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Using Medicaid to Wrap Around Private Insurance: Key Questions to Consider

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Key Take-Aways

- Medicaid premium assistance is not widely used today, and there are limited data on how well it works.
- Blending Medicaid and private insurance is administratively complex for states, and some states have discontinued their programs.
- Details about a new Senate proposal to use Medicaid funds to wrap around private insurance subsidized with federal tax credits are unclear and changing but seem to provide federal funding through Section 1115 waivers, which are granted at the discretion of the HHS Secretary and must be budget neutral to the federal government, leaving states with no guarantee of funding amounts or longevity.

The Senate is currently considering the Better Care Reconciliation Act (BCRA). This bill goes beyond repeal and replacement of the Affordable Care Act (ACA) to make major changes in Medicaid program financing that would reduce federal funding by $756 billion from 2017-2026 and lead to 15 million fewer people covered by Medicaid by 2026, according to the latest Congressional Budget Office estimate. Most of this reduction is due to changing federal Medicaid financing to a per capita cap beginning in 2020 and eliminating the enhanced federal matching funds for the ACA's Medicaid expansion by 2024.

There have been recent reports of potential new funding being added to the BCRA to replace some of the anticipated loss of federal expansion funding and help states fill in gaps for private coverage obtained through tax credits for people who lose Medicaid coverage. Details about the amount of funding and the exact structure of the proposal are unclear and changing but reportedly would be made available to states through Section 1115 waivers and use Medicaid to subsidize or wrap around private insurance purchased with federal tax credits. These funds are not expected to equal the loss of federal Medicaid expansion funding, and they would not replace federal Medicaid funding cuts through the BCRA's per capita cap that most Medicaid enrollees would experience.

Using Medicaid to wrap around private coverage is known as premium assistance and has been part of the Medicaid program for a long time (see Box 1 for more background on Medicaid premium assistance). The current proposal reportedly would be modeled on Arkansas' use of this approach in its Medicaid expansion, although other state experience indicates many challenges in premium assistance programs. While no legislative text has been released to date, and details remain uncertain, this issue brief raises three key questions for consideration if Medicaid "wrap around" proposals are considered.

Box 1: What is Medicaid Premium Assistance?

Medicaid premium assistance programs allow states to use Medicaid funds to purchase private coverage for Medicaid beneficiaries. Generally, federal law also requires states using these programs to provide supplemental benefits and cost-sharing protections to make the private coverage purchased with Medicaid dollars on par with what a beneficiary would receive if covered directly by the state's Medicaid program; these supplemental payments are referred to as Medicaid benefit and cost-sharing "wrap arounds." Wrap arounds are necessary because, reflecting the low incomes and greater health care needs of Medicaid beneficiaries, federal Medicaid law stipulates minimum benefit standards and maximum cost-sharing limitations for state Medicaid programs. Private insurance typically offers fewer benefits than Medicaid, and a service that is not covered by private insurance is likely to be unobtainable for people with low incomes if it must be paid out-of-pocket. Medicaid limits cost-sharing to nominal amounts for adults below poverty, while private insurance is likely to have cost-sharing in excess of Medicaid limits. A large body of research has established that cost-sharing creates a barrier to accessing needed health services.

Key Questions

1. What Do We Know From States' Experience Using Medicaid to Wrap Around Private insurance?

- **Low enrollment.** Medicaid premium assistance programs that pre-date the ACA expansion have low enrollment overall and comprise a small share of total Medicaid enrollment, primarily because relatively few Medicaid enrollees have access to or could afford private coverage. In eight states with pre-ACA premium assistance programs surveyed in 2014, enrollment ranged from 93 people in Nevada as of 2014 to over 26,000 in Texas as of 2012. Enrollment in premium assistance accounted for 5% of total Medicaid enrollment in Rhode Island and Vermont and less than 1% in five other states.[1]
- **Limited data.** Few states report Medicaid spending for wrap around benefits and cost-sharing in their premium assistance programs, making it difficult to assess the extent to which premium assistance enrollees are accessing benefits that are covered by Medicaid but not included in their private health plan and whether premium assistance programs are cost-effective compared with direct Medicaid coverage as required by federal law. Of the 45 premium assistance programs in 37 states identified in a 2010 GAO report, 36 programs reported providing some wrap around benefits, and 34 programs reported paying wrap around cost-sharing. However, only nine states reported a dollar amount for wrap around benefit spending, and four states reported a dollar amount for wrap around cost-sharing. In the 2014 survey, only two of eight states were able to report spending for administrative costs in their premium assistance programs.

2. What Administrative Complexity Does Using Medicaid to Wrap Around Private Insurance Create?

- **Overseeing multiple private health plans and delivery systems.** Most of the states adopting the ACA's Medicaid expansion do not use a premium assistance model and instead cover expansion enrollees through their existing Medicaid managed care programs. Medicaid managed care programs deliver care through a limited number of health plans that contract with the state to provide the Medicaid benefit package covered at Medicaid cost-sharing levels; these plans are generally offered by private insurers. This

approach allows states to oversee one set of health plans for all Medicaid enrollees, with covered benefits and cost-sharing determined by state contract consistent with Medicaid rules. States monitor their health plans to ensure that Medicaid funds are spent appropriately. For example, states must ensure that health plan provider networks are adequate to provide enrollees with access to care, and states set quality measures to evaluate the care provided by plans.

Unlike many other states, Arkansas did not have an established Medicaid managed care delivery system in place prior to implementing its Marketplace premium assistance model and instead moved directly from a fee-for-service delivery system to premium assistance when implementing its Medicaid expansion. Under the state's program, it contracts with a limited number of standardized plans.

- **Administering exemptions.** Arkansas' model exempts people who are medically frail from premium assistance, instead providing them with direct Medicaid fee-for-service coverage. The medical frailty evaluation involves additional time and resources for the state, health plans, and providers but has been identified as important by stakeholders to ensure that enrollees receive the benefits that best meet their needs. This is because in some cases, Medicaid provides benefits that private coverage does not, such as mental health, substance use treatment, prescription drugs, and rehabilitative and habiliative services. These often include benefits needed by people with disabilities, some of whom are eligible for coverage as expansion adults.
- **Tracking and wrapping cost-sharing.** Regardless of the number of plans in the premium assistance program, states face the challenge of tracking and managing cost-sharing under each enrollee's private plan to identify where it exceeds Medicaid limits and a Medicaid wrap is needed. Cost-sharing can vary among private market plans, creating complexity for states to track and administer. Stakeholders observed that Arkansas' Medicaid premium assistance model standardizes the participating Marketplace plans' cost-sharing design and arranges for the state to pay premiums and cost-sharing reductions directly to the plans. The direct payment from the state to the plans protects low-income premium assistance enrollees from having to make burdensome out-of-pocket payments upfront to access care and then be reimbursed.
- **Tracking and wrapping covered benefits.** As with cost-sharing, states using Medicaid premium assistance also must evaluate the benefits offered by each enrollee's private health plan to identify where Medicaid must wrap around to cover benefits that are missing. A model that offers some benefits through one delivery system and other benefits through another delivery system can be confusing for enrollees to navigate and for states to administer. The 2014 survey found that the clarity of states' written beneficiary education materials varied widely in explaining how to access wrapped benefits. Benefits can vary among private market plans, creating complexity for states to track and administer. Stakeholders noted a limited number of health plans participate in Arkansas' premium assistance program and those plans offer a standardized set of benefits, including nearly all of those covered by Medicaid. This arrangement minimizes the need for Medicaid to provide wrapped benefits. Stakeholders report some concern that beneficiaries do not always know how to access the two benefits that are provided as wrapped coverage through Arkansas' fee-for-service Medicaid program (non-emergency medical transportation and EPSDT for 19 and 20 year olds). While few details exist about the current Medicaid wrap proposal, it appears that it may be limited only to a cost-sharing wrap. In that case, Medicaid funds would be used to purchase private market coverage that includes fewer benefits than an enrollee would receive under the state's traditional benefit package.

- **Administrative or other issues lead to program discontinuation.** Indiana recently asked CMS to discontinue its Medicaid premium assistance program for employer-sponsored insurance because "[u]tilization of HIP Link has been low and administrative burden has been high." The state reports that the program had 60 enrollees as of March, 2017. Iowa had to discontinue its Medicaid premium assistance for expansion enrollees from 100-138% FPL because the participating health plans left the program; instead, Iowa now covers all expansion enrollees through its Medicaid managed care delivery system. From 2014 to 2015, at least two states (Louisiana and Vermont) discontinued their pre-ACA premium assistance programs.

3. What are the Financing Implications of Using Medicaid to Wrap Around Private Insurance Under the BCRA?

- **Funding adequacy compared to ACA expansion funding.** Details about the amount of funding involved in the current proposal are unclear and changing, but there have been news reports of adding $100 billion or $200 billion in federal funding to help states subsidize private market coverage obtained with tax credits for people who would lose Medicaid expansion coverage. It is unlikely that this amount of federal funds over 10 years can replace the lost federal funding for expansion coverage under the existing Medicaid program, assuming all expansion states receive some of the funding. According to recent estimates, states would see a $700 billion reduction in federal Medicaid funds over the 2020-2026 period if they all drop the ACA expansion, far more than the amounts being discussed in current debate. In addition, it is not clear whether all states would be helped or whether these funds would be targeted to a few states, and there is no guarantee of final funding levels after waiver negotiations. Moreover, spending under the BCRA proposal would likely be higher compared to current Marketplace premium assistance models like Arkansas, because deductibles under the private market plans would be substantially higher than under the ACA, due to changes in the private market subsidies offered and the actuarial value of the benchmark plan. This has implications for both the federal cost-effectiveness and budget neutrality tests involved in Medicaid premium assistance waivers as explained below.
- **Cost-effectiveness compared to traditional Medicaid.** Federal law requires Medicaid premium assistance programs to be cost-effective compared to coverage under the state's traditional Medicaid program.[2] However, the cost of providing private market coverage through Medicaid premium assistance under the BCRA proposal is unlikely to be comparable to the cost of providing coverage directly through Medicaid. While all enrollees likely would not use enough services to meet their plan deductible, under BCRA, the CBO estimates that the benchmark plan deductible for a single individual purchasing a plan with 58% actuarial value would be $13,000 in 2026. For comparison, Arkansas' ACA Medicaid expansion premium assistance model uses health plans with 94% actuarial value, and the state funds the deductible, which was $664 in 2014. Arkansas uses plans with 94% actuarial value because that number is set under the ACA; however, the BCRA would substantially lower the benchmark plan actuarial value to 58%.
- **Federal budget neutrality under Section 1115 waivers.** Federal Medicaid funding under the proposal would flow to states through Section 1115 waivers, although it is unclear if the $100 or $200 billion would be dispersed through waivers or outside waivers. Under long-standing policy, spending under these waivers must be budget neutral to the federal government, meaning that federal costs under the waiver must not exceed what they would be without the waiver. It is unclear how federal costs under a waiver that uses

Medicaid to wrap around private market coverage subsidized with tax credits would be lower than the costs that the federal government would incur without the waiver if the ACA expansion financing is eliminated. The BCRA repeals the ACA's federal Medicaid expansion funding, phasing the enhanced matching rate down to the state's regular matching rate by 2024. So, if the BCRA were to pass, there would be less federal funding available in the "without waiver" analysis leaving states fewer dollars for providing wrap around cost-sharing amounts.

- **Limited state funds to finance waiver coverage.** While details about the proposal remain unclear, traditionally, states still need to come up with the state share of funds under Section 1115 Medicaid waivers. This will be difficult given broader Medicaid cuts in the BCRA under the move to a per capita cap or block grant. The CBO estimates that federal Medicaid spending will fall by 26% compared to current law in 2026, leaving states with difficult choices about how to administer their programs with substantially less federal funding. It is unclear whether the $100 or $200 billion to be added to the BCRA would be additional federal funding on top of waiver funding.
- **Financing complexity.** The flow of dollars to finance coverage by using Medicaid to wrap around individual market plans obtained with tax credits in an attempt to make coverage under the BCRA affordable for those who would lose Medicaid expansion coverage would be more complex compared to traditional Medicaid financing. Under the current Medicaid program, funds flow from the federal government to the states, then from the states to plans. In comparison, the proposed approach could have federal funds flow to both states (for the wrap around) and individuals (for tax credits to purchase private coverage), and state funds could flow to individuals or plans to offset costs incurred that should be covered by the wrap around. As described above, this flow of funds would in turn require administrative costs to determine the scope of each person's wrap around and track benefits and cost-sharing. In Arkansas' model, funding flows directly from the federal government to the state to a limited number of health plans with standardized benefits and cost-sharing, protecting individuals from having to advance burdensome costs out-of-pocket.
- **Temporary and discretionary fixes.** Unlike Medicaid's traditional financing structure, including the ACA expansion, funding available under these waivers would be limited in duration and amount, and whether they would be approved at all for a given state and on what terms would be subject to the discretion of the HHS Secretary. Today, as state spending increases as a result of state policy choices and priorities, federal spending is there to meet it. There is no guarantee of additional federal funds once the initial funding is exhausted, making it difficult for states to plan their budgets. Section 1115 waivers are time-limited and authorized at the discretion of the HHS Secretary for demonstrations that further program purposes, creating additional uncertainty about whether states could access these funds in the future. Whether a particular state could obtain a Section 1115 waiver under this proposal, the amount of federal funding available, and the specific terms also would be determined at the Secretary's discretion.

Endnotes

[1] Data for the remaining state was unavailable.

[2] Cost-effectiveness requires the total cost of Medicaid premium assistance (including premiums, administrative costs, cost-sharing wraps and benefits wraps) to be comparable to cost of providing direct coverage through the Medicaid state plan. Additional factors can be taken into account when determining cost-effectiveness under Section 1115 waivers, such as savings from reduced churn between Medicaid and the Marketplace as enrollees' income fluctuates and the effect of increased Marketplace enrollment and competition due to Medicaid premium assistance.