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To: Stakeholders of the Insurance Exchange Planning Initiative
From: Brian Haile /s/
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Subj: Federal Update on Health Reform Issues

Susie Baird, Brooks Daverman and I attended the Exchange Planning Grantee Meeting on December 16-17, 2010 in Crystal City, Virginia. At that meeting, officials from the Office of Consumer Information and Insurance Oversight (OCIIO) and from the Centers for Medicare and Medicaid Services (CMS) provided a few key updates. Consistent with our commitment to full transparency, we summarize this information below for our stakeholders.

Medicaid Eligibility and Service Delivery

- **Extent of Screening:** Cindy Mann of CMS clarified that the exchange would **not** need to do a "full screening." She stated that the exchanges would **not** need to determine eligibility for long-term care and those alleging disability. She noted that the screening might be as simple as assessing adult eligibility under the 133% of the federal poverty level (FPL) standard; see "FMAP" below. [1]

- **Screening Process:** Cindy Mann emphasized that the exchange determinations would need to be "real-time" but would not elaborate on the meaning of this phrase. She also noted that CMS is reviewing the requirement that public employees determine eligibility for Medicaid. In addition, she noted that applicants for the premium assistance tax credits would first need to be screened for Medicaid and the Children's Health Insurance Program (CHIP).[2]

- **Continuous Eligibility:** Cindy Mann said that CMS was considering a 12-month continuous eligibility process for adults, but she provided no details or commitments; the CMS General Counsel is apparently reviewing this issue now.[3] On a related issue, we are also raising with OCIIO the continuous eligibility issue related to the premium assistance tax credits in order to promote consistency across programs.

[1] If true, this approach would presumably allow the exchange to qualify most Medicaid-eligible applicants as expansion adults – which has a higher FFP than the regular FMAP. Individuals that wanted "full scope" Medicaid may have to go through a more rigorous process (via Social Security and/or DHS).
[2] It is unclear whether or how CMS would enforce this requirement if an applicant affirmatively chooses not to apply for Medicaid – particularly if the individual would be eligible under categories for which the exchange may not screen.
[3] Susie Baird recalls the statements from Cindy Mann slightly differently, noting that "She [Cindy Mann] said that the law provides for continuous (12 month) eligibility for children, and that they plan to include continuous eligibility for adults in the regs."

- **PERM:**[4] Both in the larger meeting and in an offline conversation, I suggested to Cindy Mann that CMS consider granting a one-year PERM exemption for all Medicaid and CHIP eligibility determinations performed via the Exchanges. She seemed at least open to the idea as a way to allow the exchange to get their sea legs without facing federal penalties. She also and very publicly acknowledged the disconnect and contradictions between policies of CMSO and PERM, which have led states to be more conservative in their approach to verifications than she would like – and she said that CMS is already working on harmonizing the CMSO and PERM policies.

- **FMAP:**[5] Cindy Mann herself raised the issue and acknowledged the need to develop an FMAP methodology to eliminate the need for dual determinations of eligibility. Otherwise, states would have to conduct a determination for existing Medicaid categories (under the pre-PPACA[6] rules for regular FMAP) and then do a "streamlined screening" (under the post-PPACA rules for enhanced FMAP). A dual approach of this type would undermine PPACA's stated intent (and CMS' express objective) to simplify eligibility determinations. However, Dr. Mann offered no further details as to how to avoid a system of dual determinations.[7]

- **Forthcoming Rules:** OCIIO and CMS expect to issue a Notice of Proposed Rule Making (NPRM) about Medicaid/CHIP eligibility issues in Spring 2011 and a separate NPRM on the minimum essential benefit package in Fall 2011.

- **Benefit Packages:** While OCIIO indicated that the NPRM for minimum essential benefits for qualified health plans would be available in Fall 2011, several states were emphatic that the absence of this information severely constrained their ability to move forward. Likewise, states pressed OCIIO and CMS about the benchmark benefit package for Medicaid expansion enrollees (which would presumably be related to the minimum essential benefits for qualified health plans). The relationship between the benchmark benefit package and mandatory benefits for the mandatory Medicaid population was also a contentious issue. States advocated for flexibility here; see next bullet point. HHS is apparently working with the Department of Labor and the Institute of Medicine regarding these issues, but no guidance is likely in the short-term.

- **Medicaid MCOs in the Exchange:** Several states indicated that they may require their Medicaid managed care organizations (MCOs) to participate in the exchange. Several other states expressed a strong interest in allowing Medicaid-eligible individuals to select a 100% subsidy for an exchange-based insurer. At least one other state was particularly interested in serving the expansion adults via the exchange. CMS was noncommittal but may be willing to allow states to provide this as an option (in addition to the option of regular Medicaid coverage). Of course, the attractiveness of this approach is related to the CMS' definition of the benchmark benefit package for Medicaid expansion enrollees: if the benchmark benefit package resembles the minimum essential benefits for qualified health plans, then this may be worthwhile; if the benchmark benefit package more closely resembles traditional Medicaid, then this approach may not be feasible.

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[4] The Payment Error Rate Measure (PERM) is essentially the Medicaid "error rate."
[5] The Federal Medical Assistance Percentage (FMAP) is essentially the federal match rate for Medicaid expenditures.
[6] The Patient Protection and Affordable Care Act (PPACA), as amended, is the official title of the federal health reform bill enacted in March 2010.
[7] Depending on the screening requirements in the exchange (see above) and the nature of the benchmark benefit package (see below), this may become less of an issue.

IT/Systems

- **New MMIS[8] Vision:** Federal officials from both CMS and OCIIO repeatedly referenced the recent information technology (IT) guidance provided to States.[9] They stressed that this guidance would govern all future IT policy directives and related decisions at the federal level.

- **Federal Data Hub:** OCIIO confirms that HHS is working on single interface through which States will be able to access individual-level data to verify an applicant's citizenship/alienage status, Social Security benefit information, tax information, etc.

- **Expedited Advance Planning Documents (APDs):** Henry Chao and other officials from CMS talked extensively about the expedited APD process for new eligibility systems and the availability of 90/70% FFP for "eligibility claims" systems. Henry Chao also indicated that the new APD form/process description would soon be available. They indicated that CMS would not approve APDs for other projects unless these APDs conform to CMS' new vision. Henry Chao is expecting states to be extremely aggressive in their IT procurements (he was not convinced that the state RFP process needed to exceed six months). Some states commented that it would be unwise or infeasible to undertake a comprehensive overhaul of IT in the compressed timeframe of health reform.

Insurance Market Structure

- **Individual and Small Group Market Consolidation:** State officials agreed that the existing actuarial studies of the consolidation of the individual and group markets may not be generalizable to other jurisdictions. The studies from New York and Vermont both took place in the context of a community-rated insurance market, which is not the case for virtually all other states. For this reason, states are unsure how to proceed and may conduct separate (and arguably redundant) analyses for each market.

- **Group Size:** States were roughly evenly split as to whether to exercise their option under PPACA Section 1304(b)(3) to define "small groups" as 50 or fewer employees.[10] At least one state expressed an intent to expand the exchange to groups of 100+ employees in advance 2017 as permitted by Section 1312(f)(2)(B); one other state indicated that it may provide public sector employee health insurance coverage via the exchange in advance of 2017.

- **Benchmark Plans:** Oregon discussed its approach in which all insurers with at least 4,000 lives in the Oregon market are required to offer a "benchmark plan" as defined by the State. Few individuals actually purchase the plan, but the benchmark approach apparently helps to estimate actuarial value/equivalence of plans. They recommended that other states consider this type of approach by requiring insurers inside and outside

[8] The Medicaid Management Information System (MMIS) is the Medicaid claims payment system.
[9] See "Guidance for Exchange and Medicaid Information Technology (IT) Systems" (November 3, 2010), available online at http://www.hhs.gov/ociio/regulations/joint_cms_ociio_guidance.pdf and related Notice of Proposed Rulemaking at 75 Fed. Reg. 68583-95 (November 8, 2010), available online at http://www.gpo.gov/fdsys/pkg/FR-2010-11-08/pdf/2010-27971.pdf.
[10] It may be possible to define "small groups" as 50 or fewer employees for for-profit businesses and 100 or fewer employees for non-profit organizations. This may be worth discussing.

of the exchange to offer the benchmark plan(s).[11] Note: This concept is separate and distinct from the Medicaid benchmark benefit package.

- **Risk Adjustment:** OCIIO staff members appeared surprised by the suggestion that insurers might use risk adjustment, risk corridors, and reinsurance to manipulate the calculations of their medical loss ratios. OCIIO officials initially stated that risk adjustment, etc. would be exclusively a federal function; however, we explained that the PPACA did not limit state authority to engage in parallel risk adjustment structures. Further, one other state strongly spoke in favor of a locally-developed system that was market-specific and driven by technical experts. We also discussed the possibility of limiting risk adjustment and reinsurance payments to plans within the exchange so as to encourage participation and mitigate adverse selection risk.

Exchange Operations

- **Enabling Legislation:** States are roughly equally divided as to whether OCIIO should require the passage of enabling legislation as part of the February 2011 solicitation. OCIIO now seems to understand all of the relevant concerns; it is unclear how they will proceed.

- **Employer/Employee Choice Restrictions:** OCIIO staff members acknowledged that PPACA Section 1312(a)(2) could be interpreted expansively so as to allow employers to specify both the coverage level (e.g., platinum, gold, etc.) as well as carrier and possibly even benefit design. In fact, they initiated the discussion of this topic with state officials because they are interested in whether such an interpretation would help to minimize risks of adverse selection within the exchange. However, OCIIO staff members were noncommittal as to whether this was the official federal position and/or when they might provide guidance on this point. One state spoke of its recent experience, which argued in favor of allowing employers to choose benefit tier, benefit design, and carrier in order to mitigate risks of adverse selection. Additionally, another state noted that employers would need to determine how to comply with Family Medical Leave Act (FMLA) and Health Insurance Portability and Accountability Act (HIPAA) requirements related to health insurance, and such compliance could become prohibitively complicated if employees had unrestrained choice of plans on the exchange.

- **List vs. Composite Billing:** OCIIO staff seemed amenable to deferring to the states on the question of whether to allow list versus composite billing structures within the exchange. The exchange could presumably provide employers with a choice of a list versus composite bill – and allow them to set the percent contribution for premiums.[12]

- **Individual and Small Group Exchanges:** States will have the flexibility to allow insurers to participate in the individual and small group markets. However, states may want to require those participating in the small group market to also provide individual coverage via the exchange so as to promote portability.

[11] Of course, the benchmark plan would also have to meet the criteria as a qualified health plan under the PPACA.
[12] Utah noted that some employers may prefer to pay flat amounts for each employee even in a list-billing situation. However, this approach may run afoul of federal discrimination laws (e.g., Age Discrimination in Employment Act or ADEA) because of the age-adjusted structure of the premiums. This may require additional research.

- **Banking Vendor:** While not discussed explicitly, it appears clear that the structure of the exchange will require States to engage a banking vendor (e.g., to collect initial premiums from individuals and employers and remit insurers, etc.). Utah has already implemented such a contract; other states may be able to replicate and/or use requests for proposals (RFPs) or contracts for their Electronic Benefit Transfer (EBT) vendors that provide electronic debit cards for beneficiaries Food Stamps and other programs.

Qualified Health Plans

- **Benefit Mandates:** OCIIO has not provided definitive guidance as to whether any willing provider (AWP) laws are "additional benefits" within the meaning of PPACA Section 1311(d)(3).[13] If OCIIO determines that AWP are additional benefits, then states would be responsible for 100% of the actuarial costs associated with the AWP requirements -- at least to the extent that the AWP requirements apply to qualified health plans provided via the insurance exchanges.

- **Network Adequacy Standards:** OCIIO remains noncommittal about network adequacy standards. We are concerned that network standards would be difficult to promulgate across markets – and that stringent standards would substantially increase negotiating leverage of certain providers, thereby inflating health care costs. Several state officials suggested that OCIIO limit any minimum standards to primary care providers (inclusive of OB/GYN, internists, etc.) and defer to States as to the rest.

- **Network Choice:** OCIIO is just beginning to consider that insurers may wish to bid separate networks as distinct product offerings. They offered no guidance as to how to address these and related issues.

[13] We subsequently followed up with OCIIO to request clarification. As a general rule, though, OCIIO is not providing guidance on policies that are going to be addressed in regulation in the next couple of years.