

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

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January 10, 2012



Overview

- Alignment between Medicaid and Exchange as a basic tenet of the Patient Protection and Affordable Care Act
- Proposed rules on alignment issued: 76 Fed. Reg. 41866, July 15, 2011; 76 Fed. Reg. 51148-51198, August 17, 2011; 76 Fed. Reg. 51202, 51345, August 17, 2011.
- Guidance on essential health benefits for qualified health plans sold in Exchanges or in the non-Exchange individual and small group markets: Essential Health Benefits Bulletin, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
- Unknown: Scope of state discretion to interpret essential health benefits in the Medicaid benchmark plan market for newly eligible persons and other populations covered by benchmark provisions

Key Issues

- Target populations in relation to eligibility for insurance affordability programs (Medicaid, CHIP, advance premium tax credits and cost-sharing assistance, Basic Health Programs where applicable)
- Opportunities for cross-market collaboration in relation to health plans sold, and coverage and performance standards
- Goals: ease of movement, stability in plan membership and provider/patient relationships, and common measures of performance

Key Target Populations

- Adults with lower incomes, particularly given the structure of the premium tax credit, which is more generous at the lower income level
 - Newly eligible adults with fluctuating incomes
 - More than one-third can be expected to experience an income shift sufficient to move between Medicaid and the Exchange/Basic Health Program within a 12-month cycle
 - Newly eligible adults with relatively stable but low incomes who may be out of the labor market for health reasons and who may or may not qualify for Medicaid based on disability status, either with income below the Medicaid MAGI income cutoff point or under a Medicaid disability eligibility category that exceeds the Medicaid MAGI upper limit
- Children enrolled in Medicaid and CHIP but whose parents will be eligible for insurance affordability credits toward an Exchange QHP or for a Basic Health Program-participating plan: multi-market families or market alignment for families?

Eligibility Determinations and Redeterminations: Proposed Rules

- Medicaid agencies responsible for developing delegation agreements related to eligibility determinations and redeterminations
 - Standard redeterminations and redeterminations necessitated by changed circumstances that occur during an enrollment year and that may affect coverage
 - Covers all agencies among which alignment must take place (Medicaid, separate CHIP, Exchange, Basic Health Program if applicable)
 - Process and the use of single streamlined applications
 - Can address health plan selection, management, oversight, creation of fully integrated websites for applicants and participants, Navigator policy, information verification and data exchange
- State Exchanges also required to enter into delegation agreements with Medicaid agencies
- How broadly should the delegation agreements sweep? Will public Exchanges receive delegated full authority to make the Medicaid eligibility determination?

Eligibility Determinations and Redeterminations: Proposed Rules

- Obligation applies to enroll in correct MAGI-based affordability program, even if there may be subsequent dual eligibility for Medicaid coverage based on disability and using a non-MAGI income evaluation
 - NPRM discusses individuals “undergoing” separate disability evaluation, but what about those not currently “undergoing” such a separate evaluation?
 - How to assure that persons with disabilities who are enrolled on a MAGI-basis into a benchmark plan or QHP receive follow-up assistance with a Medicaid disability eligibility evaluation
 - How to identify persons enrolled in benchmark plans or QHPs who acquire disability status during a plan enrollment year
 - Key topic in a delegation agreement
- Absence of continuous enrollment guarantee during a benefit year mitigated by presumption in proposed rule that eligibility continues uninterrupted in the absence of available information showing changed circumstances
 - Key “issue” moving to annual eligibility periods
- Should physical enrollment points and website access portals at out-stationed locations be added?
- Navigator knowledge of all insurance affordability programs?

Coordinating Health Plan Coverage and Operations Policies

- Market Alignment Challenges
 - Coverage and benefit design
 - Common framework for plan certification and operations
 - Provider network composition and capabilities
 - Performance standards on matters of access, quality, and health outcomes
 - Use of practice innovations such as ACO/medical homes within provider networks
 - Incentivizing network provider participation across all product markets
 - Use of auto-enrollment
 - State insurance standards
 - Consumer rights and patient protections (e.g., coverage continuation pending appeals)
 - Incentives for multi-market participation by sellers of plan products
 - Role of national, multi-market health plans
 - CMS clarification on extent of alignment flexibility on QHP and Medicaid managed care certification and operation standards

| Insurance Affordability Program | Essential Health Benefits | Preventative Benefits | Pediatric Dental Care | Early and Periodic Screening Diagnosis and Treatment | 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 | Preventative benefits, including preventative 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 preventative 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 | Yes | Yes, subject to standards applicable to all health plans sold in individual and group health insurance markets | Yes | No | Yes |

Aligning Benefits and Coverage

- Benefit definition (e.g., habilitation, rehabilitation)
- Medical necessity (e.g., restoration or recovery test)
- Applicability of mental health parity
- Use of carve-out plans in the Medicaid market
- Pediatric care versus full scope of EPSDT
- Permissible limitations and exclusions (e.g., “educational”)
- Preventive services for adults (Benchmark, essential health benefits, and traditional adult coverage)