is comparable to the cost of providing direct coverage through state's Medicaid program. In addition to the cost of wrap-around benefits and cost-sharing protections, cost-effectiveness determinations also must include the cost of administering premium assistance programs.¹⁹

GAO REPORT ON STATE PREMIUM ASSISTANCE PROGRAMS

The GAO identified 47 Medicaid and CHIP premium assistance programs in 39 states in 2009, and received survey responses from 45 programs in 37 states.²⁰ Overall, enrollment in premium assistance programs is relatively small. Among the states reporting spending dedicated to wrap-around benefits, 2009 enrollment ranged from six beneficiaries in Alabama to nearly 8,700 in Texas. The GAO found that at least eight states target their premium assistance programs to people with high health care costs such as pregnant women, premature or low birth-weight infants, or people with HIV/AIDS, diabetes, or cancer.²¹

The GAO noted that "a reported issue with premium assistance programs is that there may be disparities in the benefits and cost-sharing protections offered to enrollees in such programs compared with those in direct coverage."²² The GAO also identified some potential advantages of premium assistance programs, such as helping families transition to private coverage, expanding coverage to family members who are ineligible for Medicaid or CHIP, and supporting the private insurance market. It also notes that while premium assistance programs could generate cost savings by leveraging employer contributions, these programs may be more expensive than direct coverage through states' Medicaid and CHIP programs.²³

Few premium assistance programs reported spending dedicated to wrap-around benefits or cost-sharing protections in 2009. Nine of the 36 programs that provided at least some wrap-around benefits reported the dollar amount spent for those benefits.²⁴ Four of the 34 programs that paid at least some cost-sharing (including copayments, coinsurance, and deductibles²⁵) reported the dollar amount spent for wrap-around cost-sharing.²⁶ Thus, limited data are available to assess state spending on wrap-around benefits and cost-sharing protections in Medicaid premium assistance programs.

Key Findings About Wrap-Around Benefits and Cost-Sharing

PREMIUM ASSISTANCE PROGRAM ENROLLMENT

States serve relatively small numbers of people in premium assistance programs that pre-date the ACA's Medicaid expansion. Enrollment in the premium assistance programs in states we examined ranges from 93 people in Nevada in 2014 to over 26,000 people in Texas in 2012 (Table 1). Despite wide state-level variation, enrollment in state premium assistance programs was a very small proportion of total Medicaid enrollment across all of the states. Enrollment in premium assistance accounted for 5% of total enrollment in Rhode Island and Vermont, and was less than 1% in all other states examined by this study.²⁷ This relatively low enrollment in premium assistance programs compared with total Medicaid enrollment is consistent with earlier research on premium assistance programs in Medicaid.²⁸

Some states target high cost/high need populations for their premium assistance programs.

Similar to the GAO report, our survey found that some premium assistance programs (Alabama and Louisiana) specifically reach out to pregnant women, while others (Nevada) target people with conditions that incur high medical costs such as AIDS and cerebral palsy. Targeting populations with high needs may make sense for states seeking to ensure that their premium assistance programs are cost-effective. However, given their more extensive health care needs, this population may be even more likely to need access to wrap-around coverage for services that are available through Medicaid but not through private insurance.

**Table 1:
State Premium Assistance Program Enrollment and Expenditures
From 2014 KCMU/CCF Survey**

| State | Program Name | Total State Spending on Premium Assistance* | % of State Spending on Premium Assistance For Wrap-around Benefits | Total Enrollment in Premium Assistance | Per Enrollee Cost | Data Year |
|--------------|--|---|--|--|-------------------|-----------|
| Alabama | Health Insurance Premium Program | \$478,444 | 49.0% | 127 | \$3,767 | FY 2014 |
| Louisiana | Health Insurance Premium Assistance Program | \$6,576,418 | 14.4% | 4,502 | \$1,461 | FY 2014 |
| Nevada | Health Insurance Premium Program | \$501,058 | N/R | 93** | \$5,388 | FY 2014 |
| Rhode Island | Rite Share | \$13,073,000 | 69.6% | 9,779 | \$1,337 | FY 2014 |
| Texas | Health Insurance Premium Payment Program | \$140,520,309 | N/R | 26,244 | \$5,354 | FY 2012 |
| Utah*** | Utah Premium Partnership for Health Insurance | \$722,509 | 48.1% | 813 | \$889 | FY 2014 |
| Vermont**** | Catamount Health & Employer-sponsored premium assistance | N/R | N/R | N/R | N/R | N/R |
| Wisconsin | BadgerCare Health Insurance Premium Program | \$163,032 | N/R | 133* | \$1,226 | FY 2013 |

NOTES: All states utilize premium assistance for employer-sponsored insurance; some states also provide premium assistance for COBRA and/or other group coverage. Data are presented for the most recent fiscal year available. Enrollment reflects data for the full year with the exception of Nevada, which reflects average monthly enrollment. Total state spending on premium assistance and per enrollee costs were calculated by KCMU/CCF based on premium assistance program spending and enrollment data provided by states. *Total state spending includes the following - AL: premiums, services not covered by private insurance but paid by Medicaid, and cost-sharing; LA: premiums, total wrap-around charges, administration fees; NV: premiums; RI: premiums, total wrap-around charges; TX: premiums; cost-sharing, administration fees; UT: state reported total expenditure; VT: premiums, benefits wrap-around; WI : state reported total expenditure. **Reflects average monthly enrollment. *** Utah only provides wrap-around coverage for CHIP dental services. CMS, Factsheet for Utah Primary Care Network Section 1115 demonstration program (Dec. 19, 2014), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-fs.pdf>. ****VT discontinued its program in 2014. SOURCE: 2014 KCMU/CCF survey of state officials in state premium assistance programs that reported spending on wrap-around benefits to GAO in 2009.

PREMIUM ASSISTANCE PROGRAM SPENDING

Few states report how much is spent on wrap-around benefits in their premium assistance programs, and to the extent that limited data are available, spending on wrap-around benefits as a percentage of total premium assistance program spending varies considerably among states. Of the eight states we studied, four (Alabama, Louisiana, Rhode Island, Utah) reported spending for wrap-around benefits in 2014, and these data demonstrate variation in this spending among states (Table 1).

The other states that responded to the survey noted their inability to break out costs for wrap-around benefits and were only able to report total spending for their premium assistance program.

The lack of data on spending devoted to wrap-around benefits in Medicaid premium assistance programs makes it difficult to assess the extent to which beneficiaries are accessing those benefits. Better data in this area would improve the ability of states and other stakeholders to determine whether beneficiaries are receiving wrap-around services. The availability of spending data broken down into categories, such as wrap-around benefits and wrap-around cost sharing protections, also could improve program monitoring and evaluation efforts. As one example, Utah is able to report the amount that it spends on the single wrap-around benefit that it offers in its premium assistance program, dental services for children (see Table 1 and Box 1).

Box 1: Utah's Wrap-Around Coverage Focused on Dental Benefits

The wrap-around benefits provided in Utah's premium assistance program are more limited in scope relative to other states' programs. Operating under the authority of a Section 1115 demonstration, the Utah Premium Partnership for Health Insurance (UPP) subsidizes employer and individual coverage for families. UPP provides an additional \$20 per month subsidy to purchase employer-sponsored dental coverage for children; however, there is no wrap-around for cost-sharing charges so families have to cover any cost-sharing associated with their employer-sponsored dental insurance. Alternatively, Utah's program provides wrap-around coverage solely for children's dental benefits for CHIP eligible children by allowing children with employer-sponsored coverage that omits dental benefits to enroll in the state's CHIP dental plan.²⁹ The narrow focus of Utah's wrap-around coverage may be easier for beneficiaries to navigate and for the state to administer because the state only subsidizes one specific benefit rather than providing access to a range of wrap-around services. According to our survey, in FY 2014, UPP enrolled 813 children in its premium assistance program with a per capita cost of \$889 (based on \$347,861 in state expenditures for wrap-around dental coverage provided through CHIP and \$722,509 in total state premium assistance program expenditures including monthly premium subsidies).

The lack of data on spending devoted to wrap-around benefits in Medicaid premium assistance programs also makes it difficult to assess whether these programs are cost-effective. Only two states (Louisiana, Texas) were able to break out spending for the administrative costs for their premium assistance programs in their responses to our survey. States are required to evaluate cost-effectiveness as part of determining eligibility for premium assistance, and this determination must include spending on wrap-around benefits and cost-sharing protections as well as administrative costs. Better data about spending devoted to the various components of premium assistance programs would allow for a more accurate assessment of cost-effectiveness.

Overall state spending on premium assistance programs varies considerably by state. Per enrollee spending ranged considerably in 2014, from a low of \$1,337 in Rhode Island to a high of \$5,388 in Nevada (Table 1). This is likely a result to some degree of the fact that states serve different populations in their programs as well as relatively low program enrollment, which could result in wide variation in per capita costs; however, it also may reflect state challenges in tracking premium assistance costs.

ACCESS TO WRAP-AROUND BENEFITS

Of the seven states we examined,³⁰ the clarity of the written materials provided to beneficiaries about how to access wrap-around benefits varied, and no state clearly conveyed the availability of EPSDT wrap-around services for children. This was despite the fact that all states targeted families with children in their premium assistance program enrollment materials. Federal regulations require states to use clear non-technical language to inform Medicaid-eligible children and their families about EPSDT, including what services are available and where and how to obtain those services.³¹ EPSDT is a broad benefit that includes regular screenings; vision, dental, and hearing services; and any treatment services necessary to correct or ameliorate physical or mental health conditions, regardless of whether such services are covered under the state’s adult benefit package.³²

Rhode Island’s materials most clearly conveyed the availability of wrap-around benefits and described some of the benefits that EPSDT provides such as dental and vision services. Rhode Island’s premium assistance program booklet for beneficiaries explains that enrollees receive two cards – a private health plan card and a Medical Assistance Card. The booklet goes on to explain that “[t]he Medical Assistance Card is used for a few extra covered benefits listed in this booklet,” and provides details on eye care, dental services, bus passes, interpreter services, additional services that have limits in the employer plan (such as physical, occupational, and speech therapy; and mental health and substance abuse services), and over-the-counter medicine.³³ Other examined states did not provide any explicit or more generalized description (similar to Rhode Island’s) of the kinds of services that children are guaranteed through the EPSDT benefit and should be able to access even when enrolled in employer-sponsored insurance.

Two states we examined, Texas and Alabama, did refer to beneficiaries’ ability to receive Medicaid covered services on a wrap-around basis, but without any explanation of what those might be. Texas’ online description of its premium assistance program states that “[o]f course, Medicaid will pay for services not covered by the employer-sponsored insurance, as long as they are Medicaid-covered services provided by a Medicaid provider.”³⁴ While Alabama’s frequently asked questions for its premium assistance program explain that “[o]nce you are enrolled in the AL HIPP program, you will have access to benefits from both programs,”³⁵ the program flyer that Alabama uses instead highlights that premium assistance includes “[c]overage of group health insurance AND Medicaid ... including benefits Medicaid may not cover.”³⁶ Nevada’s beneficiary brochure states that “Medicaid covered services *may be* included if covered through the employer health insurance,”³⁷ which does not assure beneficiaries that Medicaid benefits outside of the employer-sponsored insurance will be covered (emphasis added).

It is worth noting that in addition to written materials, a number of states also mentioned toll free numbers or third party contractors who were available to answer questions about the program as a way of educating beneficiaries about how to access premium assistance benefits. Utah’s program materials are primarily designed to inform families about the larger Utah Premium Partnership program as dental services are the only wrap-around benefit available to children eligible for CHIP. The state does include a FAQ about dental coverage which clarifies that parents can receive \$20 per month towards the cost of their employer’s dental coverage or enroll in the CHIP dental plan.³⁸

By contrast, some states’ written materials made the opposite point, underscoring that the private health plan may cover services that are not covered by Medicaid. Beneficiary materials in Alabama, Louisiana, and Nevada all highlight that private insurance may cover benefits that Medicaid does not cover. For example, Louisiana’s materials highlight that employer-sponsored health insurance “may cover services that Medicaid doesn’t cover” rather than the reverse (i.e., that Medicaid is likely to cover services that your employer’s plan does not).³⁹ Wisconsin enrollees receive a lengthy booklet about enrollment and benefits which describes the situations in which a family might be able to enroll in their employer-sponsored insurance but does not describe how premium assistance or the wrap-around benefits work in practice. However, the state indicated in its survey response that state staff calls and details the plan to the member at the time of enrollment.

ACCESS TO WRAP-AROUND COST-SHARING PROTECTIONS

States have different policies about how they administer wrap-around cost-sharing protections in their premium assistance programs, with most protecting beneficiaries from making upfront payments in excess of Medicaid limits. According to survey responses, in some states (Louisiana, Nevada, Texas), Medicaid beneficiaries receiving premium assistance do not pay cost-sharing or out-of-pocket charges directly. In Alabama and Wisconsin, beneficiaries are responsible only for paying out-of-pocket co-payments at Medicaid levels. By contrast, in Rhode Island, beneficiaries must pay the full cost-sharing required by the private plan upfront when receiving services and then are reimbursed monthly.

In six states, our survey found that wrap-around cost sharing protections are available only if beneficiaries receive services from a provider who is both in their private insurance plan network and also accepts Medicaid.⁴⁰ If the provider does not accept Medicaid, beneficiaries must pay the entire cost of the service out-of-pocket. Thus, a family who is enrolled in their employer-sponsored insurance (ESI) with the help of Medicaid premium assistance may have to pay cost-sharing that exceeds Medicaid limits to have access to the full range of providers included in the ESI network, if all of those providers do not also accept Medicaid. Some of the premium assistance programs we examined target high-cost populations who may need specialty services and are likely frequent users of health care services. These populations may benefit from access to a private insurance network that is broader than the Medicaid provider network, but they also are unlikely to be able to afford out-of-pocket cost-sharing in excess of Medicaid limits. It is likely that beneficiaries may find that the need to see a provider who accepts both their private coverage and Medicaid further restricts their provider options rather than expanding them.

Beneficiaries may be unaware that they must see a provider who accepts both their private insurance plan and Medicaid to receive wrap-around cost-sharing protections. While written beneficiary materials overall were more clear about how to access wrap-around cost-sharing protections than wrap-around benefits, they did not consistently inform beneficiaries that they needed to see a Medicaid-participating provider to receive wrap-around cost-sharing protections. Some states’ materials are explicit on this point. For example, Rhode Island’s materials clearly state this limitation by informing beneficiaries that “[i]f you go to a provider who does not accept Medical Assistance, you will be required to pay the co-payment.”⁴¹ In addition, Alabama’s materials state that “[q]ualified Medicaid recipients have most out-of-pocket expenses covered by Medicaid when a recipient elects to go to a Medicaid provider,”⁴² and similarly,

Texas' materials state that "Medicaid pays the co-pays and deductibles when people with HIPP and Medicaid see a Medicaid doctor."⁴³ By contrast, Louisiana's beneficiary flyer does not mention that the state will only cover cost-sharing charges for providers who also accept Medicaid,⁴⁴ although it does point out that "[i]f you have both Medicaid and other health insurance coverage, you may get increased access to primary care doctors, specialty care doctors, and hospitals."⁴⁵ Alabama's HIPP guide and application brochure state that "[m]embers receive ... access to a wider network of doctors through group insurance coverage" while the application mentions that "Medicaid recipients' out-of-pocket medical costs will be paid by Medicaid if they receive treatment from a Medicaid provider."⁴⁶ Wisconsin provides a lengthy information packet to potential Medicaid beneficiaries, which includes only a small subsection on premium assistance and does not discuss limitations on accessing wrap-around cost-sharing.⁴⁷

Post-ACA Premium Assistance Programs

Since 2014, a small number of states have included one or more premium assistance components as part of a Section 1115 waiver using an alternative approach to implementing the ACA's Medicaid expansion.⁴⁸ These programs differ from the premium assistance programs we examined in that they may cover a greater number of beneficiaries and often they use Medicaid premium assistance to purchase individual Marketplace coverage. Arkansas was the first state to adopt this model and requires all newly eligible Medicaid beneficiaries to enroll in Marketplace premium assistance.⁴⁹ New Hampshire will be implementing a similar approach in 2016.⁵⁰ Iowa initially required Marketplace premium assistance for newly eligible adults with income between 100-138% of the federal poverty level, but the program is now voluntary due to the loss of one of the two Marketplace plans that covered Medicaid beneficiaries.⁵¹

Some state Medicaid expansion waivers also include provisions for more traditional premium assistance programs for the purchase of employer-sponsored coverage; these are relatively small parts of the expansions approved in Iowa (which enrollment is required) and Indiana (voluntary enrollment).⁵² Other states that have debated the Medicaid expansion also have considered gubernatorial or legislative proposals that include premium assistance models.⁵³ For example, Tennessee's proposal included voluntary premium assistance for employer-sponsored coverage,⁵⁴ and Utah's proposal required premium assistance for Marketplace or employer-sponsored coverage.⁵⁵ This trend may continue as states that have not yet expanded Medicaid may be more inclined to favor the use of program designs that emphasize private coverage or other features that require waiver authority.

CMS generally has not allowed states with Medicaid expansion waivers using premium assistance to waive benefits in lieu of providing wrap-around coverage. The one exception is limited permission to waive non-emergency medical transportation benefits in Iowa⁵⁶ and Indiana.⁵⁷ For all remaining benefits that are not covered in the private insurance package, states electing to use premium assistance must provide wrap-around coverage. For example, Arkansas is providing both non-emergency medical transportation and EPSDT services for 19- and 20-year-olds through its Medicaid fee-for-service program as a wrap-around benefit for newly eligible adults (see Box 2).

Box 2: Wrap-around Coverage for Early and Periodic Screening, Diagnostic, and Treatment Benefits in States Using Marketplace Premium Assistance to Expand Medicaid

Newly eligible individuals who are ages 19 and 20 are treated as adults for the purposes of eligibility under the ACA's coverage expansion, but they are also entitled to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit package that Medicaid provides to all children up to age 21. CMS has not allowed any state to waive these benefits for 19 and 20 year olds eligible through the Medicaid expansion. As a result, this group receives EPSDT benefits via wrap-around coverage in states requiring newly eligible adults to enroll in Marketplace coverage using premium assistance to expand Medicaid.

To date, data about beneficiary access to wrap-around EPSDT benefits in Medicaid expansion waivers are available only for Arkansas. All newly eligible Medicaid beneficiaries in Arkansas receive coverage via premium assistance for Marketplace health plans, which do not cover the full extent of services required by EPSDT, such as vision and dental services. Arkansas provides EPSDT benefits through its fee-for-service Medicaid program on a wrap-around basis. In 2014, there were 9,971 newly eligible 19 and 20 year olds entitled to EPSDT benefits in Arkansas, although only 1,048 people in this group utilized wrap-around benefits, according to the state's Department of Human Services. The total annual cost to provide wrap-around EPSDT benefits to newly eligible 19 and 20 year olds was \$214,385, or \$22 per capita, for all those eligible for EPSDT wrap-around benefits in Arkansas.⁵⁸

CMS also generally has required states using Medicaid premium assistance for their new adult expansions to impose cost-sharing within Medicaid limits. This means that states electing premium assistance must determine how to administer wrap-around cost-sharing protections. Like most of the pre-ACA premium assistance programs that we examined, Arkansas' approach to wrap-around cost-sharing protections shields beneficiaries from having to front high out-of-pocket costs and be reimbursed later.⁵⁹ Because Arkansas is using a limited number of Marketplace plans for its premium assistance program, it may be administratively easier to implement this approach to wrap-around cost-sharing than in states that offer premium assistance for anyone with any employer-sponsored coverage.

Conclusion

As states' interest in Medicaid premium assistance models continues, further research is needed to examine the beneficiary experience in these programs. This is especially true for access to wrap-around benefits and cost sharing protections, as little data presently is available in this area. Premium assistance approaches could have political and practical advantages for enrollees, and implementation of new programs in the context of alternative Medicaid expansions can be informed by states' experiences with long-standing programs. At the same time, wrap-around benefits add a layer of complexity for beneficiaries, providers, and states in premium assistance programs. Explaining how the wrap-around works is a challenge, especially when broad benefits that may not be fully included in private coverage, like EPSDT, are involved. Given the complex nature of these programs and variation in state implementation, the extent to which enrollees have access to the full Medicaid benefit package and cost sharing protections is an area for continued study.

In addition, to the extent that Medicaid beneficiaries enrolled in premium assistance programs do not have access to wrap-around cost sharing protections unless they see Medicaid providers, beneficiaries are not receiving one of the key advantages often cited by proponents of premium assistance – access to a wider

network of providers. Educational materials provided to beneficiaries do not always clearly explain the availability of wrap-around benefits and cost sharing protections, particularly EPSDT, and varied considerably in the states we examined. As more states consider premium assistance models to serve greater numbers of beneficiaries, the need to understand how to best administer wrap-around benefits and cost-sharing protections is of growing importance.

Appendix:

SURVEY FOR KAISER/GEORGETOWN REPORT ON WRAPPED BENEFITS IN PREMIUM ASSISTANCE PROGRAMS

Thank you very much for your willingness to answer a short survey on your premium assistance program. We are mindful of how valuable your time is and have tried to keep this survey brief.

The purpose of this study is to examine the provision of wraparound benefits in state Medicaid premium assistance programs. Wraparound benefits are additional benefits and/or lower cost-sharing provided by Medicaid but not typically covered in a beneficiary's private insurance plan.

We are approaching you because in a 2010 study conducted by the Government Accountability Office (GAO) entitled *Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs*, STATE reported MEDICAID OR PROGRAM NAME expenditure data on the costs of wraparound benefits for FY 2009. Your state reported XXXX.

We are interested in both STATE's provision of benefits covered by Medicaid that are not covered by the beneficiaries' private insurance plans as well as expenditures to reimburse additional cost-sharing charges (such as deductibles, copayments and coinsurance) when private insurance charges are higher than those permitted by Medicaid.

1. For the most recent fiscal year available, please share enrollment and overall program expenditures for your premium assistance program.
2. For the same fiscal year, please share expenditures on premium subsidies, "wrapped benefits" i.e. benefits not covered by the beneficiary's private insurance, and cost-sharing charges paid by the state on the beneficiaries' behalf. We would appreciate if you could be as specific as possible.
3. Please briefly describe for us how the wraparound works in practice –
 - a. How do beneficiaries learn about and access benefits that are covered by Medicaid but not by their private insurance plan?
 - b. How are providers reimbursed for additional benefits covered by the Medicaid program and on what fee schedule?

- c. How is cost-sharing tracked and reimbursed? Do beneficiaries pay out-of-pocket at the point of service, and if so, are copayments limited to the Medicaid amounts?
 - d. Are there different cost-sharing reimbursement rules for providers that are participating Medicaid providers and those that are not?
4. Please share with us any program materials that you provide to beneficiaries to help them understand and access their wraparound benefits and cost-sharing protections. Are there other resources available to beneficiaries (such as call centers) if they have questions?
 5. Please share with us any additional information and/or observations you have about issues associated with providing wraparound benefits and cost sharing protections.

Endnotes

¹ See generally Kaiser Commission on Medicaid and the Uninsured, *A Look at the Private Option in Arkansas* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Aug. 2015), <http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/>; Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion Through Marketplace Premium Assistance* (Sept. 2013), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-through-marketplace-premium-assistance/>; Kaiser Commission on Medicaid and the Uninsured, *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act* (March 2013), <http://kff.org/medicaid/issue-brief/premium-assistance-in-medicaid-and-chip-an-overview-of-current-options-and-implications-of-the-affordable-care-act/>.

² United States Government Accountability Office, *Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs* (Washington, DC: United States Government Accountability Office, Jan. 19, 2010), <http://www.gao.gov/new.items/d10258r.pdf>.

³ There also are statutory authorities for states to use premium assistance in CHIP programs. See Kaiser Commission on Medicaid and the Uninsured, *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2013), <http://kff.org/medicaid/issue-brief/premium-assistance-in-medicaid-and-chip-an-overview-of-current-options-and-implications-of-the-affordable-care-act/>.

⁴ 42 U.S.C. § 1396e, <https://www.law.cornell.edu/uscode/text/42/1396e>. States also have the Section 1906A option to use premium assistance for Medicaid beneficiaries with access to employer-sponsored insurance with a minimum 40% employer contribution to premium costs. Section 1906A was limited to children and their parents when first effective in 2009, and extended to all Medicaid beneficiaries as of 2014. Unlike Section 1906 programs, beneficiaries cannot be required to enroll in premium assistance under Section 1906A. 42 U.S.C. § 1396e-1, as amended by ACA § 2003 and 10203(b)(2)(B), http://www.ssa.gov/OP_Home/ssact/title19/1906A.htm#ft118.

⁵ The top two challenges in implementing and operating premium assistance programs identified by states surveyed by the GAO in 2009 include the limited number of individuals with access to private health insurance and difficulty identifying those individuals. GAO at 11.

⁶ 42 U.S.C. § 1396d(a) (medical assistance payments “may include. . . other insurance premiums for medical or any other type of remedial care or the cost thereof”), <https://www.law.cornell.edu/uscode/text/42/1396d>. Only six states reported using Section 1905(a) authority in 2009. GAO at 15-16, Table 3.

⁷ 42 C.F.R. § 435.1015; CMS, *Medicaid and the Affordable Care Act: Premium Assistance Frequently Asked Questions* (March 2013), <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

⁸ 42 C.F.R. § 435.1015(b); CMS, *Medicaid and the Affordable Care Act: Premium Assistance Frequently Asked Questions* at 2 (March 2013), <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

⁹ See, e.g., Kaiser Commission on Medicaid and the Uninsured, *Benefits and Cost-Sharing for Working People with Disabilities in Medicaid and the Marketplace* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Oct. 2014), <http://kff.org/medicaid/issue-brief/benefits-and-cost-sharing-for-working-people-with-disabilities-in-medicaid-and-the-marketplace/>.

¹⁰ 42 U.S.C. § 1396d(r)(5), <https://www.law.cornell.edu/uscode/text/42/1396d>.

¹¹ 42 U.S.C. § 1396o, <https://www.law.cornell.edu/uscode/text/42/1396o>.

¹² See, e.g., L. Dague, “The effect of Medicaid premiums on enrollment: A regression discontinuity approach,” *Journal of Health Economics* 37, (Sept. 2014): 1-12, <http://www.sciencedirect.com/science/article/pii/S0167629614000642>; Kaiser Commission on Medicaid and the Uninsured, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Feb., 2013), <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/>.

¹³ 42 C.F.R. § 435.1015(b); CMS, *Medicaid and the Affordable Care Act: Premium Assistance Frequently Asked Questions* at 2 (March 2013), <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

¹⁴ 42 CFR § 435.1015(a)(2) and (3) (making premium assistance subject to the conditions that, *inter alia*, “[t]he agency furnishes all benefits for which the individual is covered under the State plan that are not available through the individual health plan” and that “[t]he individual does not incur any cost-sharing charges in excess of any amounts imposed by the agency under subpart A of part 447”).

¹⁵ 78 *Fed. Reg.* 42159, 42184 (July 15, 2013), <https://www.federalregister.gov/articles/2013/07/15/2013-16271/medicaid-and-childrens-health-insurance-programs-essential-health-benefits-in-alternative-benefit>.

¹⁶ CMS, *Medicaid and the Affordable Care Act: Premium Assistance Frequently Asked Questions* at 2 (March 2013), <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

¹⁷ 78 *Fed. Reg.* 42184.

¹⁸ 42 C.F.R. § 435.1015(a)(4).

¹⁹ 42 C.F.R. § 435.1015(a)(4).

²⁰ GAO at 2-3. Not all programs responded to all survey questions. All 45 programs offered premium assistance for group coverage, and 21 offered premium assistance for individual market coverage. GAO at 7. Less than half (20 programs) required beneficiaries to enroll in premium assistance. GAO at 8.

²¹ GAO at 8.

²² GAO at 2.

²³ GAO at 2.

²⁴ GAO at 9, 10, n.22. An additional three states reported \$0.00 in spending.

²⁵ GAO at 6.

²⁶ GAO at 10, n.22. An additional four states reported \$0.00 in spending.

²⁷ Kaiser Family Foundation, *Total Monthly Medicaid and CHIP Enrollment* (Washington DC: Kaiser Family Foundation, Aug. 2015), <http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/>; Kaiser Family Foundation, *Total Monthly Medicaid Enrollment* (Washington DC: Kaiser Family Foundation, Dec. 2013), <http://kff.org/medicaid/state-indicator/monthly-medicaid-enrollment-in-thousands/>.

²⁸ Kaiser Commission on Medicaid and the Uninsured, *Serving Low-income Families Through Premium Assistance: A Look at Recent State Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Oct. 2003), <http://kff.org/medicaid/issue-brief/serving-low-income-families-through-premium-assistance/>.

²⁹ For more information, see Utah Dep’t of Health, *UPP for Health Insurance Frequently Asked Questions*, <http://health.utah.gov/upp/faqs.htm#15>; Utah Dep’t of Health, *UPP for Health Insurance Comparison Chart*, <http://health.utah.gov/upp/PDF/Comparison%20Chart2014%20-%20eng%20.pdf>.

³⁰ We did not receive written materials from Vermont, although we did receive a limited response to our survey on some of the spending questions. We were not able to analyze Vermont’s materials as it discontinued its program in 2014.

³¹ 42 C.F.R. § 441.56(a).

³² 42 U.S.C. § 1396d(r)(5).

³³ Rhode Island Department of Human Services, *Rite Share Health Insurance Premium Assistance Program Brochure* (Feb. 2011), http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/rs_booklet_eng.pdf.

³⁴ Texas Medicaid and CHIP Health Insurance Premium Payment program web description, <http://www.hhsc.state.tx.us/Medicaid/hipp/>.

³⁵ Alabama Health Insurance Premium Payment Program FAQs, <http://myalhipp.com/faqs/>.

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- ³⁶ Alabama Health Insurance Premium Payment Program Brochure, www.myallhipp.com/wp-content/uploads/2012/03/AL-HIPP-Brochure_Web.pdf.
- ³⁷ State of Nevada Division of Health Care Financing and Policy Health Insurance Premium Payment Program Brochure, dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Pgms/CPT/HIPPEnglishBrochure.pdf.
- ³⁸ See “Frequently Asked Questions” Utah Department of Health Utah Premium Partnership website, health.utah.gov/upp/faqs.htm.
- ³⁹ Louisiana HIPP application and flyer on file with authors.
- ⁴⁰ In Utah where families only receive a monthly contribution towards the cost of dental coverage cost-sharing is not addressed at all.
- ⁴¹ Rhode Island Department of Human Services, Rite Share Health Insurance Premium Assistance Program Brochure (February 2011), http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/rs_booklet_eng.pdf.
- ⁴² Alabama Health Insurance Premium Payment Program, Fact Sheet, <http://www.myallhipp.com/wp-content/uploads/2012/02/Fact-Sheet.pdf>.
- ⁴³ Texas Health and Human Services Commission, “Your Guide to HIPP,” http://txhipp.qsig.net/wp-content/uploads/2014/08/HIPP_2011WelcomeKit_English1_AT.pdf.
- ⁴⁴ The state’s response to our survey indicated that this is Louisiana’s policy on wrap-around cost-sharing.
- ⁴⁵ Louisiana Health Insurance Premium Payment Program, “Pregnant and on Medicaid,” http://new.dhh.louisiana.gov/assets/medicaid/lahipp/docs/LaHIPP_pregnancy_onepager.pdf.
- ⁴⁶ Alabama Health Insurance Premium Payment Program Brochure and website materials available as noted above.
- ⁴⁷ Wisconsin’s member booklet “ForwardHealth: Your Connection to Health Care Coverage and Nutrition Benefits” <https://www.dhs.wisconsin.gov/publications/po/p00079.pdf>. Also see a state factsheet describing the program which does not clarify that providers must be Medicaid providers to be reimbursed, <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>.
- ⁴⁸ See generally Kaiser Commission on Medicaid and the Uninsured, *The ACA and Medicaid Expansion Waivers* (Feb. 2015), available at <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>. As of this writing, 31 states (including DC) have implemented the ACA’s Medicaid expansion to nearly all adults up to 138% of the federal poverty level (FPL, \$16,243 for an individual in 2015), and most states have done so as Congress envisioned in the ACA. Kaiser Family Foundation State Health Facts, *Status of State Action on the Medicaid Expansion Decision*. Data Source: KCMU tracking and analysis of state executive activity (Nov. 2, 2015), <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>. As a result of the Supreme Court decision in *National Federation of Independent Business v. Sebelius*, states may now choose whether they wish to expand Medicaid. Kaiser Family Foundation, *A Guide to the Supreme Court’s Affordable Care Act Decision* (Washington, DC: Kaiser Family Foundation, June 2012), <http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-affordable/>.
- ⁴⁹ Kaiser Commission on Medicaid and the Uninsured, *A Look at the Private Option in Arkansas* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Aug. 2015), <http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/>; Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Arkansas* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Feb. 2015), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/>.
- ⁵⁰ New Hampshire initially implemented the Medicaid expansion using its existing Medicaid delivery system. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in New Hampshire* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2015), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-new-hampshire/>.
- ⁵¹ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Iowa* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Feb. 2015), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/>.
- ⁵² Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Indiana* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Feb. 2015), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/>.
- ⁵³ For example the proposal advanced by the Florida Senate (Florida Health Insurance Affordability Exchange Program) included a premium subsidy model that would potentially subsidize employer-sponsored insurance, www.ahealthyfloridaworks.com.
- ⁵⁴ Kaiser Commission on Medicaid and the Uninsured, *Proposed Medicaid Expansion in Tennessee* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Jan. 2015), <http://kff.org/medicaid/fact-sheet/proposed-medicaid-expansion-in-tennessee/>.
- ⁵⁵ Kaiser Commission on Medicaid and the Uninsured, *Proposed Medicaid Expansion in Utah* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Jan. 2015), <http://kff.org/medicaid/fact-sheet/proposed-medicaid-expansion-in-utah/>.
- ⁵⁶ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Iowa* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Feb. 2015), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa/>.

⁵⁷ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Indiana* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Feb. 2015), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/>.

⁵⁸ Data was obtained via personal communication with the Arkansas Department of Human Services, Division of Medical Services, Coordination of Coverage Unit, April 2014, on file with authors.

⁵⁹ Kaiser Commission on Medicaid and the Uninsured, *A Look at the Private Option in Arkansas* at 11 (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Aug. 2015), <http://kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/>.