

medicaid and the uninsured

March 2013

Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act

EXECUTIVE SUMMARY

Premium assistance is the use of public funds through Medicaid or the Children's Health Insurance Program (CHIP) to purchase private coverage. States have pursued premium assistance with varied objectives, including covering parents not otherwise eligible for public coverage and promoting the use of private coverage. Implementation of the Affordable Care Act (ACA) coverage expansions is likely to spark renewed interest in premium assistance options. This brief provides an overview of premium assistance options and examines how the ACA may impact the use of premium assistance.

Premium Assistance Options and Waiver Demonstrations

States have multiple options available to provide premium assistance through Medicaid and CHIP.

These include longstanding options as well as newer options provided by the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the ACA. In addition, some states have used Section 1115 waiver authority to provide premium assistance in ways that do not meet federal requirements and options. Premium assistance options vary with regard to who may be served and whether premium assistance can be required for certain enrollees. Most of the options subsidize employer sponsored insurance (ESI), although some allow for subsidization of individual policies. Premium assistance options also vary with regard to minimum employer contributions, with the longstanding options having no minimum required contribution or a state-determined contribution and the newer options requiring an employer to pay at least 40% of premium costs. Under all of the options, states generally must provide wraparound coverage to fill in gaps in benefits between a private plan and Medicaid or CHIP benefits and pay cost sharing in excess of Medicaid or CHIP cost sharing requirements.

All premium assistance options require states to establish that providing premium assistance is cost effective. This means that the cost of covering an individual through premium assistance must be the same or less than providing "comparable coverage" to the individual in the direct Medicaid or CHIP program. CHIPRA and the ACA implemented new requirements about how cost effectiveness is calculated and make the test consistent across all premium assistance options. Under this standard, a state must include the cost of providing wraparound coverage as well as administrative costs when determining cost effectiveness. The cost effectiveness test can be applied on either an individual or aggregate basis at state option. A robust employer contribution and/or targeting of high-cost enrollees are often features of a cost effective program given that private insurance is generally more expensive than direct coverage through Medicaid and CHIP.

CHIPRA and the ACA implemented several changes that are designed to facilitate the coordination between ESI and Medicaid and CHIP coverage as part of premium assistance. These include requiring employers to provide employees residing in states with a premium assistance program with a notice of the availability of this option and requiring employers to provide a description of their ESI plan to state administrators with sufficient detail to help the state determine cost effectiveness and which wraparound benefits must be provided. CHIPRA also made the loss of public coverage as well as

eligibility for Medicaid and CHIP “qualifying events” for purposes of being able to enroll in ESI so that families can transition into ESI outside of open enrollment periods when these changes occur.

Several states’ experience with premium assistance suggests that these states generally view their programs as successful, but limited in scope due to several key challenges. Overall, premium assistance programs have been small relative to total enrollment and spending in Medicaid and CHIP. One key challenge identified by state administrators is achieving cost effectiveness, which is becoming increasingly difficult due to the overall declines in availability of ESI and increases in employee cost sharing. In addition, the increase in high deductible plans and similar products in the private market is making it increasingly difficult to compare private plans with Medicaid. Administrators also highlight challenges providing outreach and education to beneficiaries, providers, employers and caseworkers.

Premium Assistance and the ACA

A key question is how the ACA coverage expansions will affect use of premium assistance. These include an expansion of Medicaid to adults up to 138% of the federal poverty level (FPL), which was effectively made a state option by the Supreme Court, and the creation of new health benefit exchange marketplaces with advance premium tax credits for individuals between 139-400% FPL.

Increased eligibility for parents under the Medicaid expansion may increase opportunities to achieve cost effectiveness through premium assistance. Under the Medicaid expansion, parents of the vast majority of children in Medicaid will become eligible. Having the whole family eligible for Medicaid may increase the likelihood that premium assistance will be cost effective if a family has an offer of ESI, since a state can include the cost of covering all family members in its cost effectiveness determination. In addition, more adults are likely to have access to ESI as states extend eligibility up the income scale. However, as noted, continued rising costs of private coverage and as well as declines in availability of ESI for low-wage workers may still limit the feasibility of providing premium assistance through Medicaid.

Premium assistance may support enrollment of families in a single plan even if they are covered by a mix of coverage types. Under the ACA coverage expansions, a number of families may have children in CHIP or Medicaid while parents are receiving premium tax credits for exchange coverage. States may be interested in using premium assistance to give these families the option of enrolling in a single plan. States may seek to provide this alternative through existing options by subsidizing either small group or individual plans available through exchanges for children enrolled in CHIP, while ensuring that they maintain access to CHIP or CHIP-equivalent benefits and do not pay higher cost sharing.

Some states have expressed interest in purchasing exchange coverage for Medicaid enrollees. To date, use of premium assistance to purchase individual market coverage has been relatively limited. However, the new exchanges will sell individual coverage that may offer better value. Proposals are emerging that seek to purchase exchange coverage for Medicaid expansion enrollees rather than providing them direct Medicaid coverage. CMS also recently proposed regulations that clarify requirements for the purchase of non-group coverage through a longstanding premium assistance option that could be used to pursue this goal. This approach could potentially help reduce churning for individuals at the higher end of the Medicaid income scale, many of whom are expected to move back and forth between Medicaid and exchange premium tax credit eligibility. In addition, exchange coverage may offer more robust provider networks. However, one key question is whether the purchase of exchange coverage will prove cost effective since exchange coverage is expected to be more expensive than Medicaid. In addition, unless a state obtains a waiver of federal requirements, all other Medicaid provisions would still apply. As such, it will be important to ensure that wraparound coverage is provided effectively so that enrollees maintain full access to Medicaid benefits and cost sharing protections.

INTRODUCTION

Premium assistance is the use of public funds through Medicaid or CHIP to purchase private coverage. Most commonly these funds are used to purchase ESI, but, in some states, individual market coverage has been subsidized as well. States have pursued premium assistance with varied objectives—in some cases, a desire to cover parents that are not otherwise eligible for public coverage or to cover families in the same plan in a cost effective way—and, in other cases, a more ideological objective of promoting the use of private coverage. States have implemented premium assistance both through state options available in Medicaid and CHIP as well as through Section 1115 demonstration waiver authority. CHIPRA and the ACA provided states some new options to offer premium assistance and made changes to existing options, including implementing a standard definition of cost effectiveness that applies across all premium assistance options.

Beginning in 2014, coverage expansions under the ACA will take effect. These include an expansion in Medicaid to adults up to 138% of the federal poverty level, subject to state implementation, and the creation of new health insurance exchange marketplaces with advance premium tax credits available to moderate-income individuals to help purchase exchange coverage. Implementation of the ACA coverage expansions is likely to spark renewed interest in premium assistance options as Medicaid will expand to individuals with higher incomes and new exchanges may offer individual coverage policies at better value than available today. Recently, some states have expressed interest in utilizing premium assistance to align new Medicaid coverage options for parents and childless adults with coverage options that will become available through exchanges in 2014. This policy brief looks at the current landscape of premium assistance options in Medicaid and CHIP and how state choices around premium assistance may be impacted by the ACA coverage expansions.

OVERVIEW OF PREMIUM ASSISTANCE OPTIONS

States have multiple options available to provide premium assistance through Medicaid and CHIP. These include longstanding 1906 authority and the CHIP family coverage option as well as new options provided by CHIPRA and the ACA. In addition, the Centers for Medicare and Medicaid Services (CMS) recently released proposed regulatory guidance on a pre-existing but little used premium assistance option that could be used to align Medicaid and exchange coverage.¹ Some states also have implemented premium assistance programs through Section 1115 waiver authority.

Premium assistance options vary with regard to who may be served and whether premium assistance can be required for certain enrollees. Most of the options subsidize ESI, although some allow for subsidization of individual policies. Premium assistance options also vary with regard to minimum employer contributions. Under all of the options, states generally must provide wraparound coverage to fill in gaps in benefits between a private plan and the Medicaid or CHIP benefit package and pay cost sharing in excess of Medicaid or CHIP cost sharing requirements. All premium assistance options also require states to establish that providing premium assistance is cost effective. This means that the cost of covering an individual through premium assistance must be the same or less than providing “comparable coverage” to the individual in the direct Medicaid or CHIP program. Following is an overview of each of the current avenues available to states to provide premium assistance through Medicaid or CHIP (see also Appendix A for more details):

¹ See Section 435.1015 of Proposed Rule RIN 0938–AR04 Federal Register/ Vol. 78, No. 14 / Tuesday, January 22, 2013.

- **Medicaid Section 1906 Health Insurance Premium Payment (HIPP) Programs.** The Medicaid 1906 option allows states to operate a HIPP program through a state plan amendment and purchase private group coverage for Medicaid beneficiaries and, in some cases, other family members. If the option is deemed cost effective by the state, Medicaid beneficiaries may be required to enroll. All benefits and cost sharing protections provided through the state plan remain in place for enrollees. This is the most common type of premium assistance program today.
- **Medicaid Section 1905(a) Premium Payment Option.** Recent regulatory guidance issued by CMS outlines rules for a previously little-used option that allows states to use Medicaid funds to purchase coverage in the individual market. A handful of states use this option to compliment their Section 1906 programs. All benefits and cost sharing protections remain in place and enrollment is voluntary. The advent of new ACA insurance exchange marketplaces offering individual market coverage with better value is likely to spur renewed interest in this option.
- **CHIPRA Family Coverage Option.** Originally authorized with the creation of the CHIP, this option allows states to purchase group or non-group coverage and mandate enrollment as long as benefits and cost sharing meet CHIP standards. However, the cost of a parent’s coverage could not be included to determine cost effectiveness since only the children were eligible for CHIP. This largely limited the utility of this option, and only one state (MA) has adopted it.
- **Section 1115 Waiver Authority.** In addition, many states have used Section 1115 waiver authority to provide premium assistance in a variety of different ways. No regulatory parameters exist around what aspects of federal law can be waived to facilitate premium assistance,² hence different Secretaries of HHS have used this authority differently – in some cases to facilitate coverage of non-eligible family members and in other instances to limit cost sharing and benefit protections by not requiring states to provide wraparound coverage.
- **New CHIPRA Premium Assistance Options.** In 2009, CHIPRA created two new state options to provide premium assistance to children and families—one in Medicaid (1906a) and one in CHIP.³ In addition, under the ACA, the new Medicaid “1906a” option will extend to all adults in Medicaid as of January 1, 2014, when the new Medicaid adult coverage option goes into effect.⁴ Both of these new options, which can be adopted through a state plan amendment, allow for the subsidization of ESI only, with a 40% minimum employer contribution toward premium costs. Medicaid and CHIP funds may not be used to subsidize high deductible policies, health flexible spending accounts or coverage in the individual market. In addition, families must participate voluntarily and be able to opt-out and return to direct coverage on a monthly basis. Under both options, states must provide the full Medicaid or CHIP benefit package, meaning families pay the same cost sharing and children receive full EPSDT or CHIP benefits through a wraparound package if not covered by their ESI. However, the new option does allow for an ESI plan to be determined to be actuarially equivalent to a state’s regular CHIP coverage, in which case the state does not need to provide wraparound benefits, although cost sharing protections would remain in place. Adoption of either of these new options counts for the purposes of a state establishing eligibility for CHIPRA performance bonuses, which are available to states that adopt specified eligibility policies and meet enrollment targets for children. These bonuses will expire at the end of FY2013.

² Waiving cost sharing requirements is subject to a higher statutory standard, though that standard has not always been observed.

³ The new CHIPRA option is at P.L. 111-3 Section 2105 (c)(10) and the Medicaid option is Section 1906(a).

⁴ It is worth noting that § 2003 (a)(1) of the ACA which creates this new Medicaid option for adults reads as if this is a state requirement. However § 10203(b)(2)(B) declares this requirement null and void thus rendering it an option.

RECENT CHANGES MADE TO PREMIUM ASSISTANCE OPTIONS

CHIPRA and the ACA also implemented several changes related to premium assistance options that are designed to facilitate the coordination between ESI and Medicaid and CHIP coverage. These changes include the following.

- **Increasing information about premium assistance options and ESI plans.** CHIPRA requires employers to provide employees residing in states with premium assistance programs with a notice of the availability of those options. Employers must also provide a description of their plans to state administrators with sufficient detail about benefits to help a state determine cost effectiveness and which wraparound benefits should be provided.⁵
- **Expanding the definition of qualifying events.** CHIPRA made the loss of public coverage a “qualifying event” for purposes of being able to enroll in ESI. This change ensures that if a family gets a raise or other source of new income and is no longer eligible for CHIP, they could add their child to their ESI at that time and not have to wait for their annual open enrollment period. In addition, eligibility for Medicaid and CHIP was added as a “qualifying event” so that states could facilitate enrollment into ESI through premium assistance for families who become eligible for Medicaid or CHIP outside of the open enrollment period for their ESI.
- **Cost effectiveness standard.** CHIPRA and the ACA also changed the way in which cost effectiveness is calculated so that the definition is now consistent across all premium assistance options.⁶ Under the standard, states must establish that the cost of covering an individual through premium assistance is the same or less than covering the individual in the direct Medicaid or CHIP program. The Secretary has not yet issued definitive guidance on this provision. However, the statute establishes that this test is “relative to the amount of expenditures under the State child health plan ... that the State would have made to provide *comparable coverage* of the targeted low-income child involved.” The comparable coverage language has not been fully defined but, in part, reflects Congressional intent for the cost effectiveness test to include the cost of providing wraparound coverage for additional premiums and cost sharing in private insurance as well as Medicaid or CHIP benefits that are not covered in a family’s ESI plan. The statute also requires that a state must include the administrative costs of running its premium assistance program in the test. The cost effectiveness test can be applied on either an individual or aggregate basis at state option. A robust employer contribution and/or targeting of high-cost enrollees are often features of a cost effective program given that private insurance is generally more expensive than direct coverage through Medicaid and CHIP.

⁵ Subsequently, the ACA made broader changes that may have the unintended consequence of facilitating this exchange of information. See discussion of ACA required Summary Plan Description below.

⁶ See P.L. 111-3 and P.L. 111-148 §10203(b)(1). An exception to this lies in the 1905(a) option which does not include a statutory reference to cost effectiveness, however recent regulatory guidance mentioned above includes a cost effectiveness definition similar to the statutory definition described here.

STATE EXPERIENCE WITH PREMIUM ASSISTANCE PROGRAMS

In a 50-state survey of state premium assistance programs, the Government Accountability Office (GAO) found that, as of 2009, 29 states reported operating a Section 1906 HIPP premium assistance program, 16 states reported having a Section 1115 waiver program, six states report a 1905(a) program, and one state reported having a program operating under CHIP authority.⁷ Moreover, as of February 2013, five states (CO, GA, VA, WA, WI) had adopted the new Medicaid “1906a” option; none had adopted the new CHIP option provided by CHIPRA.⁸ All five of the states that adopted the new 1906a option converted to this option from existing premium assistance programs. It is likely that they converted to the new option to qualify for the federal CHIPRA performance bonus funds, which they each received in 2011.

Overall, premium assistance programs have been small relative to total enrollment and spending in Medicaid and CHIP. Total state and federal spending for premium assistance is unknown, but a conservative estimate suggests that it constituted less than 1% of all Medicaid and CHIP spending in state fiscal year 2008-2009.⁹ This low enrollment can contribute to high per-person administrative costs.

As noted above, the GAO report found that Section 1906 “HIPP” programs are the most prevalent kind of premium assistance program operating among states. To provide greater insight into these programs, we examined the experience of HIPP programs in six states (AL, LA, NV, PA, RI, TX) based on review of available data and materials and interviews with state administrators. All of these programs are operating under Section 1906 authority except for Rhode Island’s RiteShare program, which operates under the state’s Section 1115 waiver but functions like a Section 1906 program in most respects.¹⁰ These programs varied considerably in size but most, with the exception of Rhode Island, accounted for 1% or less of total Medicaid enrollment in the state. The states’ definitions of cost effectiveness differed from each other despite the new federal statutory requirements—perhaps reflecting that federal guidance has yet to be issued. In many areas, data continue to be unavailable—for example, no state had data on access to and utilization of services among premium assistance enrollees.

Because most of the programs are small and have different target populations, as well as a paucity of data, it is hard to draw conclusions across the programs. However, the examined states generally view these programs as successful but limited in scope. Some other key findings include the following:

- **Demographics of premium assistance enrollees vary but some common characteristics exist.** Of the examined states that track demographics, two mentioned pregnant women (AL, LA) as the primary focus of their programs and two mentioned children as the largest group of enrollees— Pennsylvania, because children are eligible at higher income levels, and Nevada, which indicated that the program targets children with disabilities since they are more likely to be cost effective to

⁷ *Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs* GAO-10-258R, Jan 19, 2010 This report was mandated by the Children’s Health Insurance Program Reauthorization Act of 2009. (P.L. 111-3). See Table 3 of GAO report. Nine states reported “other” programs such as COBRA continuation coverage.

⁸ Email communication with Stacey Green, Centers for Medicare and Medicaid Services, March 1, 2013.

⁹ Georgetown University estimate based on Medicaid spending from Kaiser Commission on Medicaid and the Uninsured/Urban Institute estimates based on data from CMS HCFA-64 reports, 2011, and Net Reported Medicaid and CHIP Expenditures, FY1998-FY 2009. The Centers for Medicare and Medicaid Services (CMS), March 2011. and GAO’s study *Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs* cited below which found that a total of \$222 million was spent on premium assistance between July 1, 2008 and June 30, 2009. This does not include 3 states or all of the expenses for the 42 programs that reported.

¹⁰ The main difference is that the waiver permits the state to charge premiums for those at higher income levels (starting at 150% of FPL) similar to the premiums charged to families in the RiteCare program – the state’s regular Medicaid program.

cover through premium assistance due to their higher costs. Rhode Island's program has a substantial diversity of enrollees, perhaps reflecting the program's relatively large size as a proportion of the state's Medicaid program and a higher income eligibility level of parents. Together, these findings suggest that 1906 programs tend to focus on more expensive populations, such as pregnant women or children with disabilities, to achieve cost effectiveness. In addition, the higher the income eligibility level in a state—especially for parents—the more likely premium assistance is to be cost effective because a greater number of beneficiaries will have access to ESI.

- **Market trends are going in the wrong direction for premium assistance to expand capacity.** A number of the examined states mentioned changes in the private insurance market as problematic for growth in their programs. These trends include the general decline in availability of ESI and growth in employee cost sharing, which makes it more difficult to achieve cost effectiveness. Also, administrators noted that the increase in high deductible plans and similar products within the private market make it more difficult to compare policies with Medicaid.
- **Difficulties in outreach and education remain.** All of the examined states mentioned difficulties in outreach and education of beneficiaries, providers, employers and even caseworkers as a challenge to implementing premium assistance. Even though these programs have been in place for a number of years, most of the states said they still have difficulty obtaining the necessary information from employers about their benefit offerings despite the recent statutory changes designed to facilitate obtaining this information.

HOW WILL THE ACA COVERAGE EXPANSIONS AFFECT PREMIUM ASSISTANCE IN MEDICAID AND CHIP?

A key question is how implementation of the coverage expansions under the ACA in January 1, 2014 will affect state choices around premium assistance and the levels of enrollment in these programs.¹¹ These include an expansion of Medicaid to adults up to 138% of the federal poverty level (FPL), which was effectively made a state option by the Supreme Court ruling in the *National Federation of Independent Business v. Sebelius*, and the creation of new health benefit exchange marketplaces with advance premium tax credits for individuals between 139-400% FPL to help offset the purchase of coverage.¹²

Increased eligibility for parents under the Medicaid expansion may increase opportunities to achieve cost effectiveness through premium assistance. In a state that expands Medicaid eligibility, parents of the vast majority of children in Medicaid will become newly eligible. Having the whole family eligible for Medicaid may increase the likelihood that premium assistance will be a cost effective alternative if a family has an offer of ESI, since a state can include the costs of covering all family members in its cost effectiveness determination. In addition, more adults are likely to have access to ESI as states extend eligibility up the income scale. As states consider the budgetary impact of whether or not to extend coverage, subsidizing ESI may become a subject of renewed interest. This might include efforts to enhance enrollment in a state's existing Section 1906 premium assistance program, since this is the most common type of program available today.

¹¹ The potential implications of the ACA on premium assistance were discussed in a report to the Secretaries of Labor and Health and Human Services issued by the Medicaid, CHIP and Employer-Sponsored Coverage Coordination Working Group on August 4, 2010. This Working Group was established by CHIPRA and addressed a variety of issues related to premium assistance.

¹² Individuals from 100-138% of FPL are also eligible for tax credits if they are not eligible for Medicaid.

However, as noted above, the continued rising costs of private coverage and employee cost sharing as well as the increasingly limited availability of ESI for low-wage workers make premium assistance in Medicaid an option that is inherently limited. A recent study found that the percentage of workers and dependents under 138% of FPL with ESI declined from 38% in 2000 to 29% in 2010. The highest income earners showed a much smaller decline from 92% to 90% over the same period.¹³ A recent study also underscored the point made by program administrators that the growing cost of private coverage and changing structure of coverage with higher cost sharing and deductibles makes cost effectiveness more difficult to achieve. Although premium increases moderated last year, the average cost of family premiums has increased by 97% since 2002.¹⁴

Premium assistance may support enrollment of families in a single plan even if they are covered by a mix of coverage types. In addition to the Medicaid expansion, the ACA contains a “maintenance of effort” provision to ensure that states retain their current Medicaid and CHIP income eligibility levels for children until 2019. As a result, many families with incomes over 138% of FPL may find themselves with children in CHIP or Medicaid while parents are receiving advance premium tax credits to purchase qualified health plans through exchange marketplaces. States, especially those with separate state CHIP programs, may wish to give families the option of enrolling in the same plan even if different family members are covered through different coverage programs. States may seek to provide this alternative through existing options by subsidizing either small group or individual plans available through exchanges for children enrolled in CHIP, while ensuring that they maintain access to CHIP or CHIP-equivalent benefits and do not pay higher cost sharing.

Some states have expressed interest in purchasing exchange coverage for Medicaid enrollees. In the past, purchasing individual market coverage has been done in relatively limited instances in Medicaid and CHIP, and, with the CHIPRA changes to premium assistance, Congress signaled a desire to move away from this option. However, the passage of the ACA and establishment of new state and federal exchanges may provide for individual coverage that offers better value. Recently, a few proposals have emerged that would extend Medicaid coverage to newly eligible populations either in whole or in part through the purchase of exchange coverage.¹⁵ Recently proposed regulations issued by CMS clarify requirements around the purchase of non-group coverage through Section 1905(a) appear to offer a state plan option to states interested in this approach. However, one key question is whether the purchase of coverage through exchanges will prove cost effective since coverage offered through qualified health plans is expected to be more expensive than Medicaid. Another important factor to consider is that all other Medicaid provisions would still apply – unless a state pursues a waiver of specific statutory provisions. As such, the state would need to provide wraparound coverage to ensure individuals maintain full Medicaid benefits and cost sharing protections.

This option could potentially reduce churning and facilitate continuity of coverage for those at the higher end of the Medicaid income eligibility scale – many of whom are expected to move back and forth between Medicaid and premium tax credit eligibility. In addition, exchange coverage may offer access to more robust provider networks. However, if more states implement premium assistance through this route, it will be important to ensure that wraparound coverage is provided effectively. This

¹³ Holahan, J and Chen, V. *Declining Health Insurance in Low-Income Working Families and Small Businesses* Robert Wood Johnson Foundation/Urban Institute, April 2012.

¹⁴ Employer Health Benefits 2012 Annual Survey, Kaiser Family Foundation/HRET, September 11, 2012.

¹⁵ As of this writing Ohio’s Governor Kasich has proposed purchasing exchange coverage between 100-133 for newly eligible Medicaid beneficiaries and Arkansas’ Governor Beebe has proposed covering all newly eligible Medicaid beneficiaries in this manner.

is especially important if children are moved into the exchange to ensure that they continue to receive the full Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit. Moreover, cost sharing in the exchange is likely to be higher than what Medicaid permits for both adults and children, so wraparound protections will most likely be required. Anecdotal evidence suggests that families may not be aware of their rights to obtain wraparound benefits, and states generally have not tracked access to and utilization of services in their premium assistance programs, so it is not known how well these wraparounds are working in premium assistance programs today.¹⁶

New summary of benefits and coverage requirements may provide state administrators richer information about ESI plans. Another ACA provision that may have a more immediate and practical effect on premium assistance programs is the Summary of Benefits and Coverage (SBC) document, which requires a uniform explanation of private health plans that is easily understandable for consumers.¹⁷ States have often cited the difficulty in obtaining descriptions of ESI plans as a barrier to implementing premium assistance, in general, and to the feasibility of providing wraparound benefits. For example, the selected states examined in this analysis continued to cite difficulty in obtaining information from employers as a barrier despite the new CHIPRA requirements for employers to share information, so this broader SBC requirement ACA may help states and families to assess and compare coverage options more effectively.

CONCLUSION

To date, Medicaid and CHIP premium assistance programs remain relatively limited, largely reflecting limited access to ESI among low-income individuals covered by Medicaid and CHIP and challenges to achieving cost effectiveness. However the passage of the ACA with its expansion in Medicaid and the creation of new health insurance exchange marketplaces may spur increased interest among states in premium assistance options as states explore ways to align exchange and Medicaid coverage.

Overall, the future of premium assistance is uncertain. Private market trends, including greater employee cost sharing, declining availability of coverage for low-income workers, and higher rates of cost growth in private versus public coverage increase challenges to implementing premium assistance in the group market. However, at the same time, growth in Medicaid enrollees through the ACA Medicaid expansion may increase the viability of premium assistance. Moreover, the availability of more individual coverage options through the new exchanges and the potential to reduce churning between the two sources of coverage are likely to renew interest in this area.

The brief was prepared by Joan Alker of the Georgetown University Center for Children and Families. The author would like to thank Wesley Prater, from Georgetown University Center for Children and Families for his assistance as well as the state administrators who so generously shared their time to provide information about their premium assistance programs.

¹⁶ For example, as mentioned above none of the six states we interviewed for this report had any data on access/utilization of services.

¹⁷ The final rule implementing this provision is available at http://www.regulations.gov/#!documentDetail;D=HHS_FRDOC_0001-0442

**Appendix Table 1:
Overview of Premium Assistance Options Available to States**

	Medicaid Section 1906 Option	Medicaid Section 1905(a) Option	CHIP Family Coverage Option	Options Created by CHIPRA	
				CHIP Option	Medicaid 1906a Option
Eligibility	All Medicaid eligibles	All Medicaid eligibles	Targeted low- income children and families with at least one targeted low-income child*	Targeted low-income children who have access to qualified ESI	Medicaid eligible individuals under age 19 and their parents**
Mandatory or Voluntary Enrollment	Voluntary or mandatory	Voluntary	Voluntary or mandatory	Voluntary	Voluntary
Benefits	All Medicaid services	All Medicaid services	All CHIP services	All CHIP services***	All Medicaid services
Cost Sharing	Same as Medicaid+	Same as Medicaid+	Same as CHIP	Same as CHIP***	State must pay all premiums and cost sharing for the child <age 19 and the parent
Substitution Strategy	No requirement	No requirement	Must have a six-month waiting period.	States must apply same waiting period as is applied to direct CHIP coverage	No requirement
Employer Contribution	No minimum contribution	No minimum contribution	State-determined minimum contribution	Employer must contribute at least 40% toward the cost of the premium	
Type of Coverage Subsidized	Group	Non-group	Group or Non-group	Group	Group
Cost Effectiveness	Must be cost effective relative to expenditures state would make to provide "comparable coverage" in Medicaid and/or CHIP for eligible beneficiaries. Administrative costs must be included. Can be applied on an individual or aggregate basis.				
<p>* However, a child's eligibility is not affected by a parent's decision not to enroll the child in a group health plan.</p> <p>**As of January 1, 2014 states could use this option to cover new adult Medicaid eligibles</p> <p>***Employer coverage may be actuarially determined to be benchmark or benchmark-equivalent.</p> <p>+Non-Medicaid eligible family members are eligible only to have premiums paid on their behalf (if necessary to obtain access for the Medicaid enrollee); they are not eligible for wraparound coverage of cost sharing.</p> <p>In addition, states have implemented premium assistance programs through Section 1115 waiver demonstration authority. Features of these programs are subject to approval by the Secretary.</p>					

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