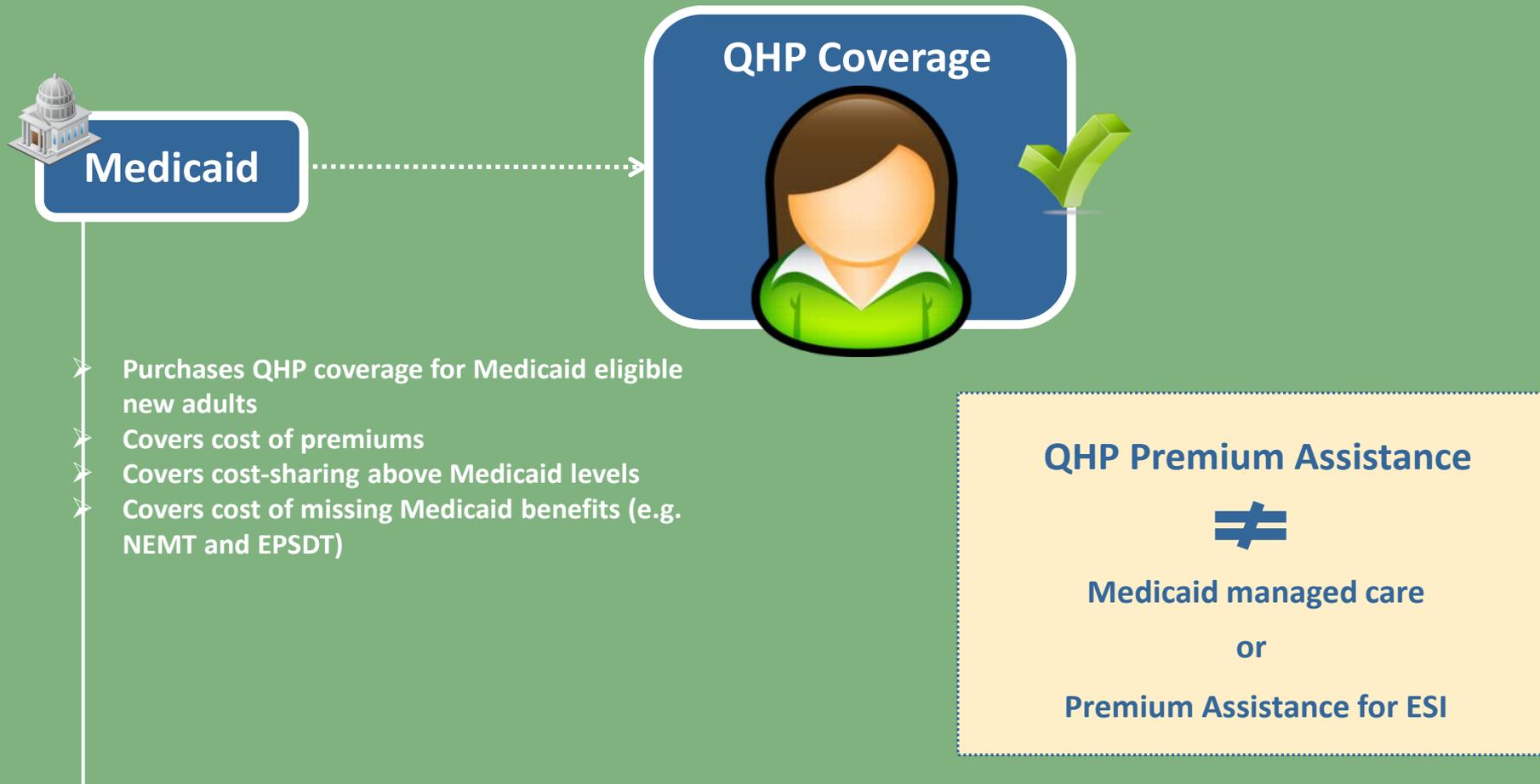


New Hampshire's Mandatory QHP Premium Assistance Waiver

Presented to Medical Care Advisory Committee

September 29, 2014

Premium Assistance In the Individual Market



Advantages to Premium Assistance

Positive impacts of implementing premium assistance:



- Enables continuity of coverage and care as individuals' and families' incomes fluctuate above and below 138% FPL
- May encourage Marketplace competition
 - Increased size of the individual market may attract more plans
 - Increased competition may drive down Marketplace premiums
- Enhances stability of risk pool through increasing potential enrollees
- Facilitates alignment of regulation and oversight across government and private markets
- Supports enhanced access to services and providers for all New Hampshire residents in the individual market, regardless of income
- Identifies populations whose needs can be well-served by private insurance market

Other States' QHP Premium Assistance Programs To-Date

	Populations Covered	Benefit Variations	Premiums	Cost-Sharing	Healthy Behavior Incentives
Arkansas 	<ul style="list-style-type: none"> ▪ Newly eligible adults with incomes 0-138% FPL ▪ Medically frail exempt 	No coverage of non-emergency use of the ER	No	Yes <ul style="list-style-type: none"> ▪ Individuals with incomes 100-138% FPL only ▪ Applied to wide range of services ▪ Consistent with Medicaid requirements 	No
Iowa 	<ul style="list-style-type: none"> ▪ Newly eligible adults with incomes 100-138% FPL who do not have access to cost effective ESI ▪ Medically frail exempt 	Non-emergency medical transportation waived for one year.	Yes <ul style="list-style-type: none"> ▪ Individuals with income >50% FPL; up to \$10/month for 100-138% FPL ▪ >100% FPL: may be dropped if fail to pay for 90 days and do not request hardship waiver 	Yes <ul style="list-style-type: none"> ▪ Individuals with income 0-138% FPL ▪ Limited to \$8 co-payment for non-emergency use of the ER 	Yes <ul style="list-style-type: none"> ▪ May reduce premium obligations

Premium Assistance Waiver: Submission Timeline

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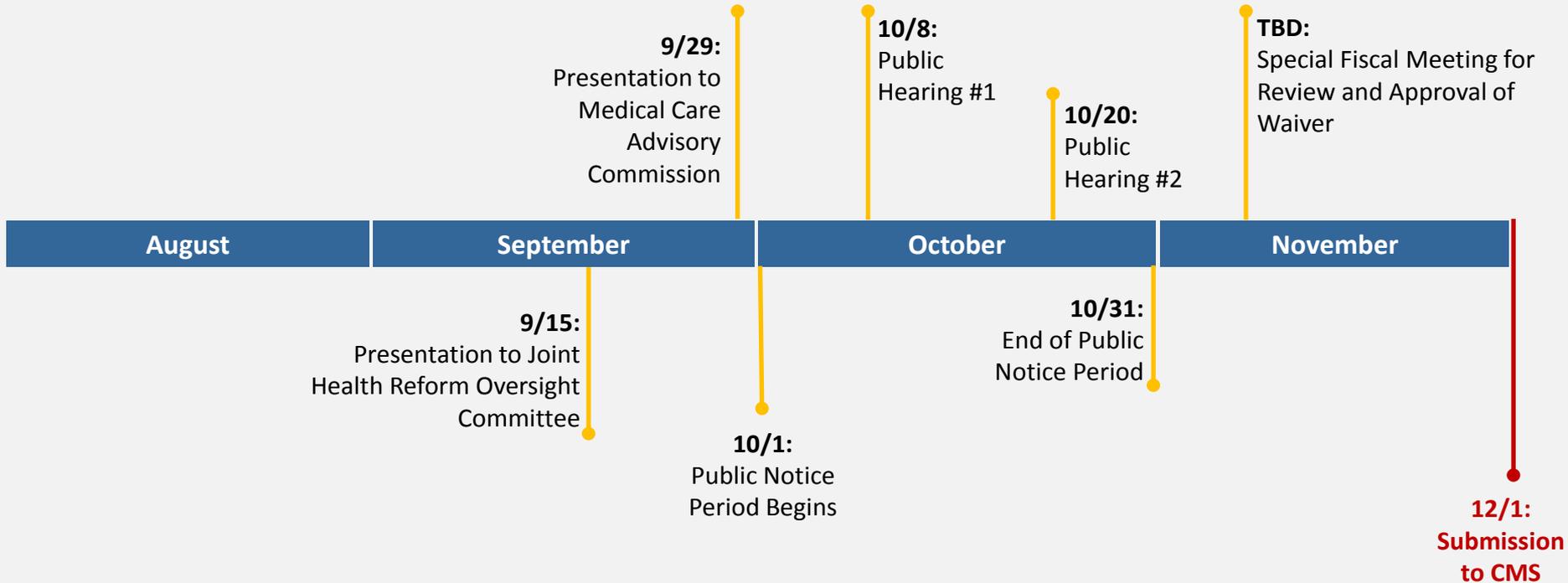
August & September:
Develop first draft of 1115 waiver

2

October:
Public Notice Period

3

November:
Finalizing waiver for submission to Fiscal Committee and CMS



Legal Requirements for Premium Assistance

Federal Legal Authority for Premium Assistance



- Historically, premium assistance in Medicaid has been permitted for employer-sponsored and individual market coverage under several sections of the Social Security Act
- Regulations finalized in July 2013 clarify that states may use premium assistance to purchase qualified health plan (QHP) coverage in the Marketplace using Medicaid funding and describe the parameters for QHP premium assistance
- Premium assistance in the individual market cannot be **mandatory**, unless the state receives an 1115 waiver under which state meets budget neutrality and cost effectiveness standards
- Guidance issued in March 2013 indicates that premium assistance waivers should end by December 31, 2016

State Legal Authority for Premium Assistance



- The marketplace premium assistance program was established in Senate Bill 413 RSA 126-A:5, XXV

Waiver Program Areas

Populations: Federal and State Requirements

Federal Requirements



- CMS has announced a policy preference for limiting mandatory QHP premium assistance to the new adult group
- “New adults” are defined as individuals who are:
 - Under 65 years of age,
 - Not pregnant,
 - Not entitled to, or enrolled for, benefits under Medicare Part A or B,
 - Not described in another eligibility category, and
 - Whose income does not exceed 133 percent of the poverty line

State Requirements



- Under SB 413, premium assistance program is for “newly eligible adults”

Populations: Program Elements

- New adults 19-64 will be required to enroll in QHPs through the demonstration
- Individuals who are HIPP eligible will be excluded from the demonstration
- Individuals identified as medically frail will be excluded from QHP premium assistance (i.e. will not be enrolled in QHPs)

Benefits: Federal and State Requirements

Federal Requirements



- New adults must receive the Alternative Benefit Plan (ABP)
- The State must wrap Medicaid-required benefits that are not covered by the QHP, for example:
 - Non-emergency medical transportation (NET)
 - EPSDT (not waivable)

State Requirements



- Under SB 413, all QHPs must offer to contract with all FQHCs operating in their region and must pay them the Medicaid PPS rate

Cost Sharing: Federal and State Requirements

Federal Requirements



- Cost-sharing must comply with Medicaid requirements, and CMS has little flexibility to waive these requirements

State Requirements



- Under SB 413, premium assistance program must promote “personal responsibility” through co-pays and other cost-sharing, as well as mandatory wellness programs

Cost-Sharing: Program Elements

- Individuals with incomes 100-138% FPL will enroll in 94% actuarial value (AV) high-level Silver-level QHPs, and will be subject to cost sharing through co-pays.
 - 94% AV Silver plans, which all QHP carriers are required by federal law to offer, are designed for individuals between 100-150% FPL who are receiving cost-sharing assistance through the federal Marketplace.
- Individuals with incomes <100% FPL will enroll in 100% AV Silver-level QHPs and will not be subject to any cost-sharing.
 - 100% AV Silver plans, which QHP carriers are required by federal law to offer, are designed for members of Indian tribes who under federal law are not subject to cost-sharing.

Choice of QHPs: Federal and State Requirements

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Federal Requirements



- Individuals must have choice of at least two QHPs

State Requirements



- Under SB 413, individuals choose from “any qualified health plans (QHPs) offered on the federally-facilitated exchange **if cost effective**”

Enrollment Process: Program Elements

Federal Requirements



- State must provide 3-month retroactive active coverage from date of application (but no coverage will be available prior to August 15)
- State must provide coverage between date of application and enrollment in QHP

State Requirements



- Under SB 413, individuals must be auto-assigned to a QHP offered by the MCO in which they are enrolled (if the MCO offers a QHP)
- Under SB 413, HIPP eligibles access HIPP
- Medically Frail will not enroll in QHPs

Enrollment Process: Program Elements

- State will establish a process by which Medicaid beneficiaries will be able to select and enroll in a QHP and the plan selection information will be transmitted to plans; FFM will not support plan selection
- Individuals enrolled in MCOs and transitioning to QHPs will remain in their MCO until the effective date of QHP Coverage. Individuals will be auto-assigned to the QHP offered by their MCO, if available, but may opt into a different plan
- NH to seek waiver to provide coverage effective as of the date of application

Plan Management: Federal and State Requirements

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Federal Requirements



- All QHPs must include ten Essential Health Benefits
- Each QHP is subject to two levels of review (state Insurance Department and CMS)
- All QHPs must adhere to state mandates

State Requirements



- Certification timeline established by NH Insurance Department to meet CMS deadlines
 - May 1: Form filings
 - June 1: Rates / Binders
 - August 7: State recommendation due to CMS/federal Marketplace
- QHPs must additionally adhere to state mandates (benchmark plans, network adequacy, etc..) and scrutiny where applicable

Interagency Cooperation: Federal and State Requirements

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Federal Requirements



- Medicaid is the “single state agency” and remains fully accountable for ensuring compliance with Medicaid requirements
- If Medicaid delegates any responsibilities to NHID, Intergovernmental Cooperation Act Waiver is required. CMS may also require that DHHS and NHID enter into a memorandum of understanding

State Requirements



- Under SB 413, premium assistance program does not limit the existing and traditional regulatory authority of NHID

Other Issues: State Requirements

State Requirements

- *Wellness Programs.* Under SB 413, premium assistance program must promote “personal responsibility” through, among other things, “mandatory wellness programs”
- *Provider Payment.* Under SB 413, “Provider payments [in the mandatory premium assistance program] shall be in an amount which shall be no less than before the effective date of this paragraph”

Budget Neutrality and Cost-Effectiveness: Federal Requirements

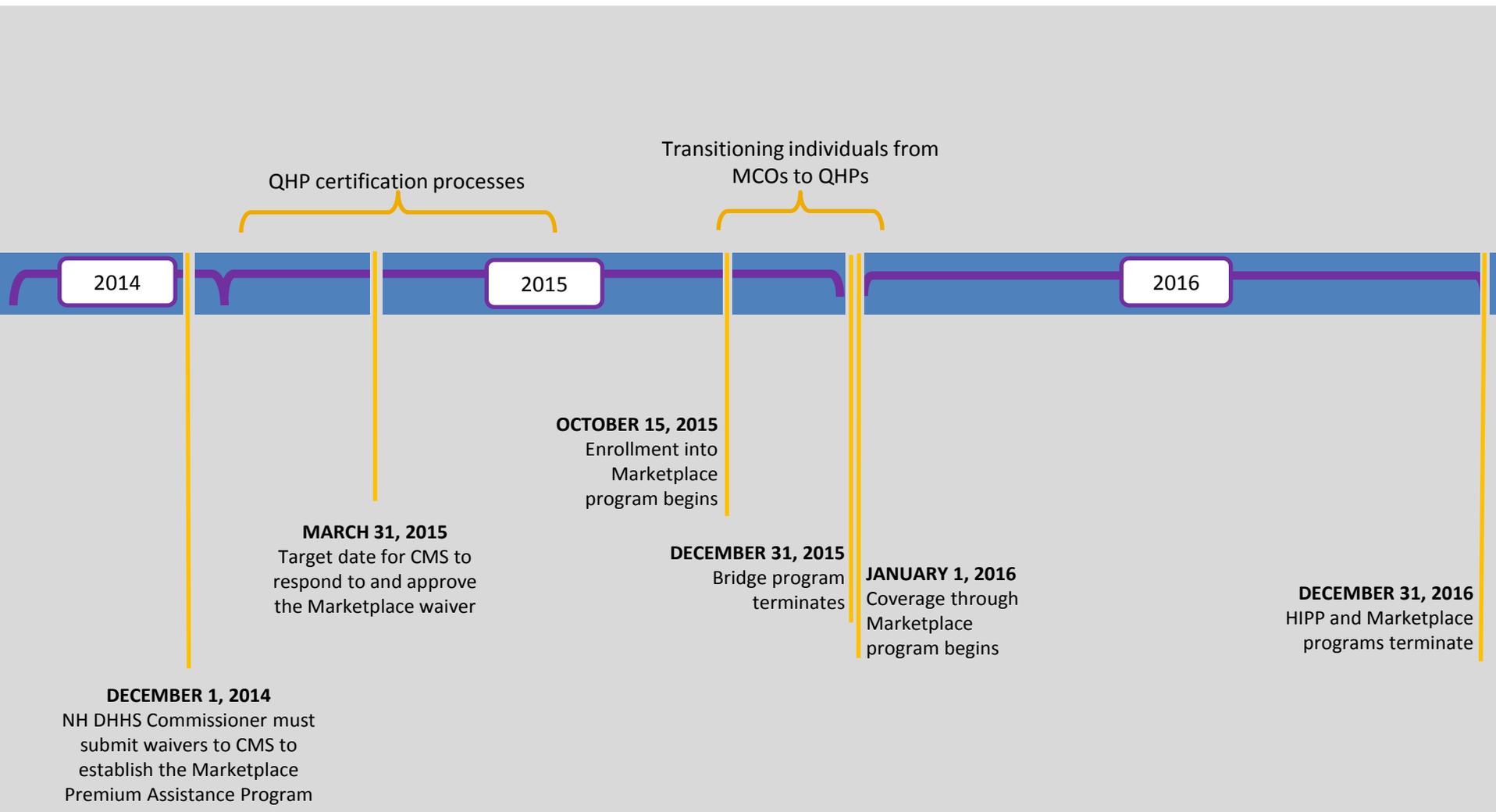
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Federal Requirements



- State must demonstrate budget neutrality in waiver to authorize mandatory premium assistance
- After the waiver and STCs are approved, New Hampshire will need to develop a cost effectiveness evaluation plan, which includes the following factors:
 - Comparison of Medicaid's cost of providing premium assistance (including QHP premiums, cost-sharing above Medicaid permissible limits and coverage of additional services) to otherwise providing direct coverage
 - Cost savings associated with reduced churning between Medicaid and the Marketplace
 - The economic benefits of increased competition in the Marketplace
 - Improved access
 - Improved patient outcomes
- Term of waiver has implications for budget neutrality

Overview of Implementation Timeline



Medicaid Premium & Cost-Sharing Rules

	< 100% FPL	100% - 149% FPL	≥ 150% FPL
<i>Maximum Allowable Medicaid Premiums and Cost-Sharing</i>			
Aggregate Cost-Sharing Cap	5% household income	5% household income	5% household income
Premiums	Not allowed	Not allowed	Permitted, subject to aggregate cap
<i>Maximum Service-Related Co-pays/Co-Insurance</i>			
Outpatient services	\$4	10% of cost the agency pays	20% of cost the agency pays
Non-emergency ER	\$8	\$8	No limit
Rx Drugs	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: 20% of cost the agency pays
Institutional	\$75 per stay	10% of total cost the agency pays for the entire stay	20% of total cost the agency pays for the entire stay

- Specific services are exempt from cost-sharing, including emergency services, family planning and pregnancy-related services
- Specific populations are exempt from cost-sharing requirements (e.g., pregnant women, spend-down beneficiaries, and individuals receiving hospice). However, exempt individuals may be charged cost-sharing for non-preferred drugs and non-emergency use of the emergency room
- Services may not be denied for individuals who fail to make co-payments if their income <100% FPL; services may be denied for those with incomes >100% FPL
- If non-preferred drugs are medically necessary, preferred drug cost sharing applies