

Report on Health Reform Implementation

State Efforts to Promote Continuity of Coverage and Care under the Affordable Care Act

Heather Howard
Chad Shearer
Princeton University

Editor's Note: Thanks to funding from the Blue Shield of California Foundation and the Robert Wood Johnson Foundation, JHPPL has begun the coordination of an Engaged State Health Reform Research Network to bring together people from different backgrounds (practitioners, stakeholders, and researchers) involved in state-level health reform implementation to inform and extend health reform across the United States. A network website will document implementation projects across the country, workshops will be held, and JHPPL will publish essays under this new section based on findings emerging from network participants. All essays in the section will be published open access.

—Colleen M. Grogan

Abstract Many states have worked tirelessly over the past two years to develop health insurance exchanges and prepare for the expansion of their Medicaid programs in order to meet the requirements of the Patient Protection and Affordable Care Act. Programs to expand coverage, however, do not necessarily ensure seamlessness for many individuals who are likely to experience shifts in program eligibility due to changing circumstances (e.g., income fluctuations, family composition changes, etc.). A number of states are actively working to limit the impact of changes in program eligibility by developing policies that limit either the incidence of program eligibility changes and/or the impact those changes have on individual consumers. Various emerging state approaches take into account program history, the desire for state flexibility, and the political and operational challenges states face in developing coverage expansions that work for consumers, stakeholders, and policy makers.

Overview

The Patient Protection and Affordable Care Act (PPACA) ushered in a new culture of affordable health insurance coverage, made available through a continuum of subsidies collectively known as insurance affordability programs (IAPs) for individuals below 400 percent of the federal poverty level (FPL): Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Program (BHP) state option, and advanced premium tax credits (APTCs)/cost-sharing reductions (CSRs) for exchange qualified health plans (QHPs). To make this seamless system of coverage a reality, the PPACA requires both a single streamlined application for all IAPs and a coordinated process for IAP eligibility and enrollment.

Current estimates of the PPACA's impact suggest that in 2022, the Medicaid expansion will cover 12 million people and the health insurance exchanges will cover 25 million individuals (Banthin and Masi 2013). Despite this robust vision of a full spectrum of coverage, concerns about affordability remain, especially as low-income individuals and families face premiums and co-payments, as well as large cost-sharing increases up the IAP income scale (Fernandez and Gabe 2012). Besides being disproportionately low income, 23.8 percent report fair or poor health status, and 40 percent report one or more chronic conditions (Carrier, Yee, and Garfield 2011). Moreover, each year, up to 50 percent of the coverage expansion population under 200 percent FPL could have an income fluctuation that would change their IAP eligibility or subsidy level (Sommers and Rosenbaum 2011). Shifting between different coverage options—Medicaid and subsidized exchange coverage—risks disruptions in coverage and discontinuity in care (*ibid.*). Given income fluctuations, the health needs of newly covered populations, and the likelihood that uninsured adults may have children already covered by public programs, states have a strong impetus and many options for smoothing the differences along the coverage continuum.

States, as core implementers of the PPACA, are exploring ways to address these concerns and ensure a true continuum of affordable coverage as individuals and families transition across the spectrum of IAPs. The Centers for Medicare and Medicaid Services (CMS 2013b) has offered to work with states on these options; the options vary and states are considering many issues in evaluating the opportunities (Manatt Health Solutions 2013). Such considerations include how the state and beneficiaries could benefit, taking into account existing Medicaid program scope, underlying waivers, ability to access enhanced Federal Medical Assistance

Percentages (FMAP), Medicaid managed care penetration, the impact on providers (Medicaid vs. private rates), and the impact on the exchange pool. Beyond these operational considerations, there are substantial financial and political considerations affecting state policy making. States generally opposed to the PPACA also generally prefer market-based solutions, but those solutions may be more expensive for the federal and state government and consumers in the long term.

This process has been further complicated by the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, No. 11-393, slip op. (U.S. June 28, 2012) upholding the PPACA, which rendered the Medicaid expansion effectively optional for states and has created new opportunities for states to test the limits of their leverage with the federal government (see also Rosenbaum and Westmoreland 2012). States more politically opposed to PPACA are attempting to use flexibility around the spectrum of coverage to expand Medicaid in a way that more closely mirrors commercial insurance. Other states, however, are pushing CMS to provide flexibility that makes coverage more seamless and often more robust, like traditional Medicaid offerings, for individuals at the lower end of the IAP continuum. Several emerging approaches can help states achieve their coverage, affordability, and continuity goals and can be tailored to fit their political and operational circumstances. Specific state policy options being considered are discussed below.

State Subsidies to “Wrap Around” QHPs

Recognizing the limits of affordability on the exchange even with APTCs and CSRs, some states, most notably Massachusetts and Vermont, are considering offering subsidies to “wrap around” exchange coverage (Commonwealth of Massachusetts 2013; see also Hague 2012 and Vermont House of Representatives 2013). Instead of providing additional benefits, these wraparound options focus on reducing out-of-pocket costs for consumers by using state-only dollars to buy down premiums and cost-sharing amounts for lower-income individuals purchasing QHP coverage. This approach addresses the affordability of coverage, but not the continuity of plans or courses of care when individuals transfer between programs. Given general state resource constraints, however, the use of state-only dollars is unlikely in all but a few unique circumstances. In a few instances, such as Massachusetts and Vermont, states that had previously expanded coverage to these low-income individuals may be able to apply savings from federal Medicaid waiver dollars to fund the wrap. As such,

this option may not be applicable outside the narrow group of states that have preexisting waivers that would allow them to fund the wrap with federal Medicaid dollars.

New Programs for Specific Populations

The Basic Health Program (BHP) option (modeled on Washington State's Basic Health Plan) was included in the PPACA as a special state coverage option for low-income families and individuals. The BHP potentially would permit states to target a special coverage program for individuals below 200 percent FPL who would otherwise be eligible for APTCs to support exchange QHP coverage. The option is intended to allow states to provide more generous, Medicaid-like financial and benefit protections for individuals below 200 percent FPL than what would be available on the exchange. This option is particularly attractive to states that had previously expanded their Medicaid program above the 138 percent FPL expansion threshold that wish to protect those beneficiaries. The option may be less attractive, however, in smaller states where a BHP could reduce the number of persons in the exchange market and possibly increase costs for exchange QHPs. In February 2013, CMS (2013b) issued FAQs indicating intention to issue guidance on the BHP option by the end of 2013, with final rules in 2014; therefore, the BHP will not be an option until 2015.

Given that BHP is not an option until 2015, interested states are faced with deciding how to bridge the gap in 2014. The aptly titled "bridge plan" would allow states to create a program where families eligible for different IAPs would be covered by the same issuer, and where certain eligible individuals would not have to switch plans when eligibility changes. Based on a concept developed by Tennessee, this plan meets the dual goals of continuity of coverage within a family, and continuity of insurer and provider network, creating a "one family, one card across time" approach (Tennessee Insurance Exchange Planning Initiative 2011). Neither the PPACA nor subsequent regulations address the bridge option directly, though CMS (2012: 6) has said Medicaid managed care plans can be certified as qualified health plans for the purposes of offering a bridge plan as long as that plan agrees to certain terms. As with previous unifying plans and standards approaches, the bridge option addresses only continuity of coverage and not affordability. It is also restricted to consumers transitioning from Medicaid to exchange coverage or family members of those in Medicaid managed care.

Given these complexities, it is not surprising that only one state, California, is pursuing this option in 2014. Covered California (the state's exchange), has requested approval from federal officials to establish a three-year Bridge Program Demonstration Project, under which the exchange would contract with Medicaid managed care plans to offer QHP coverage for certain populations (Covered California 2013). Though Tennessee originated the bridge concept, it is not able to implement it because of its status as a federally facilitated marketplace and non-Medicaid expansion state. Interestingly, the state of Washington is developing a reverse bridge program called Apple Health Plus, under which QHPs would provide limited Medicaid plans that would sustain "coverage and provider network connections when family members with Exchange coverage become eligible for Medicaid" (State of Washington Health Care Authority 2013).

Purchasing QHP Coverage for Medicaid Expansion Populations

Another option for states is to create a seamless coverage continuum by enrolling Medicaid expansion populations into exchange QHPs through a program called premium assistance. This is effectively the reverse of the BHP, extending commercial QHP products down to lower-income individuals as opposed to expanding Medicaid products of the income scale. This approach would provide stability by allowing all newly covered populations to choose from the same "products" regardless of underlying Medicaid expansion or QHP eligibility. Premium assistance would not necessarily reduce the premium and cost-sharing differences during income shifts, however, and in fact could be more expensive for consumers and the federal and state governments depending on how it is implemented. Federal officials at CMS have provided guidance on this approach in response to requests from Arkansas and a number of other states exploring the feasibility of this option (CMS 2013a). Despite the significant attention Arkansas's approach has attracted from other states eager to experiment and differentiate themselves, the devil is in the operational details, since CMS requires that Medicaid expansion beneficiaries enrolled in QHPs through premium assistance continue to receive all Medicaid benefits and cost-sharing protections. This requires states to wrap around QHP benefits and cost sharing, which could cause the program to run afoul of the cost-effectiveness requirements (e.g., premium assistance costs in the aggregate must be comparable to providing coverage through Medicaid) (CMS 2013a).

Arkansas's plan to use Medicaid funding to purchase QHP coverage offered on the exchange is even more interesting given the fact that Arkansas is not running its own state-based exchange in 2014. Though the state would be purchasing coverage available on the federally facilitated exchange, it believes that it could do so in a way that meets both the wraparound and cost-effectiveness requirements, partly because of the general effect of competition among exchange QHPs (Arkansas Department of Human Services 2013a, 2013b). The Arkansas legislature approved the approach, negotiations between the state and CMS continue, and other states are waiting with bated breath to see exactly what the final plan looks like (Sellers Dorsey 2013).

Retain Historical Coverage Expansion

States can choose to maintain their existing program in 2014, either as a bridge to a potential BHP or other alternative approach in 2015. This approach may be the most attractive for continuing current program levels and providing continuity for a vulnerable population. Under this scenario, a state would maintain a popular preexisting program, thereby preventing disruption for beneficiaries and minimizing the administrative complexity of creating a new coverage model that might need to be updated yet again in 2015 or later. This option elegantly mitigates the increased cost-sharing hurdle otherwise associated with a shift to QHP coverage by providing consumers whose incomes are between 138 percent FPL and the state's existing expanded eligibility level with their current, more affordable coverage. Continuing a previous expansion would allow a state to gain experience from the first year of full PPACA implementation, including developing insights into the extent of the churn problem and the populations most affected. Despite the benefits of affordability, continuity of care, and administrative simplicity, this option carries a significant state fiscal impact, including the additional cost of continuing Medicaid coverage at the state's regular federal match and the opportunity cost of lost federal tax dollars that would have flowed to APTC recipients.

Minnesota is continuing its current MinnesotaCare program in 2014 for residents without access to other affordable health care and will pursue federal funding under the Basic Health Program (BHP) in 2015 to cover that population going forward. This approach, codified as part of the Omnibus Health and Human Services Finance bill in May 2013, allows the state to pursue a demonstration waiver that will both continue the existing

program and expand it to provide coverage for all uninsured persons between 138 percent FPL and current program income levels (H.R. 1233, 88th Leg. [Minn. 2013]). Because Minnesota had already expanded coverage to much of this population, this approach provides continuity for those already enrolled and does not carry the same level of operational and financial risk that might accompany this bridge to a BHP in other states.

Unifying Plans and Standards

Finally, some states, recognizing that subsidized QHP coverage carries the risk of churn and associated discontinuity of coverage and disruption in care, are using contract language with Medicaid managed care and QHP issuers to provide seamless plan options or to reduce the impact of plan changes. Nevada, for example, requires Medicaid managed care plans to offer at least one silver- and one gold-level QHP that meet additional MCO Transition QHP standards, such as same provider network and same geographic area for the Medicaid and QHP offerings (Scott 2013). Maryland took a different approach, requiring plans in all markets to follow strict rules around continuity of care for a course of treatment when individuals transfer between products and programs (Maryland Health Progress Act of 2013 [2013 Md. Laws 159]; Maryland Health Benefit Exchange 2013). Both approaches leverage state influence over purchasers to ensure continuity of care during transitions between IAPs, but neither approach addresses the affordability of coverage as individuals move up the IAP income scale.

Conclusion

PPACA holds great promise for creating a new culture of coverage, in which individuals and families have access to a continuum of options depending on their income. Despite this vision of seamless options, risks remain regarding affordability and the continuity of coverage and care, especially as changes in income affect IAP eligibility. As discussed above, states are continuing to explore and indeed exploit their role as laboratories of innovation, seizing on both opportunities in the PPACA and new leverage points with the federal government to adopt creative policies and programs to mitigate these concerns. The experience that states garner as they test these new approaches over the initial years of full implementation will prove important to future state and federal policy making.

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