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Georgetown UNIVERSITY Health Policy Institute

Implementing Health Care Reform: Key Questions for States

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Under health care reform, the federal government is tasked with establishing the framework under which many provisions of the law are implemented. Within this framework, though, state policymakers will make many key decisions and serve as critical partners in the implementation process. States must begin planning soon for the bulk of reforms that go into effect in 2014. In fact, there are many key decisions that states can begin to consider now to ensure ultimate success. The following provides a "starter list" of the most immediate questions for state policymakers and the child and family advocates working with them to contemplate.

Planning and Funding

• What type of planning and decision-making body will the state establish for implementing health reform? States have primary responsibility for governance and operation, within federally set standards, of key components under the law, including decisions related to the exchanges and public program structure. Development of strategic and operational plans, along with an assessment of needed resources, are critical to the successful and smooth implementation of health reform.

• How will the state ensure representation from consumers, advocates, and other stakeholders? A state will want to build a process for ensuring that consumers and groups working on behalf of child and low-income constituencies have a real voice at the table. The health reform law, in fact, requires that states consult with stakeholders when designing and establishing the exchange structure and functions.

• Will the state apply for a planning grant to establish the exchanges? States will receive federal funding by March 23, 2011, for planning and start-up costs required to establish the exchanges. The application process will start prior to that date. Applying for this funding (and seeking renewal each year) is critical for states – and will serve as an important early look at which states are making forward movement. If a state fails to establish an exchange, the federal government will set up and operate an exchange in the state. Since this decision could be made as late as a year before the exchanges are operational in 2014, states that do not establish their own exchanges could be at a possible disadvantage in terms of planning and coordination.

• How will the state assist families in navigating health care reform? The media attention surrounding health care reform has already left families confused about their coverage options. There is funding available beginning this year for states to establish or support consumer assistance offices and health insurance ombudsman programs. Applying for this funding will allow states to educate and assist families in obtaining health coverage now (through Medicaid, CHIP, high-risk pools, etc.), monitor whether insurance plans are effectively implementing the reforms in place this year (such as the elimination of pre-existing conditions for children), and set the stage for educating consumers about new coverage options available to them in 2014. (Exchanges also are required, beginning in 2014, to provide "navigator" grants to community groups to provide outreach and enrollment assistance.)

Exchanges

• What will exchange governance structures look like? The federal law is silent on the specifics of what type of oversight body and staff leadership the exchanges must have. While further guidance will be forthcoming, a state will want to consider the composition of an exchange board or similar body; specifically, how it will ensure representation by consumers and child and low-income advocacy groups. In addition, a state will need to determine whether insurance companies will be represented.

• How will the exchanges be administered and will certain or all tasks be contracted out? It is not too early to determine how a state will ramp up its efforts to ensure that the exchanges are fully operational by 2014. One option a state can consider is using the Medicaid or CHIP agency to administer exchange functions, particularly eligibility for tax credits and cost sharing subsidies, since they already have many of the required structures in place.

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• How will the exchanges be sustained financially? The federal start-up funding is available only through December 31, 2014 (the first year of operation), since the exchanges are meant to be self-sustaining. States can generate funds to run the exchanges through fees charged to participating health insurance plans, or other means as they determine.

• What geographic region will the exchanges cover? Smaller states may want to consider setting up multi-state exchanges, as allowed under the law. Under this scenario, governance issues and plan regulation become even more critical because of the need for cross-state work. States also have the option to establish, within some parameters, subsidiary exchanges for geographically distinct areas. This may be an option for larger states, but only if the pool of people remains large enough to sufficiently spread risk among participants (see further discussion following).

Private Insurance Marketplace

• How can the state ensure that insurance reforms are working for children and families? A primary component of the health reform law is a set of insurance reforms that will make it easier for individuals and families to get and maintain health insurance. Most reforms go into effect in 2014, but some are effective earlier (such as requiring that all new plans after September 23, 2010 provide "Bright Futures" preventive care with no cost sharing). States will want to consider strong monitoring and oversight to ensure that the reforms work as intended.

• How will states structure the exchanges to be strong players in the insurance market? Exchanges will only be successful if they are large enough to minimize adverse selection, attract high quality plans, generate administrative efficiencies, and use market clout to negotiate lower premiums. States will want to consider combining their individual and small employer exchanges into one "risk pool," defining employers as those with 100 or more employees (instead of taking up the option to limit employer size), and applying market reforms equitably in and outside the exchanges so that plans do not have a disincentive to participate in the exchanges.

• How will the state minimize the potential of adverse selection among plans in the exchanges and between the markets in and outside of the exchanges? Because "grandfathered" plans are exempt from certain insurance reforms and health plans can operate exclusively outside the exchanges there is a risk that the exchanges will attract sicker and more costly individuals. This can result in ever-rising premiums, making coverage unaffordable and threatening the long-term viability of the exchanges. States can minimize adverse selection by establishing a large enough risk pool in the exchanges and enacting conforming market protections in the state-regulated market outside the exchanges so that there is more of a level playing field. States also have a critical role in ensuring compliance and oversight of new risk adjustment, reinsurance, and risk corridor provisions. Inside the exchanges, states will also need to monitor and adjust for adverse selection among exchange plans, particularly if sick and healthy enrollees gravitate to different plan tiers.

Medicaid/CHIP

• How can the state best continue to make progress on enrolling children and families already eligible for Medicaid and CHIP while it prepares for the 2014 eligibility changes? The attention devoted to planning for 2014 should not distract states from continuing progress to enroll uninsured children and parents in health coverage for which they are already eligible. In fact, states can take advantage of public interest in

health reform to reach those who may not realize they are already eligible for Medicaid and CHIP. Enrolling more eligible individuals now will help ease the transition to broader coverage later.

• How can the state most efficiently ensure strong linkages between the exchange and Medicaid/CHIP? Aligning the enrollment and renewal processes will be vital to ensuring a true "no wrong door" in which families are not bounced back and forth between programs. States should put at the top of their list whether there are any changes needed to Medicaid/CHIP to allow for this coordination. For example, a state with enrollment periods shorter than one year in Medicaid or CHIP may want to move to annual renewals to better align with exchange coverage and the tax credits.

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• How can a state begin to build the technological infrastructure needed for a coordinated and seamless enrollment and renewal system for families? Medicaid, CHIP, and the exchange tax credits and subsidies are integrally linked in health care reform – families are meant to apply to all programs using a single online application. To make this a seamless system for families – and to cut down on administrative difficulty on the backend – states will want to consider their technological capacity for creating these linkages. While federal guidance should provide some assistance, a state can consider setting up a working group now to begin to build these systems. A state can pave the way toward electronic interfaces by implementing Medicaid's and CHIP's proven automated linkage with the Social Security Administration, as allowed under CHIPRA to verify applicant citizenship status.

• Does the state want to cover certain individuals through a "basic health" program rather than the exchanges? States can choose to negotiate with health plans to provide coverage (at benefit and premium cost sharing levels allowed under the exchanges) to those not eligible for Medicaid with income between 133 and 201 percent of the FPL. These states will receive 95 percent of the federal funds that would have been paid toward enrolled individuals' exchange subsidies. This option may be particularly appealing to states that already cover adults at these income levels or those wishing to coordinate coverage for this population within the Medicaid structure (and potentially cover children and parents together).

• Does the state want to implement Medicaid reforms early for adults? In 2014, adults with income below 133 percent of the FPL will be eligible for Medicaid. States have the option to move early to provide this Medicaid coverage to adults. For this population, states will receive the regular Medicaid matching rate until January 1, 2014, and then will qualify for even more generous federal support.

• Does the state want to implement Medicaid and CHIP reforms early for children? States can immediately (prior to 2014 when states will be required to do so) move children currently receiving CHIP coverage below 133 percent of the FPL to Medicaid where they will receive important EPSDT benefits. Since CHIP funds can be used for Medicaid expansions, states can continue to secure the CHIP enhanced match between now and 2014, and likely thereafter. In addition, states now have the option to provide CHIP coverage to children of state employees as long as a state meets certain requirements in regards to its employee coverage.

Georgetown Center for Children and Families (CCF) is an independent, nonpartisan policy and research center who mission is to expand and improve health coverage for America's chidlren and families. CCF is based at Georgetown University's Health Policy Insitutute.

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