

State Insurance Exchanges: An Overview

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The Basics

- Established by § § 1311 and 1321 of PPACA
 - Establishment, structure, functions, powers, duties
- Purpose: the creation of a health insurance market for “qualified” individuals and “qualified” groups
- Broad state discretion
 - Whether to establish by January 2014
 - Structure and governance
 - Multi-state
 - subsidiary,
 - merge individual and small group (Small Business Health Options Program, SHOP) markets
 - Qualified groups (qualified individuals governed by federal law)
 - Degree of Medicaid integration
 - Qualified health plan (QHP) coverage standards (beyond essential health benefits), network standards, access standards, and performance standards
- Deluge of interpretive regulations:
 - Exchange organization and structure and operation
 - Qualified health plans
 - Exchange and Medicaid eligibility and the eligibility determination process
 - Minimum Medicaid interactions
 - Premium tax credits

Qualified Individuals Eligible for QHP Enrollment

- Citizen or legal U.S. presence (no durational test as in Medicaid)
- Resident of state within Exchange service area
- Not incarcerated (undefined) other than incarceration pending disposition of charges (undefined)
- Residence can be where primary taxpayer resides or where a spouse and dependents reside

Qualifying for an “insurance affordability program”

- Medicaid
- CHIP
- Basic Health Program
- Premium tax credits and cost-sharing reduction assistance
- Use of “modified adjusted gross income” financial eligibility test
- Affordability program evaluation must be requested

Enrollment and eligibility determination assistance

- Websites
- Navigators

Exchange/Medicaid Alignment

- “No wrong door” concept to guide the process
- Eligibility determinations and redeterminations, information collection and information exchange
- Other relationships?

Context

- Within 12 months of enrollment, half of all low income adults (<200% FPL) will have experienced one or more changes between Medicaid and a state insurance Exchange
- By 48 months, churning at least 4 times will affect nearly 40% of low income adults
- Adults subject to churning tend to be younger (19-29), men, married, without children, well educated, urban residents, uninsured at the beginning of the cycle, and with below-poverty income.

Challenges

- Enrollment fatigue
- Breaks in coverage
- Breaks in continuity of care if QHPs fail to participate in all insurance affordability programs

Addressing the Challenges

- Alignment Medicaid and Exchange policy at all points:
 - Medicaid/Exchange joint policy development
 - eligibility determination and redetermination for insurance affordability programs
 - plan enrollment
 - plan participation and performance measurement across all insurance affordability program markets (Medicaid, CHIP, Basic Health Program, premium tax credits and cost-sharing reduction assistance)

Medicaid/Exchange Joint Policy Development

- Required by both Exchange and Medicaid eligibility determination rules
- Written agreements addressing state option regarding delegation of Medicaid eligibility determination authority to an insurance Exchange.
- Joint policy development also can cover the development of a fully integrated eligibility determination system, shared websites, and health plan participation and performance standards.

Aligning Medicaid and Exchange Eligibility Determination and Redetermination Procedures

- MAGI-related populations (children <18, pregnant women, parents, nonelderly adults not eligible for Medicare) whose incomes make them eligible either for Medicaid or premium credits
- Children and adults with disabilities who may also fall into a MAGI-related group and who begin coverage on this basis but who must be transitioned into Medicaid if eligible
- Annual redetermination procedures
- Simplified reporting and updating procedures
- Navigators who are knowledgeable about all insurance affordability programs and health plan offerings

Aligning Health Plan Enrollment Policies

- Medicaid health plans – autoenrollment with opt-out/plan-switching time period, either as part of eligibility determination process or following a determination
- Qualified health plans – voluntary selection preceding the insurance affordability program eligibility determination
- Switch to unified system of auto-enrollment with opt-out/plan switching period, followed by insurance affordability program eligibility determination
 - Autoenrollment across the affordability program market and use of autoenrollment to reward quality measurement, accessible networks, and the ability to manage patients with and without disabilities

Aligning Health Plan Coverage and Performance Measurement

- Core benefit package reflecting essential health benefits and covered preventive services
 - Understanding the distinctions between essential health benefits offered by QHPs and health plans serving newly eligible adults, and Medicaid benefits for the traditional Medicaid population. Examining and adjusting for the particular differences on the following items and services: EPSDT, habilitation, mental health services, substance use disorder treatment in the case of essential health benefits, as well as coverage of preventive services for traditional Medicaid adults.
- Supplemental benefits for people entitled to the full Medicaid package
- Performance measures that emphasize continuity of enrollment across insurance affordability programs, measures that reflect continuity of care, not only measures that reflect briefer periods of care.

Questions

- Who enrolls? Who does not enroll?
- Who is the insurance affordability program population for the new credits?
- Do states launch basic health programs?
- What happens to Medicaid access for non-MAGI populations, particularly people with disabilities?
- What happens to separate CHIP programs?
- Are there in fact wrong doors?
- Navigator role
- How do states structure and govern their Exchanges? Who does not run its own Exchange
- How do states organize and shape the purchaser market in terms of small groups?
- What are states' QHP standards and additional benefits?
- What QHP rules are established for essential community providers, and how do essential community providers position themselves in the market?
- How do health care providers position themselves in relation to Exchange products?
- Do states develop a unified health plan market across insurance affordability programs?