Legislative Brief

FAQs on Exchanges, Market Reforms and Medicaid

The Affordable Care Act (ACA), which was enacted on March 23, 2010, includes significant changes related to health care coverage. Among other things, the ACA calls for the creation of state-based Affordable Health Insurance Exchanges (Exchanges) to facilitate the purchase of insurance, requires insurers to comply with a new set of market reforms and expands the Medicaid program.

On Dec. 10, 2012, the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) issued **Frequently Asked Questions (FAQs)** to answer questions regarding the implementation of the Exchanges and the Medicaid expansion.

MEDICAID EXPANSION

The ACA calls for a nationwide expansion of Medicaid eligibility, set to begin in 2014. Under the expansion, nearly all adults under 65 with family incomes of up to 133 percent of the federal poverty level (FPL) would qualify for Medicaid.

Originally, the ACA required states to comply with the new Medicaid eligibility requirements, or risk losing their federal funding. The Supreme Court's ruling in the ACA case, however, limited the federal government's ability to penalize states that don't comply, effectively making the expansion optional. Even if they choose not to expand their Medicaid program, states will continue to receive their standard federal contributions for individuals who were already eligible for Medicaid coverage in their state.

States are not under a deadline for deciding to expand Medicaid and can drop out of the expansion program later if they participate initially.

Federal Matching Funds

For states that implement the Medicaid expansion, the federal government will cover 100 percent of the cost of the first three years of the expansion (2014-2016), gradually phasing down to a 90 percent share. The FAQs clarify that states must fully expand Medicaid eligibility up to 133 percent of the FPL to receive the 100 percent federal matching funds. This means

that states that implement partial Medicaid expansions (that is, expansions to less than 133 percent of the FPL) will not receive the full federal funding.

The FAQs note that states do have the option of implementing a partial Medicaid expansion. However, any partial expansion would be subject to the regular federal matching rate (that is, the federal match that states received before the expansion). Additionally, HHS intends to allow states significant discretion as to the "benchmark" benefit plans they will offer the Medicaid expansion population, as long as they cover the 10 categories of essential health benefits. States will also have some control over the cost sharing they will impose, particularly for recipients with incomes above 100 percent of the FPL.

Effect of the Supreme Court Ruling

The FAQs further clarify that the Supreme Court ruling releases the states only from the Medicaid expansion requirement. States must still coordinate Medicaid eligibility with the exchanges if they wish to stay in the Medicaid program. They must also convert their income eligibility standards for most groups to the modified adjusted gross income (MAGI) standard used for premium tax credit eligibility.

HEALTH INSURANCE EXCHANGES

The ACA also requires each state to have an Exchange to provide a competitive marketplace where individuals and small businesses will be able to purchase private health insurance coverage. The Exchanges are scheduled to be operational by **Jan. 1, 2014**, with enrollment expected to begin on **Oct. 1, 2013**.

States have three options with respect to their Exchanges. A state may:

- Establish its own state-based Exchange;
- Have HHS operate a federally facilitated Exchange (FFE) for its residents; or
- Partner with HHS so that some FFE Exchange functions can be performed by the state.

State-based and State Partnership Exchanges

States that intend to pursue a state-based Exchange or a state partnership Exchange must submit a short declaration letter and an Exchange blueprint to HHS for approval. In November 2012, HHS extended the deadline for states to submit this notification and blueprint to:

- **Dec. 14, 2012**, for states that intend to establish their own Exchange; or
- **Feb. 15, 2013**, for states that would like to partner with HHS to establish an Exchange.

The FAQs clarify that HHS will not further extend the deadline beyond the current date. Additionally, the FAQs outline federal funding that is available to states that establish a state-based or state partnership exchange, and describe a federal data hub that states will be permitted to use, free of charge for exchange, Medicaid and Children's Health Insurance Program (CHIP) activity.

Federally Facilitated Exchanges

HHS will operate federally facilitated Exchanges in each state that does not move forward with implementing its own Exchange or select the partnership model. The FAQs state that HHS intends to work with these states to preserve the traditional responsibilities of state insurance departments when establishing FFEs. HHS plans to coordinate with the states to take advantage of regulatory efficiencies, such as relying on states with effective rate review programs for rate review of qualified health plans.

The FAQs also reiterate that the FFEs will be funded through monthly user fees. Although HHS previously proposed that the rate for these fees will be 3.5 percent of the premium, the FAQs note that this rate may be adjusted to take into account state-based Exchange rates.

OTHER TOPICS

The FAQs address a number of other topics that states have expressed concern about, including, but not limited to:

- **Bridge Plans** – The FAQs endorse a "Medicaid bridge plan" that states could use to ease the transition for consumers out of Medicaid or CHIP coverage. A bridge plan would be certified as a Medicaid managed care plan, but could continue to offer coverage through a single insurer and provider network to households transitioning out of Medicaid, or that have children in Medicaid or CHIP and adults in the Exchange.
- **The Navigator Program** – The FAQs also describe in greater detail how the navigator program will work. Navigators are organizations, or in some instances individuals, that will receive grants from the Exchanges to educate and assist consumers to better understand their insurance options.