Building a Better Health Care Marketplace

Policy Brief #6: The Exchange and Public Programs

While the exchange represents a significant new opportunity for states to improve the quality and affordability of health insurance, it is only one piece of the larger health care landscape. Public programs, including Medicaid and the Children's Health Insurance Program (CHIP), will continue to play a significant role, and the way they interact with the exchange will be important to the success of both.

Medicaid, in particular, will see its eligibility significantly increased in 2014, the same year the state exchange will open its doors. Many of those who apply for Medicaid will not be eligible for that program, but could qualify for tax credits to buy coverage on the exchange – and vice versa, as some of those who enter the exchange might also be eligible for a public program. Further, over time consumers might move from one to the other as their income fluctuates. States that carefully address these eligibility, enrollment, and transition challenges will save money due to increased efficiency, and consumers will have an easier experience getting their coverage. Those that do not run the risk of burying the promise of health reform in confusion and red tape.

About this Series:

The creation of a new health insurance exchange offers states an opportunity to improve health care and lower costs by pooling consumers' bargaining power, creating economies of scale, and pushing insurers to delivering lower costs and higher quality. CALPIRG Education Fund's *Building a Better Health Care Marketplace* project provides recommendations to advocates and policymakers for how to create a strong, pro-consumer exchange. Support for the project is generously provided by the Robert Wood Johnson Foundation. For further information on this project, and other policy briefs in this series, please visit http://www.calpirg.org.

Beyond these coverage issues, the state can also take action to integrate its public programs with the exchange to achieve greater effectiveness. Some of the consumer tools that the exchange will develop could be used in public programs as well to improve the consumer experience, and aligning the quality-improving, cost-lowering policies pursued by the exchange and public programs will similarly increase the effectiveness of both.

CALPIRG Education Fund
1107 9th St., Ste. 601
Sacramento, CA 95814
916-448-4516 ph
info@calpirg.org

Eligibility and Enrollment

One of the most important functions that the exchange will serve is to help qualifying consumers get access to affordability tax credits to help them pay for their coverage. However, some of those who try to buy coverage through the exchange will inevitably be eligible instead for a public program, such as Medicaid or CHIP. Then, when families actually apply, the picture could be even more complex, as different family members might be eligible for different sources of coverage.

In order to meet these challenges, the exchange must make it simple for consumers to enroll in the program that is appropriate for them. This means it must coordinate its eligibility systems with those of the state's public programs, to catch whether an applicant for coverage is eligible for one of them instead. If so, the exchange should forward the application to the relevant agency, which can then process the paperwork and enroll the applicant, without requiring the applicant to submit duplicate forms or visit another office.

Similarly, states should make sure that if a consumer applies for a public program such as Medicaid, but does not qualify, that he or she is immediately connected to the exchange. Whatever door a consumer enters through, they should quickly and easily receive the appropriate coverage, and to the extent possible, the state should employ a single eligibility and enrollment system.

At every step, as the state develops its eligibility and enrollment system, it must strive to create a simplified, streamlined process that avoids red tape and efficiently gathers the information it needs, both from applicants and from existing data sources – for example, a state could allow applicants to enter their social security numbers to allow the application system to access their age, income information contained in their tax returns, participation in other public programs, or other needed information.

Creating this streamlined no-wrong-door enrollment system will be important to ensuring that consumers are able to easily sign up for coverage. Not only will this benefit those consumers, it will also be important for ensuring that the exchange has a stable risk pool – the larger the number of enrollees, the more stable the exchange will be, and the applicants most likely to be turned off by a complex application process will be those who are healthy and least in need of coverage. Further, states will need to both create new eligibility and enrollment systems for the exchange, and update their existing Medicaid systems to account for new eligibility changes in the federal reform law. They should take the opportunity to integrate these systems, rather than creating two parallel but separate systems.

Transitions and Renewals

Year after year, exchange enrollees will need to renew their coverage. If their income increases and they no longer are eligible for subsidies, they likely will continue to purchase coverage through the exchange – but if their income decreases, they will become eligible for Medicaid rather than subsidized exchange coverage, and if they go to work for an employer that offers job-based coverage, they will likely exit the exchange. Similarly, Medicaid enrollees whose incomes increase will become newly eligible for coverage through the exchange. And those who turn 65 will become eligible for Medicare. Managing these transitions will be critical to ensuring that the state's exchange remains stable over time.

Ideally, the state's system will obtain updated information from enrollees in both public programs and the exchange each year (either directly from enrollees, or via tax returns or other data sources). Based on this information, if the enrollee's eligibility has not changed, their coverage should be automatically renewed after giving the enrollee a chance to opt out. If the enrollee instead becomes newly eligible for some other source of coverage, the exchange should present the enrollee with their new choices – however, even if the enrollee does not specifically take action, the exchange or Medicaid should automatically enroll them.

Only if the enrollee specifically opts out of coverage should they exit the system – otherwise consumers may fall through the cracks, leaving them without coverage and potentially in violation of the federal law's individual coverage requirement. Differences in the timing of eligibility determinations and the commencement of coverage mean that the state must pay careful attention to realize this goal of seamless coverage and renewal.

Navigators and Outreach

Experience with existing public programs has clearly shown that simply giving consumers new coverage options is not enough to guarantee that they will exercise them – if members of the public do not understand how they can access those options, they will not take advantage of them. As discussed above, broad enrollment will not only help the beneficiaries affected, but also increase the stability of the exchange's risk pool, giving the state another reason to prioritize enrolling eligible consumers in the exchange.

Simply posting information on a state website and running a few public service announcements will not be enough to drive the necessary enrollment. Specific outreach efforts will be needed. However, it will be difficult for the state to reliably target those who will be eligible for coverage through the

exchange without also targeting those who will be eligible for coverage through an expanded Medicaid program or some other public program. In order to maximize their investment in outreach, then, the state should ensure that its efforts inform members of the public about the exchange as well as about other public programs.

One particular area where states should take into account the role of public programs is in deciding how to run its navigator program, through which the exchange will contract with individuals and organizations to reach out to particular communities to provide information and help eligible consumers enroll in the exchange. In many states, insurance brokers or agents have pushed to be the primary or even the sole providers of navigator services. But while many brokers possess significant expertise about private coverage, and have deep relationships with some small businesses, in many states they may not have the required knowledge about public programs, or the language or cultural skills needed to effectively perform outreach to underserved communities.

As a result, in designing their outreach efforts, states should make sure that they have all their bases covered – in some communities, brokers can be an effective information source, but a strong navigator program should also include a wider array of organizations, particularly those with longstanding ties to priority communities and constituencies.

Leveraging Consumer Tools and Aligning Incentives for Quality and Lower Costs

As a forthcoming policy brief will discuss, the exchange has the opportunity to create ratings, comparison tools, standardized forms, and other services to allow consumers to easily understand their coverage options when purchasing coverage through the exchange's web portal. While most of these tools will be developed with an eye towards individual and small group private coverage, some of them might also be helpful for allowing public program beneficiaries to understand their coverage. This will especially be the case in states that have a significant number of Medicaid Managed Care plans, since in those states, enrollees will similarly have to assess which of their options is the best choice for them. As a result, states may want to incorporate these aspects of the exchange's systems into those of their public programs, as well as pursuing the enrollment and eligibility integration discussed above.

Finally, as discussed in the previous policy brief in this series, one of the key policy innovations exchanges should pursue is encouraging private insurers

to adopt reforms to how they pay for care that would reward high-quality, lower-cost care. The impact of these reforms will be heightened if similar reforms are also instituted in the public programs administered by the state, so that providers don't face a confusing, contradictory array of different payment systems. State employee benefit plans could also be incorporated into this effort.