Medicaid Expansion Through Premium Assistance: Arkansas, Iowa, and Pennsylvania’s Proposals Compared

Arkansas, Iowa, and Pennsylvania have proposed implementing the Affordable Care Act’s (ACA’s) Medicaid expansion by using Medicaid funds as premium assistance to purchase coverage for some or all newly eligible Medicaid beneficiaries in Marketplace (formerly called Exchange) Qualified Health Plans (QHPs). Arkansas and Iowa’s § 1115 demonstration waivers have been approved by the Centers for Medicare and Medicaid Services (CMS), and Pennsylvania’s application has been released for public comment. These states seek demonstration waiver authority primarily because they propose to make premium assistance enrollment mandatory for affected beneficiaries. Iowa and Pennsylvania also propose to waive their obligation to provide wrap-around benefits and to impose premiums not otherwise allowable under federal law; Pennsylvania additionally proposes to require beneficiaries to participate in job search activities. Iowa will cover newly eligible adults with income below 100% FPL through another waiver involving Medicaid managed care, and Pennsylvania’s waiver proposal includes some provisions that affect populations currently eligible for Medicaid coverage. This fact sheet compares the states’ proposals. Key similarities and differences between the proposals are summarized in Table 1 below and further details are included in Table 2 beginning on the next page.

<table>
<thead>
<tr>
<th>Table 1: Key Similarities and Differences Between States’ Medicaid Expansion Premium Assistance Proposals</th>
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<tr>
<td><strong>Overview:</strong> Would use Medicaid funds to pay premiums for Marketplace QHPs for some or all newly eligible Medicaid beneficiaries under the ACA’s expansion.</td>
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<td><strong>Duration:</strong> 2014-2016</td>
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<td><strong>Coverage Groups:</strong> All newly eligible beneficiaries ages 19 to 64: parents between 17-138% FPL, and childless adults between 0-138% FPL. (Would include currently eligible parents and children in future years.)</td>
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<td><strong>Enrollment:</strong> Would be mandatory for affected beneficiaries and exempt beneficiaries who are medically frail.</td>
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<td><strong>Premiums for Enrollees:</strong> None</td>
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<td><strong>Cost Sharing:</strong> Required for enrollees between 100-138% FPL. (Would require for those between 50-100% FPL in subsequent years.)</td>
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<td><strong>Benefits:</strong> QHPs would provide services in the state’s Medicaid Alternative Benefit Plan. Prescription drug coverage would be limited to the QHP formulary.</td>
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<td><strong>Wraparound Benefits:</strong> Provided on a fee-for-service basis. EPSDT provided FFS. One year waiver of non-emergency medical transportation.</td>
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<td><strong>QHP Oversight:</strong> Written agreement between state Medicaid agency and QHP (and state insurance departments in AR and IA) covering data reporting and auditing.</td>
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<td>Element</td>
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**Benefits:**

- **QHP benefits package:**
  - QHPs would provide services in the Medicaid Alternative Benefits Package (ABP).
  - ABP will be the same as Medicaid state plan benefits package.
  - Waiver application indicates that ABP will be at least equivalent to state employee plan benefits package and that state will provide dental benefits through a capitated commercial dental plan carve-out.
  - QHPs would provide essential health benefits based on small group plan with largest enrollment benchmark.
    - (For currently eligible beneficiaries, state would create 2 adult benefits packages: 1 for “low risk” beneficiaries and 1 for “high risk beneficiaries.” Enrollment in benefits package based on health screening during online application. Exceptions to limits on benefits will be granted for chronic illness/serious health condition and denial jeopardizes life or results in serious deterioration; if cost-effective; if necessary to comply with federal law.)
Table 2: States’ Medicaid Expansion Premium Assistance Proposals Compared

<table>
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<tr>
<th>Element</th>
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<th>Iowa (approved)</th>
<th>Pennsylvania (proposed)</th>
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<td><strong>Federally qualified and rural health centers (FQHC/RHC):</strong></td>
<td>Beneficiaries will have access to at least 1 QHP that contracts with at least one FQHC/RHC.</td>
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<td>Seeks waiver of FQHC/RHC provider access requirements/would defer to QHP provider network.</td>
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<td>Waiver application indicates that state will develop alternative FQHC/RHC payment methodology that moves from FFS per visit payments to those that account for service intensity and reduction in the uninsured. If unable to do so timely, state reserves right to seek waiver of FQHC/RHC reimbursement rules.</td>
<td>No other FQHC/RHC provisions in demonstration approval.</td>
<td>Seeks waiver to limit FQHC/RHC reimbursement to the amount that the FQHC/RHC negotiates with the QHP, instead of the prospective payment system amount.</td>
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<td><strong>Prescription drugs:</strong></td>
<td>Limited to the QHP formulary. Prior authorization within 72 hours instead of 24 hours.</td>
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<td><strong>Family planning providers:</strong></td>
<td>State covers out-of-network family planning providers on FFS basis.</td>
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<td>Seeks waiver of requirement to cover all family planning providers.</td>
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<td><strong>Wrap-around benefits:</strong></td>
<td>Provided on a FFS basis (non-emergency medical transportation and EPSDT).</td>
<td>One year waiver of obligation to provide non-emergency medical transportation for all newly eligible beneficiaries, after which impact on access to care will be evaluated. EPSDT provided on FFS basis.</td>
<td>Seeks authority to waive provision of any benefits available through low risk ABP that are not included in QHP benefits package, such as non-emergency medical transportation. (Newly eligible 19 and 20 year olds would receive EPSDT through Medicaid managed care plans.)</td>
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<td><strong>Retroactive coverage:</strong></td>
<td>Would provide 3 months’ coverage prior to application date on FFS basis.</td>
<td>State will provide direct Medicaid coverage between date of eligibility and QHP enrollment. Retroactive coverage not mentioned.</td>
<td>Seeks authority to waive the requirement to provide retroactive coverage.</td>
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<td><strong>Appeals:</strong></td>
<td>Demonstration enrollees would use the state fair hearing process for all appeals. State may submit SPA delegating hearing responsibility to another state agency.</td>
<td>Demonstration enrollees would use the QHP appeals process for denials of QHP-covered benefits and state fair hearing process for eligibility appeals.</td>
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<td><strong>Financing:</strong></td>
<td>Estimates that the cost of covering the demonstration population will be the same with the waiver as without the waiver: $118 million in CY 2014, $126.4 million in CY 2015, and $135.4 million in CY 2016.</td>
<td>Does not specify cost without the waiver. Estimates that the waiver will cost $137 million in CY 2014, $205 million in CY 2015, $213 million in CY 2016, $221 million in CY 2017, and $230 million in CY 2018.</td>
<td>Waiver application indicates that state “is proposing a per capita budget neutrality model for the populations covered under the demonstration, including [premium assistance] participants. Actual waiver expenditures for these populations will be applied against the without waiver budget limit.” No further detail specified.</td>
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<td><strong>Cost-Effectiveness:</strong></td>
<td>May use state-developed tests of cost-effectiveness that differ from those otherwise permissible.</td>
<td>Not specified.</td>
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<td>Oversight:</td>
<td>State Medicaid agency (and state insurance departments in AR and IA) will enter into MOU with QHPs regarding enrollment, payment of premiums and cost-sharing reductions, reporting and data requirements, notices, and audits.</td>
<td>Demonstration approved 9/27/13.</td>
<td>Released for state public comment period prior to CMS submission on 12/6/13.</td>
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<td>Within 6 months of implementation and annually thereafter, state must hold forum for public comment.</td>
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<td>Evaluation:</td>
<td>State must submit draft evaluation design within 60 days of demonstration approval.</td>
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<td>Waiver application lists hypotheses to be tested.</td>
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<td>Evaluation shall be conducted by an independent entity.</td>
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<td>Reporting:</td>
<td>State must submit quarterly and annual reports to CMS.</td>
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**Endnotes:**
