ISSUE BRIEF
FEBRUARY 2017

The COMMONWEALTH FUND

Building the Coverage Continuum: The Role of State Medicaid Directors and Insurance Commissioners

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ABSTRACT

Issue: The Affordable Care Act has expanded coverage to 20 million newly insured individuals, split between state Medicaid programs and commercially insured marketplaces, with limited integration between the two. The seamless continuum of coverage envisioned by the law is central to achieving the full potential of the Affordable Care Act, but it remains an elusive promise. **Goals:** To examine the historical and cultural differences between state Medicaid agencies and insurance departments that contribute to this lack of coordination. **Findings and Conclusions:** Historical and cultural differences must be overcome to ensure continuing access to coverage and care. The authors present two opportunities for insurance and Medicaid officials to work together to advance the continuum of coverage: alignment of regulations for insurers participating in both markets and collaboration on efforts to reform the health care delivery system.

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Commonwealth Fund pub. 1930
Vol. 4

BACKGROUND

The Affordable Care Act (ACA) established a continuum of health insurance coverage available to all Americans and a foundation on which to build critical reforms of our health care delivery system. The law provides subsidized coverage to households with annual incomes up to 400 percent of the federal poverty level (FPL) in two ways: 1) by extending Medicaid eligibility to anyone with an income lower than 138 percent of the FPL and 2) by offering a sliding scale of tax credits to purchase marketplace plans to anyone with an income from 138 percent to 400 percent of the FPL. The result has been the biggest coverage expansion since Medicare and Medicaid were established in the 1960s—more than 20 million newly insured.[1]

Because the coverage continuum comprises two distinct programs—Medicaid and qualified health plans (QHPs) offered through the marketplaces—the ACA included a "no wrong door" policy that required state Medicaid and marketplace officials to work together to ensure applicants were enrolled in the appropriate program based on their income and other eligibility criteria.[2] For states with their own marketplaces, integration was achieved by establishing a single eligibility system for both programs. However, integration is not as advanced in the 39 states that rely on the federal

HealthCare.gov website for eligibility and enrollment determinations. In those states, applicants may start with either the Medicaid program or HealthCare.gov, but their application will be handed off to the other program if that is what their eligibility dictates.

The challenges inherent in such handoffs underscore the case for collaboration between Medicaid agencies and departments of insurance (DOIs), each of which have roles to play in implementing the ACA's coverage continuum. For example, every state DOI is responsible for licensing and monitoring the solvency of marketplace insurers, and most play a broad role in the certification of QHPs. And all but four state DOIs have been certified to handle rate reviews for QHPs.[3] Medicaid agencies have even broader oversight responsibilities and are increasingly relying on managed care organizations (MCOs) to deliver benefits.

Applicants who move between Medicaid and marketplace insurance plans are likely to experience less disruption if the two coverage sources are closely aligned. Although the new administration's proposal to repeal and replace the ACA may effect significant changes in the roles of state Medicaid agencies and DOIs, both will still have opportunities to better align their regulatory efforts and collaborate on broader delivery system reform efforts.

MEDICAID AND INSURANCE OFFICIALS TRAVEL DIFFERENT ROADS

As a former New York State Medicaid Director and a former Oregon and Pennsylvania Insurance Commissioner, we have found collaboration among the two bodies to be difficult, and our personal experiences were reinforced by interviews with current and former state officials. (See Appendix A for a full list of interviewees.) Our interviewees cited many impediments to collaboration, but a common theme was that Medicaid agencies and DOIs have different histories and missions. Medicaid directors are running a public program that has evolved from a welfare program to an insurance program, with the regulatory role focused on limiting the state's financial exposure while ensuring enrollees have access to cost-effective, high-quality care. Insurance commissioners are regulating commercial insurance markets that rely on competition among financially sound insurers, with the regulatory role focused on solvency protection and fair treatment of consumers. The Affordable Care Act has exposed those differences even as it created important opportunities to bridge them. Before turning to the opportunities, however, we start with the new challenges for DOIs and Medicaid.

For Medicaid agencies, the first priority under the Affordable Care Act was modernizing their eligibility policies and systems and connecting with the new marketplaces. Expansion states were also required to enroll millions of additional adults and children into coverage. As enrollment grew, the imperative to ensure that Medicaid was purchasing cost-effective, high-quality care likewise grew. Alignment with the marketplace or collaboration with DOIs was a second-order priority. DOIs had their own challenges in certifying insurers for marketplace participation, including new entrants to the commercial market such as Medicaid managed care organizations and co-ops, which often presented unique solvency problems related to federal risk adjustment and risk-corridor programs that did not work out as anticipated.[4] These responsibilities have taxed scarce DOI resources, especially with the increased spotlight on ensuring that benefit plans are both affordable and do not discriminate against vulnerable populations.

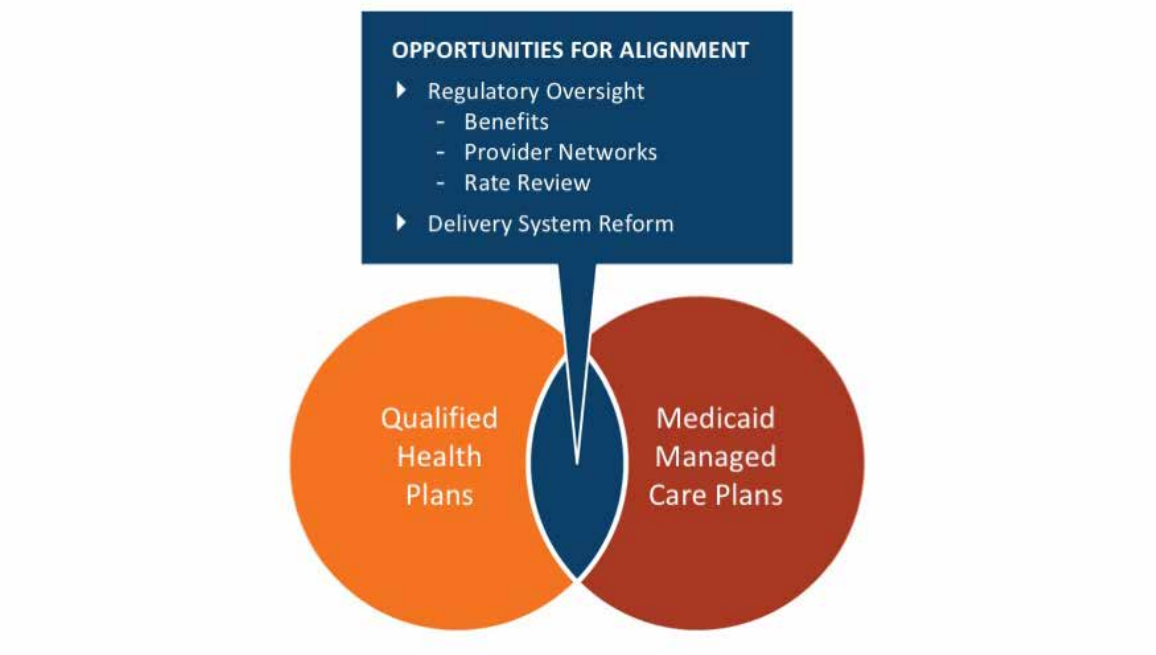
In addition to having competing priorities, DOI and Medicaid officials tend to see the world differently. Insurance regulators see Medicaid as a welfare program with overly bureaucratic rules that impede innovation and make the program a difficult partner. Medicaid officials see DOIs as

insensitive to the needs of low-income consumers and overly deferential to insurers. The two groups also see many Affordable Care Act issues from different vantage points. For example, most DOIs embrace limited open-enrollment periods to protect the risk pool, while Medicaid agencies shun them as a barrier to coverage.

We acknowledge these differences, as well as the broader challenges in making coverage affordable across varied populations. Nevertheless, there are clear improvements that can be made by bridging the differences between the two sides.

OPPORTUNITIES FOR COLLABORATION

Two opportunities stand out. First, the Affordable Care Act has encouraged more insurers to offer both Medicaid and marketplace coverage, creating new opportunities for Medicaid and insurance officials to align their oversight policies. Second, the law has spawned a host of new payment reform initiatives whose long-term success depends on aligning public and private payers, creating even broader opportunities for Medicaid and insurance officials to take a lead role in implementing delivery system reform across state agencies and public and private payers.



Growth in Multiprogram Carriers

The Affordable Care Act has incentivized insurers of all kinds to compete to enroll people in both marketplace plans and Medicaid: large national carriers scrambling to acquire cross-market capacity, Medicaid managed care organizations moving into the marketplaces, and regional provider-based insurers doubling down on their mission to serve all segments of the population. A recent national study found that 41 percent of marketplace insurers also offered Medicaid managed care plans in the same state.[5] Such plans have fared well in the marketplaces.[6]

The Affordable Care Act has increased incentives for insurers to participate in both Medicaid and the marketplaces to grow overall membership and to retain members who move between the two

programs. This is a trend that regulators should encourage as it minimizes coverage and care disruptions if enrollees can keep the same insurer (and potentially the same providers) when they move between programs.

Insurance and Medicaid officials can support this trend by pursuing common strategies to address program differences that create inefficiencies and impede cross-market growth. Three fertile areas are benefits, where there is significant alignment between the "essential health benefits (EHBs)" offered by QHPs and the "alternative benefit plans" offered to Medicaid expansion adults;[7] provider networks, where DOIs and Medicaid agencies could align their network adequacy standards to make it easier for insurers to offer cross-market continuity of care; and rate reviews, where both agencies are responsible for ensuring actuarially sound and affordable rates, albeit in somewhat different contexts. (DOIs review rates and focus on insurer solvency and cost to the consumer, while Medicaid agencies set rates for the health plans with which they contract and focus on cost to the state.) Notably, the new federal Medicaid Managed Care regulations explicitly recognize the goal of Medicaid and marketplace alignment and track QHP rules in such areas as medical loss ratio requirements.[8]

To the extent that insurance and Medicaid officials can achieve consistent rules across markets, they will enhance efficiency and better serve consumers moving between Medicaid and marketplace coverage—primarily by reducing confusion and lapses in care that inevitably accompany care handoffs.[9] Following are examples of progress in regulatory alignment.

- In Washington State, the Insurance Commissioner has worked closely with Medicaid officials to ensure that Medicaid MCOs understand and meet network adequacy standards for QHPs after several MCOs were rejected for marketplace participation because of noncompliance with QHP network standards. Finding common ground on network adequacy standards has opened broader dialogue over other common regulatory issues.[10]
- In Oregon, the Governor's office of health reform convened a task force to develop recommendations for aligning requirements for Community Care Organizations (CCOs), Oregon's version of Medicaid MCOs, and commercial insurers. One point of alignment was similar data standards for cost control and quality data that are required of CCOs and of commercial insurers as part of the Oregon Insurance Division's rate review process.[11]
- In multiple states with their own marketplaces, including New York, Rhode Island, and Washington, Medicaid MCOs are offered in the marketplaces, thereby enabling Medicaid beneficiaries to complete the eligibility and enrollment process at one site and allowing all marketplace participants to compare plans across both markets, identifying those that will be available as their income fluctuates.[12]
- Arkansas and New Hampshire have maximized benefit alignment by enrolling their Medicaid expansion adults into QHPs under Medicaid Section 1115 waivers that require close collaboration between Medicaid and insurance officials. Both states required marketplace insurers to enroll Medicaid beneficiaries in QHPs specifically designed to meet most Medicaid rules, thereby both minimizing the need for the Medicaid agencies to offer out-of-plan benefits and ensuring a virtually seamless experience as enrollees move between Medicaid and the marketplace.

Payment and Delivery System Reform

States have multiple levers and play multiple roles in delivery system reform, with Medicaid agencies and DOIs ideally positioned to develop shared goals that can be embraced by payers and providers. In states where Medicaid and insurance officials work closely together, health system transformation is more feasible, as evidenced by Arkansas' success in advancing cross-market reforms. Key to that success was the central and committed role of the Governor and dedicated staff across state agencies.[13]

Medicaid agencies are a leading force for delivery system reform, both because Medicaid is the single largest payer in every state, covering more than a quarter of the population in expansion states, and because Medicaid programs face severe cost pressures.[14] Medicaid directors are advancing patient-centered medical homes, bundled and episodic payments, and other payment and delivery models to transition from a volume-based to a value-based system, and billions in federal dollars are flowing to states to support these efforts.[15,16] Notably, in the vast majority of states (39 plus the District of Columbia), Medicaid managed care organizations are the preferred delivery model.[17] And the new Medicaid managed care regulations both authorize and encourage states to use their managed care contracts to require health plans to deploy value-based payments with network providers and to align with other payers, including the commercial insurers regulated by DOIs.[18]

DOIs have not played as significant a role in delivery system reform, with most commercial market leadership coming from self-insured employers. But that is changing as states are raising the bar for commercial insurers, with Massachusetts setting global-budget targets, Rhode Island requiring commercial insurers to make certain levels of investments in primary care, and Oregon requiring carriers to disclose their cost-control activities as part of rate filings.[19] In the 46 states where the DOI is responsible for part or all of the QHP certification process, insurance regulators and marketplace officials also have federal authorization to impose higher certification standards on QHPs. These developments offer insurance regulators a growing set of precedents for collaborating with their Medicaid colleagues to encourage, if not require, insurers to align with other payers on delivery system reform efforts.

CONCLUSION

The Affordable Care Act created a national coverage paradigm promising continuity of coverage and improved health for individuals and communities. Implementation of this vision was left largely in the hands of states, including to state Medicaid and insurance officials that had little in common and rarely coordinated their policies. The Affordable Care Act provides new authority, but real continuity of coverage and care requires Medicaid agencies and DOIs to articulate a common mission and to put in place consistent rules to advance it. Progress has been slow to date, given barriers related to the agencies' differing histories and missions, but the goal remains a worthy one. We hope that the opportunities for collaboration outlined in this brief will trigger a dialogue among our former state colleagues on how—together—they can improve our health care system. Even if the Affordable Care Act is changed, the imperative of continuous coverage and affordable care will remain, making collaboration across Medicaid and insurance officials a continued priority.

NOTES

[1] U.S. Department of Health and Human Services, "20 Million People Have Gained Health Insurance Coverage Because of the Affordable Care Act, New Estimates Show," News release (HHS, March 3, 2016).

[2] Section 2201 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

[3] Center for Consumer Information and Insurance Oversight, *State Effective Rate Review Programs,* Fact sheet (CMS, n.d.); and T. S. Jost, "CMS Sees No 2015 Risk Corridor Payouts But Contemplates Settling Insurer Lawsuits," *Health Affairs Blog,* Sept. 12, 2016.

[4] In the first two years of risk adjustment, small, regional health insurers and upstart co-op plans have incurred much larger charges under the risk-adjustment program than anticipated. Further, due in part to budget neutrality requirements, insurers have received only 12.6 percent of their risk-corridor requests, which has forced several insurers to sue and others to shut down. See B. Herman, "ACA's Risk Adjustment Hammers Small Plans Again," *Modern Healthcare,* published online June 30, 2016.

[5] Association for Community Affiliated Plans, *Overlap Between Medicaid Health Plans and QHPs in the Marketplaces: An Examination* (ACAP, April 2016).

[6] E. Mershon, "Medicaid Plans Succeed in Obamacare as Others Struggle," *Roll Call,* published online May 23, 2016.

[7] Section 1302 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

[8] "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," 81 *Fed. Reg.* 27497 (May 6, 2016); and Centers for Medicare and Medicaid Services, *Medicaid and CHIP Managed Care Final Rule (CMS 2390-F)—Improved Alignment with Medicare Advantage and Private Coverage Plans,* Fact sheet (CMS, April 25, 2016).

[9] Churn was expected to be a significant issue following implementation of the Affordable Care Act, with studies estimating that millions of lower-income people would churn between Medicaid and marketplace plans. For example, one study estimated that over the course of the year, 50 percent of adults with incomes below twice the federal poverty level for an individual would move between QHP and Medicaid coverage at least once, and a quarter would move more than once. However, though data on churn since the implementation of the ACA is scarce, initial reports indicate that it may be less common than initially feared and disruption for individuals transitioning across coverage programs mostly minimal. See B. D. 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,* Feb. 2011 30(2):228–36; and B. D. Sommers, J. A. Graves, K. Swartz et al., "Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact," *Health Affairs,* April 2014 33(4):700–7.

[10] M. Kreidler, interview with Manatt Health, July 2016.

[11] J. Ario, "Recommended Strategies for Advancing Health Reform," Presentation to the Oregon Health Policy Board, Nov. 5, 2013.

[12] Manatt Health Solutions, *Report from the States: Early Observations About Five State Marketplaces* (State Health Reform Assistance Network, Dec. 2013).

[13] D. Bachrach, L. du Pont, and M. Lipson, *Arkansas: A Leading Laboratory for Health Care Payment and Delivery System Reform* (The Commonwealth Fund, Aug. 2014).

[14] J. Paradise, *Medicaid Moving Forward* (Henry J. Kaiser Family Foundation, March 2015).

[15] National Association of Medicaid Directors and Bailit Health, *The Role of State Medicaid Programs in Improving the Value of the Health Care System* (NAMD and Bailit Health, March 22, 2016); V. Smith, K. Gifford, E. Ellis et al., *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016* (National Association of Medicaid Directors and Henry J. Kaiser Family Foundation, Oct. 2015); and K. Dybdal, L. Hartman, and D. Spencer, *State Medicaid Reforms Aimed at Changing Care Delivery at the Provider Level: Final Report* (State Health Access Data Assistance Center, Aug. 2015).

[16] CMS has awarded nearly $950 million in grants to states through the State Innovation Models (SIM) initiative, launched in 2012 by the Center for Medicare and Medicaid Innovation (CMMI) to design and test innovative, state-based, multipayer health care delivery and payment systems. Delivery System Redesign Incentive Payment (DSRIP) programs, which allow states to use federal Medicaid matching funds to make incentive payments to providers that participate in delivery system reform initiatives, represent another mechanism for significant investment. Approximately $32 billion in federal and state funds have been committed to state DSRIP programs to date, with the federal government alone having allocated approximately $17.5 billion. See Kaiser Commission on Medicaid and the Uninsured, *The State Innovation Models (SIM) Program: A Look at Round 2 Grantees,* Fact sheet (Henry J. Kaiser Family Foundation, Sept. 2015); and M. Schoenberg, F. Heider, J. Rosenthal et al., *State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools* (National Academy for State Health Policy, March 2015).

[17] J. Paradise, *Medicaid Moving Forward* (Henry J. Kaiser Family Foundation, March 2015).

[18] 42 C.F.R. § 438.6(c); "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules," 80 *Fed. Reg.* 31124 (June 1, 2015).

[19] S. Zemel and T. Riley, *Addressing and Reducing Health Care Costs in States: Global Budgeting Initiatives in Maryland, Massachusetts, and Vermont* (National Academy for State Health Policy, Jan. 2016); C. F. Koller, T. A. Brennan, and M. H. Bailit, "Rhode Island's Novel Experiment to Rebuild Primary Care from the Insurance Side," *Health Affairs,* May 2010 29(5):941–47; and Families USA, *States Making Progress on Rate Review* (Families USA, Oct. 2011).

APPENDIX A. LIST OF INTERVIEWEES

Nathan Johnson
Chief Policy Officer, Washington State Health Care Authority

Deborah Kelch
Executive Director, Insure the Uninsured Project

Christopher Koller
President, Milbank Memorial Fund and former Rhode Island Health Insurance Commissioner

Mike Kreidler
Insurance Commissioner, Office of the Insurance Commissioner, Washington State

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Acknowledgment

The authors wish to acknowledge the assistance of Allison Garcimonde of Manatt Health.

Editorial support was provided by Martha Hostetter.

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