

Medicaid's Role in the Health Benefits Exchange: A Road Map for States

A Maximizing Enrollment Report

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EXECUTIVE SUMMARY

On March 23, 2010, President Obama signed into law the Affordable Care Act (ACA), sweeping federal legislation designed to bring about near universal coverage and transform how health care is paid for and delivered throughout the United States. Under federal health reform, 32 million Americans are expected to gain coverage through an expansion of Medicaid to 133 percent of the Federal Poverty Level (FPL); premium subsidies for individuals with incomes between 134 percent and 400 percent of the FPL; new insurance markets – Health Benefit Exchanges – through which individuals and small businesses may compare coverage options and purchase insurance; and reforms of private health insurance. Barely a year after passage, states are crafting Exchange legislation and designing and building the systems for individuals to secure a determination of their eligibility for a subsidy and enroll in coverage. This paper examines the issues that states will confront as they consider how best to integrate Medicaid into the administration and operation of the Exchange and into the continuum of coverage in the Exchange.

Eligibility, Enrollment and Outreach

The pathway for coverage for adults and children eligible for subsidized coverage – Medicaid, the Children’s Health Insurance Program (CHIP) or premium tax credits – will be new state Health Benefit Exchanges (Exchanges). The ACA requires state Exchanges to establish a single integrated process to determine consumer eligibility for the full range of subsidies and to facilitate enrollment into coverage. In designing a streamlined subsidy-eligibility process, states will require additional guidance from the federal government on a number of issues, including income counting rules under the statute’s modified adjusted gross income standard, third-party verification of income, and identification of “newly eligible” Medicaid beneficiaries for which states will receive enhanced federal matching dollars. Other eligibility decisions are within the purview of states. These include establishing continuous eligibility, presumptive eligibility or waiting periods for CHIP programs. In all cases, states will need to compare state eligibility rules with federal law and regulations, evaluating both legal requirements and practical considerations as they build systems intended to facilitate subsidy eligibility determinations and enrollment in and retention of health insurance coverage.

Once a consumer is determined eligible for a subsidy, a second critical Exchange function is triggered; namely, health plan enrollment. This raises a critical question for states: whether to place the business process for enrollment into Medicaid and CHIP in the Exchange or in a separate Medicaid process. Continuity of coverage as well as administrative efficiency argue for providing enrollment functionality in the Exchange, and this is especially true for states that rely on managed care plans in their Medicaid and CHIP programs. Integration of Medicaid into the coverage continuum in the Exchange facilitates outreach and education of consumers and eases comparison shopping; it also enables consumers whose incomes fluctuate to more easily transition among products and plans. Recognizing that consumers may move back and forth between full subsidies (Medicaid) and partial premium subsidies, states will want to consider whether some or all plans in the Exchange should be required to offer the full range of subsidized and nonsubsidized products.

Health Plan Contracting, Standards and Requirements

The ACA requires the Secretary of the Department of Health and Human Services (the "Secretary") to establish minimum requirements for the certification of qualified health plans (QHPs) in the Exchange. States may impose additional requirements on QHPs, and states will want to consider aligning the

quality, access and reporting requirements for QHPs and Medicaid managed care plans. Standardization of these requirements will support value purchasing both in Medicaid and the private market and enable consumers to access consistent information about plans. In addition, states will want to revisit their Medicaid managed care purchasing strategies, considering whether and how best to leverage the purchasing power of the Exchange. The ACA requires states to establish a state program for risk adjustment that applies to health plans in the small group and individual markets both inside and outside the Exchange. Again, in creating an Exchange that serves all consumers regardless of income level, states should consider the potential value of a single, standard risk adjustment program across all coverage options.

Benefit Package Design

States will also have to address multiple questions about the design of benefit packages in the Exchange, including both covered benefits and consumer cost-sharing obligations. The ACA mandates that QHPs provide a federally mandated “essential benefit package.” The ACA also mandates that newly eligible Medicaid beneficiaries receive a benchmark benefit which must be at least as generous as the essential benefit package. And benchmark exempt populations must receive a standard Medicaid benefit package. While alignment of covered services simplifies transitions among subsidy levels and plan enrollment, that may not be possible under federal law or may not be advantageous for states seeking to maximize federal financial support. In addition, the cost-sharing cliff between Medicaid and premium tax subsidies for individuals with incomes above 138 percent of the FPL may argue for taking advantage of the ACA option to establish a basic health program for families with incomes above 138 percent of the FPL and below 200 percent of the FPL. States' choices also will be influenced by the ability to access enhanced federal funding for services provided to newly eligible Medicaid beneficiaries.

Exchange Infrastructure

Finally, at the same time that states are resolving how to integrate Medicaid into the continuum of coverage options available to individuals with incomes below 400 percent of the FPL, they must also consider where Medicaid fits in the administration of the Exchange. Integration with state Exchanges has the potential to bring down Medicaid costs by bringing eligibility and enrollment systems, consumer outreach and education, health plan oversight and administrative infrastructure to scale across multiple payers. States must consider how to tap into the expertise of both its Medicaid and insurance agencies in governing the Exchange, and then resolve which of the current functions of each agency could be consolidated in the Exchange. Significantly, to the extent that Medicaid functions are consolidated in the Exchange, federal matching dollars will be available to support the operations of the Exchange post-2014, when the ACA mandates that they be self-sustaining.

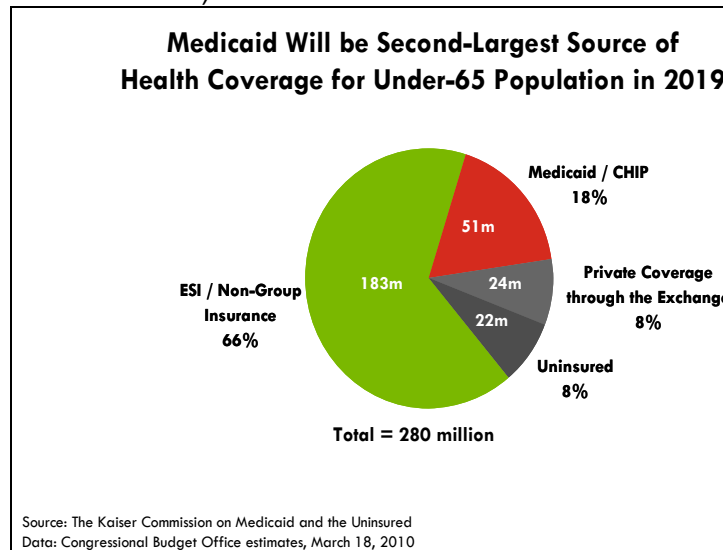
The pace of development of state Health Benefit Exchanges is picking up. Hundreds of millions of federal dollars have been made available to states and all but a handful of states have begun implementation work. This paper offers a road map of issues states will want to consider in building, operating and financing their Exchanges and effectively integrating Medicaid into the continuum of subsidy and coverage options. One thing is clear: a successful Exchange will build on the expertise and resources embedded in state Medicaid and insurance agencies.

INTRODUCTION

Authorized in 1965 as a companion to Medicare, Medicaid started out as a small welfare-related program providing health insurance coverage to poor mothers and children receiving cash assistance. In the decades that followed, many states gradually expanded Medicaid to cover more working families; in 1996, as part of federal welfare reform, the program was delinked from cash assistance. A year later the creation of the Child Health Insurance Program (CHIP) continued to expand the base of working families using public health insurance coverage for their children, and to a more limited extent, other family members. Today, many Medicaid beneficiaries and most children receiving coverage through CHIP are part of working families, whose employers either do not offer health insurance or offer coverage that is not affordable.

With the passage of federal health care reform, Medicaid completes its transition from poverty program to major health insurer, becoming a linchpin of the nation's health insurance infrastructure. Under the Patient Protection and Affordable Care Act, Medicaid is identified as one of four "State Health Subsidy Options" that will be available to individuals with incomes below 400 percent of the federal poverty level (FPL) in 2014. The four options are:

1. State Medicaid programs (for individuals with incomes below 139 percent of the FPL);
2. State Child Health Insurance Programs (for children with incomes between 139 percent of the FPL and state eligibility ceiling);
3. State programs under Section 1331 of the ACA establishing a basic health plan (where offered, for individuals with incomes between 139 percent and 200 percent of the FPL);¹ and
4. Qualified health plans offering products for individuals eligible for premium tax credits and for cost-sharing reductions (for individuals with incomes between 139 percent and 400 percent of the FPL).



¹ ACA, Sec. 1413(c).

By 2019, Medicaid is expected to be the nation's single largest insurer, covering 25 percent of the total population including those over 65. In short, **Medicaid is health insurance.**² So while many talk about aligning Medicaid and the Exchange, it is more accurate to consider and plan for Medicaid's role *in* the Exchange: first, as a subsidy option; and second, as a coverage vehicle. In addition, state Medicaid agencies can— and under federal guidance must partner with state insurance agencies in planning and operating state Health Benefit Exchanges (Exchanges or HBEs).

How and where Medicaid fits into the administration and operations of this new health care marketplace is of no small consequence. While overarching rules for creating and operating the Exchange are federal, myriad policy and implementation decisions are in the hands of states. In most states, the early planning for the HBE has been tasked to the state agency charged with oversight of commercial insurance, the state Medicaid agency, or some combination of both. While state Medicaid directors and insurance commissioners have generally approached the health insurance market from very different vantage points, with a clear demarcation between public and private coverage, the ACA brings those worlds together in the administration of the HBE, providing states with new opportunities to consolidate and rationalize the oversight of public and private insurers and powerful new tools to drive delivery system reform. The historic silos between public and private coverage break down further in the Exchange, where Medicaid is one offering in a continuum of subsidy and coverage options.

Each state will determine where and how to structure Medicaid in its state Exchange. This paper identifies opportunities and decision points for states as they consider how to most effectively integrate Medicaid in new state Exchanges in each of the following areas:

- Eligibility, enrollment and outreach for state health subsidy programs;
- Health plan contracting, standards and requirements;
- Benefits; and
- Governing, operating and financing the Exchange.

² Medicaid has multiple roles, including providing vital support for safety net providers and long term care services for elderly and disabled consumers. These functions do not negate Medicaid's increasingly important role as a health insurer; they simply supplement it.

ELIGIBILITY, ENROLLMENT AND OUTREACH IN THE EXCHANGE

The pathway to coverage for adults and children eligible for State Health Subsidy Programs will be new state HBEs through which individuals, regardless of income, may “apply for enrollment in and receive a determination of eligibility for participation in, and continue participation in applicable State Health Subsidy Programs.”³ In addition to determining an individual’s eligibility for a subsidy, that same system must facilitate enrollment into the state health subsidy program for which the consumer qualifies.⁴

Determining Eligibility for State Health Subsidy Programs

A consumer-centric approach to health subsidy eligibility is the starting point for universal coverage in the ACA.⁵ The law requires state Exchanges to provide a single, integrated process to determine consumer eligibility for the full range of health subsidy programs, including Medicaid, CHIP, the Basic Health Program⁶ (should the state elect to establish one) and premium subsidies. Depending on their income, low- and moderate-income individuals with incomes below 400 percent of the FPL may qualify for a full subsidy under Medicaid, a full or substantial subsidy through CHIP or a partial subsidy through premium tax credits and cost-sharing reductions. The Exchange is also the point of entry for individuals seeking to purchase private coverage without a subsidy.

By law, the health subsidy eligibility process must be streamlined, transparent and technology-enabled, providing a first-class consumer experience. In short, the process that state Exchanges implement for health subsidy eligibility will be applied uniformly to all consumers who wish to determine whether they are eligible for any type of health subsidy program, regardless of their income level.

The chart below maps an eligibility and enrollment workflow for consumers seeking coverage through Health Benefit Exchanges.

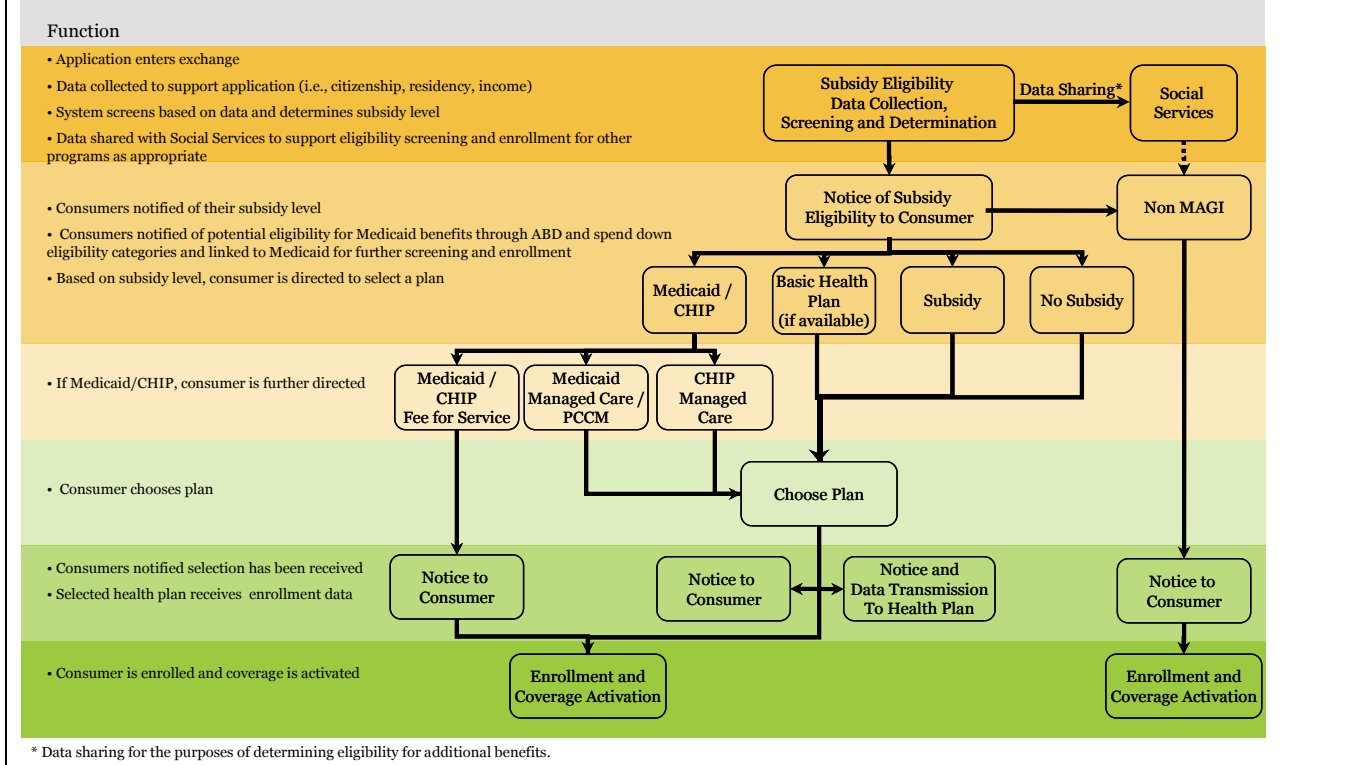
³ ACA, Sec. 1413(a).

⁴ ACA, Sec. 2201.

⁵ ACA, Sec. 1561. Note that Appendix A of these standards provides overarching guidance with respect to a “consumer centric approach” to eligibility and enrollment in health insurance, and includes “superior customer service” as central to that approach.

⁶ The ACA gives states the option to establish a “Basic Health Program” through which it may enter into contract with health plans to provide essential health benefits to individuals with incomes above the new Medicaid threshold of 133 percent FPL and up to 200 percent FPL who would otherwise access coverage through the State exchange.

The Continuum of Coverage in State Exchanges



Several barriers confront states as they endeavor to create Exchange health subsidy eligibility processes consistent with the vision and requirements of the ACA. Some of these barriers require federal solutions. Others are within a state’s scope of authority to resolve.

Eligibility Issues Requiring Federal Resolution

To develop a streamlined and efficient subsidy-eligibility process, states will rely on HHS to address the following issues:

- **MAGI Definition.** While the ACA requires state Exchanges to apply the modified gross adjusted income (MAGI) income calculation methodology in determining eligibility for all health subsidies, including Medicaid and CHIP,⁷ the law does not preempt federal law or state plan/waiver obligations with regard to “point-in-time” or “countable income” requirements in Medicaid.⁸ There are some income sources that are currently counted for Medicaid eligibility determination, but not for tax purposes, including child support and Supplemental Security Income. Adding to the complexity of aligning the Medicaid and MAGI definitions of countable income, there may be some sources of taxable income under MAGI that are not counted for Medicaid. CMS has broad discretion in defining whether the MAGI definition applied in Exchanges will “add or subtract” certain income sources. States require early and detailed guidance from CMS to ensure that the sources of income that are included, as well as family

⁷ ACA, Sec. 2002.

⁸ ACA, Secs. 2002, 2001

size rules under MAGI, are determined uniformly and rationally across all subsidy programs in 2014.

- **Income Verification.** The ACA requires automated verification of income to determine eligibility for all health subsidy programs in the Exchange – including Medicaid, CHIP and premium tax subsidies – through use of tax return data.⁹ The law recognizes the imperative of using a single, simple set of income eligibility rules across all subsidy populations to ensure that individuals are able to access the correct subsidy without an overly burdensome process. The ACA allows for HHS to determine advance payments of premium credits using information provided through Exchanges, including consumers' prior year tax filings and any self-reported changes. The United States Department of Health and Human Services (HHS) will make advance payments directly to health plan issuers for consumers who qualify and enroll in coverage. The law also provides that at the end of the taxable year, a reconciliation process must occur through which advance payments are subtracted from premium tax credits. Excess payments will be recouped from consumers through tax adjustments.

While the ACA limits the amount that may be recouped from households under 400 percent FPL to no more than \$400, or \$250 for those filing taxes as unmarried individuals,¹⁰ the Medicare and Medicaid Extenders Act of 2010¹¹ increases those limits significantly to between \$600 and \$3,500.

The immediate implications of this ACA change relate to ongoing discussions among CMS, states and the IRS regarding the authority and income data requirements for determination of eligibility for, and advance payment of, premium tax credits. There is significant (now heightened) concern about the potential for consumer exposure to recoupment of excess advance payments of credits.

To ensure that Exchanges are able to implement the ACA vision of an automated eligibility determination process allowing for streamlined, technology-enabled access to all State Health Subsidy Programs, states require a resolution from HHS that allows consumers' most recent available tax year filing to be used to calculate both eligibility/advance payments and premium credits claimed by consumers on tax filings. Alternatively, HHS could allow for use of tax data coupled with consumer attestation of "current annual income" verified through automated third-party data for subsidy eligibility, calculation and reconciliation. This alternative would require additional technical assistance and guidance from HHS that Exchange systems include robust income data matching functionality.

State Exchanges should also consider how best to establish a robust process for consumers to provide updated or changed information regarding income or household composition that could affect their eligibility for premium tax subsidies.

- **Medicaid “Medical Support” Requirement.** Another area in which states require federal action relates to the federal “medical support” mandate. Currently, federal statute compels states to ask all Medicaid applicants for information regarding parents or spouses who might

⁹ ACA, Sec. 1411.

¹⁰ ACA, Sec. 1411.

¹¹ Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309.

be legally responsible for providing medical support to Medicaid beneficiaries, and empowers the state to bar adults who fail to comply from enrolling. The ACA provides a new eligibility determination framework for most Medicaid applicants by using the MAGI income calculation, which defines the applicants' household as their tax filing unit. "Absent" parents who are not reported on the tax return will not be counted in the household, nor will their income be used to determine eligibility under MAGI. The ACA also creates a new paradigm for ensuring that individuals obtain health insurance for their dependents through the individual mandate and imposes penalties for those who fail to acquire it. In short, the ACA recasts coverage access, affordability and personal responsibility in a manner which may make obsolete the Medicaid medical support requirement. States require guidance from HHS with regard to whether the ACA eligibility and penalty/mandate framework can be relied upon in lieu of medical support enforcement provisions. HHS could consider options including sponsoring an amendment to the federal statute eliminating the medical support requirement.

- **Medicaid and CHIP Program Integrity Audits.** State Medicaid and CHIP programs are subject to a number of federal integrity and error rate audits of the eligibility decisions including the Payment Error Rate Measurement Program (PERM),¹² and the federal Medicaid Eligibility Quality Control Program (MEQC).¹³ Partnership with CMS to reevaluate and align eligibility audit requirements and the new eligibility rules and process that will emerge in response to the ACA will be crucial for states in 2014 and beyond.
- **Tracking Medicaid "Newly Eligible."** Finally, the ACA provides for enhanced federal funding for consumers who become "newly eligible" for Medicaid pursuant to the federal expansion of the program up to 139 percent of the federal poverty level.¹⁴ While critical, the increased federal funding may create an obligation that state Medicaid programs ensure that new enrollees are truly "newly eligible" (i.e. would not have been eligible under the state's existing Medicaid eligibility rules) in order for the state to claim the enhanced match. The promise of a single, simplified health subsidy eligibility process in state Exchanges is lost if states are required to re-screen every consumer who becomes newly eligible to determine if he or she would have been eligible under the state's prior Medicaid eligibility rules. States will need to work with CMS to develop a tracking framework that permits a simple method of claiming the enhanced match, perhaps a single income threshold or a sampling method to avoid running "shadow" systems of existing eligibility rules as part of Exchange health subsidy eligibility processes.

Guidance from HHS will also be required on a range of other issues. For example, states will need to understand how to address mid-year income and eligibility changes that could cause an individual who was eligible for premium tax credits to become newly eligible for Medicaid coverage. In addition, states will need to understand how to reconcile their CHIP waiting periods against individual mandates, and the new ACA contingency requirement that a parent may not enroll in coverage unless the individual's child is enrolled in coverage.¹⁵

¹² 31 U.S.C. 3221.

¹³ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services 42 C.F.R. Part 431.800(ff).

¹⁴ ACA, Sec. 2001(a)(3).

¹⁵ ACA, Sec. 2001(a)(4)(A)(3)

Eligibility Issues Requiring State Resolution

In some cases, barriers to implementing the ACA requirements for a streamlined and integrated health subsidy eligibility process are within states' authority to resolve. For example, three states still require an asset test for children applying for Medicaid; 25 states examine assets for non-pregnant parents seeking Medicaid coverage.¹⁶ The ACA precludes requiring an asset test as part of an Exchange health subsidy eligibility process for most Medicaid applicants.¹⁷ States will have to eliminate their asset test requirements for most Medicaid beneficiaries by 2014. Two states still have an asset test for their CHIP program and may want to consider their elimination to further alignment and coordination across programs.

Other state Medicaid eligibility requirements are not expressly prohibited by the ACA, but states may be well advised to eliminate them to enable a technology-driven, administratively streamlined and consumer-centric approach to health subsidy eligibility. These requirements include fingerprinting and drug and alcohol screening, among others. States may also consider implementing policies that would further simplify the eligibility and enrollment pathway, including extending third-party verification processes to non-MAGI populations and establishing an enrollment pathway through the Exchange. States may also consider establishing 12-month continuous eligibility for children and adults to minimize frequency of transitions in coverage and reduce the risk of coverage gaps and disruptions in care. Resolution of these issues will be within a state's scope of authority and responsibility to consider and remove, as appropriate, in designing Exchange eligibility functions.

State Decisions in Exchange Eligibility and Enrollment Process Development

Must Eliminate	May Eliminate
<ul style="list-style-type: none"> ▪ Face-to-face interview ▪ Asset test (for most populations) ▪ Income and/or expense disregards ▪ Multiple, separate application forms for Medicaid/CHIP adults and children ▪ Paper documentation (except in cases where data matching indicates a discrepancy with information provided by the consumer) 	<ul style="list-style-type: none"> ▪ Fingerprinting ▪ Drug and alcohol screening ▪ Consumer reporting of eligibility information that may be obtained through data matching to federal and state databases (unemployment benefits, workman's compensation, SNAP, military pay, Veteran status, etc.) ▪ Documentation of income that is not verifiable through the IRS

¹⁶ Heberlein M., T. Brooks, J. Guyer, S. Artiga, J. Stephens "Holding Steady, Looking Ahead: Annual Findings Of A 50 State Survey Of Eligibility Rules, Enrollment And Renewal Procedures, And Cost Sharing Practices In Medicaid And Chip, 2010-2011," Kaiser Family Foundation, January 2011.

¹⁷ ACA, Sec. 2002.

Determining Health Subsidy Program Eligibility

Summary	Exchange subsidy eligibility determination must be a single, accessible function for all consumers to determine whether they are eligible for subsidies, including Medicaid, CHIP, Basic Health Plan or premium tax credits.
Issues	States are challenged to create an accurate subsidy eligibility process across all State Health Subsidy Programs without being overly burdensome for consumers or administratively costly for states.
Decision Points	<p><i>For the Federal Government:</i></p> <p>How will MAGI countable income and family size rules be aligned across all health subsidy programs?</p> <p>What mechanism will be created for simple, hassle-free verification of income for health subsidy eligibility determination, premium tax credit advances, and advance reconciliation?</p> <p>Can states be relieved of the obligation to gather “medical support” information from consumers eligible for the Medicaid subsidy?</p> <p>When will guidance be issued to align eligibility audit requirements including PERM and MEQC requirements with new simplified eligibility rules and process?</p> <p>What methodology best provides states with a simple mechanism for enhanced match claims?</p> <p><i>For States:</i></p> <p>Which current application and eligibility process requirements in state Medicaid must be eliminated to comply with the ACA requirements for Exchange subsidy eligibility determination?</p> <p>Which additional state requirements should be eliminated or implemented to create a consumer friendly subsidy determination process?</p> <p>How will the state create a seamless process to identify non-MAGI Medicaid-eligible consumers and transition them to the process they need to obtain coverage?</p>

Enrolling Consumers in Coverage and Ensuring Coverage Continuity

Once a consumer has established eligibility for a health subsidy program, a second critical Exchange function is triggered: the consumer shops among insurance products and health plans and enrolls in a product and/or health plan. (For consumers who elect to forego a subsidy eligibility determination, the shopping and enrollment function is the first Exchange service they will encounter.)

The health plan shopping and enrollment process in the Exchange is a distinct function from the health subsidy eligibility process. While the ACA mandates that states create “no wrong door” access to a streamlined process for health subsidy eligibility determinations (for Medicaid, CHIP, Basic Health Plan, and premium tax credits), the law does not require states to enroll consumers in Medicaid and CHIP health plan coverage (to the extent the state provides such coverage through plans) in the Exchange.^{18,19} Thus, once a consumer is determined *eligible* for a full health subsidy through Medicaid or CHIP, an Exchange could, theoretically, redirect the consumer to a separate business process to *activate* their coverage through health plan selection and enrollment. In any case, however, states must ensure a streamlined enrollment process, including enrollment in coverage.

Continuity of coverage as well as administrative efficiency argue for providing health plan enrollment functionality in the Exchange for all consumers, regardless of their subsidy. This will be particularly true for states with large or growing Medicaid managed care programs. As a practical matter, Medicaid-eligible consumers need the same level and quality of information about their health plan and/or provider choices as those eligible for premium tax subsidies or no subsidies. If designed properly, state Exchanges can be efficient and effective mechanisms for educating all consumers about their plan choices – including plan characteristics such as benefits, provider network options, and quality and consumer satisfaction.

Providing shopping and enrollment capacity for all consumers in the Exchange is particularly relevant for families with some members eligible for public coverage and others for private coverage (with or without subsidy). Through the Exchange, families can easily identify plans that offer Medicaid coverage, private coverage and those that offer both Medicaid/CHIP and private products. Moreover, Exchange-based enrollment for all insurance options would enable families to shop for and activate coverage for every member of the household through a single portal, regardless of the subsidy for which a particular family member is eligible.

An additional consideration for states in developing Exchanges that promote seamless insurance enrollment is whether states should require all or some participating Qualified Health Plans (QHPs) to offer both Medicaid/CHIP and private insurance products. As noted above, families seeking coverage in the Exchange may have household members eligible for different health subsidies, and individuals may transition over time between Medicaid and tax subsidies as income fluctuates. Providing a first-class health plan shopping experience as well as coverage continuity for these consumers may be best achieved by states requiring or creating incentives for some or all QHPs to offer both Medicaid/CHIP and private insurance products. For families who experience income fluctuations that

¹⁸ ACA, Sec. 1413.

¹⁹ ACA, Sec. 2201.

result in changes in eligibility year-to-year, this remedy would also provide coverage continuity by allowing them to stay in the same plan, albeit with a different level of subsidy.²⁰

Enrolling Consumers in Coverage	
Summary	A key function of the Exchange is creating a marketplace in which consumers may shop and select and enroll in health insurance. The ACA mandates that Exchanges be accountable for eligibility determinations but not explicitly for Medicaid/CHIP health plan enrollment actions.
Issues	States must address how to meet streamlining and customer experience goals through both eligibility determinations and enrollment functions. Despite the fact that the ACA doesn't give accountability for Medicaid or CHIP health plan enrollment to the Exchange, states must design business processes and technical system supports that work effectively across the Exchange and Medicaid for both eligibility and enrollment functions.
Decision Points for States	<ul style="list-style-type: none"> ○ How will the state implement health plan enrollment for consumers who are determined Medicaid/CHIP-eligible through the Exchange? ○ Should states integrate Medicaid/CHIP health plan enrollment into the Exchange enrollment function? What are the technical options for making this happen? ○ Can both fee-for-service and managed care Medicaid enrollment be effectuated in the Exchange?

Providing Consumer Outreach and Education

In order to access health subsidies and coverage enrollment, consumers will require significant information about their coverage options and how to access the Exchange. By 2014, state Exchanges must establish grant programs to award funding to “Navigators,” entities that will provide consumers with fair and impartial information about their health insurance options, and offer assistance to facilitate enrollment in health insurance coverage.²¹ The Navigator program is intended to support robust consumer outreach and education regarding the:

- Value of health insurance;
- Availability of subsidies to offset premium costs;
- Mandate to purchase insurance; and
- Types of subsidies and coverage available.

²⁰ Rosenbaum S. and Sommers B., "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs*, Issue No. 2. Vol. 30 228-236.

²¹ ACA, Sec. 1311(i).

While the ACA does not specifically require Navigators to educate consumers about health subsidy programs and insurance coverage through Medicaid and CHIP, states should consider the practical value of an integrated approach to consumer outreach and enrollment facilitation for the full continuum of subsidies and coverage options available to consumers in 2014. Indeed, community-based Navigators will encounter and must be prepared to connect a wide range of consumers to subsidies and coverage, regardless of their income levels.

States may also look to their Medicaid agencies for lessons learned in consumer outreach as they design Navigator functions in their Exchanges. Medicaid agencies' efforts to draw eligible consumers into coverage with outreach and education have met with mixed success. Such capacity has not historically existed in states' private markets – except through insurance brokers and employers.

Consumer Outreach and Education	
Summary	Exchanges must create Navigator programs to conduct outreach and education to consumers regarding the availability of subsidies and coverage, as well as the requirement to obtain coverage, in 2014. Strategies must take into account a shift away from “public assistance” to insurance programs, recognizing that different populations will now be screened and eligible for publicly subsidized insurance coverage.
Issues	The ACA does not require states to integrate Medicaid/CHIP subsidies and coverage into their Navigator programs, but states should consider integration as both practical for consumers and supportive of coverage and seamless goals.
Decision Points for States	<p>Should Navigators outreach to and educate consumers regarding Medicaid and CHIP subsidies and eligibility as part of a full continuum of coverage?</p> <p>What lessons can states learn from state Medicaid programs in designing their Navigator programs?</p> <p>How do private brokers relate to or fit into the Navigator infrastructure?</p>

HEALTH PLAN CONTRACTING, STANDARDS AND REQUIREMENTS IN THE EXCHANGE

Federal law requires the Secretary of Health and Human Services (Secretary) to establish minimum certification requirements for “qualified health plans” (QHPs) that participate in Exchanges.²² As with many of the ACA requirements, implementation details with respect to QHP selection are left to the states. States may determine the extent to which the Exchange will wield its purchasing power in the market: by accepting all plans that meet minimum requirements for instance or by becoming an “active purchaser” which contracts only with plans that meet robust requirements and offer the most competitive premiums. Regardless of the role the Exchange assumes, it must at least provide information that permits informed consumer selection of an appropriate health plan.

Whether or not states elect to require some or all insurers to offer Medicaid, CHIP and private insurance products in the Exchange, it is possible and desirable to align health plan standards and requirements in the Exchange, including quality, access and reporting requirements for all plans that participate in the Exchange across the continuum of coverage. Standardization of these requirements will support value purchasing both in Medicaid and the private market and enable consumers to access consistent information about plans. States will also want to consider the extent to which alignment of benefits among state health subsidy programs and between such programs and QHPs offering nonsubsidized products is necessary and desirable to achieve continuity of coverage through Exchanges.

Health Plan Contracting

The Exchange presents an opportunity for states to revisit their managed care contracting strategy. Two models illustrate the ends along a continuum of purchasing strategies for integrating Medicaid in the Exchange.

1. **Minimal Integration.** This model most closely mirrors current practice. State Medicaid agencies would continue to contract with managed care plans on behalf of Medicaid beneficiaries outside the private insurance market. Medicaid beneficiaries select or are assigned to one of the state-contracted plans. The most notable departure from current practice would be linkages required to ensure seamlessness between the Exchange eligibility determination process and health plan enrollment.
2. **Maximum Integration.** This model represents the other end of the continuum of integration of Medicaid and Exchange contracting functions. Here, the state purchases through the Exchange the Essential Benefit Package from QHPs for Medicaid beneficiaries. Because Medicaid requires additional services, the state would also provide wraparound benefits or purchase riders for the additional benefits and reduced cost sharing. This model would effectively require Medicaid-only plans to expand their product offerings and become a QHP.

Many states will choose a hybrid approach, continuing to contract for a separate Medicaid product, but aligning its requirements for Medicaid managed care plans with those imposed on QHPs. In taking

²² ACA, Sec. 1301.

this approach, states will want to consider the potential roles of both QHPs and Medicaid-only plans in serving Medicaid beneficiaries. They will also want to consider whether to require or incent some or all QHPs to offer Medicaid/CHIP and private market products, and likewise whether to incent Medicaid-only plans to become QHPs. Finally, states will want to evaluate the benefits of developing a unified purchasing strategy for Medicaid beneficiaries and QHPs within the Exchange.

Health Plan Contracting	
Summary	Exchanges present states the opportunity to revisit their Medicaid/CHIP managed care contracting strategy.
Issues	States may consider the degree to which contracting for Medicaid/CHIP managed care should be integrated into the Exchange.
Decision Points for States	<p>Should states require or incent QHPs to offer a Medicaid product?</p> <p>Should states require or incent Medicaid plans to become a QHP?</p> <p>Should the benefits purchased for Medicaid beneficiaries be provided through a separate product or be built on the essential benefit package offered by QHPs with riders or wraparound benefits?</p> <p>Should states develop a unified purchasing strategy for Medicaid beneficiaries and QHPs within the Exchange?</p>

Certification of Qualified Health Plans

The ACA requires the Secretary to establish minimum requirements for the certification of qualified health plans, including:

- Marketing requirements;
- Network requirements that ensure sufficient choice of providers;
- Inclusion of “essential community providers” (includes Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospital (DSH) hospitals and family planning clinics, among others);
- Accreditation by the Exchange or by an entity or entities recognized by the Secretary for the accreditation of health plans with respect to performance on:
 - Clinical quality measures
 - Consumer access
 - Utilization management
 - Quality assurance
 - Provider credentialing
 - Complaints and appeals
 - Network adequacy and access;

- Implementation of quality improvement strategies;
- Utilization of a uniform enrollment form;
- Utilization of a standard format for presentation of benefits; and
- Provision of information on quality measures, including pediatric quality reporting measures, for health plan performance.²³

Existing state licensure and certification requirements for insurers address many of these standards. Particularly in states offering Medicaid and/or CHIP coverage through managed care plans, participating health plans are already bound to meet these and more rigorous quality and consumer protection requirements through state statute, regulation and contract. As states establish QHP standards according to HHS guidance, they may want to consider HHS’s QHP standards against existing Medicaid managed care requirements and insurance regulations to align and create a single set of standards for all plans participating in the Exchange, regardless of the insurance products they provide. States may also consider the unique capabilities and capacities required of Medicaid and CHIP managed care plans to determine if there are specific standards that should be required of QHPs offering Medicaid and CHIP coverage. Finally, states may look to the plan certification process in their Medicaid managed care program as a potential model for QHP certification.

Qualified Health Plan Standards	
Summary	The ACA requires the Secretary to develop minimum standards for certification of qualified health plans eligible to participate in state Exchanges. States may supplement these requirements.
Issues	States may consider whether all plans in the Exchange, regardless of the insurance products they provide (Medicaid/CHIP, private products), should meet the same set of QHP requirements.
Decision Points for States	<p>Should all plans offering coverage in the Exchange be required to meet the same QHP standards, regardless of the type of coverage they offer?</p> <p>To what extent should states apply the requirements in existing Medicaid managed care and CHIP contracts to QHPs?</p> <p>Are there unique capabilities that drive specific QHP requirements for plans offering Medicaid/CHIP?</p>

²³ ACA, Sec. 1311(c)(1).

Information and Reporting Requirements for QHPs

The ACA requires Exchanges to make both descriptive and evaluative information available to consumers.

- **Descriptive Information:** The ACA requires that plans, including QHPs, use a uniform format, uniform definitions of insurance and medical terms, and understandable terminology to describe benefits and coverage. The Secretary is charged with development of the standard definitions for insurance-related terms such as coinsurance, co-payments, out-of-pocket limits, preferred provider and grievances and appeals, and for medical terms such as hospitalization, hospital outpatient care, emergency room care, home health care, medical equipment and emergency medical transportation and “such other terms as the Secretary determines are important to define so that consumers may compare the medial benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).”²⁴

To ensure transparency in coverage, the law also requires QHPs to provide information in plain language on:

- Claims payment policies
- Periodic financial disclosures
- Data on enrollment and disenrollment
- Data on denied claims
- Data on rating practices
- Information on cost sharing; individuals must be able to secure cost-sharing information on specific items or services in a timely manner
- Information on enrollee rights
- Other information as determined appropriate by the Secretary²⁵

States may consider the value of applying this framework across all coverage options and standardizing the same information (as relevant) across health plans offering Medicaid, CHIP and private coverage. Standardization across all coverage vehicles will ease plan selection and provide transparency and continuity for all consumers, regardless of their underlying subsidy.

- **Evaluative Information.** Pursuant to the ACA, state Exchanges must also make available to consumers evaluative information to assist them in distinguishing among plans. For example, the law requires the Secretary to develop an enrollee satisfaction survey system to evaluate the level of satisfaction with QHPs and present the information in a manner that allows individuals to easily compare satisfaction among comparable plans.²⁶

One can readily imagine state Medicaid agencies and state Exchanges using the same survey instrument and presentation format for health plans offering Medicaid, CHIP, and/or private insurance coverage. All consumers will be interested in substantially the same information when making plan choices. As noted earlier, some existing requirements in Medicaid and

²⁴ ACA, Sec. 2715.

²⁵ ACA, Sec. 2311(e)(3).

²⁶ ACA, Sec. 1311(c)(4).

CHIP may provide a basis for standardization. For example, CHIPRA mandates the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as the standard consumer satisfaction measurement tool for voluntary use by Medicaid and CHIP. The use of this tool could be extended to all products offered in the Exchange.

State Medicaid agencies may also want to work with HHS as the survey instrument is being developed to ensure it addresses most particularly the concerns of individuals with chronic illnesses or those for whom English is not their first language. While these concerns are not unique to Medicaid/CHIP beneficiaries, they are of particular concern to chronically ill and limited English proficient (LEP) populations. Medicaid agencies have particular concern in ensuring the survey instrument serves chronically ill and LEP populations because they disproportionately serve these populations.

Information & Reporting Requirements for QHPs	
Summary	The ACA requires the Secretary to develop minimum standards for QHP information and reporting requirements. States may supplement these requirements.
Issues	States may consider applying information and reporting requirements across all health plans – including those that provide private coverage and those that provide Medicaid/CHIP coverage – in the interest of transparency and continuity for all consumers.
Decision Points for States	Should QHP information and reporting requirements be applied to all health plans, including those that provide Medicaid/CHIP coverage? Are there unique features of Medicaid/CHIP-eligible consumers that influence whether states impose the same standards for information and reporting in Medicaid/CHIP?

Risk Adjustment

The ACA requires states to establish a “Permanent State Program for Risk Adjustment” that applies to health plans in the small group and individual markets both inside and outside Exchanges.²⁷ The law indicates that the risk-adjustment methodology will be developed as part of a consultative process between the states and HHS.

Risk adjustment is an assessment of the “actuarial risk” of a health plan’s enrollees and allocation of risk assessments and payments among the private or public plans that are being evaluated. Each enrollee’s specific risk score is determined based on clinical conditions (“flags”), typically captured through claims data. These flags include age, gender, prescription medication history, diagnostic encounters and, in Medicaid and CHIP, covered populations’ eligibility category. A health plan’s risk score is an aggregation of each enrollee’s score and can be compared against an average risk profile across all enrollees in a specific population using actual experience or national data. If a health plan has few high-risk score individuals, it will have a lower than average overall actuarial risk score. Conversely, a high actuarial risk score will reflect more higher-risk enrollees compared to the average.

²⁷ ACA, Sec. §1343.

In order to limit the financial risks associated with adverse selection, this new state program will collect fees from lower actuarial risk plans to make additional payments to higher actuarial risk plans (the “risk adjustment” of premiums or funding levels).

Risk assessment and/or adjustment mechanisms are already used in many states for rate setting and clinical analysis of the Medicare, Medicaid, and private or commercial insurance markets. Today, these mechanisms are generally specific to each risk pool – differing in terms of the conditions or clinical “flags” that trigger risk indicators.²⁸ In creating an Exchange that serves all consumers regardless of income, states should consider the potential value of a single, standard risk adjustment program across all coverage options. A single risk adjustment program could calibrate risk adjustment across all insured populations through development of a new, broader set of clinical flags.

There are significant benefits to a standard risk adjustment program for all stakeholders. First, it supports continuity of coverage for consumers: if, over time, a consumer changes health plans, they “carry their risk score with them” to their new health plan. Health plans know upon enrollment of previously enrolled consumers with high clinical risk factors, allowing plans to appropriately target resources and services to their members and better manage overall health costs and clinical outcomes. From states’ points of view, a standard risk adjustment program across all insured populations provides greater, population-based predictability of health costs – supporting a more refined approach to rate setting in the Medicaid/CHIP programs, and evaluation of premium rates in the private market.²⁹ Additionally, states are likely to realize administrative cost savings in implementing a single risk adjustment mechanism that eliminates the need for risk “rescoring” and tracking and recalibration of risk score across different coverage vehicles.

As states weigh in on forthcoming HHS guidance with respect to risk adjustment, and as they implement risk adjustment in their HBE, they should consider the benefits of choosing a single, risk adjustment program that calibrates risk adjustment flags across Medicaid fee-for-service, Medicaid managed care, Medicaid Primary Care Case Management (PCCM), CHIP, Basic Health Program and the private, commercial insurance market. HHS could support this alignment and simplification by “certifying” several risk adjustment methods that use consistent data elements from which state Exchanges may choose.

²⁸ Rong Y and D Laurent. "What Kind of Risk Adjustment Systems Are Necessary for Health Insurance Exchanges," National Healthcare Reform Magazine, November 4, 2010. Available at: <http://www.healthcarereformmagazine.com/article/what-kind-of-risk-adjustment-systems.html>.

²⁹ J Bertko, Personal Interview, December 16, 2010.

Risk Adjustment	
Summary	The ACA requires the Secretary to develop, in collaboration with states, a risk adjustment program that will apply to all plans in the individual and small group market, both inside and outside the Exchange.
Issues	While the ACA does not require states to apply risk adjustment in Medicaid, nor to apply the same risk adjustment program to government programs, there may be value to consumers, plans and the state in having a single, common risk adjustment program for all insured populations, including Medicaid/CHIP.
Decision Points for States	Should states consider weighing in with HHS asking for development of a single risk adjustment program or certification of several risk adjustment methodologies for all covered populations – including consumers in Medicaid/CHIP?

Quality Strategies and Reporting

The ACA encourages states to leverage broader health reform priorities through their Exchanges, including payment reform, development of medical homes and integrated delivery systems and reductions in health care disparities.

- The Secretary, in conjunction with experts in health care quality, must develop guidelines with respect to payment structures that incent activities focused on: (1) health outcomes improvement such as care coordination and the use of the medical home model; prevention of hospital readmissions; (2) improvement of patient safety and reduction of medical errors; (3) promotion of wellness and health; and (4) reduction of disparities. The guidelines must also require QHPs to report on the applicable Exchange activities in order to implement.³⁰
- Effective January 1, 2015, QHPs may only contract (1) with hospitals that utilize patient safety evaluation systems and implement mechanisms ensuring comprehensive discharge planning reinforced by appropriate health care professionals post-discharge and (2) health care providers that implement mechanisms to improve health care quality.³¹

These requirements are in addition to those listed as conditions for certification, which, as noted above, include the obligation of each QHP to provide information on quality measure for health plan performance.³² Again, states will want to consider applying the same quality strategies to Medicaid managed care plans, PCCM programs, Basic Health Program, CHIP plans and QHPs.

³⁰ ACA, Sec. 1311(g).

³¹ ACA, Sec. 1311(h).

³² ACA, Sec. 1311(c)(1).

Quality Strategies and Reporting	
Summary	The ACA requires the Secretary to develop guidelines for provider payment structures that incentivize improved health outcomes through evidence-based care models and require QHPs to report on their activities to improve patient outcomes. Starting in 2015, QHPs may only contract with hospitals that have adopted mechanisms recognized by the Secretary as improving health care quality.
Issues	States may consider aligning quality-based payment structures and quality requirements across the continuum of health insurance coverage options offered in the Exchange, including Medicaid/CHIP managed care plans?
Decision Points for States	<p>To what extent might the state impose quality improvement mandates on the relationship between all QHPs, Medicaid and CHIP plans as part of a multipayer strategy to improve quality and contain costs in the state's health care system.</p> <p>What level of consistent quality requirements can be applied across all plans in the Exchange to support multipayer quality improvement and measurement in the state?</p>

BENEFIT PACKAGE DESIGN IN THE EXCHANGE

As states plan for Exchange implementation, they confront myriad issues and decisions about benefits, including covered services and consumer cost-sharing obligations, offered across the new continuum of health insurance coverage. The ACA includes several mandates about covered benefits and cost-sharing, but leaves many benefit decisions to the discretion of states. The issue of aligning covered benefits among different categories of Medicaid beneficiaries and between Medicaid and private coverage (both subsidized and nonsubsidized) presents a number of particularly thorny issues for states.

Essential Benefits

The ACA mandates that qualified health plans provide a federally mandated “essential benefits package” for all products offered in the Exchange.³³ The law outlines a basic definition of essential health benefits and requires the Secretary of HHS to further define the package through guidance to states. The essential benefit package must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitation and habilitation services, laboratory services and preventive, wellness and chronic disease management and pediatric services.³⁴ States may require QHPs to offer benefits outside of the essential package defined by the Secretary, but in making such requirements, the state accepts financial responsibility for the additional cost.³⁵ States with current statutory or regulatory “benefit mandates” for licensed insurers must consider these mandates in the context of essential benefits, and seek to influence the Secretary’s definition of the essential package for those benefits the state deems necessary for comprehensive coverage. Ultimately, for those state mandates that are not part of the final essential benefit definition, states will be required to eliminate the benefit or accept financial responsibility for providing it to consumers who purchase private coverage in the Exchange.

Medicaid “Benchmark” Benefits

The ACA requires that states provide a “benchmark benefit package” of covered services to those consumers who become newly eligible pursuant to the ACA’s Medicaid expansion.³⁶ Benchmark benefits may be less generous than a state’s standard Medicaid benefit package, but must be at least as robust as the essential benefit package mandated for plans offering private coverage in the Exchange. Benchmark benefits must include certain benefits beyond those in the essential benefit package, including Early Periodic Screening, Diagnosis and Treatment (EPSDT) for children, nonemergency transportation and family planning services. Benchmark benefits may include additional service, subject to federal approval.

³³ ACA § 1302.

³⁴ ACA § 1302

³⁵ ACA § 1302 (a)

³⁶ ACA Sec. 2001 (c)

Newly eligible Medicaid beneficiaries who must receive benchmark benefits include all childless adults, and parents above the state’s 1996 welfare level and below 139 percent of the FPL. States also have the option of extending benchmark benefits to some currently eligible populations. Finally, some populations, whether newly or currently eligible, are exempt from benchmark and must receive the state’s standard Medicaid package of benefits. The “benchmark-exempt” populations include parents below the state’s 1996 welfare level; aged, blind and disabled populations; some pregnant women; and the medically frail.³⁷ The chart that follows compares the potential benefit options available to the states.

Benefit	Essential Benefits	Minimum Benchmark	Maximum Benchmark*	Standard Medicaid
Physician services	X	X	X	X
Lab and x-ray	X	X	X	X
Inpatient hospital services	X	X	X	X
Prescription Drugs	X	X	X	X
Pediatric services incl. oral and vision care	X	X	X	X
Mental Health & Substance Abuse	X	X	X	X
Outpatient hospital services	X	X	X	X
Rehabilitative and habilitative services	X	X	X	X
EPSDT		X	X	X
Family planning		X	X	X
Non-emergency medical transportation		X	X	X
Federally Qualified Health Center/ Rural Health Center services		X	X	X
Nursing facility services			X	X
Home Health Care Services			X	X

*Subject to HHS approval

States will receive 100 percent (declining to 90 percent over time) federal funding for the cost of benchmark benefits provided to newly eligible Medicaid beneficiaries. It also appears states will receive this enhanced federal funding for newly eligible beneficiaries who are benchmark-exempt and will receive the standard Medicaid benefit package.

³⁷ ACA Sec. 2001 (a); Social Security Act § 1937(a)(2)(B).

Several factors may influence state decision-making with regard to Medicaid benchmark benefit package design as they plan for 2014, but perhaps most compelling will be the drive to maximize federal funding and reduce or eliminate state funding obligations. Most obviously, states may attempt to limit their future need to pay for new Medicaid beneficiaries by designing a minimum benchmark package consistent with the essential benefit, thus excluding costly services like long-term care.

Alternatively, states may consider creating a more robust benchmark benefit that includes an array of services typically used by more complex and costly populations who today “spend-down” to Medicaid eligibility levels. In taking a more expansive approach to benefits covered in the benchmark package, states may be able to maximize federal funding by attracting to the benchmark benefit consumers who would otherwise opt to enter Medicaid in the spend-down eligibility category. States would receive the more generous federal match rate for services provided to these consumers, versus the state’s lower match rate for spend-down-related Medicaid expenses.

Finally, the potential to secure enhanced federal funding for newly eligible medically frail individuals receiving the standard Medicaid benefit package may provide an additional pathway for enhanced match for these high-needs populations.

Beyond funding considerations, states may consider providing a uniform benefit package for all nondisabled, nonelderly adults in Medicaid – across both the currently eligible and newly eligible populations – to facilitate less complex administration of benefits in Medicaid for the state agency, contracted health plans and consumers.

States will require federal guidance as they develop benchmark benefit packages for services provided by institutions that are primarily engaged in providing diagnosis, treatment or care for individuals with mental illness or chemical dependence. If the essential benefit package covers inpatient services for mental illness or chemical dependence and does not exclude specialized facilities, then Medicaid’s benchmark benefit must likewise cover services for mental illness and chemical dependence and may not exclude specialized facilities. However, under the Social Security Act, mental health and chemical dependence services provided by specialized facilities referred to as “institutions of mental disease (IMDs)” are not eligible for federal matching dollars; i.e., they are not covered by federal Medicaid.³⁸ Thus, the question is whether mental health and chemical dependence services provided by IMDs will be eligible for federal matching dollars when they are provided in Medicaid’s benchmark benefit as specifically required by the ACA if they are provided in the essential benefit package as well. Similarly, to the extent that the essential benefit package includes Medicaid optional services, states may have to include these services in their benchmark benefit even if they are not currently covered in their standard Medicaid benefits.

³⁸ 42 U.S.C. §1396d.

Cost Sharing

Beyond covered services, the ACA provides incentives for states to align consumer cost-sharing requirements for preventive services between Medicaid and private coverage. Starting in 2013, the ACA provides that Medicaid programs cover preventive services and immunizations for adults. The ACA further provides that the federal government will pay an additional one percent of the cost of preventive services if states eliminate consumer cost sharing for these services.³⁹ For these same services, the ACA mandates that in plan years beginning on or after September 23, 2010, all private insurers, including QHPs in the Exchange, provide coverage without consumer cost sharing.⁴⁰ In addition to accessing increased federal funding, states that eliminate consumer cost-sharing for preventive services in Medicaid would provide consistency and transparency of benefits across the continuum of coverage for consumers.

Benefit Package	
Summary	State Exchanges will offer a continuum of health insurance coverage options, and states will be charged with developing benefit packages – consistent with federal guidance – across the continuum of coverage. The ACA mandates a “benchmark benefit” for consumers who are newly eligible for Medicaid through expansion of the program in 2014. The law also requires an “essential benefit package” that must be provided by QHPs participating in the Exchange.
Issues	States have financial, administrative and seamlessness considerations in defining benefits across the continuum of coverage that will be available in 2014.

³⁹ ACA § 4106. Health Affairs Health Policy Brief "Preventive Services Without Cost Sharing," December 28, 2010.

⁴⁰ ACA § 1001 [PHSA § 2713]. This requirement does not apply to "grandfathered" plans. Federal Register: Group Health Plans and Health Insurance coverage Rules Relating to State as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule. Vol. 75, No. 116/Thursday, June 17, 2010. pp. 34571-34572. Available at: <http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf>.

<p>Decision Points</p>	<p>For States:</p> <p>Should the benchmark benefit be a minimal package to minimize state financial obligations?</p> <p>Would a more robust benchmark benefit maximize federal funding for state Medicaid programs, and reduce current state funding levels for spend-down Medicaid beneficiaries?</p> <p>Should states seek to provide a uniform benefit package for all community-based Medicaid consumers from 0-139 percent FPL? What are the fiscal pros and cons of doing so? What are the administrative pros and cons of doing so?</p> <p>Should states seek to ensure alignment of the Medicaid benchmark benefit with the essential benefit offering to consumers eligible for private coverage in the Exchange?</p> <p>Should states eliminate cost sharing for preventive services in Medicaid?</p> <p>For the Federal Government:</p> <p>To the extent that the essential benefit package includes mental health and chemical dependence services provided by IMDs, will federal matching dollars be available for these services Medicaid's benchmark benefit?</p>
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EXCHANGE INFRASTRUCTURE: GOVERNANCE, OPERATIONS, AND FINANCE

As states turn from planning to implementation of HBEs (and expansion of Medicaid), Medicaid and state Exchanges continue to have a potentially symbiotic relationship. Medicaid programs stand to benefit from Exchange operations. Integration with state Exchanges has the potential to bring down Medicaid costs, by bringing eligibility and enrollment systems, consumer outreach and education efforts and administrative infrastructure to scale across multiple payer sources. With increased reliance on automated systems developed in concert with private payors, streamlined eligibility systems offer the opportunity to reduce bureaucracy and cost.

At the same time, Medicaid offers a crucial source of both up-front funding and ongoing operational support for state health benefit Exchanges. The ACA provides up-front planning funds for Exchanges, but requires that Exchanges become self-sustaining by January 1, 2015, with operating revenues generated through assessments or user fees to participating health insurance issuers or other means.⁴¹ A recent Notice of Proposed Rule Making (NPRM) promises enhanced federal matching funds for state IT development of Medicaid eligibility systems at 90 percent, and continuing enhanced matching funds of 75 percent for Medicaid-related functions within Exchanges operations over time.⁴² Proportionally based on population, Medicaid is the single largest potential funder for the up-front and ongoing costs of eligibility determinations and enrollment, as well as potentially other shared functions of Medicaid and state Exchange operations. In short, Medicaid funding is key to Exchange infrastructure sustainability.

Governing the Exchange

Among the most important questions that states will face in implementing the ACA coverage mandates are related to the structure and administration of the Exchange. Both the state Medicaid and insurance agencies bring essential expertise to the task. The insurance agency regulates health insurance companies and health insurance markets. The Medicaid agency oversees the largest insurance programs in the state, and (in some states) the health plans that contract to serve those programs. Alone or in conjunction with the state's social services agency, Medicaid operates the state's eligibility and enrollment system(s).

A high-priority task for states that are planning their Exchanges is determining governance structure. The ACA authorizes states to operate Exchanges through an existing or new state agency, an independent public entity or a nonprofit established by the state.⁴³ Whatever structure a state selects, the role of its Medicaid agency in the governance and operations of the Exchange must be considered.⁴⁴

⁴¹ ACA, Sec. 1311(d)(5).

⁴² Federal Register: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities. Vol. 75/Monday, November 8, 2010. p. 68583.

⁴³ ACA, Sec. 1311(d).

⁴⁴ The Medicaid Agency's role in the governance and operations in the Exchange should be distinguished from Medicaid's role in the Exchange as a subsidy and coverage option. These latter roles are discussed later in the paper.

States that decide to operate the Exchange through an independent public agency or nonprofit should consider allocating one or more board seats to Medicaid leadership. This could include the Medicaid director, the medical director or, as in California, the Secretary of Health and Human Services (to whom the Medicaid director reports).⁴⁵ If the Exchange is operated by an existing state agency (e.g., the department of health, human services or insurance) or a newly established state agency, decision-making authority will rest with the designated agency head. Medicaid, and other agency input, may be integrated through advisory committees or cross-reporting structures.

Operating the Exchange: Systems and Administrative Resources

The efficient operation of the Exchange and the seamless integration of the eligibility and enrollment functions for the full range of subsidy options will require states to thoroughly assess the administrative infrastructure currently supporting Medicaid and CHIP to determine:

- Changes necessary to facilitate integration with Exchange eligibility and enrollment functions,
- The extent to which the Medicaid and/or CHIP infrastructure offers a platform for Exchange eligibility and enrollment development, and
- The extent to which efficiencies can be realized in existing Medicaid and other administrative functions through integration.

The ACA mandates that state Exchanges integrate subsidy eligibility determination – both full subsidies in Medicaid/CHIP and tax process for all coverage subsidies for the MAGI population. State Medicaid agencies have extensive administrative structures that support eligibility and enrollment functions, including statewide information systems, trained staff and rulemaking procedures. A threshold question for states in planning HBE eligibility and enrollment functions is to what extent the existing Medicaid agency infrastructure – both systems and staff – can or should serve as the foundation of a new and integrated HBE eligibility and enrollment system.

In some states, the Medicaid eligibility and enrollment system is a sound foundation upon which to build an integrated eligibility and enrollment system for the Exchange. This is more likely in states with modern information systems and highly coordinated/seamless coordination among existing health and/or social services programs. In other states, the existing Medicaid infrastructure will not be up to the task. States with antiquated information technology, siloed program administration across existing CHIP and Medicaid programs, and/or low penetration among eligible but uninsured residents, may be better served by exploring how the creation of a new HBE eligibility system could be leveraged to make long-needed improvements in Medicaid eligibility systems and processes.

The Exchange health care subsidy eligibility system will need to collect and maintain data for determination and redetermination for eligibility for all consumers, and will be the starting point for determining eligibility for non-MAGI Medicaid populations (low-income disabled and elderly individuals) as well as consumers who may be eligible for social services programs. While few would question the value of integrating health subsidy eligibility with eligibility for social service programs – sometimes called “horizontal integration” – this can increase the cost and complexity of Exchange planning and implementation. This has led some to argue that states should prioritize harmonizing

⁴⁵ AB1602/S900

health subsidy eligibility systems – or “vertical integration” – with a longer-term goal of bridging these systems to other appropriate social services.

Beyond eligibility and enrollment, states must consider how and if other Medicaid administrative functions might be consolidated into the Exchange, and staff responsibilities integrated. Notably, the ACA specifically authorizes Exchanges to outsource certain functions to state Medicaid agencies, including the determination of eligibility for tax-credit subsidies and exemptions from the individual mandate.⁴⁶ Moreover, many of the required functions of an Exchange beyond subsidy determinations are ones with which the Medicaid agency has substantial experience, including hot line operation, certification of health plans (in states with robust Medicaid managed care programs), electronic calculators, consumer assistance and stakeholder consultation.

The Medicaid Agency’s Role in the Exchange: Planning, Governance and Operations	
Summary	The ACA and implementing guidance require collaboration and coordination between Exchanges and Medicaid but do not dictate Medicaid’s role in governance or administration of HBEs.
Issues	States will need to determine how best to leverage existing relevant expertise, resources, assets in the Medicaid/CHIP agency and how to represent Medicaid in HBE governance.
Decision Points for States	<p>To what extent can the current Medicaid eligibility and enrollment system be upgraded to include the Exchange functions with respect to subsidy determination and enrollment into coverage? Would it be more cost-effective to build an entirely new system?</p> <p>How can the state best ensure that the data collected for determination of subsidy determination for Exchange populations is equally usable for determination of coverage for the non-MAGI populations and for determination of eligibility for social services programs? Should these decisions be delayed until after 2014 to ensure a functioning Exchange by that date?</p> <p>What functions and staff of the state’s Medicaid agency can and should be integrated into Exchange operations?</p>

⁴⁶ ACA, Sec. 1413.

Financing the Exchange

HHS has announced multiple funding opportunities targeted to planning and implementation of state Exchanges, with a particular focus on funding for systems and emphasis on integration of eligibility and enrollment functionality.

Funding for Health Insurance Exchange Planning and Implementation. Three waves of funding to states will support Exchange planning and implementation efforts that are compatible with Medicaid and CHIP. The first Exchange grants were awarded September 30, 2010, with each applicant state receiving approximately \$1 million to support planning efforts. Forty-eight states (all but Minnesota and Alaska) and the District of Columbia received grants to conduct the research and planning needed to determine how their Exchanges will be operated and governed.⁴⁷ Permissible planning activities include assessing information technology (IT) needs, identifying necessary changes to state law and regulations, determining staffing needs, planning the coordination of eligibility and enrollment systems across Medicaid, CHIP, and the Exchanges, and developing performance metrics and milestones.⁴⁸

Second, recognizing that states will need significant technical assistance to develop modernized IT systems, HHS is making funding available to support the development of model information technology systems upon which other states can build. On February 16, 2011, two-year grants totaling \$241 million were awarded to 13 “early innovator” states, representing seven coalitions of states, to build IT systems for Exchanges.⁴⁹

Finally, on January 20, 2011, HHS announced a third round of Exchange grants to enable states to establish Exchanges.⁵⁰ These grants will fund states, the District of Columbia and consortia of states for implementation activities and functionalities that are integral to Exchange operations and meet HHS requirements for Exchanges.⁵¹ The award amount will vary according to the demonstrated needs of each state. States may choose their application level, which is distinguished by state progress in Exchange planning, and timing of application as multiple funding opportunities are available.

Level One of the Exchange implementation grants, designed for states that have made some progress in planning, provide funding for a maximum of two years (an initial application for one year

⁴⁷ Minnesota and Alaska did not submit applications for the Exchange planning grant in 2010. On January 19, 2011, HHS released a limited competition funding opportunity announcement for Exchange planning grants available to these two states. Minnesota applied for a planning grant but no award announcement has been made to date.

⁴⁸ Health Insurance Exchanges: State Planning and Establishment Grants. July 29, 2010. <http://www.healthcare.gov/news/factsheets/esthealthinsurexch.html>.

⁴⁹ U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, “Cooperative Agreements to Support Innovative Exchange Information Technology Systems,” October 29, 2010.

⁴⁹ “States Leading the Way on Implementation: HHS Awards ‘Early Innovator’ Grants to Seven States,” HHS Press Release, February 16, 2011.

⁵⁰ U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, “Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges,” January 20, 2011.

⁵¹ A separate funding opportunity announcement was released for the territories.

and a reapplication for up to one year). Level Two grants, designed for states that have made considerable progress in Exchange planning and have met six milestones defined by HHS, provide funding through 2014.⁵²

To date, no state matching funds have been required to access Exchange planning or implementation funds. While all three funding opportunities are targeted to the Exchange and not Medicaid, funding guidance reinforces the statutory mandate to ensure that Exchange functions related to eligibility and enrollment are fully integrated with Medicaid and CHIP.⁵³

Funding for Medicaid Systems Development and Operations. Complementing the Exchange financing, HHS has proposed to make significantly enhanced federal matching funds available for state IT development of Medicaid eligibility systems. On November 3, 2010, HHS issued a proposed rule that, if approved, would make enhanced federal Medicaid matching funds available to support development of upgraded eligibility systems.⁵⁴ A 90 percent federal Medicaid matching rate would be available for the design, development, and installation of modernized systems through calendar year 2015 and a 75 percent match will be available for maintaining and operating these upgraded systems, so long as specified conditions continue to be met. This represents a significant increase from the 50 percent matching rate currently available for such activities under Medicaid. The Notice of Proposed Rule Making notes the need for “systems transformation” in most states to fulfill new requirements under the ACA, including new eligibility rules, electronic verification of information, a streamlined application for multiple sources of coverage and seamless operation with the Health Insurance Exchanges.⁵⁵

⁵² HHS criteria for Level Two grant applications include: necessary legal authority to establish and operate an Exchange that complies with Federal requirements; establishment of an Exchange governance structure; submission of a complete budget through 2014, an initial financial sustainability plan and a plan for preventing fraud, waste and abuse; and submission of a plan describing how capacity for providing assistance to individuals and small businesses in the State will be created, continued, and/or expanded, including provision for a call center.

⁵³ Bachrach D., P. Boozang, M. Dutton, D. Holahan. 'Revisioning' Medicaid as Part of New York's Coverage Continuum," Medicaid Institute at United Hospital Fund, January 2011.

⁵⁴ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Notice of Proposed Rulemaking, "Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities," November 3, 2010, accessed at: <http://www.federalregister.gov/articles/2010/11/08/2010-27971/medicaid-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities>.

⁵⁵ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Notice of Proposed Rulemaking, "Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities," November 3, 2010, accessed at: <http://www.federalregister.gov/articles/2010/11/08/2010-27971/medicaid-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities>.

Financing the Exchange Infrastructure					
Funding Opportunities	Amount	Dates	Description	Planning and Development	Operations
HBE					
Planning Grant ⁵⁶	\$49 million in grants to 48 States (up to \$1 million each)	Awarded on 9/30/10	For States to conduct the research and planning needed to build a better health insurance marketplace and determine how Exchanges will be operated and governed.	✓	
Innovator Grant ⁵⁷	\$241 million total in 2 year grants to 7 coalitions of states/13 states (amount of grant ranging from \$6 million to \$54 million per state)	Due 12/22/10; Awarded on 2/16/11.	Rewards States that demonstrate leadership in developing cutting-edge and cost-effective consumer-based technologies and models for insurance eligibility and enrollment for Exchanges.	✓	
Establishment Grant	Will vary according to States' needs and progress	Level 1 due 3/30/11, 6/30/11, 9/30/11 or 12/30/11. Level 2 due 3/30/11, 6/30/11,	Supports development and implementation activities and functionalities that are integral to Exchange operations and meet HHS requirements for	✓	✓

⁵⁶ Health Insurance Exchanges: State Planning and Establishment Grants. July 29, 2010. <http://www.healthcare.gov/news/factsheets/esthealthinsurexch.html>.

⁵⁷ U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, "Letter to State Medicaid Directors: Federal Support and Standards for Medicaid and Exchange Information Technology Systems," November 3, 2010.

		9/30/11, 12/30/11, 3/30/12 or 6/29/12. Awarded 45 days after application deadline.	Exchanges.		
Medicaid					
Enhanced Federal Funding for Medicaid Eligibility Determination and Enrollment Development ⁵⁸	90% Federal Financial Participatio n (FFP)	Through the end of 2015.	Design, development and installation or enhancement of eligibility determination systems that comply with federal standards for integrated eligibility systems.	✓	
Enhanced Federal Funding for Medicaid Eligibility Determination and Enrollment Maintenance ⁵⁹	75% FFP	After 2015 (available prior to 12/31/15 for systems already developed or adapted in compliance with new rules).	Maintain and operate eligibility determination systems that comply with federal standards for integrated eligibility systems.		✓
Administrative Matching Funds	50% FFP	Available continuously.	Build, maintain and operate eligibility systems that do not meet standards necessary for enhanced matching funds.	✓	✓

⁵⁸ Federal Register: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities. Vol. 75/Monday, November 8, 2010, p. 68583.

⁵⁹ Federal Register: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities. Vol. 75/Monday, November 8, 2010. p. 68583.

Many questions remain regarding how these funding streams can best be used to support integrated design and implementation of eligibility and other functions across Medicaid and the Exchanges. Federal guidance requires appropriate allocation of costs across the Exchange and Medicaid funding streams,⁶⁰ while at the same time mandates that planning for Medicaid system transformation be done in full partnership with state Exchanges. How to allocate costs across funding streams for joint eligibility and enrollment systems has yet to be determined; however, it will be in states' interest to maximize planning and development funding for the Exchange, which does not require state matching funds. It also will be in states' interest to pursue Medicaid planning and development dollars as soon as possible, both to meet the tight timelines for implementing new systems and to maximize the opportunity to draw down 90 percent federal match. To the extent design and operating funds are supported by Medicaid, states may want to explore opportunities to fund the state share through revenue generated through the state's Exchange. Finally, ongoing enhanced federal matching funds for Medicaid operations are likely to be an important part of Exchange sustainability planning.

Financing the Infrastructure	
Summary	Integrated eligibility and enrollment systems for Medicaid and state Exchanges will be funded through a combination of federal grant funds for planning, development and early operations of state Health Benefit Exchanges, enhanced federal matching funds for development and operation of Medicaid information systems, and, eventually, operating revenues generated through assessments or user fees to participating health insurance issuers within the Exchange.
Issues	While the ACA provides grant funding for the planning, development and early operations of the HBE, it requires that HBEs become self-sustaining by January 1, 2015. Medicaid is an important funding partner in both HBE development and in ensuring HBE financial sustainability.
Decision Points for States	<p>How can states best leverage the combination of Medicaid and Exchange grant funds to support integrated planning and operations while complying with federal cost allocation requirements?</p> <p>Can states realize Medicaid administrative efficiencies – and therefore cost savings – through sharing eligibility systems costs with state Exchanges?</p> <p>Can State Exchange revenues support state Medicaid share to draw down enhanced federal matching funds under Medicaid?</p>

⁶⁰ See U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, "Cooperative Agreements to Support Innovative Exchange Information Technology Systems Funding Opportunity Announcement," CFDA 93.525, October 29, 2010. See also U.S. Office of Management and Budget Circular A-87 relocated to 2 C.F.R., Part 225.

CONCLUSION

Health Benefit Exchange development is rapidly picking up pace across the country, with most states relying on the expertise of both insurance and Medicaid officials. In August 2010, California was the first state to pass legislation authorizing the creation of the California Health Benefit Exchange, an independent public entity with a five-member board, one of whom is the state Secretary of Health and Human Services, who oversees California Medicaid. Companion legislation directs that the Exchange will be an active purchaser of health plans and will determine eligibility for and effectuate enrollment in state health subsidy programs. In November the National Association of Insurance Commissioners adopted the American Health Benefit Exchange Model Act. In January, Indiana Governor Mitchell Daniels issued an Executive Order requiring the Indiana Family and Social Services Administration, in cooperation with the Indiana Department of Insurance and other applicable state agencies, to establish an Indiana nonprofit corporation to serve as that state's Exchange. Forty-nine states have received federal grant funding for Exchange planning; the lead agencies for these projects vary but are generally the state's insurance or health/Medicaid agency or the governor's office. At least a dozen states have issued RFPs for subject matter expertise to implement planning grant projects and at least a dozen states have introduced legislation to establish a state Exchange. Thirteen states are recipients or co-recipients of federal "Innovator Grant" funding to develop systems infrastructure to support Exchange eligibility and enrollment functions.

The new round of federal "exchange establishment" grant funding to states, announced on January 20, 2011, will fuel additional state activity in Exchange planning. HHS has made clear its expectations that to be successful in attracting such funding, states will have to demonstrate progress in key planning milestones including governance, information technology infrastructure and stakeholder engagement in the planning process. Intense and focused planning activity at the state level is crucial to meeting the HHS implementation timeline for state Exchanges: (i) implementation readiness by January of 2013; (ii) a soft launch of the exchange in July 2013; (iii) full launch in January 2014; and (iv) a self-sustaining HBE in January 2015. A state's failure to meet any one of these milestones comes at a high price—loss of autonomy and funding to create a state-run exchange.

As this road map points out, central to state planning efforts should be an evaluation of Medicaid's role in planning and operating the Exchange, as well as Medicaid's role in the continuum of coverage in the Exchange. Collectively, Medicaid will be among the country's largest insurers and the foundation of coverage in the Exchange. Medicaid may bring core expertise and operational capacity to "jump start" Exchange infrastructure development. It most certainly can bring funding to support Exchange sustainability in the long run. Medicaid and Exchange planning processes can equally benefit each other's development during this time of transition. Medicaid brings much to the Exchange planning process moving ahead in states; state Exchanges have the potential to bring much to states' efforts to operate efficient and effective Medicaid programs.