



Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters

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Addressing the high cost of health insurance premiums – the prime reason that 48 million Americans are uninsured – is at the heart of the Affordable Care Act’s (ACA) coverage expansions. While affordability of premiums is dominant, premium payment and collection policies and practices also play a significant role in ensuring that all eligible families and individuals enroll in and retain public coverage. Recent news highlighting the large proportion of low-income uninsured households that are “unbanked,” meaning that no household member has a checking or savings account, has focused attention on flexible payment options. Yet, there are many other aspects of premium administration that can ease or add to the burden of premiums and cost-sharing affecting the ability of low-income individuals and families to enroll and maintain secure coverage.

Although there was a strong attempt in the ACA to align many policies across coverage sources—Medicaid, the Children’s Health Insurance Program (CHIP) and subsidized coverage in the new health insurance marketplaces—not all facets of premium administration are consistent. From payment options and collection procedures to grace periods and cancellation rules, policies differ by coverage source. This brief focuses on these issues from the perspective of the low-income individuals and families who are eligible for Medicaid, CHIP and financial assistance in the new health insurance

marketplaces. In addition to taking a close look at the federal policy landscape on premium administration, this brief provides examples of approaches to smooth out some of the tricky spots.

Background

As the primary source of health insurance for our nation’s poor seniors, people with disabilities, pregnant women, and low-income children, Medicaid has historically restricted premiums. Over time, states have been given greater flexibility in charging premiums and cost-sharing,¹ although federal parameters continue to protect the lowest income families and individuals. Premiums cannot be assessed in Medicaid for individuals with income lower than 150 percent of the federal poverty level (FPL) without waiver authority,² and never under the poverty level for people who qualify for categorical eligibility, including mandatory groups of children, pregnant women and parents.³ Federal rules allow separate CHIP programs to charge premiums, which are limited for children with income between 100 and 150 percent of the FPL but are not restricted above 150 percent of the FPL.⁴ However, the ACA’s realignment of eligibility in Medicaid for all children with income at 133 percent of the FPL effectively raises the minimum threshold at which premiums can be charged to children.⁵

Affordability of premiums is dominant but how premiums are administered will impact the ability of low income families to enroll and retain coverage.



Creating too many premium tiers can be complicated to administer and difficult for families to understand.

Despite these limitations and ample evidence that premiums are a barrier to coverage for low-income families⁶, a number of states charge premiums and therefore have experience in collecting premiums. As of January 1, 2013, nearly two-thirds of the states charge premiums or enrollment fees for children enrolled in Medicaid and/or CHIP within federal guidelines.⁷ Only one state, Wisconsin, which covers parents in Medicaid with income up to 200 percent of the FPL, charges premiums starting at 133 percent of the poverty level.⁸ However, two-thirds of the states (19 of 26) offering expanded coverage for adults largely through Medicaid Section 1115 waivers charge premiums or enrollment fees, and almost half of those (nine states) charge premiums regardless of the enrollee's income level.⁹ The future of these waiver programs remains uncertain given that the ACA mandates coverage for all low-income adults up to 133% of the poverty level, where Medicaid premium restrictions apply. However, some states are eyeing waivers rather than a traditional Medicaid expansion to extend coverage to more low-income adults under the ACA.

There are a number of aspects of premium collection that may ease the burden on low-income families; some of which, but not all, are addressed in federal regulations. In addition to the premium and cost-sharing limitations noted above, federal regulations require states to describe how premiums will be administered in their state plans and to inform beneficiaries of cost-sharing requirements at enrollment and renewal, or when changes are introduced.¹⁰ Grace periods, reasonable notice before cancellation and certain disenrollment policies are also prescribed in federal rules but little guidance is given on payment options and collection methods.

How are premium levels determined?

States have latitude in Medicaid and CHIP to set premium amounts and frequency within federal guidelines. While a few states charge annual enrollment fees (which are still considered premiums)

or establish a quarterly payment schedule, fixed monthly premiums are more prevalent. Some states use income tiers to establish a limited number of premium levels. Many states also set a maximum premium for all children in a family, usually two or three times the individual child rate,¹¹ and most states that offer family-based coverage establish a premium for the entire family.¹² Although the financial ability to contribute to health care costs increases with income, creating too many premium tiers can be complicated to administer and difficult for families to understand. In the absence of 12-month continuous eligibility,¹³ enrollees must report income changes, which may trigger a premium adjustment. Given that low-income families experience frequent fluctuations in income,¹⁴ setting premiums as a percentage of income, as states have contemplated from time to time, would require more frequent adjustments and be even more burdensome for families and states.

The cost of administering and collecting premiums should be considered when deciding whether to assess nominal premiums in Medicaid and CHIP. Premium collection costs and monitoring out-of-pocket caps may exceed the value of premiums, calling into question the logic of charging nominal premiums. For example, Virginia imposed a \$15 per child per month premium on families with income between 150-200 percent of the FPL. The state permanently eliminated the premiums when nearly 4,000 children were at risk of losing coverage for nonpayment of premiums and a study indicated that the state was spending \$1.39 in administrative cost to collect every \$1 in premium.¹⁵

Premiums for subsidized marketplace coverage will depend on the level of premium tax credits and the plan selected. Explaining how premiums will be determined for individuals and families who qualify for financial assistance in purchasing a qualified health plan (QHP) in the marketplace is best illustrated by the examples shown in Boxes 1 and 2.¹⁶ Federal rules set the "expected



premium contribution” for qualifying families at between two and nine and half percent (2 - 9.5%) of household income based on a sliding scale. The expected premium contribution is then subtracted from the cost of the second lowest priced Silver-level plan¹⁷ in each marketplace (also called the benchmark plan) to determine the amount of premium subsidy or premium tax credit (PTC). Individuals may choose to receive their PTCs as a tax refund or accept them on an “advanced” basis (APTC) to be directly applied to the cost of the specific plan they ultimately purchase. If the family’s plan choice costs less than the benchmark, their actual premium will be less than the expected premium contribution. Alternatively, if they pick a more expensive plan, their premium will be higher.¹⁸

Premium liability for subsidized QHP coverage is not final until taxes are filed for the coverage year. A complicating factor when individuals or families receive APTCs to subsidize coverage in the marketplace is that their actual premium liability is not final until taxes are filed for the coverage year. This is often referred to as the reconciliation process.¹⁹ Initially, premiums will be based on projected income for the upcoming coverage year. If actual income is higher than the projected income used to determine the expected premium contribution and calculate the APTC, the individual or family may owe additional taxes or (get a lower refund if their taxes are overpaid). Conversely, if income for the coverage year is lower than expected, the individual or family will be eligible for a tax refund.

QHP premiums will depend on the level of premium tax credits and the plan selected.

Box 1

QHP Premiums

Example 1: Single Individual

- John earns \$22,984 per year (200% FPL).
- He is eligible for a premium tax credit, with an expected contribution of 6.3 percent of his income, or \$1,448 a year.
- The three lowest cost silver plans providing self-only coverage in John’s area are Plans A, B, and C, priced at \$4,800, \$5,000, and \$5,200, respectively.
- Plan B, which is the second lowest cost silver plan, will be used as the benchmark. This means John gets \$3,552 in a premium tax credit to subsidize the plan he purchases. ($\$5,000 - \$1,448 = \$3,552$ (APTC))
- If he buys Plan A at \$4,800, his premium cost will be \$1,248. ($\$4,800 - \$3,552 = \$1,248$)
- If he buys Plan C at \$5,200, his premium cost will be \$1,648. ($\$5,200 - \$3,552 = \$1,648$)

Box 2

QHP Premiums

Example 2: Parents and Two Children

- Peter, Mary and their two children earn \$52,953 per year (225% FPL).
- They are eligible for a premium tax credit, with an expected contribution of 7.18 percent of income, or \$3,802 a year.
- The three lowest cost silver plans that cover the entire family are Plans A, B, and C, priced at \$10,000, \$11,000, and \$12,000, respectively.
- Plan B, which is the second lowest cost silver plan, will be used as the benchmark. This means the family gets \$7,198 in a premium tax credit to subsidize the plan they purchase. ($\$11,000 - \$3,802 = \$7,198$).
- If they buy Plan A at \$10,000, their premium cost will be \$2,802. ($\$10,000 - \$7,198 = \$2,802$)
- If they buy Plan C at \$12,000, their premium cost will be \$4,802. ($\$12,000 - \$7,198 = \$4,802$)



Maximum out-of-pocket cost-sharing in Medicaid and CHIP includes premiums.

Are premiums included in caps on out-of-pocket spending?

Unlike private insurance and QHP coverage in the marketplace, Medicaid and CHIP spending caps include premiums. Cost-sharing caps, often called out-of-pocket caps (OOP) in private insurance, establish the maximum level of spending that individuals and families are expected to pay for benefits covered under their plan. After an enrollee's share of costs reaches their out-of-pocket cap, the plan pays the full cost of covered health care services. Spending caps limit the financial burden of cost-sharing on the lowest income families and people with higher health care needs. In both Medicaid and CHIP, the maximum level of cost-sharing is set at five percent of family income, and includes premiums and all cost-sharing for covered benefits. States must administer the cap in Medicaid on either a monthly or quarterly basis while the CHIP cap applies to the length of the child's eligibility period (up to 12 months).

States may not impose responsibility for tracking cost-sharing limits on beneficiaries (often called the "shoe-box" method) in Medicaid or CHIP.

If the state adopts premiums and cost-sharing requirements that could exceed the five percent aggregate cap in Medicaid, it must have an effective mechanism to track cost-sharing, inform beneficiaries when they have reached their applicable limit, and cease cost-sharing until the end of the cap period.²⁰ CHIP programs must establish procedures that do not primarily rely on a refund as the method to ensure that eligible children are not charged cost sharing in excess of the five percent cap, and must inform enrollees of their maximum cost-sharing amount.²¹ Most Medicaid programs have set premiums and cost-sharing at a low enough level that this has not been an issue in the past and thus may not have effective monitoring procedures in place. This bears watching as states expand Medicaid to more parents because the five percent cap applies to the collective charges for all family members enrolled in Medicaid.

What are states' premium collection policies and practices?

States and marketplaces may delegate premium collection to other entities. Most state agencies use third party administrators (TPA) to oversee premium collection in Medicaid and CHIP, using their contracting authority to set payment policies and ensure TPA compliance. In states where the federal government will operate the marketplace, all payments will be made directly to the QHP issuer. Enrollees will be directed to QHP websites for instructions on making premium payments based on the issuer's payment policies. State-based marketplaces may establish their own payment policies, including choosing to collect premiums directly from enrollees and submitting to issuers, a process called "premium aggregation."²² Aggregating premiums may add value for consumers through ease of payment and for QHP issuers by having a single source of payment.²³ In particular, premium aggregation ensures that premium payment and collection policies are standardized for all enrollees, making it easier for assisters to help educate consumers.

Research in the summer of 2013 indicates that states are split on the concept of premium aggregation despite its benefits. Information gleaned from exchange websites and other documents suggests that five states (CA, CO, NM, NY, and OR) will not aggregate premiums while seven states (CT, MA, MN, NV, RI, VT, and WA) have either decided to do so or have requested the systems capacity to do so. Two states (DC and MD) will collect only the initial premium to expedite enrollment and three states (HI, ID, and KY) remain undecided at the time this research was conducted.²⁴

Clear communication is key to making sure that families understand payment policies, including where and how to pay, due-dates, grace periods, and penalties for non-payment. New plain language standards for communicating with consumers should be incorporated in all payment-related communications.²⁵ There should also be



easy ways for enrollees to get additional information or consumer assistance. Call center representatives, eligibility workers, navigators and other consumer assisters who work directly with families should be trained and knowledgeable about payment policies and procedures, and be able to explain them to people with language, cultural or other barriers. “New member calls” may be an effective strategy to ensure that families understand their payment obligations and options, as well as how to use their benefits and access care.

What options do enrollees have for paying premiums?

Recent attention highlighting the large proportion of low-income uninsured households without bank accounts – nearly 38 percent of households earning less than \$50,000 are unbanked or underbanked²⁶ – heightened concerns about premium payment options in the health insurance marketplaces. However, this problem applies equally to Medicaid and CHIP. Payment options should not discriminate against individuals without bank accounts. Given that persons of color are both disproportionately unbanked and uninsured, providing payment alternatives for the unbanked is important to achieving both coverage and health equity goals.

Offering multiple, convenient payment options will boost enrollment and retention of coverage.

While consumers are increasingly turning to online services to pay bills rather than relying on checks and cash to transact business, one size does not fit all. Accepting debit and/or credit card payments, allowing cash alternative options, and accommodating cash payments at convenient locations near public transportation are also important options for lower-income families and particularly for those who are unbanked. At the same time, payment via automatic bank account withdrawal, known as electronic funds transfers (EFT), is a popular and cost-effective payment option.

There are no specific federal requirements re-

garding payment options in Medicaid or CHIP, which leaves it up to the states to decide which payment options work best. Virtually all states with premiums accept check or money order payments by mail. A number of states also accept debit, credit and e-check payments online or over the phone. At least two states (Wisconsin and the Florida CHIP program) have set up a system for some families to pay via payroll deductions. Florida Healthy Kids, which administers CHIP, has established a relationship with 600 Fidelity Express locations to accept cash payments in person. Families enrolled in California’s former CHIP program, Healthy Families, were able to pay premiums at Western Union offices.²⁷

On the other hand, recently enacted federal rules do require multiple payment forms in the federal and state-based marketplaces. Marketplace rules require, at a minimum, that QHP issuers allow all enrollees to pay by paper check, cashier’s check, money order, EFT, and any general-purpose pre-paid debit card for both the initial and ongoing payments. Additionally, issuers or marketplaces must always present all payment options so consumers may select the method of payment they prefer.²⁸ While this rule falls short of accommodating cash payments at convenient after-hours locations near public transportation,²⁹ it was a big improvement over the initial guidance.³⁰ Even before the final rule, the heightened awareness of this issue prompted California QHP issuers to offer a broad array of payment options. A background brief prepared for the Covered California Board indicated that all 12 QHP issuers planned to accept personal checks, cashier’s checks, money orders, debit cards and at least two credit cards. Nine of the 12 issuers planned to accept EFT payments, (which now is required by federal rules) and half indicated they would take cash payments (although the hours and locations of such sites were not detailed).³¹

Federal rules require multiple payment options for QHP coverage, but there is no parallel provision in Medicaid and CHIP.



In collecting late payments, a human touch will be most effective in exploring if a family's income has decreased.

State agencies, marketplaces and QHP issuers may want to think creatively about ways to further ease the burden of paying premiums. State Medicaid and CHIP agencies might consider an advance payment incentive. For example, in Delaware, families can pay three months and get one premium-free month, pay six months and get two premium-free months, or pay nine months to get a full year of coverage. A similar payment program had been in place in California's CHIP program before it was transformed into a CHIP-funded Medicaid expansion. Consumers currently pay utility bills at places like grocery stores, so finding partnerships among retail and big box chains that serve low-income consumers could help provide new, convenient options for premium payment. Mobile device payment mechanisms (e.g., smart phones or other mobile wireless devices), popular in developing countries where more than half of the population is unbanked, offer promising options as well.³²

Allowing premium sponsorships may be effective in promoting enrollment among low-income individuals and families. Washington state's exchange "Health Plan Finder" is developing a formal program by which third parties can sponsor premiums on behalf of enrollees. While the ACA explicitly allows tribal entities to pay premiums on behalf of tribal members, Washington is taking it a step further by extending the option to pay premiums on behalf of enrollees to private foundations, nonprofits and other entities.³³ Another example is a one-year pilot project to help the lowest income individuals and families pay their premiums in one Wisconsin county.³⁴

What's involved in the collections process?

There is little specific federal guidance on the collections process itself. Medicaid and CHIP agencies, marketplaces or QHP issuers have lots of freedom to determine how premiums are billed (e.g., old-fashioned payment coupons, monthly statement or electronic account), as well as the timing, content, frequency, and method (e.g.,

phone, mail or electronic) of payment reminders. It is important to note that, unlike QHP coverage where payment in advance of the coverage period is required and CHIP coverage where prepayment may be required, Medicaid recipients cannot be required to "prepay" a premium.

The tone and frequency of payment reminders and notices are important. Prompt billing, frequent reminders and follow-up by mail and phone are established best practices in managing accounts receivable in health care.³⁵ Families should be coached not intimidated in the collections process.³⁶ The New Hampshire CHIP experience (detailed in Box 6) illustrates that taking a mission-driven approach to premium administration can result in high rates of on-time payment and low levels of nonpaid premiums leading to coverage cancellation.

In collecting past-due premiums, effort should be made to explore whether a family's income has decreased. While payment notices should urge enrollees to contact the agency if their income has changed, a human touch may be more effective. In a phone call, a customer service representative can explore if a household member has experienced a job loss or reduction in earnings and assess whether the individual or family qualifies for a lower or no premium.³⁷ This is particularly important in states with 12-month continuous coverage where families are not required to report changes in income.

*Medicaid explicitly allows for premiums to be waived if requiring payment creates an undue hardship.*³⁸ Low-income families live on very tight budgets. Unexpected expenses such as a major car repair or a temporary loss of income mean that families may have difficulty making ends meet. In situations where the financial crisis is temporary, waiving the premium can help families through a time of need without losing their health coverage.



How do grace periods and cancellation for nonpayment work?

While “grace periods” are a common practice in insurance, differences in how they work may confuse families. It is common for all types of insurance to allow ‘grace periods’ or a certain amount of time to pass after the premium due date before the coverage is cancelled. Insurance industry practice often allows for reinstatement of coverage, if premiums are paid within a certain amount of time, even after cancellation. Consumers who have purchased other types of insurance may be accustomed to such policies, making it imperative that any reinstatement policy be clearly communicated to enrollees.

Box 3

During grace periods, notices should use clear, plain language to communicate:

- Options to have eligibility reviewed for a lower premium or no-cost coverage, particularly if someone has experienced a job loss or a decrease in income.
- The final date that payment must be received and whether there is an opportunity for reinstatement of coverage if payment is received after that date.
- The consequences of non-payment in terms of disenrollment and any lockout period before a family or individual can re-enroll.
- Requirements, if any, to repay outstanding periods upon re-enrollment.
- Any liability the individual or family may have for the cost of services received during a grace period if premiums are not paid.

Medicaid and CHIP offer different grace periods, as well as different consequences for nonpayment. Medicaid requires a 60-day grace period for individuals subject to premiums. All enrollees must receive reasonable notice of any adverse ac-

tion,³⁹ including disenrollment for nonpayment. Beyond disenrollment, no further consequences, including “lock-out” periods, can be applied in Medicaid.⁴⁰ CHIP rules require that states send a notice of overdue payments to families no later than the seventh day of CHIP’s minimum 30-day grace period. If the premium remains unpaid at the end of the grace period, the disenrollment process must offer the family an opportunity to have their eligibility reviewed for a lower premium or Medicaid eligibility.⁴¹ If disenrolled for nonpayment, children in CHIP may be “locked out” of coverage for up to 90 days, but coverage must be reinstated if outstanding premiums are paid before the end of the lockout period. After the lockout period, families may reenroll but they cannot be required to repay back premiums as a condition for reenrollment (although federal rules do not prevent states from continuing efforts to collect back premiums).⁴² After a lockout period, CHIP has flexibility in determining the reenrollment process, including requiring families to complete the full application process.

Box 4

Complying with new CHIP Lockout Rules

As of January 2012, only five states (MN, MO, PA, FL, and WI) had CHIP lockout periods of more than 90 days, although 24 states required families to pay outstanding premiums before re-enrolling. These states will need to update their policies based on final rules released on July 5, 2013. Several states allow children to reenroll without a new application if premiums are paid shortly after cancellation (i.e., 30 – 60 days), or if the state has adopted 12-month continuous eligibility and the child is within the 12-month period.

While subsidized coverage in the exchange provides a three-month grace period, issuers are not required to pay claims after the first month of non-payment. For individuals and families who receive advance premium tax credits, QHP

Medicaid, CHIP and QHP coverage offer different grace periods and consequences for nonpayment of premium.



Both qualitative and quantitative data are needed to thoroughly assess the impact of premiums and related administrative practices.

issuers must provide a grace period of three consecutive months. But importantly, the QHP is only obligated to pay claims during the first month of the grace period and must notify health care providers of the possibility of denied claims during the second and third months of the grace period.⁴³ It is critical that enrollees understand these rules, (see example in Box 5) which impact not only their liability for health care costs but also their ability to re-enroll in coverage for the current calendar year.

Box 5

What happens if an individual or family does not pay their premium within the three-month grace period in the marketplace?

If a QHP enrollee does not pay their premiums for the months of January, February and March, on March 31st, the QHP must cancel coverage retroactively to January 31st. The enrollee may be liable for any health care services used in the months of February and March. Upon cancellation, there is no opportunity for reinstatement. Additionally, the individual or family may not reapply for QHP coverage until the next open enrollment period (October 1 – December 7 of each year) for coverage beginning the following January 1, unless another circumstance or “qualifying event” such as marriage or birth of a child qualifies them for a special enrollment period.

What data collection and reporting is needed?

Both quantitative and qualitative data are needed to thoroughly assess the impact of premiums and related administrative practices. Robust data collection in eligibility, enrollment and payment systems should be designed to produce a broad array of information about enrollment, disenrollment, payments by source, timely payment, as well as collection efforts including follow-up calls and notices. States should require TPA contractors responsible for premium administration to

report data on a monthly basis. Trending premium and payment-related experience over time can inform decision-making by pinpointing issues that require attention. Following and reacting to trends will help states mitigate the potential negative impact of premiums.

There are several questions that research should endeavor to answer:

- *To what extent are premiums a barrier to enrollment for eligible applicants?* Numerous studies have illustrated how premiums are a barrier to coverage. States that charge premiums should track the data needed to better understand the extent to which premiums impact enrollment of eligible individuals. These data include capturing the number and proportion of applicants who are determined eligible but do not enroll.
 - *Is affordability of premiums the primary cause for disenrollment for nonpayment?* It is important to compare the number and proportion of enrollees who are disenrolled for nonpayment to other disenrollment reasons. However, it is also important not to assume that all nonpayment is the result of inability to pay. CHIP experience suggests that some enrollees who are disenrolled for nonpayment actually leave the program for other reasons (e.g., becoming eligible for Medicaid, enrolling in an employer plan or moving out of state).
 - *When premium changes are implemented, what are the immediate impacts on new enrollment and disenrollment?* As noted previously, there is ample evidence that premium increases suppress new enrollment and spur disenrollment. The immediate impact of premium increases can be swift and significant. For example, in Wisconsin, 17 percent of enrollees with income between 133 and 150 percent of the FPL disenrolled in the first month after the state lowered the income level at which premiums are assessed in July 2012.⁴⁴
- Quantitative data does not paint the full picture. Qualitative data should also be gathered through family surveys or notations in customer accounts. Probing why a family did not enroll or did not



pay is important, as is determining their insurance status post-disenrollment. This information is most useful when collected along with family demographics including family size and income. These data will add helpful context to quantitative

data and inform an overall assessment of how premiums impact enrollment and retention, and in evaluating how the premium assessment and collection process can be improved to promote ongoing coverage.

Box 6

A Mission-Driven Approach to Premium Administration: New Hampshire's Healthy Kids/CHIP Experience

Until CHIP was folded into Medicaid in 2012, it was administered by the legislatively created non-profit organization, New Hampshire Healthy Kids Corporation (NHHK). The experience of NHHK illustrates that a mission-driven approach to customer service and family-focused assistance can make a difference in premium collection. Enrollment and accounting staff were trained in effective customer service techniques and constantly reminded of the organization's core mission to keep kids enrolled. NHHK adopted a variety of strategies to enhance premium payment and minimize cancellation of coverage due to nonpayment of premium:

- NHHK embraced a “three strikes before you’re out” policy – Underlying all administrative functions at NHHK was a requirement for a minimum of three contacts with a family before the organization took negative action, although staff often made more attempts in order to fulfill the organization's mission to cover all eligible children. This included efforts to obtain missing information before closing applications, collect initial premium to finalize enrollment, and minimize cancellations due to nonpayment of premiums.
- New member calls helped educate families moving from one coverage option to another – These calls focused on families transitioning between Medicaid, CHIP and the full-cost buy-in option where premiums and payment requirements differed.
- Automated payments provided a convenient way for families to pay while boosting on-time payments and reducing administrative costs. Nearly half (45 percent) of enrolled families chose to have monthly premiums deducted directly from a bank account.
- Phone payments offered a last-chance opportunity to avoid cancellation. The ability to take an electronic payment over the phone saved many children from losing coverage just hours before payment deadlines.
- Collections efforts included a “human touch” – Connecting by phone with families was essential for staff to assess if a family's circumstances warranted further assistance, such as screening for Medicaid or a lower premium or offering a premium rescue.
- “Rescuing premiums helped preserve coverage” – If families were experiencing a temporary loss of income or unexpected major expense, NHHK used charitable donations to rescue premiums.

In fiscal year 2009, similar to prior years, more than 90 percent of premiums were paid on time, and only 1.6 percent of premiums were uncollected due to nonpayment.

Source: Email correspondence with NH Healthy Kids Director of Operations & Enrollment, July 27, 2009.

*A mission-driven,
consumer-oriented
approach can improve
premium collection
results.*



Conclusion

As noted throughout this brief, handling premiums with care really matters. Administering premium payment and collection in ways proven to encourage enrollment and retention of coverage is an essential aspect of mitigating the coverage and health disparities that exist for low-income individuals and families and people of color.

Flexible payment options will help to meet the needs of all consumers. Making sure that consumers, and particularly those who are unbanked or underbanked, have viable options for paying premiums is crucial to their enrollment and retention of coverage.

Implementing consumer-friendly payment and collection policies will boost retention. Communication with enrollees using best practices in plain language and friendly collection processes will help identify people who may be eligible for lower premiums and improve the likelihood that enrollees understand payment requirements and the consequences of nonpayment.

All consumer assisters, including call center representatives, eligibility workers, navigators, certified application counselors, should be well trained and knowledgeable about the premium policies and how they impact different individuals and families. From payment options to collection procedures to cancellation rules, there are many circumstances where consumers need to be educated about how premiums and cost-sharing work and the potential impact of their choices and actions.

Collecting, analyzing and acting on premium and payment experience data are key to maximizing the effectiveness of our coverage programs. As states implement coverage expansions, either through the marketplace or Medicaid, reviewing how they administer premiums and monitoring the impact on low-income families should be a priority. Just as the level of premiums can be a financial burden and enrollment barrier for low-income families, a lack of flexible ways to make payments and nowhere to turn when a temporary

financial crisis hits can make it difficult for families to retain coverage. Evaluating and using data to drive policy and program improvements will help ensure that all eligible individuals can benefit from health coverage.

Endnotes

1. The Balanced Budget Act (BBA) of 1997, which created CHIP, and the Deficit Reduction Act (DRA) of 2005, amended by the Tax Relief and Health Care Act of 2006 (TRHCA), gave states increased flexibility to impose premiums and cost-sharing in Medicaid and CHIP, subject to out-of-pocket spending caps.
2. Federal authority to waive premium and cost-sharing rules is governed by SSA §1916(f), which sets specific requirements for premium and cost-sharing waivers.
3. While Medicaid is targeted to people in financial need, income is not the only factor considered in determining eligibility. An applicant must demonstrate that he or she fits into one of five coverage groups, or categories. The five mandatory categories are: children up to age 19; pregnant women; parents (and other caretakers of children) in families with dependent children; individuals with serious disabilities; and the elderly.
4. In CHIP, premiums under 150% of poverty are limited to no more than \$19 per month depending on income and family size, above 150% of poverty premiums are unlimited, although total cost-sharing is subject to a maximum five percent of income spending cap.
5. W. Prater and J. Alker, "Aligning Eligibility for Children: Moving the Stairstep Kids to Medicaid," Kaiser Commission on Medicaid and the Uninsured, August 2013.
6. S. Artiga and M. O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experience," Kaiser Commission on Medicaid and the Uninsured, May 2005.
7. M. Heberlein, T. Brooks, J. Alker, S. Artiga and J. Stephens, "Getting Into Gear for 2014: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013," Kaiser Commission on Medicaid and the Uninsured, January 2013.
8. Ibid.
9. Ibid 7.
10. 42 CFR 447.57.
11. Georgia exempts children under the age of 6, but by and large, premiums are the same for children regardless of age.
12. Ibid 7. Louisiana, Maryland, Michigan, Rhode Island, Nevada, and Utah charge family-based premiums.

Just as premiums can be a financial burden and enrollment barrier, a lack of flexible ways to pay and nowhere to turn during a financial crisis makes it difficult for families to be covered.



13. 12-month continuous eligibility is a policy option available to states that enables children enrolled in Medicaid or CHIP to maintain coverage for a full year regardless of changes in family income or household size. States have the option to adopt 12-month continuous eligibility for adults through the Section 1115 waiver process. State Health Official Letter #13-003, May 17, 2013, Re: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014.
14. M. Klawitter and C. Morgan-Cross, "Low-Income Households and Income Volatility," Evans School of Public Affairs, University of Washington, August 2012.
15. Virginia Department of Medical Assistance Services memo, (May 15, 2002); see also, L. Summer & C. Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies," The Commonwealth Fund (June 2006)
16. These examples were drawn from "Premium Tax Credits: Answers to Frequently Asked Questions," Center on Budget and Policy Priorities, July 2013.
17. Qualified health plans are categorized as Bronze, Silver, Gold or Platinum based on the plan's actuarial value.
18. For a comprehensive explanation of how premium tax credits and plan selection impact the actual cost of QHP coverage, view the Center on Budget and Policy Priorities webinar on "Premium Tax Credits: Beyond the Basics," at <http://www.healthreformbeyondthebasics.org>.
19. Kaiser Family Foundation, "Reconciliation of Advance Payments for Health Insurance Premiums," February 2011.
20. C. Mann, "CMCS Informational Bulletin," Center for Medicaid, CHIP and Survey & Certification, May 27, 2010.
21. 42 CFR 457.505.
22. Although marketplaces may choose to aggregate premiums, federal rules require that QHP enrollees have the option to pay premiums directly to their plan. 45 CFR 155.240.
23. Federal Register Vol. 77 No. 59, page 18338.
24. The information was collected between July 1 and July 2, 2013 from state exchange documents and reports, including but not limited to: exchange work plans, budgets, requests for proposals (RFPs), approved contracts, board recommendations, meeting minutes, and press releases. Most documents were found on state exchange websites or posted on StateReform.org.
25. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing. ACA § 1311(e)(3)(B).
26. Silas, J. "Fair Premium Payment Policies and Practices in Covered California," Consumers Union, June 2013.
27. Ibid 7.
28. 45 CFR 155.1240.
29. Ibid 26.
30. "Letter to Issuers on Federally-facilitated and State Partnership Exchanges," April 5, 2013.
31. Covered California Board Background Brief, "Premium Payment Policy Update," August 2013.
32. J. Donner and C. Andres Tellez, "Mobile banking and economic development: Linking adoption, impact and Use," Asian Journal of Communication, 2008.
33. For additional information, see <http://www.wahbexchange.org/>. Slides from webinars, as well as the application for premium sponsorship are available online.
34. Stephen Ross, "Program Helps Low-Income Wisconsin Residents Pay Premiums, ModernHealthCare.Com, September 2013.
35. "Getting More from Self-Pay: 7 Tips for Improving Patient Payments, AetnaHealth, Inc., March 2011.
36. Ibid 26.
37. Medicaid regulations require a process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.
38. 42 CFR 447.80(a)(3).
39. 42 CFR 435.919 requires that states give timely and adequate notice concerning adverse actions.
40. 42 CFR 447.55(b)(5)
41. 42 CFR 457.570.
42. 42 CFR 457.570(c).
43. 45 CFR 155.270(c).
44. "Wisconsin Medicaid Premium Reforms: Preliminary Price Impact Findings Revisited," State of Wisconsin Department of Health Services.

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