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A Primer on Premium Assistance Programs Used to Privatize Medicaid Expansion

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On January 22, 2013, the Centers for Medicare & Medicaid Services ("CMS") published draft regulations regarding the Affordable Care Act ("ACA") that included a proposal for states to use Medicaid/CHIP funding to purchase coverage for eligible beneficiaries in the individual market.[1] This option—often referred to as "premium assistance" or "Medicaid privatization"—reflects a popular push across states to modify the structure of Medicaid expansion under the ACA. Although the privatization of Medicaid expansion was unforeseen by the drafters of the ACA, key constituents, such as hospitals, physician groups, and insurers, can use past experiences and a close analysis to better understand the impact these programs may have. This article seeks to explain the criteria by which CMS may allow premium assistance, the legal basis by which the programs are justified, recent developments regarding premium assistance, and key concerns for health care providers, insurers and other key stakeholders as these programs are implemented.

What Is Premium Assistance?

Premium assistance programs allow states to provide funding to eligible individuals to purchase insurance through the private market, as opposed to obtaining coverage through traditional Medicaid. These programs effectively privatize Medicaid by moving enrollees to the private market. As such, they are often popular with more conservative politicians, analysts and stakeholders. Although eligible beneficiaries will be seeking coverage through the private market, these individuals (1) remain Medicaid enrollees with all the attendant rights and entitlements available as such and (2) cannot be included in cost-sharing schemes that exceed the amounts allowed under Medicaid rules. Therefore, insurers seeking to offer products to this population, as well as any state legislators looking to create such a program in their states, must remember that these individuals will be a hybrid of private market customer and governmental program beneficiary.

The rationale behind premium assistance programs is based on predicted increased efficiency of the private markets and a reduction of churn. Economists predict that more competition on the health insurance exchanges will provide an incentive for private insurers to reduce costs in order to attract Medicaid eligible individuals, which will in turn deliver care more cheaply than a government program. Increasing and improving the risk pool of these plans by funneling Medicaid recipients into the private market may also allow private insurance premiums and costs to go down. The inverse—funneling a large number of new enrollees into existing traditional Medicaid networks—would likely not have a similar positive effect. Instead, states would likely be forced to increase the rates they pay to health care providers to convince them to take on the additional Medicaid patients.

Policy makers also hope that premium assistance programs will reduce churn, or situations in which individuals will repeatedly gain and lose Medicaid coverage due to income fluctuation. According to a 2011 study, as many as 28 million adults during the first year of Medicaid expansion could fall prey to churn.[2] Premium assistance programs would address churn by keeping these individuals on the same plan—the only variation would be whether Medicaid or the individual pays the premiums for the plan. Reducing churn would save money by reducing administrative costs and providing better, and more consistent, care to individuals.

[1] 78 Fed. Reg. 4593 (January 22, 2013).

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[2] Benjamin D. Sommers and Sara Rosenbaum, "How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs*, vol. 30, issue 2 (February 2011).

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Despite these arguments, many have raised concerns that Medicaid premium assistance programs will end up being a costly political compromise. According to the Congressional Budget Office, the cost to provide Medicaid coverage per individual is about $6,000 per year, whereas the cost to purchase comparable insurance through a health insurance exchange is predicted to be $9,000 per year.[3] In Massachusetts, which has a long established health insurance exchange, the yearly cost of Medicaid in 2009 was $2,965 whereas the cost of a comparable plan was $5,143.[4] States are likely to be cost-insensitive in the near future, as the federal government must pay 100% of the costs of Medicaid expansion until 2017, but will likely become cost-sensitive after that. Therefore, whether Medicaid premium assistance programs can deliver on comparable costs remains an open and critical issue for the future of these plans.

Medicaid premium assistance plans existed before the turmoil of Medicaid expansion under the ACA brought them to the forefront of health care news. States have long been allowed to use Medicaid premium assistance to wrap around employer coverage for employed individuals eligible for Medicaid. Doing so allowed states to cover some or all of the premium and cost-sharing obligations an individual might face under his or her employer based coverage. While these programs have been considered successful, they have remained small. In 2010, a survey by the United States Government Accountability Office showed that half of the then-existing Medicaid premium assistance programs had fewer than 1,000 enrollees and only one program had more than 30,600 participants.[5] Any premium assistance programs implemented under Medicaid expansion will likely be the largest such program to date, and will probably dwarf any previous programs of this type.

What Criteria Must Be Met to Create a Premium Assistance Program?

According to materials issued by CMS and the Department of Health and Human Services (''HHS''), a Medicaid premium assistance program must be designed to comply with cost, coverage, expansion and cost-sharing requirements before CMS will approve the program as part of Medicaid expansion. Each of these requirements creates unique challenges for the implementation of a successful premium assistance program.

I. Cost

HHS has made it clear that the cost of coverage under a proposed premium assistance plan must be the same or less than the cost of comparable coverage through traditional Medicaid or CHIP.[6] Although HHS has not articulated a test for comparability, a CHIP statute has defined a cost comparability test for premium assistance under CHIP to be ''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.''[7] Even this articulated test, however, is vague and not entirely helpful for parties looking to design premium assistance programs, or for stakeholders looking to predict the structure of such programs implemented in their markets.

As discussed below, HHS has given several indications that it will be generous when applying this test, including its treatment of the premium assistance plan proposed by Arkansas to address Medicaid expansion. Additionally, HHS has indicated that it will consider savings from reduced churn and increased competition—two factors that economists predict will allow premium assistance programs to save money but, due to the small size of previous premium assistance programs, have not been proven to materialize under these programs. Stakeholders should be aware that states implementing these programs may be cost-sensitive due to this criterion, depending on how strictly HHS enforces the cost comparability test.

II. Coverage

The ACA requires that all individuals in the expansion population be offered an alternative benefit plan, which includes the ten categories of essential health benefits defined in the ACA and its attendant regulations.[8] Individuals in the expansion population enrolled in premium assistance will be entitled to the mandated package of benefits. Therefore, the state Medicaid agency will either have to obtain a waiver from CMS or provide any benefits missing from private plans utilized by this population. Hospitals and other health care providers in states considering Medicaid premium assistance programs as part of Medicaid expansion should be advised to continue to expect full coverage of these services for this population, as if their states had chosen the traditional Medicaid expansion path originally envisioned by the Obama administration.

Insurers, however, may be concerned about this requirement, especially if state Medicaid agencies do not work to cover the missing benefits through a wrap-around program. The comparable cost requirement, as discussed above, makes meeting the coverage requirement more difficult for states and for insurers seeking to offer appropriate products to this population. Medicaid is generally more comprehensive than private, lower-cost plans. According to 2013 testimony to the Subcommittee on Health to the Committee on Energy and Commerce in the U.S. House of Representatives by Judy Feder of the Urban Institute, private plans usually have higher administrative costs than Medicaid, making it more difficult to offer the same benefits at the same cost. Any insurer looking to design products to

[3] Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (July 2012).

[4] Michael T. Doonan and Katherine R. Tull, ''Health Care Reform in Massachusetts: Implementation of Coverage Expansions and a Health Insurance Mandate,'' *The Milbank Quarterly*, vol. 88, issue 1 (March 2010).

[5] *Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs*, GAO-10-258R (January 19, 2010).

[6] Centers for Medicare and Medicaid Services, '' Frequently Asked Questions: Medicaid and the Affordable Care Act: Premium Assistance'' (March 29, 2013).

[7] 42 U.S.C. § 1397ee.

[8] 42 U.S.C. § 1396u-7.

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take advantage of Medicaid premium assistance must keep in mind this requirement.

III. Expansion

Medicaid expansion, as envisioned by the ACA, requires states to extend Medicaid to all adults earning up to 133% of the federal poverty level. Although the Supreme Court in *National Federation of Independent Business et al. v. Sebelius*[9] famously struck down mandatory state participation in Medicaid expansion, CMS has made it clear that states are not permitted to use Medicaid expansion funds to expand coverage for only part of this population.[10] Specifically, CMS stated that ''the Affordable Care Act does not provide for a phase-in or partial expansion.'' States proposing premium assistance programs that do not cover all of the expansion population will not be approved unless the state in question is willing to provide coverage of these individuals in some other fashion.

This criterion eliminates a ''dip your toe into the pool'' approach to the roll out for Medicaid premium assistance programs. As noted above, the previous premium assistance programs have been relatively small, with many consisting of a few hundred enrollees. Because of the extreme jump in numbers, states will be unable to utilize the infrastructure, or even some of the lessons, of the previous programs. Additionally, any entities serving this population—from insurers to health care programs to suppliers of health care programs—must anticipate rapid growth through the creation of these programs. Like anything experiencing rapid growth, key stakeholders should be prepared for growing pains as these programs are created.

IV. Cost Sharing

As of January 2013, the Social Security Act and HHS regulations strictly limit deductibles, copayments or coinsurance charges to Medicaid beneficiaries under 100% of the federal poverty line to nominal amounts. Individuals between 100% and 150% of the federal poverty line may be charged up to 10% of the cost of the service or a nominal charge. Additionally, many key services and vulnerable populations are exempt entirely from cost sharing. Total cost sharing shouldered by the enrollees may not exceed 5% of family income.[11] In order to contravene these restrictions, states must pursue a waiver from CMS.

This requirement directly conflicts with the trend in the private payor world of increased individual responsibility and cost sensitivity in the form of co-payments and cost sharing. In 2006, the average low income adult's annual out-of-pocket costs with private insurance was $771, whereas a comparable individual under Medicaid would pay only $106 annually out of pocket.[12] Insurers seeking to enroll the expansion population must be aware that not only must they meet the comparable cost criteria, but they must do so without the help of extensive cost sharing. State legislators and stakeholders seeking to design premium assistance programs or to approve private plans for participation in such programs must be aware that either the private plans will include minimal cost sharing or that the state Medicaid agency must cover the cost-sharing burden for the enrollees. Some relief on this issue may be forthcoming, as in January 2013 HHS released a Notice of Proposed Rulemaking that including a proposal to streamline Medicaid premium and cost-sharing regulations and give states additional flexibility to impose cost sharing on Medicaid enrollees.

V. Other Criteria

HHS also articulated several requirements for Medicaid premium assistance programs in the same FAQ outlining the four broader criteria. HHS will only consider proposals that provide beneficiaries with a choice of at least two qualified health plans (''QHPs'') and make arrangements with QHPs to provide any necessary wrap around benefits and cost sharing. HHS intends for this requirement to foster competition and to make coverage seamless for those on the cusp of the expansion population. HHS also strongly prefers programs that limit premium assistance to individuals who would benefit from entering the private market, such as healthy adults. Populations described as requiring special consideration under section 1937(a)(2)(B) of the Social Security Act, such as the medically frail, are not appropriate participants in these programs. Similarly, CMS strongly recommends that states choose to target adults in the expansion population with income between 100% and 133% of the federal poverty line because this population is more likely to be subject to churning, as described above, and will benefit the most from participation in the private market. Lastly, waivers for premium assistance programs under Medicaid expansion will conclude by the end of 2016, in order to provide information for state innovation waivers that begin in 2017.

What Is the Legal Basis for Medicaid Premium Assistance?

Understanding the legal basis for premium assistance will give key stakeholders a better understanding of how to shape appropriate Medicaid premium assistance programs, and how to best anticipate their implementation. Unfortunately, HHS has so far declined to comment on the legal basis for premium assistance programs associated with Medicaid expansion. Nevertheless, from other sources it is possible to piece together the probable legal basis for these programs.

In 1994, the Office of the Inspector General concluded that premium assistance for Medicaid eligible adults was allowed under sections 1905 and 1906 of the Social Security Act.[13] Section 1905 allows that:

The payment described in the first sentence [which defines the term ''medical assistance''] may include expenditures for Medicare cost-sharing and for [Medicare] premiums . . . and [except in the case of elderly or disabled Medicare beneficiaries] other insur-

[9] 132 S. Ct. 2566, 567 U.S. ___ (2012).

[10] Centers for Medicare and Medicaid Services, ''Frequently Asked Questions: Medicaid and the Affordable Care Act: Premium Assistance,'' (March 29, 2013).

[11] 42 U.S.C. § 1396o.

[12] ''Health Policy Brief: Premium Assistance in Medicaid,'' *Health Affairs* (June 6, 2013).

[13] Office of the Inspector General, *Medicaid Payment of Premiums for Employer Group Health Insurance*, OEI-04-91-01050 (May 1994).

ance premiums for medical or any other type of remedial care or the cost thereof.

OIG's analysis was echoed in a December 2012 FAQ released by CMS, which noted that the authority for premium assistance is found in section 1905(a).[14] CMS also noted in the same FAQ that premium assistance would have to pass a cost effectiveness test, but declined to elaborate on the mechanics of the test.

What Are the Recent Developments in this Area?

This section looks at several states in order to examine the possible outcomes of proposed premium assistance programs, and to give readers a better understanding of how to evaluate potential programs and their likelihood of implementation. Arkansas's program will be discussed as the likely template moving forward. Pennsylvania's newly proposed program will be examined as an example that attempts to even further revamp Medicaid and Medicaid expansion. Tennessee's experience will be analyzed for evidence of HHS's reluctance to compromise on its four articulated criteria. Lastly, Florida's privatization of Medicaid will be discussed as an example of privatization without Medicaid expansion.

I. Arkansas

Arkansas's proposed premium assistance program has advanced the furthest towards federal approval and implementation. As such, it is the closest thing to a template available for other states interested in Medicaid privatization. Stakeholders should watch the outcome of this program closely and expect to see other states model their programs on Arkansas's.

The Democratic governor of Arkansas, Michael Beebe, wanted to take advantage of the opportunities afforded by Medicaid expansion. However, the Republican-led state legislature made it clear that they would not accept Medicaid expansion as it stands, because of a reluctance to expand the size of Arkansas's Medicaid program from roughly 700,000 pre-expansion to a potential 950,000 post-expansion. The premium assistance program, as proposed, was intended to bridge the political and philosophical differences between the two sides by funneling the expansion population into the private market as opposed to a government run program.

The Arkansas program is simple—federal Medicaid dollars will be used to buy private insurance for everyone in the expansion population. The cost will come out to be approximately $15,000 per year for each of the roughly 225,000 individuals eligible for the program.[15] Individuals will be sent to the health insurance exchange to shop for a plan, like other, higher-income, consumers. They will be able to select any ''silver'' level health plan available on the exchange, meaning that Arkansas health insurers will not have to offer a special product for these customers. Medically frail beneficiaries will be funneled into traditional Medicaid and wrap around services for those with employer-based insurance would be available on a fee-for-service basis. The program would run from 2014 through 2016. Cost sharing would be limited to federal requirements and the state would directly pay premiums.

Arkansas's program also includes elements to ease the transition and improve the experience for participants. Of the 637 guides Arkansas will hire to guide consumers through health insurance selection, 100 will be specially trained and dedicated to the Medicaid expansion pool. Additionally, Arkansas hopes to attract 6-8 health insurance carriers to sell silver plans on the exchange. This itself will be a significant change in a state largely dominated by Blue Cross Blue Shield. Interested insurers submitted a full application to the program by the end of June and approved plans were sent to the federal government at the end of July.

In its application to the federal government, the Arkansas Department of Human Services argued that several unique factors make premium assistance more affordable there than in the rest of the country. First, expansion of Medicaid via exchanges would only cost 13-14% more than expansion of traditional Medicaid. The fact that this proposal would cost more than the expansion of traditional Medicaid indicates that HHS may allow some wiggle room on cost comparability, at least during the initial phases of premium assistance. Second, because of the small size of its Medicaid program pre-expansion, expansion without privatization would increase Arkansas's Medicaid program by 40%, overwhelming the system.

HHS received the application for an 1115 waiver to implement this program in August and has not yet formally approved or commented on this application. However, HHS did indicate its approval of the concept proposed by Arkansas through talks with key state officials in the spring of 2013 and the program is widely considered likely to be approved. Arkansas hopes to get such approval by October 1, 2013, when open enrollment begins.

II. Tennessee

In contrast to the largely positive federal response Arkansas has enjoyed, Tennessee's proposed program was rejected before it could even submit a formal application. Governor Bill Haslam proposed a plan to use Medicaid expansion dollars to buy private insurance, just as in Arkansas. However, his plan would require co-payments beyond those authorized by federal regulations, effectively requiring individuals from the expansion population to pay the same co-payments as higher-income individuals enrolled in private insurance. Plans also could forgo the full coverage required by the ACA. Haslam and other sources reported that the reception from HHS was chilly due to the co-payment issue. As a result of this reception, Haslam declined to further pursue a premium assistance model of Medicaid expansion.

Tennessee's experience is instructive in determining the extent to which HHS will work with states to implement Medicaid expansion in the form of premium assistance and privatization. Stakeholders should expect HHS to hold firm to the four key criteria it articulated in the March FAQ, even if it means squashing plans for Medicaid expansion in states that would be unlikely to

[14] Centers for Medicare and Medicaid Services, ''Frequently Asked Questions: Medicaid and the Affordable Care Act: Premium Assistance'' (December 10, 2012).

[15] Arkansas Department of Public Health, *Arkansas Draft 1115 Waiver for Public Comment* (June 26, 2013).

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embrace the expansion of traditional Medicaid. HHS's firm stance on this point provides some clarity for those trying to predict the shape of possible premium assistance programs in their states.

III. Pennsylvania

On September 16, 2013, the Governor of Pennsylvania, Tom Corbett, announced a new Medicaid proposal titled *Healthy Pennsylvania*. *Healthy Pennsylvania* aims to revamp traditional Medicaid and to apply the revamp to a new Medicaid privatization program to address the expansion population. Because the proposal is so new, as of the writing, HHS has not responded to the plan. Pennsylvania should be seen as a counterpoint to Tennessee, which also sought to revamp the requirements of Medicaid through its privatization proposal.

Healthy Pennsylvania seeks to revamp traditional Medicaid by aligning the adult benefit packages with national standards for coverage, adding monthly premiums, and strongly encouraging enrollees to search for work. The monthly premiums would be structured on an upwards sliding scale of no more than $25 per individual or $35 per household per month. Individuals and households with 50-133% of the federal poverty level (FPL) would be required to pay these premiums. This approach is dramatically different than the current Medicaid scheme, which, as discussed above, does not allow for cost sharing. Additionally, *Healthy Pennsylvania* would allow individuals to reduce their monthly premiums when they participate in health and wellness appointments and actively engage in job search and training programs. Once again, this is a novel approach to Medicaid that is outside the scope of the current program.

Corbett also proposed applying these changes, including monthly premiums and discounts for individuals participating in health and wellness appointments and job search and training programs, to a Medicaid privatization program incorporated in *Healthy Pennsylvania*. *Healthy Pennsylvania* proposes the implementation of a private option program for the Medicaid expansion population. This private option program would cover approximately 520,000 currently uninsured adults. Medically frail adults in the expansion population would be allowed to select the private option program or to enroll in traditional Medicaid.

Healthy Pennsylvania seeks to take the privatization program of Arkansas one step further by incorporating cost sharing and incentives to work. These requirements contravene the current regulatory scheme. Stakeholders should monitor the federal reception of *Healthy Pennsylvania* as a litmus test for the range of freedom HHS will grant the states as the states design privatization programs.

IV. Florida

Unlike Arkansas, which couples premium assistance and privatization with Medicaid expansion, Florida is already firmly committed to premium assistance and privatization in its Medicaid program while still questioning whether to embrace expansion. Florida's experience suggests that stakeholders in states that have not embraced Medicaid expansion should keep premium assistance programs on their radar as these programs gain a higher profile in the political and regulatory landscape.

In 2005, Florida obtained an 1115 waiver to enroll Medicaid eligible individuals in privately managed care plans in five counties. In February 2013, HHS granted approval for Florida to expand this program state-wide. Under this program, the Florida Agency for Health Care Administration (''AHCA'') will evaluate and select managed care plans to participate. Medicaid eligible individuals that do not fall into certain groups, such as the medically frail or pregnant, will be required to enroll in one of the approved plans available in their area. The stated goal of this program is to move all of Florida's estimated 3 million Medicaid enrollees into privately-managed health care plans. About 1.9 million Medicaid enrollees in Florida were previously funneled into managed-care plans under the 2005 waiver.

Although this program is not technically premium assistance, as the enrollees are placed in specially designed plans as opposed to sent to the private market to enroll in the same plans that private consumers pick, it operates on a very similar model. The state Medicaid program largely farms Medicaid recipients to private insurance plans, which face pressure to provide comparable coverage at comparable cost. Initially, some insurers dropped out because of the difficulty of earning profits serving this population. Beneficiaries and health care service providers were also unhappy about denial of medical services, low reimbursement rates and red tape. However, a later study conducted by the University of Florida showed that the pilot program, started under the 2005 waiver, saved taxpayers money, and resulted in better coordination of care and access to specialists for the enrollees. Therefore, providers and insurers in states that adopt premium assistance programs would do well to look to Florida's experiment for guidance.

In contrast to premium assistance and privatization, Medicaid expansion in Florida has had a history worthy of a soap opera. Governor Rick Scott was initially a very vocal opponent of Medicaid expansion. However, late in 2012, he reversed his position and reluctantly endorsed it. Despite Governor Scott's change of heart, the Republican dominated state Senate has been reluctant to embrace Medicaid expansion. The state legislature floated several alternative plans, including one to turn Medicaid into an wholly state-funded program, costing the state $237 million per year and giving each eligible beneficiary $2,000 in a health savings account. As of now, the Governor declined to call a special summer session to make a decision on Medicaid expansion, although the Obama administration has expressed interest in working with Florida, even so close to the intended roll out of Medicaid expansion. This means approximately 1.2 million people in Florida, who would have been covered under Medicaid expansion, will be left to find and finance their health insurance privately.

Florida shows that although Medicaid expansion is a popular vehicle for Medicaid premium assistance and privatization programs, it is by no means the only avenue for these programs. Therefore, even in states that opt for traditional Medicaid expansion or reject Medicaid expansion entirely, stakeholders should be prepared for premium assistance programs.

What Should Stakeholders Keep in Mind?

Stakeholders, including insurers and health care providers, should continue to monitor this area for further developments. Stakeholders must keep in mind that this is an area that may develop and change rapidly, so even stakeholders in states that are not immediately considering premium assistance programs should remain apprised of developments in this area. Stakeholders in states that do implement these programs should prepare for an influx of consumers to the private market while remembering that these new customers will have different rights than regular private market customers.

Interested parties should expect programs to develop rapidly. The timeline for implementing premium assistance programs is growing increasingly tight. On October 1, 2013 health insurance exchanges across the country will open their doors and begin to evaluate people's eligibility for coverage. This will be a natural point to introduce a premium assistance program. Indeed, Arkansas is hoping that it will be given the green light to implement its proposed program in time for this deadline. Another natural implementation date will be on January 1, 2014, with the proposed start of Medicaid expansion. HHS has not provided any clear deadlines for waiver applications or guidance as to when states will have missed the opportunity to funnel Medicaid expansion funds into premium assistance programs. Considering that federal officials in Florida renewed calls for Florida lawmakers to accept Medicaid expansion in late July, it is likely that HHS will be extremely accommodating to any straggler applications from states. Therefore no stakeholders should assume that premium assistance programs are out of the question in the near future, even in states that do not look poised to implement such programs.

Parties should also expect programs to change rapidly. There will be another period of uncertainty in 2017. At that point, waivers granted by CMS will expire. Also, states will begin to be responsible for a portion of the bill for Medicaid expansion. Some states may choose to reconsider premium assistance programs at this point, especially if they turn out to be measurably more expensive than traditional Medicaid.

Insurers in states that do implement premium assistance and Medicaid privatization should expect a flood of increased traffic to the private insurance market, especially if only a few health plans are chosen for participation in the program. This flood will increase the traffic on the exchanges, as well as the customer base for insurance plans. As seen in Arkansas, the push to give enrollees several options may open markets that had previously been dominated by one insurer. Insurers will also have to prepare their physician and hospital networks to handle the influx of enrollees.

Additionally, stakeholders must prepare to treat individuals enrolled in private insurance through a Medicaid premium assistance program as ''neither fish nor fowl.'' Medicaid enrollees in private plans will still retain many of their rights and entitlements as Medicaid recipients. For example, individuals enrolled in Medicaid private plans will likely retain their rights to request a fair hearing to challenge coverage decisions. As noted above, states will need to establish mechanisms to provide any mandated benefits that are not included in private plans. As also discussed previously, insurers and states must work together to avoid violating copayment caps imposed by Medicaid regulations.

Conclusion

Because of the political situation, Medicaid expansion is likely to be realized in some states only through privatization. The most commonly proposed vehicle of privatization is a premium assistance program. Stakeholders should be aware that HHS has articulated four required criteria for these programs, although the details of some of the criteria are largely unspecified. Stakeholders should also keep in mind that the development of these programs can happen rapidly and that when they are implemented, these programs will dramatically impact the private market.

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