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ACHA Medicaid Advocacy Primer[1]: A Proposal for Providing Medicaid Eligible Students with an Option for Student Health Insurance Coverage

Background

American College Health Association began exploring issues related to Medicaid coverage, eligibility, portability and use of Medicaid dollars to purchase student health insurance plans (SHIPs) in 2011. The opportunity for states to participate in Medicaid expansion under the Affordable Care Act (ACA), which would result in over 5 million students meeting Medicaid eligibility, raised the importance of this issue for several reasons, including recognition that Medicaid may not be the best option for coverage for college students given shortcomings in portability and provider network limitations. Because Medicaid typically offers 'emergency only' coverage for students studying outside the state, the coverage may not meet benefit criteria for schools that require students to carry health insurance. This is especially problematic for students who are studying outside of their home state. Moreover, Medicaid-covered students studying at in-state institutions that are located in rural areas with limited health care provider networks may also be negatively impacted due to lack of access to mental health providers or specialists.

There is interest on the part of some schools to advocate for payment for SHIP and student health benefit plan (SHBP) premiums with Medicaid dollars as a reasonable option for Medicaid eligible college students, as well as interest for this option on the part of some state legislators looking for more cost-effective coverage options for their state's Medicaid beneficiaries. Although it appears, following the Supreme Court ruling in June 2012, that fewer states may opt into Medicaid expansion, which would have significantly increased the number of students eligible for Medicaid, the idea continues to present as one worth exploring. Since advocacy efforts for applying Medicaid funds to the payment of SHIP/SHBP premiums will be primarily focused at the state level, the purpose of this primer is to raise awareness of this potential opportunity for expanding meaningful student health insurance coverage, and to provide interested members with information that may be helpful to their advocacy efforts.

[1] This primer serves as a guide to assist members who are interested in engaging in state advocacy on the issue of providing Medicaid eligible students with an option for coverage through a student health insurance program using Medicaid dollars. The information provided is not intended to serve as legal advice. College and university administrators responsible for student health plans should assess, with their campus insurance administrators, financial aid officers and legal counsel, the impact this proposal may have on their student population. The viability of this proposal may vary from state to state as well as institution to institution.

Frequently Asked Questions

Q1. What is the status of Medicaid Expansion?

A1. As a result of the ACA, beginning in January 2014, Medicaid will increase its national eligibility limits for adults at or below 133 percent of the Federal Poverty Level (ex. 2012 - $14,856 for one person) and open coverage to include childless adults age 19 through 64 years of age. The original ACA legislation would have required states to participate in the expansion or risk losing federal funding for their current program. The Supreme Court ruled in June 2012 that states could not be punished for refusing to participate in Medicaid expansion thereby giving states the option to opt in or out of this provision of the ACA without penalty.

As of February 14, 2013, 23 states and the District of Columbia have opted to participate in the expansion, 13 states have elected not to participate, three are leaning toward participating, five are leaning toward not participating and seven are undecided/have no comment. There is no deadline for states to make a decision on whether to opt in or out of Medicaid expansion. In fact, the states can decide to opt in or opt out at any time. A regularly updated map showing each state's position with respect to Medicaid expansion may be viewed at www.advisory.com/MedicaidMap.Another helpful link on Medicaid expansion is provided via the American Public Health Association at: www.apha.org/advocacy/Health+Reform/ACAbasics/medicaid.htm

Q2. How does a state's decision to opt into Medicaid expansion affect insurance coverage for the college population?

A2. If a state opts in, the number of college-aged students who are eligible for Medicaid coverage will significantly increase. Therefore, the impact on managing health care for

students would likely shift to consideration of coverage under Medicaid which may or may not meet schools' health insurance coverage requirements or may present barriers to care because of network restrictions. Given the concerns regarding access to care for any student with Medicaid, another coverage option like student health insurance is worth considering even if the Medicaid covered student is in a state that has opted out of the expansion.

Q3. How do I determine how many students attending my institution are Medicaid eligible?

A3. Since Medicaid eligibility is primarily based on family income, the financial aid office on your campus may be in the best position to assist you with this calculation.

Q4. Are states permitted by law to use Medicaid funds to purchase SHIPs/SHBPs?

A4. It appears that states are able to make the determination that an alternate insurance plan can be considered an acceptable option. Section 1905(a) of the Social Security Act provides a pathway to premium assistance allowing states to enroll Medicaid eligible persons in individual insurance market plans that are "cost-effective" (See Q/A9). Since the students would still be considered Medicaid beneficiaries under this option, they would remain entitled to all benefit and cost-sharing protections for Medicaid Beneficiaries. States may have to provide additional (i.e. wrap around) benefits to ensure cost-sharing is not above Medicaid requirements and, for example, ensure that Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") benefits are available to those under 21. States may apply for a Section 1115 waiver to exempt a premium reimbursement program from some or all of these requirements. Additionally, the benchmark benefits statute described below provides authority to actually enroll people in plans that are deemed to meet the alternative benefit plan requirements.

Q5. If student health insurance appears to be a better coverage option for Medicaid eligible students, is there a way to offer that option to students while not disadvantaging them from a financial or benefits standpoint?

A5. ACHA is aware of two states, Montana and Minnesota, that determined it was cost-effective for Medicaid dollars to be used to purchase the institution's student health insurance for a student while providing secondary coverage (commonly referred to as "additional" or wrap around coverage) to the student for services not covered by the SHIP/SHBP. In the case of Montana, payment is issued directly from the State Medicaid Office to the institution. In Minnesota, students can petition their State Medicaid Office to pay for the SHIP/SHBP with the student receiving reimbursement from the state for payment of the plan.

Q6. What are "Alternative Benefit Plans" under the benchmark statute and do such plans offer additional opportunities for state Medicaid funding of SHIPs/SHBPs?

A6. The benchmark statute was added by the Deficit Reduction Act of 2005 to provide states flexibility to amend their state Medicaid plans without obtaining a waiver to offer different coverage options to targeted populations consisting primarily of healthy adults and children. (*See* 42 U.S.C.A. 1937). The ACA made several changes to the benchmark statute, including designating the benchmark packages as "Alternative Benefit Plans". Any Alternative Benefit Plans proposed by a state for a targeted population must provide benefits at least equal to or actuarially equivalent to one of the three commercial insurance products[2] or a fourth "Secretary-approved" benchmark package identified in the benchmark statute.

To provide states flexibility to design benefits based on the special needs of the target population, Alternative Benefit Plans are exempt from Medicaid "comparability" and "statewideness" requirements. This allows the Alternative Benefit Plan to provide different benefits to the target population than to other Medicaid beneficiaries and to utilize managed care or services that are geographically limited within the state. However, Alternative Benefit Plans must meet other Medicaid requirements for coverage, including transportation services, care in rural health clinics and federally qualified health centers, and Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services for children under 21 either as part of the benefit package itself or through a combination of the benefit package and "additional services" provided by the state (i.e. wrap around coverage). (*See* 42 U.S.C.A Section 1937 and 42 C.F.R. Sections 345, 365, and 390).

Beginning in 2014, all Medicaid benchmark and benchmark-equivalent plans must include the ten categories of "essential health benefits" ("EHBs") under the ACA. The proposed regulations, issued on January 14, 2013 by HHS ("Proposed Regulations"), also clarify that Alternative Benefit Plans must cover family planning services, mental health benefits, prescription drug coverage, and comply with provisions of the Mental Health Parity and Addiction Equity Act beginning in 2014. In addition, states will have additional flexibility in 2014 to designate an EHB package that is benchmarked to private plans in their state, or design their own EHB benefit package, subject to HHS approval. Alternatively, a state may select any of the three commercial plans designated by HHS as an EHB benchmark reference plan.

The proposed regulations address application of EHBs to Alternative Benefit Plans, define the states' role and two-step process for designating EHB benchmarks for Alternative Benefit Plans, and streamline eligibility, enrollment and appeals among Medicaid, the Children's Health Insurance Program ("CHIP") and available federal assistance for low-

[2]The three commercial insurance "benchmark" or "benchmark-equivalent" packages are as follows:
(1) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program;
(2) State employee coverage that is offered and generally available to state employees; and
(3) The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state.

income persons obtaining coverage through an exchange. (*See* Proposed 42 C.F.R. 335, 345, 347, and 435).

Q7. Under what circumstances could a SHIP/SHBP be considered an Alternative Benefit Plan?

A7. For a state to designate a SHIP/SHBP as an Alternative Benefit Plans, such plans would need to meet the minimum coverage requirements under the ACA and Medicaid, including wrap around coverage, and provide EHB benchmark or benchmark equivalent coverage. The extent to which SHIPs/SHBPs offering lesser coverage could successfully obtain HHS approval as an Alternative Benefit Plan is unclear. There does not appear to be any precedent for designating lesser coverage as a benchmark or benchmark equivalent package by HHS since states have historically used the Alternative Benefit Plan option sparingly and in most cases for the purpose of providing additional services to adults in special needs categories such as those with diabetes or heart disease. However, HHS does have limited authority to approve an Alternative Benefit Plan deviating from the otherwise applicable Medicaid requirements if a state can satisfactorily demonstrate that implementing such required provisions would be directly contrary to their ability to implement Alternative Benefit Plans. (*See* 42 U.S.C.A. Section 1937).

Q8. Do the proposed regulations impact the appropriateness of advocacy for states to subsidize SHIPs/SHBPs under CHIP when the student is eligible for Medicaid?

A8. The proposed regulations make many modifications streamlining eligibility, enrollment and appeals to coordinate the federal insurance assistance provided under Medicaid, CHIP and the premium assistance and cost-reduction subsidies available for certain low-income individuals purchasing insurance through an exchange beginning in 2014. (*See* Proposed 42 C.F.R. 431 and 435). However, it does not appear that the proposed regulations would impact the current provisions under Medicaid and CHIP that permit Medicaid funds to provide premium assistance for individual health policies not offered through an exchange by a state plan amendment or Section 1115 waiver from HHS. (*See* 42 U.S.C.A. 1905(a) and 2105(c)(3)). HHS is expected to issue additional guidance regarding simplification of the waiver process and addressing ACA changes to Medicaid.

Q9. Is there a standard formula that states use to perform a cost-effectiveness test between SHIP/SHBPs and Medicaid?

A9. No. Each state uses its own formula to make a determination of cost-effectiveness. The Proposed Regulations that would apply to premium assistance for individual market plans under Section 1905(a) authority align the cost effective determination for those plans with the current requirements for premium reimbursements under group health plans. Specifically, the Proposed Regulations provide that "the cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits for items and services covered under the Medicaid State plan, but not covered under the

individual's health plan, must be comparable to the cost of providing direct coverage under the State plan."(*See* Proposed 42 C.F.R. 435.1015). The comparison may also include any assistance with cost-sharing that the Medicaid program had to provide as well.

Q10. What are the benefits of using Medicaid funds to purchase SHIPs/SHBPs for both the Medicaid eligible student and the state?

A10. Benefits would include:

- Affordability[3] (student insurance costs may be lower than Medicaid costs)
- Improved access to care for low income families using health insurance that is designed to provide comprehensive coverage tailor made to address issues prevalent in the college population (e.g. mental health, alcohol and other drugs)
- Improved access to local provider networks with reasonable co-payments and deductibles as well as access to worldwide coverage including medical evacuation and repatriation of remains
- Decreased financial burden for students who have Medicaid coverage but find that they must purchase a SHIP/SHBP anyway because the Medicaid plan does not meet the institution's health insurance requirements
- Decreased burden to state Higher Education Opportunity Programs (HEOPs) and universities for financial aid costs related to paying for student health plans for low-income students

Q11. What data should I gather to better understand how this issue impacts students on my campus?

A11. Consider the following:

- Partner with financial aid office to determine an estimate of number of students on your campus that may be eligible for Medicaid.
- Prepare a cost/benefit analysis to aid in the discussion with university government relations about the size and scope of the concern.
- In addition to providing the cost and benefit structure of your student insurance program, provide a comparison between the benefits provided by the SHIP/SHBP and Medicaid.

Q12. Who should I approach to advocate on this issue?

A12. Consider the following contacts:

- A good place to start is to speak with the government relations staff of your institution**.** They will be able to tell you which department/person in state

[3] A comparison should be done between the institution's student health plan coverage and cost compared to the state Medicaid program.

government is responsible for managing the issue, such as, the state Medicaid Director.

- Approach other institutions in the region to identify those with shared interest.

Q13. How should I approach an advocacy issue with state legislators/officials?

A13. Your approach should consider and incorporate the following:

- Prepare ahead of time for the meeting. If you are going with a group, decide on the role each person will play.
- Establish relevance – make sure the person understands how this issue impacts the people they represent.
- Be specific about the issue. Use case examples when possible to illustrate your rationale.
- Be specific about how you would like the person to support your position.
- Provide briefing materials that you can leave behind.
- Be patient – do not expect an immediate response.
- Let the person know how you can help (provide more information, data, speak with others)
- Consider various options which may ultimately result in Medicaid payment for SHIP/SHBP programs (ex- possibly begin the process with advocating for a cost benefit analysis and/or feasibility study)

Q14. What language might be helpful in advocating for a cost benefit analysis and/or feasibility study?

A14. The first step may be to suggest to your state legislator(s) that your state calculate the cost of providing Medicaid versus using Medicaid dollars to purchase a student insurance plan to determine the cost-effectiveness of the idea.

An example of language that has been used in one state to advance a resolution designed to require that the calculation be determined is below:

Referred to Committee on HIGHER EDUCATION AND EMPLOYMENT ADVANCEMENT

Introduced by:

(HED)

AN ACT CONCERNING THE USE OF MEDICAID FUNDS TO PAY HEALTH INSURANCE COSTS FOR MEDICALLY INDIGENT STUDENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. () The Commissioner of Social Services and the president of the Board of Regents for Higher Education shall study the effectiveness of requiring state Medicaid to pay the cost of

premiums for health insurance sponsored by a constituent unit, as defined in section 10a-1 of the general statutes, and provide supplemental health insurance coverage for students enrolled in a constituent unit who are (1) not covered by any other health insurance plan, and (2) eligible for state Medicaid benefits. Not later than (date), the commissioner and president shall report on such study, in accordance with the provisions of …… of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to higher education and human services.

Statement of Purpose:

To require a study of the effectiveness of requiring state Medicaid to pay the cost of institution-sponsored health insurance premiums and provide supplemental coverage to medically indigent students enrolled in a constituent unit.

American College Health Association
1362 Mellon Road, Suite 180
Hanover, MD 21076
(410) 859-1500
(410) 859-1510 fax
www.acha.org