

Report from the Study Panel on Health
Insurance Exchanges created under the

Patient Protection and Affordable Care Act

Building a Relationship between Medicaid, the Exchange and the Individual Insurance Market



*Sara Rosenbaum
and Trish Riley*

January 2012



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Study Panel on Health Insurance Exchanges

Deborah Chollet, Co-Chair

Senior Fellow
Mathematica Policy Research

Sara Rosenbaum, Co-Chair

Harold and Jane Hirsh Professor
of Health Law and Policy
George Washington University School of
Public Health and Health Services

Lawrence Atkins

Executive Director, U.S. Public Policy
Merck & Company

Gary Claxton

Vice President
Kaiser Family Foundation

Brian Coyne

Senior Vice President, Federal Government
Relations
Amerigroup Corporation

Rick Curtis

President
Institute for Health Policy Solutions

Anne Dunkelberg

Associate Director
Center for Public Policy Priorities

Jonathan Gruber

Professor of Economics
Massachusetts Institute of Technology

Alvin Headen

Associate Professor of Economics
North Carolina State University

Timothy Jost

Robert L. Willett Family Professor of Law
Washington and Lee University

Renée M. Landers

Professor of Law and Faculty Director
Health and Biomedical Law Concentration
Suffolk University Law School

Amy Lischko

Associate Professor, Public Health and
Community Medicine
Tufts University School of Medicine

Richard P. Nathan

Former Director
Nelson A. Rockefeller Institute of Government

Len Nichols

Director, Health Policy Program
George Mason University

Alice Rosenblatt

Health Actuary
AFR Consulting, LLC

Dean Rosen

Partner
Mehlman Vogel Castagnetti, Inc.

David R. Riemer

Senior Fellow
Community Advocates Public Policy Institute

Murray Ross

Vice President and Director
Kaiser Foundation Health Plan & Kaiser
Permanente, Institute for Health Policy

Paul Van de Water

Senior Fellow
Center on Budget and Policy Priorities

Alan Weil

Executive Director
National Academy for State Health Policy

Tim Westmoreland

Visiting Professor of Law & Research Professor
Georgetown University

The views expressed in this report are those of the study panel members and do not necessarily reflect those of the organizations with which they are affiliated.

Authors

Sara Rosenbaum

*Harold and Jane Hirsh Professor of Health Law and Policy
George Washington University
School of Public Health and Health Services*

Trish Riley

*Visiting Fellow and Lecturer in State Health Policy
George Washington University
School of Public Health and Health Services*

NASI Project Staff

Lee Goldberg

Study Director and Vice President of Health Policy

Sabiha Zainulbhai

Health Policy Assistant

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GLOSSARY OF ABBREVIATIONS

| | |
|-------|---|
| ACA | Patient Protection and Affordable Care Act |
| CHIP | Children's Health Insurance Program |
| EPSDT | Early Periodic Screening, Diagnosis and Treatment |
| MAGI | Modified Adjusted Gross Income |
| NPRM | Notice of Proposed Rulemaking |
| QHP | Qualified Health Plan |

Introduction

The alignment of Medicaid and State Health Insurance Exchange (Exchange) policy and practice is a basic tenet of the Patient Protection and Affordable Care Act (ACA). Through both legislative provisions and implementing regulations, the ACA addresses this relationship.¹ At the same time, the federal framework provides states with considerable discretion to flesh out the fuller dimensions of system interaction.

Even as the federal framework is still evolving, this report examines the practical and conceptual factors that underlie the federal/state relationship. It describes dimensions of collaboration that could help establish a seamless continuum of coverage for those who may move between eligibility for Medicaid or for tax subsidies in the Exchange. Proposed regulations outlining eligibility determination obligations of state Medicaid agencies and Exchanges have been issued. Still to appear are regulations defining essential health benefits, but sub-regulatory policies were issued in a special federal bulletin on December 16, 2011. These will define the scope of essential health benefits to be offered by Qualified Health Plans (QHPs)², which in turn also will define the coverage obligations of Medicaid “benchmark” coverage for newly eligible persons as well as the extent of coverage under the state Basic Health Program option.

The opportunity for states to align both enrollment and market policies across Medicaid and state Exchanges have been further advanced as a result of a policy bulletin issued by

¹ The principal statutory provisions related either directly or indirectly to Medicaid and Exchange interactions are as follows: 42 U.S.C. §18041, added by PPACA §1321 (pertaining to state flexibility in operation and enforcement of Exchanges); 42 U.S.C. §13031(d)(4)(F) and (6), added by PPACA §1311 (delineating basic Exchange functions including Medicaid eligibility screening and consultation with state Medicaid programs); 42 U.S.C. §18083, added by PPACA §1413 (delineating streamlined enrollment procedures through an Exchange and State Medicaid, CHIP, and Health Subsidy Programs); 42 U.S.C. §18081m added by PPACA §1411 (directing the Secretary of HHS to establish a program for determining if applicants are qualified individuals for purposes of enrolling in a QHP offered through an Exchange as well as for advance premium tax credits and cost sharing subsidies); 42 U.S.C. §18082, added by PPACA §1412 (requiring the Secretary to establish a program for making advance determinations and payment of premium tax credits and cost-sharing reductions); and 42 U.S.C. §1396a(e), added by PPACA §2002 (use of modified adjusted gross income (MAGI) standard for certain Medicaid eligibility groups. Key federal regulations proposed to date are as follows: Proposed 45 C.F.R. §§155.405 and 155.260 (use of a single streamlined application and data exchange) (76 Fed. Reg. 41866, July 15, 2011); Proposed 42 C.F.R. §§431.10(b)-(d) and 431.11 (state organization and general administration requirements of Medicaid agencies), proposed 42 C.F.R. §435.1200 (coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges, and Other Insurance Affordability Programs (76 Fed. Reg. 51148-51198, August 17, 2011); Proposed 45 C.F.R. §§155.305, 155.310, 155.330, and 155.345 (Eligibility standards eligibility determinations, and eligibility redeterminations by Exchanges and coordination by Exchanges with Medicaid, CHIP, the Basic Insurance Program, the Pre-Existing Condition Insurance Program) (76 Fed. Reg. 51202, 51345 (August 17, 2011).

² Qualified health plans (QHPs) are those offered by licensed insurers that are certified to meet standards established in the ACA and by state Exchanges and that charge the same premium for plans offered inside and outside the Exchange.

the United States Department of Health and Human Services on December 16, 2011.³ The bulletin affords states considerable discretion in interpreting and implementing the federal essential health benefit provisions of the Affordable Care Act and allows states to make significant choices regarding the relationship between the essential health benefit requirements and state benefit mandates. Although the guidance does not indicate whether states will be afforded similar discretion to interpret the essential health benefit provisions in a Medicaid context, an important purpose of applying the essential health benefit provisions to Medicaid's pre-existing benchmark plan requirements for certain populations was to promote greater seamlessness across the Medicaid and Exchange markets. As a result, the flexibility offered in the December bulletin might be expected to carry over into Medicaid as well, thereby offering states additional incentives toward market alignment. These federal essential health benefit policies, when combined with greater alignment around health plan performance standards, hopefully will encourage cross-market participation by health plans and provider networks.

Finally, multi-state plans also carry implications for the Exchange/Medicaid relationship to the extent that these health plans will be expected to be offered in both the Exchange and Medicaid markets.

Certain state decisions yet to be made also will affect the scope of the Medicaid/Exchange relationship. One important question is whether states that currently do so will maintain separately administered Children's Health Insurance Programs (CHIP) as a distinct "insurance affordability program"⁴ (as the term is established by proposed federal Medicaid and Exchange eligibility determination regulations issued in August 2011) or merge them into Medicaid.⁵ The answer to this question may turn on whether CHIP is reauthorized and if so, whether federal financial participation rates for children covered under separate CHIP programs remain higher (although the higher CHIP rate is also available to states that implement CHIP as a Medicaid expansion). Another is whether states will use the ACA option to expand Medicaid beyond the mandatory minimums or select a Basic Health Program option.⁶ All of these pending policies and decision points will further shape Medicaid/Exchange interactions, since they will determine both the range of insurance affordability programs that require coordination as well as the points on the income scale at which interaction will occur.

³ Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin", December 16, 2011, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf (accessed online December 19, 2011)

⁴ Proposed 45 C.F.R. §135.300 (state insurance Exchange eligibility determination rules); proposed 42 C.F.R. §435.4 (Medicaid eligibility determination rules).

⁵ Currently 38 states operate separately administered CHIP programs.

⁶ 42 U.S.C. §1396a(a)(10)(A)(ii)(XX) added by PPACA §2001(e); Proposed 42 C.F.R. 435.218(a) and (b).

This report begins with an overview of the individuals and families who can be expected to receive assistance under insurance affordability programs, which include Medicaid, CHIP, advance premium tax credits and cost sharing reductions, and Basic Health Programs. Particular focus is placed on the characteristics of individuals whose incomes place them at or near the Medicaid/Exchange dividing line. The report then identifies opportunities for greater collaboration and alignment in key areas: establishing a joint strategy to align policies governing the design and administration of health plans across multiple markets including alignment of coverage and benefit design, plan administration responsibilities, provider network requirements, measures of access and quality performance, and policies governing financial operations, appeals, and other matters.

Several considerations make Medicaid/Exchange alignment essential. The first is the level of income mobility experienced by the individuals and families eligible for insurance affordability programs. The second consideration is the hard starting and stopping points of the programs, which in turn create income cliffs which must be addressed in order to avoid constant changes in eligibility. A third related consideration is the absence of a minimum annual enrollment period that would offer a modicum of stability over time. The fourth consideration is the association, shown in health services research, between continuity of care on one hand and improved health care quality and system efficiency on the other.⁷ Given this association, as well as the impact on individuals and families of having to constantly switch health care providers, a goal of Medicaid/Exchange interaction might be to promote continuity of care regardless of insurance affordability program market.

Newly Eligible Persons and the Importance of a Companion Focus on People with Disabilities

NEWLY ELIGIBLE INDIVIDUALS AND FAMILIES

Studies of the people who will gain coverage under the ACA suggest that regardless of whether the entry point into coverage is Medicaid or the Exchange, they will fall into two basic groups. The first is comprised chiefly of adults (i.e., parents of minor children and adults ages 19 to 64 who do not have minor children and are not yet eligible for Medicare⁸ who are outside the employment market either because of serious health

⁷ Benjamin Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Health Insurance Exchanges", *Health Affairs* 30, no. 2 (February 2011): 228-236.

⁸ Proposed 42 C.F.R. §§435.110 and 435.119.

problems or other reasons). Whatever their incomes, the point is that income is relatively stable and less likely subject to the type of fluctuation that might result in frequent movement between Medicaid and the Exchange. One report by the Kaiser Commission on Medicaid and the Uninsured estimates that the potential Medicaid “new eligible” population includes approximately 5.4 million uninsured low income adults with incomes below 50 percent of the federal poverty level.⁹ A separate study finds far higher new enrollment numbers, ranging from 8.5 million to 22.4 million persons, when total enrollment, or enrollment including individuals eligible under current law standards as well as newly eligible individuals, are factored in.¹⁰

Wherever the final Medicaid enrollment numbers settle, it is clear that some of the newly enrolled population will have incomes low enough to fall well below the point at which a Medicaid/Exchange transition might occur. Once enrolled, this population might be expected to remain in Medicaid on an ongoing basis. But a second group of newly eligibles, includes millions of individuals who can be expected to have incomes that fluctuate based on work and family circumstances. One study of income dynamics among low income adults ages 19 to 60 years of age found that within six months, more than a third of all adults with family incomes below 200 percent of the federal poverty level can be expected to experience sufficient income fluctuation to shift from Medicaid to the Exchange or the reverse; this figure can be expected to rise to 50 percent of all low income adults (approximately 28 million persons) over the course of a year.¹¹ This study further found that over a four-year time period, nearly 40 percent of the low income adult population likely will experience four or more Medicaid/Exchange shifts as a result of income fluctuation.¹² Further estimates suggest that this mobile population is more likely to be young (under 30), male, married, and with higher educational attainment, making this a group whose participation in the insurance market will be important to its success.

Other studies examining Exchange enrollment offer additional insight into newly eligible persons. These studies tend to focus on all people with incomes under 400 percent of the federal poverty level (the upper income level for premium subsidies, today approximately \$88,000 for a family of four), thereby encompassing both people whose incomes position them near the Medicaid/Exchange dividing line as well as those whose economic circumstances place them further away from this point. Even for the higher income group

⁹ Lisa Dubay, Allison Cook, Bowen Garrett, *How Will Uninsured Childless Adults be Affected by Health Reform?* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2009.

¹⁰ Benjamin Sommers, Katherine Swartz and Arnold Epstein, “Policymakers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians Under Health Reform”, *Health Affairs* 30, no. 11 (November 2011): 2186-2193.

¹¹ *Issues in Health Reform*, op. cit.

¹² *Id.*

however, job loss would be enough to create a risk of shift in affordability program. Looking at the under 400 percent-of-poverty group as a whole, the Center for Studying Health System Change has concluded that while nearly 40 percent are estimated to have chronic conditions or to be in fair to poor health, approximately one-third will have no reported health care access problems and no recent health issues. According to the study, the younger healthy individuals who will gain access to insurance are sufficiently concerned about coverage (more than 40 percent also will have uninsured family members) to be motivated to purchase and maintain it.¹³ An additional study by the Kaiser Family Foundation found that the presence of more generous subsidies at the lower end of the premium assistance scale may mean that disproportionately the initial wave of new enrollees may be more likely to be lower income and thus to find themselves at the Medicaid/Exchange dividing line.¹⁴

Taken together, these studies suggest that the individuals and families who seek coverage will be lower income members of working families, and furthermore, that although people with chronic health conditions are overrepresented among the newly eligible population, a substantial number are in good health with no major recent issues. Enrolling them and keeping them and their families enrolled and connected to a high quality health plan will be a central task of the Medicaid/Exchange interaction. Thus, while state Medicaid agencies obviously will also need to prepare for enrollment of the very poorest adults who will experience a disproportionate level of poor health, it is also essential to understand Medicaid as part of the continuum of affordability programs for workers and their families.

PEOPLE WITH DISABILITIES

Most of the focus related to Medicaid under health reform has been on newly eligible persons whose eligibility will be determined based on modified adjusted gross income (MAGI): pregnant women, children under 19, parents and caretaker relatives, and adults ages 19 to 64 who are ineligible for Medicare and who do not receive Medicaid on the basis of blindness and disability.¹⁵ But while the MAGI-related income methodology does not apply to beneficiaries with disabilities, many people who in fact have disabilities serious enough to qualify for Medicaid may be enrolled in either Medicaid benchmark coverage or a QHP in the Exchange with accompanying premium tax credits and cost-sharing reductions. Identifying these children and adults and assuring their continued

¹³ Peter Cunningham, *Who are the Uninsured Eligible for Premium Subsidies in the Health Insurance Exchanges?* Washington, DC: Center for Studying Health Systems Change, Research Brief #18, December, 2010.

¹⁴ Erin Trish, *A Profile of Health Insurance Exchange Enrollees*, Washington, DC: Kaiser Family Foundation, March 2011.

¹⁵ Proposed 42 C.F.R. §§435.110-435.119.

access to Medicaid based on disability will be important. Individuals whose disabilities qualify them for Medicaid who are instead enrolled in the Exchange plan could be subject to a denial of premium tax credits since the ACA makes them unavailable to individuals who qualify for other “minimum essential coverage”. In fact, in some states, Medicaid eligibility based on disability may be higher than the Exchange MAGI income threshold as a result of coverage expansions enacted over the past decade.

Furthermore, the same is true in the case of individuals whose apply for Medicaid based on their MAGI incomes. As with applicants who seek coverage through state Exchanges, it is possible that many of the newly eligible Medicaid beneficiaries will have health conditions serious enough to meet applicable disability standards. Identifying these individuals will be important because they will be entitled to broader benefits. Thus, introduction of a disability screener at the point of enrollment will be an important consideration for states.

Developing the Medicaid/Exchange Relationship

ESTABLISHING A FORMAL MEDICAID/EXCHANGE COORDINATION RELATIONSHIP

A coordinating mechanism is the starting point for the relationship under both the ACA and proposed rules. Consistent with the terms of the statute, the Medicaid proposed rules assign responsibility to state Medicaid agencies for the integrity of the Medicaid eligibility determination process.¹⁶ State Medicaid agencies will also be responsible for clarifying agency authority to enter into written agreements with other federal, state, or local agencies, including government-operated Exchanges that delegate eligibility determination powers to another government agency.¹⁷ Under a delegation agreement, which must also describe the staffing plan used by the delegee agency,¹⁸ the Medicaid agency remains responsible for assuring that eligibility determinations are made in a manner consistent with federal requirements and retains final authority over eligibility standards and procedures.¹⁹

Even where a state Medicaid agency elects not to delegate eligibility determination authority, the proposed Medicaid and Exchange eligibility determination rules require a written agreement governing coordination of eligibility determinations. The proposed

¹⁶ Proposed 42 C.F.R. §431.10(c)(3).

¹⁷ Proposed 42 C.F.R. §431.10(c)(2) and (d).

¹⁸ Proposed 42 C.F.R. §431.11.

¹⁹ Proposed 42 C.F. R. §431.10(e).

Medicaid rule would require written agreements regardless of delegation decisions, and the Preamble describes these agreements as follows:

Section 435.1200(c)(2) proposes that State Medicaid agencies enter into one or more agreements with the Exchange and other insurance affordability programs as necessary to ensure coordination of eligibility and enrollment, including coordination with a Basic Health Program if applicable. States may also use such agreements to coordinate related activities, such as health plan management. States may design these agreements in different ways that reflect their governance structures. We see three broad options. First, one or more of the entities (the Exchange, Medicaid or CHIP agencies) could enter into an agreement whereby some or all of the responsibilities of each entity are performed by one or more of the others. Second, a State could develop a fully integrated system whereby the responsibilities of all entities are performed by a single integrated entity. Third, each entity could fulfill its responsibilities and establish strong connections to ensure the seamless exchange of information and data.²⁰

The proposed Exchange regulations parallel the Medicaid notice of proposed rulemaking (NPRM), requiring that state Exchanges enter into agreements with Medicaid (and CHIP agencies where relevant) “as are necessary to fulfill the requirements” of the law related to eligibility determinations.²¹

The proposed Medicaid regulations, coupled with the Preamble language, clarify the federal expectation of a working relationship across insurance affordability programs that sweeps broadly. The relationship has eligibility determinations and redeterminations as its core, but as the Preamble notes, states have the authority to use the agreement structure to coordinate their policies and activities on a full array of matters, including health plan selection and oversight, the creation of a fully integrated Internet website for applicants and program participants that supports an integrated eligibility determination process, policies governing the role and responsibilities of Navigators, and policies related to information verification and data exchange. Thus, states have the option to expand their agreements to cover all aspects of Medicaid/Exchange operations that must be addressed if the alignment of affordability programs is to be achieved. Because the maintenance of a written agreement is a Medicaid state plan administration function, federal financial participation to support the development and ongoing operation of the agreement presumably will be available at administration matching rates (typically 50 percent federal financial participation).

²⁰ 76 Fed. Reg. 51148, 51167 (Aug. 17, 2011). The Preamble also notes that a shared eligibility service function among the insurance affordability programs would qualify for 90 percent federal funding for development of the system and 75 percent for operations thereafter. 76 Fed. Reg. 51167 (Aug. 17, 2011).

²¹ Proposed 45 C.F.R. §155.345.

ALIGNING THE ELIGIBILITY DETERMINATION AND REDETERMINATION PROCESS

In accordance with the provisions of the ACA, the Medicaid and Exchange eligibility determination NPRMs²² anticipate alignment of the eligibility determination and redetermination process. The proposed regulations governing eligibility determination are in addition to a proposed rule issued in July 2011, which establishes general federal standards for Exchanges and qualified health plans.²³

In order to foster coordination, the ACA assigns to Exchanges a responsibility to “inform individuals of eligibility requirements for the Medicaid program. . . and if, through screening of the application . . . the Exchange determines that such individuals are eligible for [Medicaid] enroll such individuals.”²⁴ Exchanges are obligated to consult with state Medicaid agencies in carrying out this and other functions.²⁵ At the same time, the law preserves the obligation of state Medicaid agencies to make Medicaid eligibility determinations for newly eligible persons as well as individuals eligible for Medicaid under traditional eligibility categories.

The NPRM governing Exchange eligibility determination functions in the individual market proposes to establish Medicaid eligibility screening and enrollment as a basic obligation of all insurance Exchanges. In effect, the NPRM interprets the phrase “if, through screening of the application,” as a compulsory rather than discretionary activity.²⁶ Thus, under the proposed rules, Exchanges must determine as Medicaid eligible any individual who satisfies Medicaid’s citizenship/legal status and residency requirements, has household income at or below the “applicable Medicaid MAGI-based income standard,” and is a member of one of four specified MAGI-related groups (children, parents and caretakers, pregnant women, and adults under age 65 who do not receive Medicare).²⁷ The proposed Exchange eligibility determination rules further specify that if an Exchange determines that an individual is eligible for Medicaid, the Exchange must “notify the state Medicaid . . . agency and transmit relevant information. . . promptly and without undue delay.”²⁸

²² 76 Fed. Reg. 51202 (August 17, 2011) (Exchange eligibility determinations in the individual market); 76 Fed. Reg. 31148 (Aug. 17, 2011) (Medicaid eligibility determinations).

²³ 76 Fed. Reg. 41866 (July 15, 2010).

²⁴ 42 U.S.C. §13031(d)(4)(F).

²⁵ 42 U.S.C. §13031(d)(6)(D).

²⁶ Proposed 45 C.F.R. §155.305(c).

²⁷ *Id.*

²⁸ Proposed 45 C.F.R. §155.310(d)(3).

Under the proposed rules, this eligibility determination and enrollment obligation on the part of an Exchange also means that where an individual has applied for Medicaid on a non-MAGI basis (i.e., where the basis of eligibility is disability or blindness or the need for long term care), an Exchange must, if an individual also seeks help through the Exchange, find the individual eligible for Medicaid if he or she is eligible for Medicaid if MAGI-based Medicaid eligibility is established. Conversely, the Exchange must find individuals to be qualified for QHP enrollment and advance premium tax credits and cost-sharing reductions if Exchange eligibility standards are met, even if the individual has MAGI-related income that exceeds Medicaid eligibility standards but has separately filed a Medicaid application linked to disability or blindness (categories for which financial eligibility may exceed MAGI limits).²⁹

Despite the extensive role envisioned for Exchanges in the Medicaid eligibility determination process (as well as the redetermination process), the ACA preserves the obligation of state Medicaid agencies to assure compliance with all federal requirements applicable to state plan operations, including the eligibility determination process.³⁰ In this sense, the Exchange role in Medicaid eligibility determinations and enrollment can be thought of as a feature of the broader Medicaid eligibility determination system at both initial and redetermination stages.³¹

The ACA also requires that this process work in reverse. Under the law, Medicaid agencies have an obligation under the proposed rules to use a “single streamlined application for all insurance affordability programs” (either designed by the Secretary of Health and Human Services or a Secretarially-approved alternative form)³² and to assist individuals found ineligible for Medicaid by “assess[ing] such individuals for potential eligibility for other insurance affordability programs and promptly and without undue delay transfer[ing] such individuals’ electronic account to any other program(s) for which they may be eligible.”³³

The dual nature of these obligations under the law is central to the success of program Medicaid/Exchange alignment. Exchanges are obligated, as a matter of federal policy, to play a role in Medicaid eligibility determinations, while Medicaid agencies are obligated to identify and electronically transfer into the proper “insurance affordability program”

²⁹ Proposed 42 C.F.R. §435.1200(g)(2).

³⁰ PPACA §1413.

³¹ See proposed 42 C.F.R. §435.916 (periodic redeterminations of Medicaid eligibility by state Medicaid agencies), and proposed 45 C.F.R. §155.330 (c) (Exchange redetermination obligations, including the obligation to cross-check Exchange eligibility data and QHP enrollment against Medicaid determinations).

³² Proposed 42 C.F.R. §435.907.

³³ Proposed 42 C.F.R. §435.1200(g)(1).

(including QHP enrollment with advance premium assistance and cost-sharing reductions) any individual who is ineligible for Medicaid but who appears to meet the standards of another program. The basis for this alignment is the ACA's intent to create an integrated eligibility determination process for insurance affordability programs while assuring that no premium tax credits are paid in any month in which an individual is eligible for other forms of "minimum essential coverage."³⁴

The insurance affordability program alignment obligation also applies to the redetermination process. In the case of Exchanges, the obligation is both annual³⁵ and also can arise during a "benefit year"³⁶ if the Exchange "receives and verifies new information reported by an enrollee or identifies updated information" through data matching.³⁷ Under the proposed rule, Exchanges must require individuals to report changes that may affect eligibility within 30 days of any change³⁸ and must verify the information.³⁹ Exchanges also must periodically examine available data sources (as described in the proposed rule and including information pertaining to citizenship and legal status, residency, incarceration, and household income)⁴⁰ and must examine information related to death or Medicaid or CHIP eligibility determinations.⁴¹ In the event that the Exchange verifies a change in status through updated information, it must redetermine eligibility and notify the individual's employer.⁴²

The NPRM proposes to modify Medicaid agencies' longstanding redetermination obligations to run parallel to those applicable to Exchanges. Medicaid agencies must periodically redetermine Medicaid eligibility for individuals eligible on the basis of the MAGI-related income test annually or earlier if an agency receives information about a change in circumstances that may affect a beneficiary's eligibility.⁴³ If eligibility cannot be redetermined from available information, the agency must prepare and send to beneficiaries a pre-populated renewal form, allowing individuals at least 30 days to respond.⁴⁴

³⁴ PPACA §1401.

³⁵ Proposed 45 C.F.R. §155.335.

³⁶ Proposed 45 C.F.R. §155.330.

³⁷ Proposed 45 C.F.R. §155.330(a).

³⁸ Proposed 45 C.F.R. §155.330(b)(1).

³⁹ Proposed 45 C.F.R. §155.330(b)(2).

⁴⁰ Proposed 45 C.F.R. §§155.305 and 155.315.

⁴¹ Proposed 45 C.F.R. §155.330(c).

⁴² Proposed 45 C.F.R. §155.330(d).

⁴³ Proposed 42 C.F.R. §435.916(a) and (d).

⁴⁴ Proposed 42 C.F.R. §435.916(a)(3).

This emphasis on an annual redetermination process with no interruption unless circumstances change or information is insufficient is designed to encourage annual enrollment periods, with a supported reapplication process only if an eligibility redetermination cannot be made from available information. While more frequent Medicaid routine and periodic eligibility redeterminations are not prohibited, the NPRM seeks to move agencies toward a standardized annual process, thereby allowing greater alignment with proposed Exchange practice, as a means of achieving continuous eligibility without interruption. As in the case of Exchanges, if a Medicaid agency's redetermination of eligibility indicates that the individual is no longer Medicaid eligible, the agency is obligated to "assess the individual for eligibility for other insurance affordability programs and transmit electronic account and any relevant information used to make the eligibility determination to the appropriate program . . ." ⁴⁵

Both state Exchanges and state Medicaid agencies must meet new verification procedure standards whose purpose is to assure that to the maximum extent feasible, agencies assume responsibility for verifying the essential elements of initial and ongoing insurance affordability program eligibility. The proposed rules identify numerous sources of eligibility verification information, covering both financial and non-financial information. ⁴⁶ Medicaid agencies may require additional information from individuals applying for or receiving assistance only if the information cannot be obtained electronically or if the information obtained is "not reasonably compatible" with information provided by or on behalf of the individual. ⁴⁷ Similarly, Exchanges must use available information to render redetermination decisions and must transmit the results of their decisions to individuals enrolled in QHPs and those receiving premium tax credits. ⁴⁸

Coordination with a state Exchange on matters of eligibility and enrollment is a condition of participation under proposed Medicaid eligibility determination rules. ⁴⁹ In this regard, one of the basic decisions that a Medicaid agency will have to make is whether to allow Exchanges to actually make the Medicaid eligibility determination as opposed to carrying more limited functions related to screening for eligibility and transmitting information to the Medicaid agency for a formal determination of eligibility. Alternatively, the NPRM allows the Medicaid agency to elect to retain its power to determine eligibility while requiring that the agency establish a process for assuring that the entire Medicaid

⁴⁵ Proposed 42 C.F.R. §916(a)(4).

⁴⁶ Proposed 45 C.F.R. §155.320 (governing Exchanges) and proposed 42 C.F.R. §§435.948 and 949.

⁴⁷ Proposed 42 C.F.R. §435.952.

⁴⁸ Proposed 45 C.F.R. §155.335.

⁴⁹ Proposed 42 C.F.R. §435.1200(c).

eligibility determination can be completed through the Exchange application process itself.

As noted earlier, proposed federal regulations give state Medicaid agencies the responsibility for deciding whether to retain their eligibility determination authority or delegate this authority in cases in which the Exchange operates as a public agency.⁵⁰ In the event of a delegation, the Medicaid agency, as noted, would be obligated to exercise policy and operational oversight. In creating this option, the Preamble notes that numerous states currently delegate their Medicaid eligibility determination functions to other public agencies. At the same time, as the Preamble notes, the ACA does not alter federal Medicaid law requiring that a public agency determine eligibility for Medicaid.⁵¹ The Preamble thus proposes to allow delegation where an Exchange is a public agency, as long as the Medicaid agency retains full supervisory powers over the delegee's operations. The Preamble further states that "if Exchanges are established as a non-governmental entity . . . the coordination provisions in the law may mean the co-location of Medicaid state workers at Exchanges or other accommodations to ensure coordination is accomplished."⁵²

States will make a key decision as to whether to delegate formal eligibility determination functions to a separate public agency or to retain this responsibility as the single public entity empowered to determine eligibility. States will simultaneously pursue companion efforts to make entry points into the eligibility determination process more accessible, through Exchange alignment and information transfer, as well as supplemental activities such as outstationed Medicaid enrollment, which has been a feature of Medicaid since the 1980s. State decisions in this regard will likely depend on several factors, including Exchange resources to manage delegated powers. Most likely however, the decision will rest, as the Preamble notes, on the tradition of the state, that is, whether the state historically has utilized other public agencies (e.g., state mental health or developmental disability agencies) in Medicaid eligibility determination and redetermination procedures. Where the Medicaid agency retains its eligibility determination responsibility, other pathways to coordination will be required so that the Exchange can act as the locus of eligibility determinations, even if the personnel conducting the determinations are not the staff of the Exchange. The fundamental policy aim is a process that, for applicants and persons receiving insurance affordability program assistance, is to the greatest degree possible, conducted through the Exchange and without additional contact with a second agency.

⁵⁰ Proposed 42 C.F.R. §435.10(c)(1)(iii).

⁵¹ 76 Fed. Reg. 51148, 51169.

⁵² 76 Fed. Reg. 51169.

The importance of structuring the Medicaid/Exchange relationship around eligibility determinations extends beyond the MAGI-related eligibility categories and includes categories such as blindness and disability, which remain tied to traditional eligibility standards such as eligibility based on disability. Although delegation to an Exchange of eligibility determination responsibilities for disability-based eligibility is not contemplated under the NPRM,⁵³ assuring appropriate disability determinations in this type of situation is important.

The NPRM specifies that individuals “undergoing” a separate Medicaid eligibility determination based on disability cannot be pended or denied coverage through an Exchange if they also apply to the Exchange and meet its eligibility standards for both QHP enrollment and premium assistance and cost-sharing reductions.⁵⁴ In such a situation, the NPRM specifies that an Exchange is obligated to enroll such individuals⁵⁵ and that the Medicaid agency is obligated to notify the Exchange once its disability-based eligibility determination is complete.⁵⁶

While the NPRM addresses situations in which an individual seeks coverage through this dual approach, it does not directly address the protocol to be used when an individual who potentially qualifies for Medicaid based on blindness or disability has sought coverage solely through the Exchange. Because Medicaid offers more comprehensive coverage, assuring access to Medicaid by Exchange-eligible individuals whose incomes exceed Medicaid MAGI levels becomes an important aspect of the Medicaid/Exchange eligibility relationship. Medicaid agencies and Exchanges might address several matters, including determining which individuals should be identified as potentially eligible for a second-level Medicaid eligibility determination, the process to be used for identifying such individuals, the transmission of information from the Exchange to the Medicaid agency, timelines for a second level determination, and the final transmission of information back to the Exchange.⁵⁷

⁵³ Proposed 42 C.F.R. §431.10.

⁵⁴ Proposed 42 C.F.R. §435.1200(g)(2). Financial eligibility standards for persons with disabilities may be significantly higher than MAGI income because of special state options to use more liberal income eligibility standards under federal law.

⁵⁵ Proposed 42 C.F.R. §435.1200(g)(2).

⁵⁶ Proposed 42 C.F.R. §435.1200(g)(2)(i) and (ii).

⁵⁷ Nor does the NPRM address the situation in which an individual enrolled in Medicaid based on multiple Medicaid categories has been an issue for decades, the challenge of accurately identifying such individuals grows in importance. This is because Medicaid coverage for newly eligible persons covered through benchmark plans (which will be equivalent to the essential health benefits available under qualified health plans sold in Exchanges) may be less generous than coverage based on disability, where traditional Medicaid coverage standards apply. This may be a situation in which health plans can play a critical role in identifying members whose health status indicates the potential presence of a disability serious enough to meet the Medicaid disability eligibility standard.

COORDINATING HEALTH PLAN COVERAGE POLICIES AND ADMINISTRATION AND OPERATIONS ACROSS INSURANCE AFFORDABILITY PROGRAM MARKETS

Individuals eligible for enrollment in Exchanges will derive coverage through membership in QHPs.⁵⁸ In Medicaid, coverage through comprehensive risk-based plans represents a dominant form of state plan administration. The Medicaid and CHIP Payment and Access Commission reports that as of 2009, 47 percent of all Medicaid beneficiaries were enrolled in a comprehensive risk-based managed care arrangement, while among children, the figure rose to 85 percent.⁵⁹ This figure can be expected to grow in coming years, as states increasingly move to develop managed care systems for persons with disabilities and dual enrollees and as newly eligible beneficiaries are enrolled in “benchmark plans”. States’ CHIP coverage policies similarly are governed by managed care arrangements, with the vast majority of all children receiving benefits under separate CHIP programs covered under a managed care arrangement.⁶⁰

Because of the potential for frequent migration across insurance affordability programs, states may wish to pursue strategies that will better promote stability of plan enrollment and care regardless of changes in the source of insurance affordability assistance. Medicaid and commercial products generally have differing provider networks and different provider payment rates, as might a Basic Health Plan should a state elect to establish one. Different markets also may have different “cultures.” For example, in many states, auto enrollment (that is, assignment to a plan with a subsequent period of time during which members may switch to another plan) is an important feature of Medicaid managed care and, as with Medicare Part D, is designed to address problems of non-selection or selection of plans whose provider panels are full. Auto enrollment generally is viewed by health plans as positive because it assures plans a certain volume of business. Furthermore, some states use auto enrollment as a quality incentive, awarding additional members to plans that are considered quality performers. To the extent that auto enrollment becomes a feature of state Exchange operations in order to assure that all individuals and families are connected to a health plan, it might be considered as an incentive for encouraging Medicaid plans to move into an Exchange market. States have other options for incentivizing cross market participation. They might consider classifying multi-market participation as a bonus in quality performance measurement. They might also require Exchange participation by all Medicaid plans or vice versa. State Medicaid agencies might consider eliminating their separate purchasing activities and instead pay a premium to purchase Exchange plans, although this option

⁵⁸ PPACA §1311.

⁵⁹ *Id.*

⁶⁰ *Id.*

may prove costly and also assumes that the conditions of participation for health plans under Medicaid are identical to those that apply in the Exchange market, which is not the case.⁶¹ States might also require QHPs and Medicaid plans to recognize each others' provider networks in order to allow individuals and families whose affordability subsidies shift to remain with their providers. States also might consider using state funds to establish minimum annual enrollment periods in health plans in order to eliminate the risk of mid-year plan switching, although this investment, while valuable, does not guarantee continuity of care beyond the minimum enrollment period. Finally, the federal government might promote the potential for continuity of both coverage and care by requiring health plans participating in state Exchanges as national QHPs also to operate in the Medicaid market and accept Medicaid enrollees. A unified market serving all insurance affordability programs allows individuals seeking both enrollment and affordability assistance to select from a product market that meets the standards required of all affordability programs.

Regardless of which option states choose, state Medicaid agencies and Exchanges seeking a more integrated plan market for insurance affordability programs can benefit from the joint development of a common framework for plan certification and operations. This common framework would encompass the full range of issues that arise in managed care administration, from enrollment procedures through plan oversight and operational requirements. Specific matters to be addressed under a joint operating framework would include methods for reconciling differences in benefit and coverage design to the greatest degree possible⁶² (See Figure 1), provider network composition and capabilities, access measures, and applicable conditions where provider certification and payment and payment are concerned. Collaboration also would necessarily entail development of a common set of performance standards and compatible standards in the area of patient and consumer protections, internal and external appeals, and marketing and consumer information. While some key differences inevitably will persist, state policy options are sufficiently broad under the proposed federal Exchange regulations as well as federal laws applicable to Medicaid managed care to permit states to move in common purpose to a considerable degree across both markets.

At the same time, it is true that alignment of the Medicaid and Exchange markets represents a complex undertaking given the level of federal regulatory standards applicable to both the Medicaid and Exchange markets. Although some key conditions of participation (such as health care access timeframes) may be under state control, other

⁶¹ Deborah Bachrach, Patricia Boozang and Allison Garcimonde, *Medicaid Managed Care: How States' Experiences Can Inform Exchange Qualified Health Plan Standards*, Washington, DC: Center for Health Care Strategies, November 2011.

⁶² Certain differences are inherent in the two laws.

aspects of market alignment may be affected by federal regulatory requirements, for example, in the area of internal and external appeals, where federal Medicaid regulations establish important differences. Federal Medicaid managed care regulations, issued a decade ago, merit a review aimed at ensuring that, to the maximum degree feasible given the constraints of federal statutes, compatibility can be achieved in Medicaid and commercial insurance markets in the states. In this regard, the federal government might consider an initiative that focuses on analyzing and updating existing Medicaid managed care regulations in order to promote joint market participation and greater stability of care. This updating effort could be accompanied by a special federal approval process that assists states that seek to develop joint markets with contracting activities and management support to achieve compatibility.

Federal regulations issued to date do not address the issue of product alignment across insurance affordability programs. However, at a broad level, standards governing QHPs⁶³ as well as Medicaid and CHIP plans⁶⁴ are sufficiently similar⁶⁵ to enable the Department of Health and Human Services to develop standards that move toward a common framework for plan structure, operation, and performance in order to encourage a unified approach to the insurance affordability program market.

The development of a common framework will benefit from an inclusive approach. To this end, managed care companies that traditionally have offered health plans in publicly sponsored markets have highly relevant experience to bring to bear on this task. This includes experience in administering different benefit packages with different cost-sharing standards for different member groups, provider network design to reflect the needs of a diverse population, experience in multi-program member enrollment, outreach and marketing, and member services, and relevant experience in addressing widely divergent population and member health needs. Similarly experienced in addressing the challenges of a multi-market standard-setting exercise are organizations providing services to populations enrolled in publicly sponsored plans, such as patient advocacy organizations and insurance ombudsmen. Also of crucial importance are organizations representing safety net and traditional Medicaid providers, with extensive experience in delivering managed care services to divergent, publicly sponsored populations. As such, states focusing on the formation of a Medicaid/Exchange workgroup addressing product

⁶³ HHS presumably will establish qualification standards for “standard health plans” sold in basic health programs that are consistent with standards applicable in the QHP and Medicaid/CHIP markets.

⁶⁴ The Children’s Health Insurance Program Reauthorization Act (CHIPRA) applies Medicaid managed care standards to CHIP products. Pub. L. 111-3, §403.

⁶⁵ The principal relevant provisions of law applicable to the alignment of insurance affordability programs are PPACA §§1302 and 1311 (related to essential health benefits and qualified health plans sold in Exchanges); 76 Fed. Reg. 41866 (July 15, 2011) (NPRM related to Exchanges and qualified health plans), 42 U.S.C. §1396b(m) and 1396u-2 (managed care provisions), and 42 C.F.R. Part 438 (Medicaid managed care regulations).

alignment might consider a broad approach to the task that convenes all stakeholders along with state experts in order to arrive at a common framework that encourages broad plan and provider participation and coverage stability.

Certain issues emerge as meriting focus in efforts to promote greater market alignment.

Enrollment

One of the most important challenges arises in the context of enrollment. Depending on the state, the dynamics of Medicaid and Exchange enrollment potentially may be quite different. In the case of Medicaid, two basic approaches to enrollment appear to be common. Under one approach, which resembles that contemplated under the federal Exchange eligibility determination regulations, individuals applying for Medicaid select or are assigned to (with opt-out rights) a health plan at the time of application. Following their Medicaid eligibility determination, individuals are then formally enrolled in the plan. Under this approach, the Medicaid eligibility determination phase effectively is embedded in health plan selection/enrollment, much the way that the process is envisioned in federal Exchange eligibility determination regulations.

The alternative approach is to stage plan selection or enrollment following an eligibility determination. Under this approach, the question of affordability is first answered, followed by a time period during which plan enrollment takes place. This model is essentially the inverse of the model envisioned under the Exchange regulations and is designed to account for the fact that not all Medicaid eligibility categories are eligible to enroll in managed care arrangements. As Medicaid's use of managed care grows, it may be that eligibility determinations will more commonly be paired with managed care enrollment.

In both Medicaid managed care models, auto enrollment is a principal feature of the enrollment process. Auto enrollment is expressly contemplated under Medicaid managed care regulations, with an emphasis on autoenrollment processes that weighs autoenrollment assignment based on access standards, the strength and diversity of provider networks (including potentially the use of providers highly experienced in treating low income populations), and plan quality performance.

The issue of autoenrollment in QHPs sold in Exchanges is not explicitly addressed in either the statute or regulation. This places emphasis on plan selection, but increasingly both the federal government and state governments have recognized that the plan selection process can occur either prior to or following enrollment, given the importance of actually effectuating coverage, the potential to use auto enrollment (a form of market share strategy) as a means of incentivizing plans and providers, and in order to assure that enrollment matches health plan capacity within geographic areas. Given the very large numbers of individuals who become eligible for coverage in 2014 and the need for an approach to enrollment that assures that eligibility is smoothly translated into health care

access, the Medicaid/Exchange coordination process might wish to devote time to the question of how and under what circumstances the autoenrollment tool will be used both to achieve efficient enrollment and as an incentive to develop plans that participate in all insurance affordability program markets.

Coverage, including Benefits and Cost-sharing

As noted, companies offering health plans in multiple markets have considerable experience with benefit and cost-sharing tiering that adjusts coverage to the level of membership. The ability to adjust coverage to program tiers will be important in the Medicaid/Exchange relationship because of important distinctions among affordability programs in the scope and extent of coverage. Figure 1 offers illustrative examples of variation in benefit and coverage design across health insurance affordability programs. While there are important differences, there is sufficient commonality to make a coordinated approach feasible.

In addition to important differences in patient cost-sharing, certain notable issues arise in cross-program benefit design coordination efforts:

- **Benefits covered under state Medicaid plans for traditional enrollees but not included in health plan contracts.** While coverage for newly eligible beneficiaries may be limited to benchmark standards, Medicaid’s “comparability” requirements mean that for traditional enrollees, state Medicaid plans may cover certain benefits in addition to services available through their managed care contracts. For example, a state might include in its managed care contract rehabilitation facility coverage for up to 100 days per incident when needed by individuals recovering from acute illnesses or injuries; the state plan, by contrast, also might cover rehabilitation services on a fee-for-service basis for beneficiaries with serious and chronic physical or mental illness requiring extended treatment to maintain health or avert further deterioration. Similarly, a state plan may cover home health services solely as a fee-for-service benefit and not as part of its contract with managed care organizations. Coordinating coverage between and among managed care contracts (many states use multiple contracts, with separate contracts covering behavioral health care and pharmacy services, for example) with services that remain in the fee-for-service system has been a challenge for state Medicaid programs historically. Efforts to align Medicaid managed care and Exchange health plans will necessarily have to consider how to coordinate participation and performance requirements in states that utilize multiple Medicaid contracts and that retain certain services within the state Medicaid fee-for-service system. For example, a Medicaid program might decide to retain separate behavioral health contracts for its beneficiary population even though the Exchange system is built on a qualified health plan model that assumes a single plan with all covered essential health benefits “carved in.” In these cases, qualified health plans participating in the Medicaid market might need to be dually certified as providers of both behavioral and physical care in the Medicaid market.

- **Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefits.** In the case of children enrolled as traditional beneficiaries or under Medicaid “benchmark” plans, coverage would include the items and services that fall within the federal EPSDT benefit. Many of these items are services found in a traditional managed care coverage arrangement (e.g., comprehensive and periodic health examinations, vision and hearing care, immunizations, treatment for acute episodes of illness or injury). Other benefits, particularly long term interventions to ameliorate the effects of serious and chronic physical, mental, and developmental conditions disclosed through the screening process may, as with state plan benefits generally, not be included in a standard managed care agreement. Assuring that plans participating in the insurance affordability program market will be able to coordinate their coverage with additional coverage and benefits available to children whose affordability program source is Medicaid will be an important aspect of alignment.
- **ACA-level preventive services for traditional adult Medicaid beneficiaries and separate CHIP program enrollees.** The ACA requires coverage of preventive benefits, as defined by the Secretary, across the entire non-grandfathered market of health insurance sold in the individual and group markets and employer-sponsored health benefit plans. Since the preventive services requirement is one applicable to all health plans sold in the individual and small group markets, QHPs sold in Exchanges will be required to meet this standard. Presumably the Secretary also will extend a preventive coverage standard to both Medicaid benchmark plans and basic health plans because of the overall requirement that their coverage mirrors the level of coverage available under QHPs operating under essential health benefit rules. Ironically perhaps, in the case of Medicaid coverage for traditional adult beneficiaries, preventive benefits as defined under the ACA remain a state option⁶⁶ with the exception of certain services for women, including family planning services and supplies. Coordination efforts will need to determine whether to establish a preventive services coverage standard for traditional adults consistent with the standard available through qualified health plans, basic health plans, and benchmark plans. Similarly separately administered CHIP programs will need to make a determination regarding whether to align CHIP coverage standards with the preventive standard applicable in these other markets.
- **Habilitation and substance use disorder services for programs subject to the essential health benefit coverage standard.** Essential health benefits encompass both habilitation services and substance use disorder treatment services. Habilitation is not a recognized coverage class under the traditional Medicaid program, although treatments and procedures considered habilitative in nature potentially would qualify for coverage within Medicaid’s definition of preventive benefits. The extent to which

⁶⁶ For children entitled to EPSDT, all age appropriate preventive benefits would be covered.

Figure 1. Benefit and Coverage Design Under Insurance Affordability Programs: Selected Benefits

| Insurance Affordability Program | Essential health benefits | Preventive benefits including family planning services as a required benefit | Pediatric Dental Care | Early and Periodic Screening Diagnosis and Treatment (EPSDT) | Mental Health Parity Rules |
|---|--|--|---|--|---|
| “Traditional” Medicaid coverage | No, governed by traditional Medicaid coverage rules which may allow broader coverage | Optional for adults, required for individuals under age 21 as a component of EPSDT; family planning services and supplies are required | Yes, as a component of EPSDT | Yes | Applies to managed care entities that contract with state Medicaid programs |
| Newly eligible Medicaid beneficiaries entitled to “benchmark” coverage | Yes | Preventive benefits, including preventive services for women, presumably covered | Yes, as a component of EPSDT, which applies to Medicaid benchmark plans | Yes | Yes |
| Basic Health Program enrollees | Yes | Presumably yes, if preventive services separately are considered part of essential health benefits | Yes | No | Yes |
| Separately administered CHIP programs | No | Well child care only, state option to cover more broadly | Yes | No | Yes |
| QHP enrollment through Exchanges with premium tax credits and cost-sharing reductions | Yes | Yes, subject to standards applicable to all health plans sold in the individual and group health insurance markets | Yes | No | Yes |

traditional state Medicaid coverage standards would encompass substance abuse disorder treatment could be expected to vary from state to state. Similar variation and coverage limitations could be expected under separate CHIP programs. As a result, coverage policies for these two service classes emerge as another area of focus in efforts to better align coverage across insurance affordability programs.

Consumer and Patient Safeguards

Medicaid and CHIP managed care standards contain consumer and patient protections in areas also subject to regulation in the case of QHPs and basic health plans. Issues addressed in the case of Medicaid and CHIP managed care regulations include appeals procedures, access to care, access to emergency services, network adequacy, provider communications, and access to plan information.⁶⁷ Comparable safeguards and protections, which also include direct access to pediatric and obstetrical services, exist under patient protections applicable to non-grandfathered health insurance products sold in the individual and small group markets as well as employer sponsored plans.⁶⁸ In the case of qualified health plans sold in state Exchanges, certain “essential community provider” standards also apply to network composition requirements; since many of these providers also represent a significant source of treatment to Medicaid and CHIP enrollees, the absence of a directly comparable standard in Medicaid and CHIP should not present a significant barrier to coordination.⁶⁹

Federal standards aligning consumer protections and plan safeguards across insurance affordability program markets have not yet been developed. However, the comparability of the issues regardless of the program, as well as considerable state flexibility to refine standards in their contracts, likely would allow states to develop common consumer and patient standards for contractors participating in multiple programs.

Plan Quality and Performance Measurement

Insurance affordability programs uniformly require that participating health plans meet standards for quality performance.⁷⁰ One of the challenges in any quality performance measurement system is sufficiently stable enrollment over a sufficiently long time period to allow the application of robust measures that require continuity of care in order to produce reliable performance measures. The quality of care over time lies at the heart of many performance measures (e.g., the proportion of children fully immunized by age

⁶⁷ 42 C.F.R. §§438.100, 438.102, 438.114, 438.406-420.

⁶⁸ 42 U.S.C. §300gg-15, 300gg-19, 300gg-19A.

⁶⁹ Access to federally qualified health centers is explicitly addressed in Medicaid managed care arrangements carried out under §1915 waiver authority.

two, the proportion of individuals with certain chronic health conditions such as diabetes or asthma who demonstrate health stabilization or improvement over a year). By aligning health plan products sold across insurance affordability program markets, states would be able to foster greater continuous enrollment over time regardless of the specific financing source for which an individual may be eligible at any particular point in time. Such a result would, in turn, allow joint purchasing strategies in which a common, core set of measures that look at performance longitudinally, thereby strengthening quality performance measurement.

Conclusion

As the Exchange implementation effort proceeds and as Medicaid undergoes a major transformation, aligning the markets represents a distinct but essential aspect of this road to reform. Much of this alignment has to do with the eligibility determination and redetermination process. But as coordination produces more stable enrollment, an important associated task becomes aligning the care delivery arrangements in which people will enroll. Such alignment can be expected to help promote participation by individuals and families, because the health and health care benefits of coverage can be more fully experienced. Furthermore, better coordination of the market for insurance affordability program products emerges as a potential strategy for attracting greater participation by market competitors and greater involvement by participating providers.

Achieving coordination begins with the establishment of a coordination mechanism at the state level, governed by the agencies involved in coordination and inclusive of the stakeholder interests in a more unified operation. Ideally the mechanism would address not only the technical aspects of eligibility determination, but also the integration of outreach and enrollment practices, consumer enrollment tools such as websites and navigators, data information and Exchange, and health plan participation and quality performance standards. Ultimately the aim of health reform is stable, continuous, and affordable health care, with alignment of multiple affordability programs as providing a basic mechanism for advancing this result.

⁷⁰ See, e.g., 42 U.S.C. §1396u-2 (Medicaid managed care); 42 U.S.C. §1397 (CHIP); 42 U.S.C. § (Basic health Program); 42 U.S.C. § (qualified health plans sold in health insurance Exchanges).

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

1776 Massachusetts Ave., NW
Suite 400

Washington, DC 20036-1904

Telephone (202) 452-8097

Facsimile (202) 452-8111

E-mail: nasi@nasi.org

Website: www.nasi.org