



Health Insurance Exchanges: New Coverage Options for Children and Families

by Dawn C. Horner and Sabrina Corlette

Executive Summary

State-based “exchanges” will provide individuals and small businesses with affordable health insurance coverage. All non-incarcerated U.S. citizens and lawfully present immigrants, as well as small businesses with up to 100 employees (with state option to initially limit to smaller firms) will be eligible for exchange coverage. Tax credits will be available to help families and individuals purchase exchange coverage if they have annual incomes up to 400 percent of the FPL and are not eligible for a public program or have affordable employer coverage. Those at lower incomes will also receive cost sharing subsidies and stronger limits on out-of-pocket costs.

States will receive federal funding to establish exchanges by 2014 and will have significant flexibility to decide how to operate them. If a state elects not to or fails to establish an exchange, the federal government will set up and operate an exchange in the state. If states operate their own exchanges, they must ensure they are self-sustaining after 2014. A governmental or nonprofit agency must run the state-based exchange and it should be designed with consumer and other stakeholder input. States have options to:

- Set up separate exchanges for individuals and small businesses or serve both populations in the same exchange;
- Establish regional exchanges with other states and/or operate multiple exchanges within their boundaries to serve geographically defined areas;
- Enact conforming market protections and plan requirements in the state-regulated market outside the exchanges to help mitigate adverse selection within the exchanges; and

- Implement an alternative state Basic Health Program for those who are ineligible for Medicaid/CHIP and have incomes up to 200 percent of the federal poverty level.

Exchanges will have primary responsibility to:

Screen and certify health plans as “qualified” to participate in the exchange and oversee plan practices related to marketing, adverse selection, network adequacy, premiums, and quality.

Assist people and small businesses in making informed health care decisions by providing uniform information to consumers on costs, benefits, provider networks, and other relevant data. In addition, exchanges must set up a toll-free hotline and help people secure coverage through a “navigator” program and consumer assistance grants.

Implement and operate eligibility, application, and enrollment procedures for those seeking exchange coverage and/or the tax credits and cost sharing subsidies.

Create seamless eligibility and enrollment linkages with Medicaid and CHIP by utilizing a single streamlined application and new income standard for individuals or families applying for coverage, as well as building electronic interfaces to verify, establish, and update eligibility for Medicaid, CHIP and tax credits.

Administer key features in the law by certifying who is exempt from the individual responsibility requirement and penalty for failing to have coverage, and who is eligible for exchange coverage due to employer coverage being unaffordable.

State-based “exchanges” will provide individuals and small businesses with affordable health insurance coverage.

The design choices states will make will have major implications for all of those served by the exchanges, including children. These include strong protections against adverse selection into exchange plans, active oversight and monitoring of plan performance and quality, and the provision of clear information to consumers on their health coverage options. Additionally, it is important that available child-only plans work as intended and that the specialized benefit needs of children are adequately addressed.

Children and families will face some unique challenges in navigating the new health reform world. Families could be “split” with children in Medicaid or CHIP and parents in the exchanges. And due to changing family circumstances, families could find themselves moving back and forth between exchange and Medicaid and CHIP. To ensure that the exchanges work for children and families, federal officials and states will want to consider a number of steps.

- Build ongoing relationships between the exchange, Medicaid and CHIP officials, and children’s health advocates, and consider whether to house responsibility for the tax credit and cost sharing subsidy eligibility process with Medicaid.
- Apply policies that will facilitate the development of a “no wrong door” enrollment system, including aligning, to the greatest extent possible, Medicaid/CHIP rules and verification requirements and creating simple and efficient procedures for families to report “changes of circumstances.”
- Build coordination between the delivery systems used by exchange and Medicaid and CHIP plans, including offering the same plans and creating overlapping provider networks.
- Support the development of dynamic technology applications that will facilitate the connection between the programs and place less of a burden on families navigating in between.

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Introduction

A key feature of the Patient Protection and Affordable Care Act (ACA)¹ is state-based “exchanges.” These new health insurance marketplaces are designed to provide uninsured (and in some cases underinsured) individuals and small businesses with the ability to purchase affordable health insurance coverage for themselves and their employees respectively. States that establish and operate exchanges will do so within federal guidelines, although states will have the flexibility to make a number of distinctive design choices.

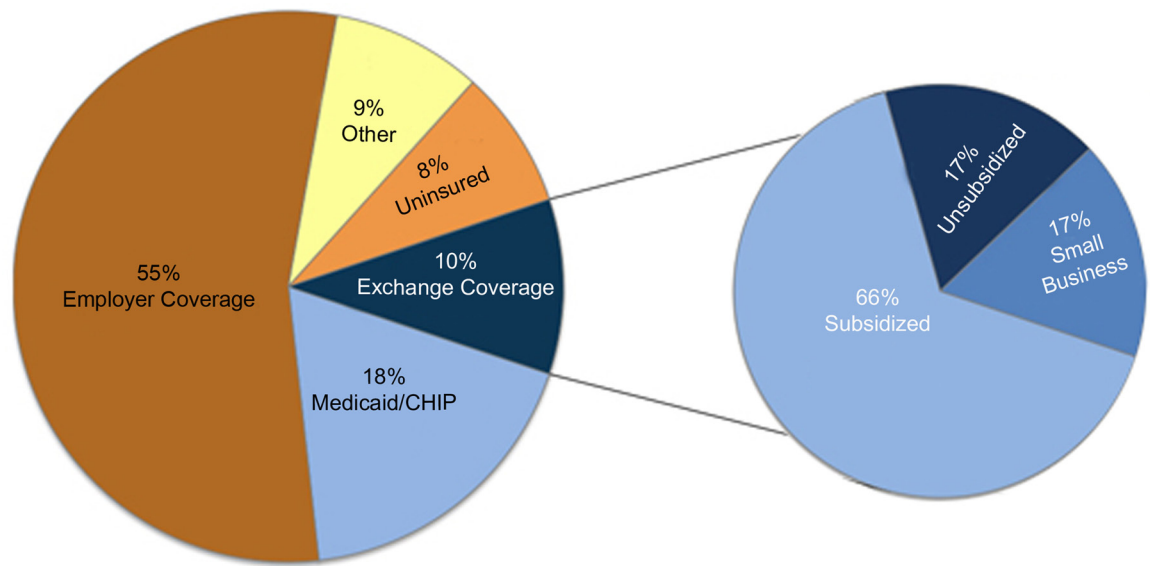
The state-based exchanges are designed to function almost like large employers’ human resources departments, albeit on a much larger scale. For example, the exchanges will work with insurers to provide individuals and families with a vetted selection of health plans meeting standards related to quality, cost, access, and benefits. Individuals and families will be able to comparison shop for the best coverage options available to them, and in most cases, will receive federal financial assistance (in the form of premium tax credits and cost sharing subsidies) to help them purchase that coverage. The exchanges (like many large purchasers) will also have the authority to use their clout to drive plan improvements, including quality of care and premium cost savings.

Overall, some 29 million people are expected to secure coverage through exchanges by 2019. Of these, 19 million will receive coverage with premium assistance, 5 million will receive coverage with no premium assistance, and 5 million will enroll through their small business employer.² (See figure 1.)

For families with children, exchanges will offer an important new route to affordable coverage not available before on the individual market. While many of the decisions made about exchanges will have implications for the broader population, some will have specific ramifications for children with families. Of particular importance is the extent to which exchanges build seamless connections with Medicaid and the Children’s Health Insurance Program (CHIP), which serve one in three of the nation’s children.³

This issue brief summarizes the exchanges, the options available to states and states’ primary responsibilities—with a particular focus on the implications for children and families.

Figure 1. Sources of Coverage After Health Care Reform Implementation, 2019



Source: Georgetown Center for Children and Families analysis of Congressional Budget Office, “H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation),” March 20, 2010.

* Other includes Medicare and individual coverage outside the exchange.

Overview of Exchanges and State Choices

States are charged with establishing exchanges for individuals and small businesses by January 1, 2014. The principal responsibilities of the state-based exchanges will be to:

1. Screen and select health plans, based on federally-defined standards, for eligibility to participate in the exchanges, and promote higher quality, more cost-effective care.
2. Assist people and small businesses in making informed decisions about their coverage options.
3. Implement and operate application and enrollment procedures, including the determination of applicants' eligibility for premium tax credits and cost sharing subsidies.
4. Create seamless eligibility and enrollment linkages with Medicaid and CHIP.
5. Help administer other key features of the new law, including the individual and employer responsibility requirements.

The federal government (primarily through regulations released by the Secretary of Health and Human Services) will establish the general framework under

which the exchanges will operate. However, the success of the exchanges depends heavily on states and the decisions they make. (See figure 2.)

Funding. States will receive federal funding for planning and initial start-up costs associated with the exchanges (as well as other related provisions of the ACA). The first round of funding (up to \$1 million per state over a 12-month period) will be distributed by September 30, 2010 via an application process. Guidance on further funding is expected in 2011.⁴ The Department of Health and Human Services (HHS) will likely utilize the funding process to identify states that choose not to or fail to establish exchanges, at which point the federal government will set up and operate an exchange in the state directly or by contracting with a nonprofit group. The health reform law provides HHS with the authority to make this decision no later than January 1, 2013.

The federal funding will be available only through December 31, 2014 (the end of the first year of operation of the exchanges), as the exchanges are meant to be independent and self-sufficient starting in 2015. One of the decisions for a state is to determine how it will fund the ongoing operations of its exchange(s), which could include fees on health insurers.

States will have a number of threshold choices to make in regard to how the exchanges will operate.

Design Decisions. In addition to a long-term funding source, states will have a number of threshold choices to make in regard to how the exchanges will operate. These include:

- **Scope and geographic area.** States have flexibility in determining the basic framework for operating the exchanges. A state can establish separate exchanges to serve individuals (and families) and small businesses or a single combined exchange that serves individuals and small businesses together. (Small businesses are defined as those with up to 100 workers, although states can elect to limit participation to employers with 50 or fewer workers in 2014 and 2015).⁵ A state can also join with other states to create a multi-state regional exchange. Or alternatively, states can establish subsidiary exchanges within geographically distinct areas within the state. In making these choices, a state will most likely want to take into account its unique demographics, policy environment, and current health insurance marketplace. A particularly important factor in any decision-making will be whether the chosen exchange structure has a sufficient number of enrollees to be sustainable and to limit adverse selection. (See further discussion below on adverse selection issues.)
- **Administration.** A state can elect to operate its exchange(s) as a governmental agency or a nonprofit, or a combination of the two. States can contract out certain, or all, tasks, although they cannot contract with a health insurance company. Recognizing the established history of Medicaid agencies in administering subsidized coverage programs, the law specifically

allows states to use Medicaid to administer exchange functions or tasks, including determining eligibility for the tax credits and cost sharing subsidies. In addition to the primary functions of the exchanges, the chosen administrator will have to maintain financial accounting systems within the purview of HHS.⁶

- **Consumer input and governance structures.** While the federal law is silent on what type of oversight body and staff leadership the exchanges must have, states will need to establish the structure and composition of such bodies. This is an important avenue for ensuring that the exchanges include representation from consumers and other stakeholders, including those speaking for the interests of children and families. The law also gives a strong nod to the involvement of these groups, specifically requiring exchanges to consult with the following stakeholders in carrying out its activities: consumers, small businesses, state Medicaid offices, and individuals or organizations working on behalf of hard-to-reach populations or that have experience in enrollment activities.

- **Market interactions and adverse selection.**⁷ The health reform law does not eliminate the existing small employer and individual insurance markets. The existence of different markets inside and outside of the exchanges has some critical implications for state exchanges. Primarily, states will need to grapple with how they can mitigate situations in which sicker, and more costly enrollees, are steered to the exchanges from the other pre-existing markets (referred to as adverse selection) and how they can ensure that plans have no disincentive to participate in the exchanges.

Figure 2. State, Exchange, and Federal Responsibilities

States	Establish exchanges, determining who will operate them; apply for federal funding for planning and start-up costs in first year; make decisions about long-term funding, scope and geographic area, and governance structures; address issues of long-term stability, including whether to apply market reforms outside of the exchange.
Exchanges	Select, monitor, and oversee the quality of plans; help families navigate coverage options; administer eligibility for and enrollment in premium tax credits and cost sharing subsidies; coordinate with Medicaid/CHIP; help to administer individual and employer responsibility requirements.
Federal Government	Establish minimum criteria for plans that can be offered in exchanges; fund planning for start up of exchanges; operate exchanges in states that elect not to or fail to do so; establish standards for consumer assistance; develop eligibility and enrollment procedures and systems; monitor and oversee exchange compliance and financial stability.

Most notably for children, the essential benefit package must provide services specifically geared toward them, including pediatric oral and vision care, prenatal and postnatal care, and habilitative services.

As referenced, ensuring that the exchanges serve a sizeable population will help to spread risk among a larger pool, and lessen adverse selection.

Additionally, the law attempts to level the playing field among the different markets by requiring that most, but not all, plans inside and outside the exchanges, implement the same insurance reforms (e.g., guaranteed issue and rating rules).⁸ Health plans in the exchanges must also treat individuals in all of their plans (whether inside or outside the exchange) as part of a single pool and charge the same premium for the same plan inside and outside the exchange. However, since these rules (and other exchange plan requirements) do not apply to plans operating exclusively outside of the exchanges, and there is no requirement that insurers offer the same plan inside and outside of the exchanges, states should consider enacting conforming market protections and plan requirements in the state-regulated market outside the exchanges. States also have a critical role in ensuring compliance and oversight of new risk adjustment, reinsurance, and risk corridor provisions that will be established to mitigate the financial risk to health plans of providing coverage to more costly enrollees.⁹

- **Alternative state health plan.** Under the ACA, states can also choose to implement a Basic Health Program (BHP) that provides coverage to children, parents, or adults who otherwise would be covered through the exchanges, specifically, those not eligible for Medicaid with incomes up to 200 percent of the FPL. States would negotiate with health plans to provide the coverage (at a minimum, the coverage must be as strong as what is available through exchange plans as it relates to benefits, premiums, and cost sharing levels) and receive 95 percent of the federal funds that would have been paid toward exchange subsidies. If implemented in a state, coordination between the BHP, the exchanges, and Medicaid and CHIP will be critical.

Primary Exchange Responsibilities

The exchanges have five key areas of responsibility under the health reform law. They are required to screen and certify participating health plans; assist consumers in making informed choices concerning their health coverage; operate application and enrollment procedures; create seamless linkages with Medicaid and CHIP; and administer the personal and employer responsibility requirements. All of these areas are described in more detail below.

1. Screen Participating Health Plans and Promote Higher Quality, More Cost-Effective Care

A vital role of the state-based exchanges is certifying which plans can participate. At a minimum, the ACA requires that all health plans wishing to sell coverage in the exchanges offer at least an “essential health benefit” package (as defined by HHS).¹⁰ The exchanges will offer four benefit “tiers” (bronze, silver, gold, and platinum) that will be differentiated in terms of the costs to consumers.¹¹ The health insurers that offer exchange plans will offer individual and/or family policies. The law also requires plans to offer child-only policies, reflecting that policymakers wanted to ensure that children could still secure coverage (at a lower cost than an individual adult policy would provide) even if their parents are covered through other means (e.g., via an employer) or are ineligible for an exchange plan (e.g., parents who are undocumented immigrants).

Most notably for children, the essential benefit package must provide services specifically geared toward them, including pediatric oral and vision care, prenatal and postnatal care, and habilitative services. Beyond the essential benefits packages, exchange plans must provide children with a comprehensive package of preventive care services (referred to as Bright Futures), including immunizations, well-child visits, vision and hearing tests, health and behavioral assessments, and developmental screenings, with no cost sharing.¹²

These federal standards are only a floor and states can require plans to cover services for adults and children that are not in the minimum package, although they must fully offset any additional premium costs. In fact, a number of states already have policies mandating that plans cover specific services, some of them critical to children. For example, 16 states and the District of Columbia mandate that insurers offer at least some level of services for autism in the policies sold through the individual market.¹³ While some of these requirements may correspond to the essential benefits package, others may not, and states will face decisions on whether to maintain these existing mandates.

Additionally, exchanges must ensure that participating plans comply with federally-defined standards such as meeting marketing requirements, not designing benefit packages intended to lead to adverse selection, providing an adequate choice of providers in their

Exchanges have broad responsibilities to ensure that consumers can make informed health care coverage choices.

networks (including essential community providers), being accredited by a quality assurance entity like the National Committee for Quality Assurance (NCQA), and implementing a quality improvement strategy. States have broad authority, however, to also exclude plans if doing so is “in the interests of” individuals and employers in the state. States will need to make early assessments about whether to apply only the federal standards, which could broaden the array of available plans, or whether to take on a more robust role in selecting and/or negotiating with plans in the interest of consumers, such as limiting participation only to the plans that are deemed to deliver the highest value.

As with most employer and individual plans outside the exchanges, the exchange plans must also abide by a set of insurance reforms. For example, insurers will no longer be able to deny coverage, restrict benefits, or charge more based on a person’s health status or gender. States will continue to have the authority to oversee insurer compliance with these new rules (whether they operate inside or outside of the exchange).

The ACA also envisions that the exchanges will use their new market clout, in combination with provisions in the law, to play a more expansive role in facilitating marketplace reforms, particularly those related to quality of care and cost. The effectiveness of these new tools will depend on how proactively the exchanges use them when negotiating with plans. For example, to encourage quality improvement, plans in the exchanges must implement provider reimbursement strategies to improve quality and must report on efforts to improve health outcomes and other quality measurements. In addition, to keep premiums affordable, plans are required to post information about premium increases and the justifications for those increases. Exchanges will be able to exclude plans that propose unjustified increases.

2. Assist People and Small Businesses in Making Informed Health Care Decisions

Exchanges have broad responsibilities to ensure that consumers can make informed health care coverage choices. Most notably, families and individuals will be able to comparatively shop for their coverage due to new rules that require all plans in the exchanges to

submit standardized information (per federal guidance) on benefits, cost sharing, and other plan specifics. The information must also be easily understandable and culturally- and linguistically-appropriate, to better assist consumers with navigating their insurance choices.

Other consumer-oriented information exchanges will provide, within federal guidelines, include: a comparison rating system of each health plan based on relative quality and price of benefits; consumer satisfaction survey results; and an electronic calculator to determine the actual cost of coverage after premium credits are taken into account.

The ACA envisions that consumers will primarily access this information, and ultimately sign up for coverage, through a new web portal.¹⁴ However, consumers will also be able to enroll in coverage in-person, through the mail, or through a toll-free hotline, pathways that should have the capacity to provide “live” or printed consumer information.

While the ACA requires that exchanges facilitate Medicaid and CHIP enrollment for those eligible for the programs and entering the exchanges, there are no parallel consumer information requirements for this population. States will want to carefully consider how best to provide these consumers with compatible user-friendly information on Medicaid and CHIP so that they, too, can make informed health care decisions (this will be especially critical for “split” families where parents are eligible for exchange plans and their children are eligible for Medicaid or CHIP).

The ACA also creates two community assistance programs that can be used to assist persons in navigating the health insurance options available to them, including Medicaid and CHIP.

- **Navigator program:** Exchanges must fund and operate a “navigator program” that awards grants to local groups¹⁵ to provide public education activities, distribute materials, facilitate enrollment, and provide referrals to state consumer assistance agencies.

- **Consumer assistance grants:** Federal grants will be provided to states, starting in fiscal year 2010, to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs.¹⁶

3. Implement and Operate Eligibility, Application, and Enrollment Procedures

U.S. citizens, lawfully present immigrants,¹⁷ and small businesses will be eligible to purchase coverage in the exchanges.¹⁸ Undocumented immigrants are not allowed to purchase coverage even with their own funds. Because plans must comply with the broader insurance reforms previously referenced that guarantee coverage, parents should not have to worry about whether they or their child's health status will affect their eligibility for coverage.

One of the major benefits of purchasing coverage through an exchange is that enrollees can receive premium tax credits and cost sharing subsidies. And small businesses that newly offer coverage to their workers and purchase it through the exchanges will be eligible for temporary tax credits.¹⁹

Financial assistance for individuals and families is available only to low- and moderate-income people without other health coverage options. These other options include eligibility for Medicaid, CHIP, TRICARE, veterans' benefits, other public benefits, or employer-based coverage that meets minimum affordability standards (discussed in more detail below).²⁰ Specifically, those not eligible for these other coverage options with incomes up to 400 percent of the federal poverty level (FPL) will be eligible for refundable tax credits to help them buy coverage.²¹ In addition, cost sharing subsidies (that effectively lower out-of-pocket costs like co-payments, deductibles, and co-insurance) will be available to such individuals with incomes below 250 percent of the FPL.²²

Families will be able to apply for coverage and the tax credits and cost sharing subsidies through a number of doorways. HHS is charged with developing the procedures that exchanges must follow to determine a person's eligibility for the tax credits and cost sharing subsidies, in addition to Medicaid and CHIP, and enroll them in coverage. But states and exchanges will have a critical role to play in setting up these procedures, working across agencies to verify eligibility and create seamless linkages with Medicaid and CHIP, and ultimately, in ensuring that the systems work for consumers.

The ACA provides a very broad framework on how these procedures will work. The following reviews those provisions specific to the tax credits and cost

sharing subsidies, with the following section looking more closely at the role of exchanges in coordinating with Medicaid and CHIP.

- **Enrollment periods.** Persons will enroll in exchange coverage (whether with or without a subsidy) during specific enrollment periods, much like they would if they had employer-sponsored insurance. Enrollment periods will be based on the calendar year with special enrollment allowed for changes in circumstances, such as birth of a child.²³

- **Applicant information.** Reflecting policymakers' interest in keeping the application process as simple as possible for families, the ACA specifies a relatively narrow set of information that exchanges are expected to seek from persons applying for coverage through the exchange: (1) name, address, and date of birth; (2) SSN and, if a lawful immigrant, other documents attesting to immigration status; and (3) employer coverage information, if applicable. Those seeking the premium tax credit or reduced cost sharing also will submit information on income and family size based on the previous taxable year, in addition to information on any change in circumstances since completing their tax return.²⁴

Under the ACA, HHS is required to develop a single application that individuals or families can use to apply for the exchange subsidies, Medicaid, CHIP, or a BHP. While the law does not specifically address what additional information will be needed to make a Medicaid, CHIP, or BHP eligibility determination, the application will most likely need to ask for information beyond what is required for exchange coverage. (See further discussion below.)

- **Verification.** To further simplify the process for families, the ACA requires HHS to establish a verification system for exchange coverage that relies on automated and electronic data matching to verify applicant information. For example, information for determination of the subsidies will be sent to the Internal Revenue Service for verification of household income and family size; and to verify citizenship and immigration status (even for those not applying for subsidies), to the Social Security Administration and/or Department of Homeland Security. The exchanges also will be responsible for addressing any inconsistencies identified through this verification process, including providing applicants with the opportunity to correct any unverifiable information.²⁵ The intent of the ACA

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is to decrease the burden placed on families to gather and submit paper documentation. However, to build these new pathways and create seamless linkages with public programs, the verification requirements for exchange coverage will need to be coordinated with those required for Medicaid, CHIP, or BHP.

4. Create Seamless Eligibility and Enrollment Linkages with Medicaid and CHIP

One of the most challenging and important aspects of the health reform law is the requirement that states create a “no wrong door” for individuals and families seeking coverage. States must establish procedures for screening applicants no matter where they initially seek coverage (whether through an exchange, Medicaid, CHIP, or a BHP, if applicable in that state) and enrolling them in the appropriate program, without making applicants go through additional, burdensome steps to find out which program they are eligible for. It is also vital that exchanges coordinate closely with Medicaid and CHIP because many people will move back and forth between subsidized exchange coverage and public program eligibility as their income fluctuates. Moreover, some families will be “divided,” with parents in subsidized exchange coverage and children in Medicaid and CHIP. (This is because Medicaid and CHIP already cover children at income levels well above the 133 percent of the poverty line cutoff that will apply to most parents, and are obligated to continue doing so through at least 2019.)

The ACA offers a set of policy changes designed to help create this seamless eligibility and enrollment system.

- **A new income standard, the Modified Adjusted Gross Income (MAGI)**, will be used when determining eligibility for the exchange subsidies, CHIP, and most populations under Medicaid.²⁶ As a result, Medicaid and CHIP will have to adopt new definitions of income as well as household size and composition rules that conform to this new standard. Medicaid and CHIP also cannot establish asset tests for most populations.

- States must use the HHS-developed **single, streamlined application form** (or an alternate form approved by HHS) to enroll persons in exchange subsidies, Medicaid, CHIP, or a BHP.²⁷ A state can create a different or supplemental form for persons, such as those with disabilities, whose eligibility will not be determined using the MAGI.

- Exchanges and Medicaid agencies must operate linked **web portals** through which families can obtain information on their eligibility for the different programs and enroll in coverage. States must establish electronic interfaces that will enable the exchange of information between the programs, accept an electronic signature for all programs, and utilize data matching to federal databases whenever possible to establish, verify, and update eligibility.

- As described previously, exchanges can **contract with Medicaid** to conduct subsidy eligibility determinations for the exchange. This could significantly help facilitate implementation of the exchanges. For example, during the development of Massachusetts’ health reform plan, officials decided to contract with the Medicaid agency for eligibility and enrollment in order to ensure successful implementation within a short timeframe.²⁸

Further guidance and strong partnerships between exchanges and the Medicaid and CHIP agencies will be critical to turning these policies into systems that work for consumers. Some of the challenges include aligning the program requirements of the tax credits and cost sharing with those required under Medicaid and CHIP, identifying ways for promoting continuity of care as people move between the programs, capturing change of circumstances at enrollment, renewal, and during the coverage year to ensure families are connected with their best coverage option, and building technology systems to make the exchange of data feasible.

5. Help Administer Key Features of the New Law

The exchanges also have an administrative role to play in managing some of the new requirements in the law. Starting in 2014, most individuals in the U.S. must secure a minimum level of health insurance coverage for themselves and their children. However, some persons are exempt from the individual responsibility requirement (e.g., those with religious objections) or the penalty that will be imposed for failing to have coverage (e.g., available coverage would consume more than eight percent of a family’s income). The exchanges will be responsible for certifying whether individuals are exempt from the requirement or penalty, and providing a list of those exempted persons to the IRS.²⁹

States must establish procedures for screening applicants no matter where they initially seek coverage and enrolling them in the appropriate program.

Children and families will face some unique challenges in navigating this new health reform world.

Additionally, the exchanges will be required to undertake tasks related to employer coverage requirements under the law. Employees with incomes below 400 percent of the FPL who are offered employer-sponsored health coverage can receive the tax credit or cost sharing subsidies if that coverage is determined to be unaffordable (i.e., if coverage has an actuarial value of less than 60 percent or the premium costs exceed 9.5 percent of income). The exchanges will verify whether an employee applying for coverage under the exchange meets the standard of not having access to affordable employer-based coverage and submit a list of approved individuals to the IRS.

The exchanges also will notify employers with more than 50 full-time equivalent employees of those employees that enroll in subsidized coverage. Under the ACA, these employers will be required to pay various penalties for workers receiving the subsidies.

Implications for Children and Families

Children have an enormous amount to gain from health care reform and the establishment of the new coverage pathway created by the exchanges. If the law works as intended, nearly all uninsured children will be able to secure health coverage, there will be greater security for their families as their parents also gain coverage, and the quality of care they and others receive will improve.

As a result, children and families have much at stake in the design choices states will make and child and family advocates have an important role to play in bringing their voice to the table. In designing their exchanges, states will want to ensure that there are strong protections against adverse selection into exchange plans. It also will be vital to have active oversight and monitoring of plan performance and quality and the provision of good, clear information to consumers on their health coverage options. Additionally, it is important that the child-only plans work as intended and that the specialized benefit needs of children are adequately addressed.

Children and families also will face some unique challenges in navigating this new health reform world. As discussed, children eligible for Medicaid and CHIP at the time of the bill's passage will continue to be eligible for that coverage. Since the majority of states already provide coverage to children up to at least 200 percent of the FPL, many of these children could have family members seeking coverage in the ex-

changes. In general, people will not necessarily know which program they are eligible for and many parents will face the additional burden of having to navigate multiple programs if they are to secure affordable coverage for themselves and their children. In addition, due to changing family circumstances, children and families could quite frequently find themselves moving back and forth between exchange and Medicaid/CHIP coverage. To ensure that the exchanges work for children and families, federal officials and states will want to consider a number of steps.

- **Build ongoing relationships between the exchange, Medicaid and CHIP officials, and children's health advocates.** Many states may want to consider the feasibility and effectiveness of housing responsibility for the tax credit and cost sharing subsidy eligibility process with the Medicaid agency. Even if this is not a viable option in a state, it will be important for exchanges to work closely from the beginning with Medicaid and CHIP officials, in addition to child health advocates, who have already tackled many of the issues now facing exchanges, including how to find eligible persons, write applications and notices in consumer-friendly ways, and structure enrollment pathways.
- **Apply policies that will facilitate the development of a "no wrong door" enrollment system.** There are some steps states can take to build the truly seamless enrollment system envisioned by the ACA that is particularly important for families. These include:
 - o Aligning, to the greatest extent possible, Medicaid/CHIP rules and verification requirements with the exchanges to facilitate the development of a streamlined application form and eligibility process. For example, a state with enrollment periods shorter than one year in Medicaid or CHIP may want to move to annual renewal periods to better align with exchange coverage and the subsidies.
 - o Creating simple and efficient procedures for families to report "change of circumstances" at the time of enrollment, renewal, and during the coverage year. Capturing these changes and making it easy for families to transfer coverage when eligibility changes (especially for families no longer able to afford the premium costs of exchange coverage and are newly eligible for Medicaid and CHIP) will be critical for ensuring families do not face a gap in coverage.

- **Build coordination between the delivery systems used by the exchange and Medicaid and CHIP plans.**

With people moving back and forth between subsidized exchange coverage and Medicaid and CHIP, it will be important to identify ways for promoting continuity of care. This could include ensuring that some plans offered in the exchange also serve Medicaid and CHIP beneficiaries, creating overlapping provider networks, and requiring plans to help facilitate transitions for those in the middle of treatment.

- **Support the development of dynamic technology applications.** The exchange procedures envisioned under the ACA rely heavily on the application of smart technology systems. While federal guidance should provide some assistance, a state can consider setting up a working group now to begin to build these systems. Even with full implementation of ACA a number of years away, states can take steps now to strengthen their use of smart technology systems. For example, a state could help pave the way toward electronic interfaces by implementing the proven Medicaid and CHIP automated linkage with the Social Security Administration allowed under CHIPRA to verify citizenship status.³⁰

Conclusion

In many ways, the exchanges are the front line of health care reform. There is no question that their long-term viability to provide millions of children, families, and adults with affordable health care coverage will be dependent on a number of early decisions states make in regard to scope, structure, regulatory function, plan participation, and interaction with the market outside the exchanges. From the consumer perspective, however, the ultimate success of the exchanges will come down to how easy it is to enroll and maintain coverage that is affordable and there when they need it. Fortunately, states have a long history of applying outreach and enrollment initiatives to subsidized coverage programs, and bringing this expertise to the table will be a critical step forward for states grappling with the choices ahead of them, and for children and families seeking coverage.

Endnotes

1. The Affordable Care Act is the name commonly applied to two pieces of legislation (the Patient Protection and Affordable Care and the Health Care and Education Affordability Reconciliation Acts of 2010) that form the basis of health care reform and, in early 2010, were signed into law by President Obama.
2. Congressional Budget Office, "Cost Estimate of H.R. 4872, Reconciliation Act of 2010" (March 20, 2010).
3. C. Hoffman, et al., "The Uninsured: A Primer," Kaiser Commission on Medicaid and the Uninsured (October 2009).
4. U.S. Department of Health and Human Services Office of Consumer Information and Insurance Oversight, "State Planning and Establishment Grants for the Affordable Care Act's Exchanges," CFDA 93.525 (July 29, 2010).
5. Beginning in 2017, states can elect to allow larger employers with more than 100 workers to buy coverage through the exchange.
6. The Secretary of HHS will conduct annual audits of exchanges and has the authority to investigate or examine exchange activities. If an exchange or state has engaged in "serious misconduct" in carrying out their exchange responsibilities, the Secretary can apply penalties until corrective actions are taken. The Secretary can also establish appropriate measures to limit fraud and abuse.
7. For further discussion on this issue see: S. Lueck, "States Should Structure Exchanges to Minimize Adverse Selection," Center on Budget and Policy Priorities (August 2010).
8. There is a notable exception to this rule. Plans with "grandfathered" status, i.e., those that were in existence prior to the law's enactment and have not since made significant changes to their plans, are exempt from some of the insurance reforms. See "Group Health Plan and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan," Federal Register, 75: 34538-34570 (June 17, 2010). In addition, self-insured plans are exempt from most of the new market rules. While it is larger employers who typically self-insure (which essentially means they bear the full risk of covering their employees), there has been a trend among smaller employers to self-insure in order to avoid government regulation.
9. The ACA requires states to conduct risk adjustment for all non-grandfathered plans inside and outside of the exchanges. Risk adjustment is the process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans who enroll a disproportionate number of healthy individuals. Additionally, the ACA implements two temporary risk programs. A risk corridor program will

require plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected. In addition, states will create a temporary reinsurance program to stabilize their individual markets during the implementation of health reform. Reinsurance is a form of insurance that provides monetary protections to health plans that cover high-risk individuals.

10. Note that beginning in 2014, all new insurance plans in the individual or small group market will also be required to offer the “essential health benefits” package. Large employer groups are exempt.

11. Plans in the exchanges must offer at least a silver- and a gold-level plan. Health plans can also offer a catastrophic policy for those 30 years or younger or who are exempted from the individual coverage mandate due to income. Stand-alone dental plans will also be permitted to operate in an exchange either separately or in conjunction with a medical plan if the dental plan provides children’s oral health coverage (as required for all plans in the exchanges). Exchanges are also required to offer at least two multi-state health plans under contract with the federal Office of Personnel Management.

12. This preventive services provision applies to all new plans established on or after September 23, 2010. Health plans will additionally cover preventive services for children and adults recommended by the United States Preventive Services Task Force, immunizations recommended by the Centers for Disease Control and Prevention, and preventive care for women, such as screenings for cervical cancer and mammograms. See “Group Health Plan and Health Insurance Coverage Relating to Coverage of Preventive Services,” Federal Register, 75: 41726-41760 (June 19, 2010).

13. “Autism Specific Mandates: Individual Health Insurance Market, 2010,” The Kaiser Family Foundation, <http://www.statehealthfacts.org/comparetable.jsp?ind=852&cat=7> (accessed August 23, 2010).

14. The Secretary of HHS will also set up procedures for agents or brokers to participate in selling exchange coverage.

15. Entities can include community groups, unions, associations, chambers of commerce, and licensed agents and brokers. However, health insurance issuers are excluded. The Secretary of HHS will issue further standards for participating entities.

16. U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, “Consumer Assistance Program Grants,” CFDA 93.519 (July 22, 2010).

17. The law refers to “lawfully present residents,” the precise definition of which requires federal guidance.

18. Incarcerated individuals are specifically excluded from entering the exchanges.

19. For more information see Small Business Majority, “Small Business Healthcare Tax Credit,” <http://www.smallbusinessmajority.org/hc-reform-faq/index.php>

20. Employers must offer “free-choice vouchers” to employees with incomes at or below 400 percent of the FPL whose required contribution toward minimum essential offered coverage is between eight and 9.8 percent of household income. The vouchers will equal the employer contribution and employees can use it to purchase insurance in an exchange but they cannot receive any federal subsidies.

21. Households with income below 133 percent of the FPL will generally be eligible for Medicaid except for some lawfully residing immigrants. Lawfully residing immigrants who are not eligible for Medicaid or CHIP will be eligible for subsidies.

22. Cost sharing subsidies will be applied as an increase in the silver-level plan’s actuarial value (the measurement of the percentage of medical expenses paid by a health plan for a standard population). In addition, all plans will limit out-of-pocket costs to yearly limits set for Health Savings Accounts, with lower levels for those with incomes below 400 percent of the FPL.

23. The Secretary of HHS will establish an initial enrollment period to allow persons to enroll in coverage prior to 2014, when the exchanges become operational. In addition, the law allows the Secretary to establish special enrollment periods to cover other situations, such as loss of coverage due to non-payment of premiums. The law also requires monthly enrollment periods for native-Americans.

24. The Secretary of HHS will develop procedures for families who do not file a tax return. The Secretary also will establish a program for making advance determinations, based on the information submitted, in order to apply the tax credits and cost sharing reductions at the time of enrollment (instead of when a family next files a tax return).

25. An appeals process also will be established for individuals and employers (whose employees are found eligible for subsidized coverage and therefore are obligated to pay a fee for that employee).

26. The MAGI will not be applied to the elderly, foster children, low-income Medicare beneficiaries, and those receiving SSI.

27. Qualified health plans in the Exchange will also be required to utilize a uniform enrollment form for persons choosing health plans. Further guidance is required to understand how these forms will be integrated.

28. A. Lischko, S. Bachman, & A. Vangeli, “The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions,” The Commonwealth Fund (May 2009).

29. See Community Catalyst and Georgetown Center for Children and Families, “The New Responsibility to Secure Coverage: Frequently Asked Questions” (July 8, 2010).

30. D. Cohen Ross, “New Citizenship Documentation Option for Medicaid and CHIP Is Up and Running,” Center on Budget and Policy Priorities (April 20, 2010).