

Strategies for Building Seamless Health Systems for Low-Income Populations

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The Affordable Care Act (ACA) will expand access to health insurance for nearly all Americans, with close to 95 percent of the U.S. population covered by 2019.¹ Beyond insurance coverage, however, the ACA contains longer-term goals of health system transformation, aimed at providing efficient, high-quality health care. That transformation is possible only when patients are linked to stable health care coverage.

For no population are the twin aims of stable, affordable coverage and high-quality, efficient care more important — and more difficult to achieve — than for non-elderly, low-income individuals and families. This includes people with incomes below 200 percent of the federal poverty level (FPL), or roughly \$37,000 annually for a family of three. This group — particularly the childless adults — is most at risk of having inadequate insurance coverage or none at all, and is most likely to forego medically necessary care, experience cost-related barriers to care, and lack a regular source of care.²

For low-income families, the first step toward achieving these twin outcomes is subsidized coverage, through Medicaid or state exchanges. Making those coverage arrangements stable, however, is likely to be a far greater challenge. Yet numerous provisions of the ACA could be used to do just that — create seamless coverage for low-income individuals and families within models that advance quality and efficiency.

The Promise of Reform, the Problem of Churn

The insurance made available under the ACA has the potential to transform the relationship between low-income populations and the health care system. The ACA's greatest contribution for low-income families is its establishment of expanded public financing through Medicaid and premium tax credits, to shelter these families from unaffordable coverage.

Under the terms of the law, people with incomes up to 133 percent of FPL will be covered through the Medicaid

IN BRIEF

As health reform moves forward, churn between subsidized coverage programs is inevitable, but states can reduce the impact with design and purchasing strategies that promote seamlessness. The challenges in creating seamless health systems for low-income populations include:

- **Managing subsidy fluctuations** — developing re-enrollment and purchasing strategies that minimize churn and creating a robust outreach-building infrastructure for efficient eligibility determinations and prompt enrollment; and
- **Stabilizing coverage and care** — designing programs that provide continuity of coverage, including similar benefits, providers and health plans.

The Affordable Care Act offers numerous opportunities to stabilize coverage and care for beneficiaries as their incomes fluctuate. This brief provides a roadmap for states as they consider options for creating seamless health systems.

expansion, and those with incomes between 133 and 400 percent of FPL will be eligible to obtain coverage subsidies through both premium and cost-sharing assistance.

Individuals enrolled in exchange Qualified Health Plans (QHPs) and those enrolled in Medicaid through the expansion will be eligible for “essential health benefits,” a broad range of coverage including preventive services with no cost-sharing. The coverage will be of a level and quality that can foster strong provider/patient relationships and the appropriate use of services — assuming that the program design encourages the formation of these relationships.

Yet continuity of coverage is threatened by income fluctuations that will cause low-income patients to churn

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between the coverage options offered by insurance exchanges and eligibility for Medicaid. For most people with employer-sponsored coverage, periodic changes in income typically do not affect continuity of coverage.³ But for low-income individuals and families who will depend on publicly assisted coverage under the ACA, even a slight change in income will trigger disruptions not only in the source of the subsidy (i.e., Medicaid eligibility versus premium tax credits), but in the actual source of care.

When Disruptions in Coverage Create Disruptions in Care

In the post-reform world, specific insurance markets may, as they do today, attract specific issuers of coverage products. Pending state decisions about program design, the Medicaid market may continue to be dominated by companies that specialize in the sale of Medicaid managed care products, while the exchange market may develop a very different set of sellers.

This tendency will mean that as incomes fluctuate, families face the prospect of traversing not merely two subsidy systems, but two entirely different insurance markets with different products, different companies, and potentially different provider networks and coverage rules. Even modest changes in family income — a small change in the number of work hours, or family events such as births, marriages, divorces, or a grown child leaving home — have the potential to trigger this disruption. For families whose incomes place them near the point at which Medicaid eligibility meets the coverage options offered by insurance exchanges, there is a decisive “cliff” at which continuity of coverage and care is threatened.

The Scope of the Issue

A huge proportion of the low-income population will potentially be exposed to shifting subsidy sources and the resulting need to shift sources of care. A recent study estimated that within six months of the date

of enrollment, 35 percent of low-income adults could be expected to move from Medicaid to a QHP or vice versa. This figure rises to 50 percent (approximately 28 million people) over the course of a year. Data from the same study show that 30 percent of adults starting out with family incomes high enough to qualify for exchange subsidies will see their incomes dip below 133 percent of FPL within six months — and that figure rises to 43 percent over 12 months. In a multi-year context, the problem is even more significant: over a four-year time period, 80 percent of all persons whose incomes initially are low enough to qualify for Medicaid will lose eligibility, and over one-third will experience four or more changes in eligibility.⁴

An additional problem arises for families who initially qualify for premium credits and exchange coverage, then experience a drop in income sufficient to qualify for Medicaid. Under the law, tax credits are not available to any individual who in any month is “eligible” for “minimum essential coverage,” defined to include Medicaid, and premium credits erroneously paid out are subject to recoupment by the IRS. Thus, an income drop may not only necessitate a move to Medicaid, but may also trigger a significant recoupment liability if the income change is not rapidly reported and the shift to Medicaid is not effectuated immediately.⁵

If families predict that they may fall within this category of shifting income, they may be hesitant to enroll in coverage through the exchange for fear of advance credit repayment. Health Insurance Premium Tax Credit Treasury regulations attempt to safeguard families that end the year with household income below 100 percent FPL by imposing a special rule that does not require repayment of advance credit payment.⁶ The ACA provides no clear statutory mechanism for waiving recoupment liability, even when, paradoxically, recoupment is the result of *falling*, rather than rising, income. The U.S. Department of Health and Human Services

(HHS) attempts to address this issue in the proposed exchange regulations, which require enrollees to report, within 30 days, any income changes that impact eligibility for advanced payment of premium tax credits or enrollment in a QHP. In order to address the concerns about recoupment liability, HHS has asked for comments on the proposed regulation to address how the exchange data matching and enrollee reminders can be used to facilitate change reporting requirements.⁷

Addressing Subsidy Challenges, Stabilizing Coverage and Care

It is important to keep sight of the two challenges in this landscape. The first is income fluctuations that lead to shifting subsidy sources and potential recoupment exposure, not only as income rises, but, ironically, also as income falls into Medicaid territory. The second is the challenge of providing health care stability — ensuring that shifting subsidy sources (even if smooth and without the threat of recoupment penalties) do not also lead to loss of membership in a family’s health plan and network of providers.

Both problems need attention, since either one is sufficiently disruptive to wreak havoc in the lives of people for whom life is already an economic struggle, and to discourage them from participating in coverage programs. Furthermore, the group most likely to experience income fluctuations tends to be younger and healthier adult workers with young families⁸ — exactly the people whose participation is crucial to the success of reform.

I. Strategy: Managing Subsidy Fluctuations

a. Subsidy Eligibility Transitions

The ACA requires exchanges and state Medicaid agencies to coordinate their activities around: (1) eligibility determination for subsidies; and (2) enrollment in the appropriate program (i.e.,

Medicaid, any other state subsidy program, or the exchange system of tax credits), if found eligible.⁹ The law addresses not only initial enrollment but also continued participation in Medicaid and other state health subsidy programs,¹⁰ and it sets forth requirements related to the use of simplified forms and electronic data exchange.

Given the provisions of the law, on the one hand, and the reality of income fluctuation in this population on the other, whatever system is established would need to allow for easy monthly reporting of any change in family size or income that could affect the source of subsidy (i.e., tax credits versus state subsidization). The August 17, 2011 Medicaid program eligibility proposed rule from CMS is a good start toward this much-needed flexibility. States are allowed to maintain eligibility for current beneficiaries as long as the annual income based on modified adjusted gross income (MAGI) methods for the calendar year remains at or below Medicaid standards.

This frequent updating is essential not only to avoid errors in subsidy payments, but also to protect exchange-enrolled families from exposure to recoupment as income either rises or dips below Medicaid eligibility levels, resulting in the loss of eligibility for tax credits.¹¹ The regulations limit recoupment of premium tax credits for an individual whose employer-sponsored coverage was considered unaffordable at the time of enrollment (employee contribution exceeded 9.5 percent of household income), but whose income ultimately rose during the year, dropping the cost of the employer plan to 9.5 percent of household income or less.¹²

b. Continuous Enrollment in Subsidy Sources

In order to reduce churning between subsidy sources, a state could consider using state-only funds to effectively maintain the status quo for individuals and families who begin an enrollment period supported by one subsidy system and then experience income changes requiring a total shift to another. While this is a substantial fiscal stretch for

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many states, the benefit of this approach is that during an enrollment year, the individual would remain attached to one subsidy source and thus, to the same health plan market. Its downsides are: (1) cost;¹³ and (2) the inadequacy of the relief, given the fact that at the end of even a stabilized annual enrollment period, families may face a switch in subsidy sources and the ensuing need to shift to a different health plan market. Having to change plans and physicians yearly is hardly an improvement.

II. Strategy: Stabilizing Coverage and Care

Even if the subsidy transition system is relatively smooth and the final federal regulations allow for implementation in ways that ease the threat of recoupment against low-income families, policymakers and beneficiaries still face challenges in plan enrollment, stability in membership, and stability in care.

a. Enrolling in Health Plans: The Role of Auto-Enrollment with Opt-Out Rights

Enrolling in a subsidy system is one thing; enrolling in a health plan is another. Subsidization in itself does not guarantee that individuals will be promptly enrolled in health plans that have sufficient capacity to provide them with appropriate care.

Using Medicaid as a model, states appear to take two approaches to enrollment. In some states, applicants for Medicaid select a health plan at the time that they apply for assistance, rendering the application complete. A second approach is giving individuals the opportunity to select a plan once eligibility is determined.

In either scenario, problems can arise. For example, a person can simply fail to select a plan either at the time of application or at the time of eligibility determination. A state might address this by treating the application or eligibility determination as incomplete until a plan selection is made. But even if they do, the selected plan could turn out to be closed to new enrollment; it may not always be possible to assure availability of a first choice.

For this reason, federal Medicaid law provides for auto-enrollment, the automatic assignment of an individual or family to a health plan. Some states use auto-enrollment as a mechanism for rewarding plan performance on quality and price, or to smooth out enrollment across plans and networks. Auto-enrollment is a feature of the Medicare prescription drug plan program for individuals who receive low-income subsidy assistance, and also of some employer-sponsored health plans. Some states that use mandatory managed care for adults with disabilities also have

Eligibility for Populations with Complex Needs

One additional challenge to achieving seamless program design is the relationship between state innovations for low-income populations, the creation of a new category of eligibility for childless adults in Medicaid, and extension of coverage to low-income people whose health status is serious enough to qualify them for Medicare on the basis of disability. The programmatic intersection of coverage for this population combined with the sheer number of eligible individuals is a significant consideration for states, given projections showing rates of serious illness and disability among the newly eligible exchange population that are higher than in the privately insured population.¹⁴ It may make sense for states to pursue a broader system reform strategy that combines system innovations for working families with reforms designed to serve people with disabilities, regardless of whether they are covered by tax credits, state subsidies, or ultimately, Medicare. In this respect, Medicare participation by qualified and basic health plans will be a key consideration, an additional matter for continued federal/state collaboration throughout implementation.

experimented with auto-enrollment. People who are auto-enrolled can be given the opportunity to “opt out” by either disenrolling entirely or switching to a different plan.¹⁵

Proposed exchange rules allow for state exchanges to assist with delivery system or health plan selection for Medicaid and CHIP. If the exchange and the Medicaid/CHIP agencies agree to collaborate on this function, this assistance can take on the form of real-time transmission of enrollment transactions to health plans.

State health insurance exchanges will raise many of these same issues, with individuals facing a two-step process that either can be integrated into a single set of activities or maintained as separate. In either case, provision will need to be made to assure that individuals entitled to a subsidy (either a state subsidy or the tax credit) ultimately are enrolled in a health plan; auto-enrollment could provide that assurance.

Auto-enrollment offers an opportunity to reward plans not only on the basis of cost and quality, but on their dual participation in both Medicaid (and CHIP, where applicable) and the state’s exchange. How big a financial incentive this turns out to be cannot be known, but weighting auto-enrollment for plan behavior that improves

the stability and continuity of care for patients may operate as one such incentive.

b. Stable Membership and Provider Availability

Where health plan membership is concerned, two considerations arise. The first is maintaining membership in a single health plan over time, in order to give members an opportunity to learn plan rules, take advantage of health plan services, and establish the type of continuity that is central to measuring plan performance over time. Churning is also administratively disruptive for providers and plans. Short membership significantly affects plans’ and external reviewers’ ability to measure plan performance, since many key performance measures presume a durational relationship between the plan and the member. One obvious example is the completion of early childhood immunizations by age two — impossible for children whose membership lapses as a result of involuntary factors like loss of subsidy eligibility or a move out of the area.

A second consideration is stable access to a provider network combined with uniform network adequacy requirements among types of coverage. Provider networks can and do turn over for multiple reasons; it is not uncommon for patients to discover that their physicians are no longer with their

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Licensure Across Markets

In some states, many Medicaid managed care products are offered by issuers who participate in both the commercial and Medicaid markets. However, there are states in which Medicaid managed care organizations may not be licensed as insurance issuers, and may be authorized to do business under separate laws applicable only to Medicaid. Since QHP enrollees are also likely to move between programs, states may want to consider procurement requirements such as: (a) requiring health plans participating in Medicaid to offer exchange products; (b) mandating that managed care plans provide coverage statewide; and (c) developing provider panels that are consistent throughout the public and private products offered in the exchange.¹⁶ QHPs must be offered by “a health insurance issuer that is licensed and in good standing to offer health insurance coverage in each state in which such issuer offers health insurance coverage.”¹⁷ Since some small Medicaid managed care plans may find it difficult to meet QHP licensure or certification standards, a state might consider a special licensure class for entities that seek to offer health plans in both markets, to incentivize dual market participation while providing some regulatory relief to small players in the market.

A broader alignment approach that would take into account the challenges of both plan membership and access to health care is dual certification of health plans in both the state exchange and Medicaid (and, where applicable, CHIP) markets.

practice group or have decided to leave a network. Nonetheless, maintaining a stable relationship with a health care professional or clinic that the patient identifies as their regular source of health care¹⁸ is a factor associated with high-quality health systems.¹⁹

One possible approach to both of these issues is to require all plans serving exchange beneficiaries as well as beneficiaries receiving state subsidies to allow network participation by all health care professionals and clinics that are members of any health plan network. A primary health care provider qualified to participate in a Medicaid managed care plan network would also be qualified to participate in the network of a non-Medicaid health plan that is offered in an exchange.

The benefit of this approach is that in the event of a shift in health plan membership, the patient's relationship with his or her primary care provider would remain intact. However, this would not mitigate the challenges to patients in having to learn to navigate a new health plan, nor does it address the problem of constant turnover in plan membership that both disrupts business

operations and reduces the ability to measure quality performance over time. It also leaves open the challenge of how to develop reimbursement levels for providers participating in the new exchange plans.

Whether providers will participate in exchange plans that pay typically low Medicaid rates is an open question.

c. Plans Dually Certified for Exchange and Medicaid Participation

A broader alignment approach that would take into account the challenges of both plan membership and access to health care is dual certification of health plans in both the state exchange and Medicaid (and, where applicable, CHIP) markets. The conditions of participation that apply to Medicaid managed care organizations include no provision that would bar a plan offered by a managed care organization from being certified as a QHP. Furthermore, the performance categories that Medicaid managed care plans must meet under federal law parallel those applicable to QHP performance measures (e.g., marketing and enrollment, access to care, quality measurement, patient protections including choice of providers²¹ and appeals rights, and

Ensuring that Families Stay Together in the Same Health Plan

In addition to dual licensure of health plans and auto-enrollment, another program alignment approach to provide continuity of coverage is to control for the possibility that family members will be enrolled in multiple health plans across multiple programs. The patchwork of eligibility opportunities created by the ACA may result in families being split across different insurers. This split can mean different provider networks, challenging geographic access to providers, and administrative complexity in accessing customer service. As family size and incomes shift, coverage categories may change frequently, especially for adult household members.

To encourage continuity of care, states could consider requiring all family members to enroll in the same health plan, as is required for families enrolled in Minnesota's 1115 waiver program MinnesotaCare. The complexity of keeping families together across multiple programs spanning both Medicaid and the exchange rests with the coordination of state insurance market requirements, Medicaid, and federal flexibility in the certification process for health plans participating in the exchange.²⁰

As states await final exchange regulations and begin to plan for integrated technology tools across Medicaid and the exchange, interim modifications can be made to facilitate health plan enrollment. For example, one tool for families whose coverage spans multiple programs would be to make systems modifications to default family members to the same health plan.

the ability to offer the benefits to which members may be entitled, depending on the law under which the entity is operating).²²

d. Using the Basic Health Program Option

The most ambitious approach to addressing the problem of continuity of coverage and care for a low-income population would be use of the ACA's Basic Health Program option.²³ This option authorizes states to establish coverage arrangements (known as basic health plans or "BHPs") for individuals whose incomes exceed mandatory Medicaid eligibility requirements, but who may be unable to afford the cost-sharing requirements of exchange plans. Individuals are eligible for the Basic Health Program option if they are residents of the state, are Medicaid-ineligible, and have family incomes between 133 and 200 percent of FPL.²⁴

BHPs must meet the essential health benefit requirements for QHPs sold in exchanges. A participating state must operate its BHPs in a manner that satisfies the premium protections that would apply to individuals and families who otherwise would purchase the second-lowest-cost silver plan²⁵ coverage through state exchanges. In addition to premium protections, participating states must also adhere to cost-sharing protections, based on household income, that do not exceed platinum-level and gold-level plans.²⁶ Operation of the Basic Health Program must be aligned with Medicaid and CHIP policies and procedures.²⁷

States that take this option and are certified by the Secretary as meeting the requirements of the Basic Health Program²⁸ are entitled to receive per capita payments, adjusted for enrollee age, income, family status, health status, and other factors. Payments equal 95 percent of the premium tax credits and cost-sharing reductions that "would have been provided" for the fiscal year to eligible individuals enrolled in QHPs offered through the state's exchange.²⁹

CMS has issued a preliminary request for information (RFI) on the Basic Health Program option. The RFI seeks input from stakeholders on the key challenges and costs associated with the Basic Health Program, how it might affect the exchange, and innovative strategies states could use in contracting with standard health plans. The RFI provides preliminary insight into what conditions the Secretary may apply to the program, including:

- State program design considerations, including access;
- Managed care contracting requirements;
- Consumer protection considerations;
- Quality and performance measurement;
- Program design, including where the program fits within a state administrative structure; and
- Provider payments.

While states await further federal clarity, it is clear that the Basic Health Program option offers important flexibility on several fronts. First, in any state offering BHPs, the per capita funding to pay the plans is transferred to the state. Because the Basic Health Program is financed directly by states rather than through individual premium tax credits administered by the IRS, the risk of recoupment is eliminated. The state could utilize the same "real time" eligibility determination and payment approaches, along with plan enrollment techniques, that apply to Medicaid and CHIP, such as an annual redetermination process³⁰ and other mechanisms used to foster greater efficiencies in eligibility determinations related to financial assistance and plan enrollment.

Second, a state can use the opportunity of developing a Basic Health Program to align quality and performance measures based on population health characteristics, and can also design innovations related to care coordination, chronic disease management, and patient engagement. These can be combined with other innovations introduced into Medicaid, such as the use of

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health homes for beneficiaries with chronic health conditions and development of accountable care organizations as a key component of health plan delivery. Third, the state can stabilize enrollment for all individuals and families with incomes below 200 percent FPL. This may help avoid the types of participation disincentives that can arise for low-income families as a result of frequent movement among subsidy systems, frequent changes in plan membership, and the potential for disruption in provider networks.

There are significant limitations to this model. First, from an operational standpoint, states need to consider the administrative burden and risks associated with implementing and managing yet another publicly financed health care program. The technology coordination and health plan contracting requirements associated with implementing a Basic Health Program are significant. From a policy perspective, the Basic Health Program creates a new “cliff,” at twice the FPL. Thus, while the approach can bring more stability for a state’s poorest, most vulnerable residents, the state will need to carefully develop coordination procedures at the point at which individuals cease to be eligible for the Basic Health Program and enter the state’s exchange.

Second, as noted, many of the individuals and families reached through the ACA are young and healthy workers and their young families. States must consider whether removal of these individuals from a state exchange will significantly change the risk profile and have a premium-rating impact on remaining exchange membership. Finally, the number of beneficiaries in any state’s Basic Health Program must be a part of the decision-making process, since the sheer loss of insurable lives for the exchange plans may result in risk segmentation.

Conclusion

The great contribution of the ACA is its elimination of the financial cliffs and

inequities in coverage that low-income families have traditionally faced. Through the creation of exchanges, the Basic Health Program, and premium tax credits, the ACA makes it possible for most families to remain continuously eligible for the financial supports that are essential to health plan affordability.

The ACA offers important handles for addressing these issues. These strategies might be combined with other state flexibility measures such as Section 1115 of the Social Security Act, which permits wide-ranging innovation in Medicaid and CHIP. Section 1115 waivers offer states the potential to create a continuous coverage arrangement across the entire low-income population that offers essential health benefits, with supplemental coverage for individuals who need specialized services — children with special health care needs, for example, or adults with serious and chronic health conditions.

At the same time, the multi-subsidy approach taken by the ACA raises downstream challenges to implementation for low-income families: (1) determining subsidy eligibility and achieving subsidy enrollment; (2) monitoring individuals’ ongoing enrollment in subsidy arrangements and transitioning between subsidy systems; (3) protecting low-income families from recoupment exposure; (4) achieving efficient health plan enrollment; and (5) assuring health care access, efficiency, and continuity. Addressing these challenges will take careful planning, selection among a range of options, and the full involvement of all system stakeholders in both design and implementation.

State Health Reform Assistance Network

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.rwjf.org/coverage.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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Endnotes

¹ CBO's March 2010 cost estimates show coverage for 94% of the U.S. citizen and legally present population and 92% of the population if "unauthorized immigrants" are included in the total population count. Letter to Honorable Harry Reid, Senate Majority Leader, from Douglas W. Elmsdorf (March 10, 2010), Table 3.

² L. Dubay, A. Cook and B. Garrett, "How Will the Uninsured be Affected by Health Reform?", Urban Institute (Aug. 2009), pp.1-9.

³ Unless the decline is so steep that an individual can no longer pay the employee portion of his or her premium.

⁴ B. Sommers and S. Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs*, February 2011, 30:2, pp. 228-236.

⁵ PPACA §1401 adding IRC §36B(c): Families whose incomes drop to Medicaid eligibility levels ironically face the prospect of not only the loss of exchange tax credits but also liability for repayment of premium credits paid during months of in which they were ineligible because they qualified for Medicaid. This repayment liability is capped in the case of low-income individuals, but it is by no means zero. Under legislation enacted in 2011, recoupment can be as much as \$600.00. P.L. 112-9 (112th Cong., 1st sess.) Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011.

⁶ Department of the Treasury, IRS. 26 CFR Part 1 Health Insurance Premium Tax Credit NPRM.

⁷ Manatt Health Solutions, "Overview and Analysis of Proposed Exchange, Medicaid and IRS Regulations Issued on August 12, 2011," Robert Wood Johnson Foundation September 2011, p.18. Available at http://www.rwjf.org/coverage/product.jsp?id=72795&cid=XEM_205594.

⁸ Department of the Treasury, IRS. 26 CFR Part 1 Health Insurance Premium Tax Credit NPRM.

⁹ PPACA §§1311 and 1413.

¹⁰ PPACA §1413(a).

¹¹ Manatt Health Solutions, op cit, pp. 7-27.

¹² 76 Fed. Reg at 50935. <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/html/2011-20728.htm>

¹³ Stabilization was considered by Congressional staff and rejected as too costly, having received a preliminary \$50 billion price tag from CBO. Furthermore, why should any state subsidize at a 100 percent state financial exposure if by using available federal programs it can receive either federal Medicaid contributions or total fiscal relief in the form of the tax credit?

¹⁴ Kaiser Family Foundation, "A Profile of State Exchange Enrollees," May 2011.

¹⁵ In its accountable care organization (ACO) comments, MedPAC recommends the same approach, that is, auto-enrollment with an opt-out right, in the case of assignment of Medicare beneficiaries to ACO entities.

¹⁶ C. Ingram, S. McMahon, and S. Gore. "Ten Considerations for States in Linking Medicaid and the Health Benefit Exchanges," Center for Health Care Strategies, August, 2011. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261278.

¹⁷ PPACA §1301(a)(1)(C).

¹⁸ One interesting phenomenon is that even Medicaid beneficiaries who are members of managed care plans and thus have an assignment to a primary care provider (PCP) nonetheless may answer in a patient survey that they lack a regular source of health care. This suggests some basic disconnect between the act of primary care assignment and a member's orientation to the provider as his or her regular source of care. Since health plans use auto-assignment of members to primary health care practices (either when the member fails to select a provider or the selected provider has a full panel), this gap between the PCP process and a member's understanding of the PCP as a regular source of care suggests the need for additional efforts to build a relationship between patients and health care professionals.

¹⁹ M. Abrams et al., "Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers," The Commonwealth Fund, January 2011.

²⁰ *MinnesotaCare Guide to Health Plan Enrollment* Available at:

[http://ftp.dhs.state.mn.us/DHSGD/DHS%20Translation%20Projects/Provider%20202/Project%200447/3303/DHS-3303-ENG%20\(3-11%20marked\).pdf](http://ftp.dhs.state.mn.us/DHSGD/DHS%20Translation%20Projects/Provider%20202/Project%200447/3303/DHS-3303-ENG%20(3-11%20marked).pdf).

²¹ As a matter of federal law, Medicaid (Section 1932 of the Social Security Act), unlike the ACA (PPACA §1311(c)(1)(C)), does not guarantee beneficiaries free choice of any provider in a plan network. There is no evidence, however, that state Medicaid programs, in their contractual specifications with plans, do not require plans to allow beneficiaries to choose among available providers.

²² Medicaid benefits for traditional enrollees are significantly broader than those available to individuals and families made newly eligible under the ACA. At the same time, the benefit design for newly eligible persons is aligned under the ACA with the essential health benefit package as a result of Congressional amendments to Medicaid's "benchmark benefit" provisions. While cost sharing will differ depending on the subsidy source – a fact that underscores the need for total integration between the various subsidy systems and plan operations – the basic benefit design for individuals whose incomes are most likely to fluctuate (younger healthier workers and their families) will remain essentially the same.

²³ PPACA § 1331.

²⁴ PPACA §1331(e)(1)(A) and (B).

²⁵ This benchmark is used in calculating premium subsidies for low-income individuals and families enrolling in an exchange QHP.

²⁶ Cost sharing for individuals up to 150% FPL cannot exceed platinum level exchange plans (10%); for individuals between 151% and 200% FPL, cost sharing cannot exceed gold level plans (20%).

²⁷ PPACA §1331(c)(4).

²⁸ PPACA §1331(a)(2).

²⁹ PPACA 1331(d)(3).

³⁰ Annual eligibility redetermination is not the same as an annual enrollment period, since a reported change in income could result in the loss of assistance. Nonetheless, an annual redetermination process would allow a state to develop systems under which families need to report on income only if there is an actual change in income. A state would no longer need to so closely monitor income fluctuations as a means of helping families avert the IRS recoupment process.