Achieving Continuity of Insurance Coverage for Lower-Income New Yorkers in 2014

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Coalition of New York State Public Health Plans

NYS HEALTH FOUNDATION
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About the Coalition of New York State Public Health Plans

Established in 1995, the Coalition of New York State Public Health Plans (PHP Coalition) is an important voice for New York's nonprofit, publicly-focused health plans and the low-income people they serve. The Coalition currently represents 10 plans serving 2.8 million individuals, about three-quarters of all of the children and adults enrolled in New York's Medicaid managed care, Family Health Plus, and Child Health Plus programs. Sponsored by or affiliated with public and not-for-profit hospitals, community health centers, and physicians, Coalition plans offer decades of experience in delivering high-quality services to members who often, otherwise, experience significant barriers to health care.

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) provides new or expanded affordable coverage options to New Yorkers with incomes below 400% of the Federal Poverty Level (FPL). These coverage options, or "Insurance Affordability Programs,"[1] (IAPs) include Medicaid, the Children's Health Insurance Program (CHIP, which in New York State is called Child Health Plus, or CHPlus), advance payments of premium tax credits (APTCs), and cost-sharing reductions (CSRs), and a Basic Health Program (BHP), should the State establish one. In 2014, consumers will be connected to these programs through a streamlined, standardized, consumer-oriented, and technology-enabled eligibility process available through its Medicaid/CHIP programs and new Health Benefit Exchange (Exchange). New York's Exchange will further offer a transparent market in which individuals will be able to shop among affordable coverage options.

FIGURE 1. New Insurance Affordability Programs Authorized under the ACA

PROGRAM	DESCRIPTION	ELIGIBILITY: FPL	ELIGIBILITY: MONTHLY INCOME FOR FAMILY OF 3[2]
Advance Premium Tax Credits (APTCs) for Qualified Health Plan (QHP)[3] Coverage	Refundable and advanceable premium credits to eligible individuals to purchase insurance through Qualified Health Plans (QHPs) in the Exchange.	139–400% FPL[4] (201-400% FPL if a State creates a Basic Health Program)	$2,211–$6,363
Basic Health Program (BHP)	Optional state program under the ACA to provide coverage to individuals with incomes above the Medicaid threshold up to 200% FPL	139–200%[5]	$2,211–$3,182

The promise of the ACA is compelling; a well-designed Exchange will provide an unprecedented opportunity to enroll New Yorkers into affordable health insurance coverage. New information systems will enable simple and real-time eligibility determination for

[1] *CMS-9974-P*, "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," 76 FR 51202.

[2] Calculated based on 2012 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia, available at http://aspe.hhs.gov/poverty/12poverty.shtml.

[3] Qualified Health Plans (QHPs) are the plans certified to offer coverage in the Exchange. QHPs are defined under Section 1301 of the Affordable Care Act.

[4] The new modified adjusted gross income methodology includes an across-the-board 5% income disregard, which effectively increases maximum Medicaid eligibility levels to 138% FPL. Anyone above that, starting at 139% FPL through 400% FPL, may then qualify for APTCs, or subsidies, to purchase a Qualified Health Plan on the exchange.

[5] Though the Basic Health Program is limited to the 139–200% FPL income bracket generally, the ACA further allows legal immigrants who are at or below 138% FPL and who do not meet the required five-year waiting period for accessing Federal, means-tested benefits (such as Medicaid) to access Basic Health Program coverage.

IAPs, including Medicaid/CHPlus. After creating an Exchange and designing a new eligibility determination system, New York will need to enroll its residents in the affordable coverage for which they are eligible. In addition, New York faces a major secondary challenge: preventing interruptions of enrollment or coverage as incomes fluctuate (and, thus, eligibility for IAPs potentially changes).[6]

New York State has made clear that as it plans for implementation of the Medicaid expansion, its Exchange, and ACA eligibility and enrollment requirements, continuity of care is an essential goal of its coverage strategy.[7] The planning and policy development ongoing in the State now presents an unprecedented opportunity to construct a health insurance coverage system for New York State that insulates consumers against coverage gaps.

Income fluctuation among low-income families is well-documented. Families living within 130%–185% of the FPL have incomes subject to recurrent ups and downs and are more likely to experience frequent, small income changes than higher income earners.[8] In addition, income volatility among low-income households has increased dramatically over the past decade.[9] Research on consumers in Medicaid and CHIP confirms that income fluctuations causing changes in eligibility result in significant churning, or the loss of coverage resulting from administrative barriers to renewing coverage when eligibility changes.[10] A recent study found that "beginning in 2014, income changes may lead to the movement of millions of adults and their families between Medicaid and state Exchanges, often within months of their initial enrollment in the programs."[11]

The implications of frequent changes in eligibility are also well-documented. As low-income families' eligibility status shifts between different insurance programs, they are likely to

[6] This paper is focused on the individual Exchange and transitions in coverage across IAPs in New York. This paper does not attempt to address the well-documented issue of transitions of eligible people on and off the same public coverage program because of administrative barriers to eligibility renewal, commonly referred to as churning.

[7] NYS Department of Health comments on August 2011 proposed rules, submitted to HHS October 31, 2011, available at http://www.healthcarereform.ny.gov/docs/comments_august_2011_Exchange_functions_proposed_rule.pdf.

[8] C. Newman, "The Income Volatility See-Saw: Implications for School Lunch," U.S. Department of Agriculture, Economic Research Service, August 2006, available at http://ageconsearch.umn.edu/bitstream/7237/2/er060023.pdf.

[9] N. Bania and L. Leete, "Monthly household income volatility in the U.S., 1991/92 vs. 2002/03." Economics Bulletin 29(3):2100-2112, 2009, available at http://www.accessecon.com/Pubs/EB/2009/Volume29/EB-09-V29-I3-P59.pdf.

[10] M. Perry, "Reducing Enrollee Churning in Medicaid, Child Health Plus, and Family Health Plus," February 2009, available at http://www.nyshealthfoundation.org/userfiles/file/LakeResearch_2_2009.pdf.

[11] B.D. Sommers and S. Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid and Health Insurance Exchanges," Health Affairs, 30, no.2 (2011):228-236, February 2011.

experience breaks in coverage.[12] Coverage gaps for parents undermine continuity of care and use of preventive services not only for themselves, but also for their children.[13] Churning on and off and between programs also causes operational and care management issues for providers and managed care plans, as the experience with Massachusetts health reform initiatives has shown.[14]

To inform New York State's efforts to implement health care reform in a manner that maximizes continuity of health insurance coverage, this policy brief provides original analysis of potential income fluctuation among lower-income residents of New York State. The analysis reveals that approximately 30% of non-elderly individuals below 400% FPL enrolled in Medicaid and subsidized private market coverage through the Exchange in New York State will experience year-to-year income fluctuations. In total, approximately 1.47 million non-elderly New Yorkers enrolled in these IAP programs, representing 529,000 families, will experience income fluctuations on an annual basis that will potentially impact eligibility. Given the magnitude of this population, it is essential to adopt policies and practices that mitigate any potential losses of coverage.

This policy brief examines barriers to coverage continuity and offers detailed recommendations to minimize coverage losses when changes in eligibility do occur. Specifically, the brief offers recommendations in four areas:

1. **Insurance Affordability Program (IAP) Eligibility and Enrollment Rules:** Proposed Federal implementing guidance and existing program rules with respect to eligibility and enrollment in IAPs do not perfectly align across public market (Medicaid/CHIP) and private market (QHP) programs. Areas of divergence include income and household definitions, coverage activation periods, and IAP renewal processes. Key recommendations to address misalignment in eligibility and enrollment rules include:

   - Take full advantage of Federal flexibility to design an income reporting and verification system that maximizes consumer self-attestation, electronic verification, and accounting for predictable income changes at initial application.
   - Maintain 12-month continuous coverage for adults and children in Medicaid/CHPlus to minimize the likelihood that small income changes among low-income families will result in coverage renewal barriers and loss of coverage.

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[12] S. Rosenbaum, "Creating Comprehensive and Stable Health Insurance Coverage for All Children: Identifying and Working to Resolve the "Four-Pathway" Challenge," April 2009, available at http://www.firstfocus.net/sites/default/files/r.2009-5.6.rosenbaum.pdf and Kaiser Commission on Medicaid and the Uninsured, "Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity," October 2003, available at http://www.kff.org/medicaid/upload/Serving-Low-Income-Families-Through-Premium-Assistance-A-Look-At-Recent-State-Activity-PDF.pdf.

[13] L. Ku and M. Broaddus, "Coverage of Parents Helps Children, Too," October 2006, available at http://www.cbpp.org/cms/?fa=view&id=754.

[14] R. Seifert, G. Kirk, and M. Oakes, "Enrollment and Disenrollment in MassHealth and Commonwealth," Prepared for the Massachusetts Medicaid Policy Institute, April 2010, available at http://bluecrossfoundation.org/~/media/MMPI/Files/2010_4_21_disenrollment_mh_cc.pdf.

- Auto-enroll consumers transitioning from QHP coverage to Medicaid to stay within the same health plan (to the extent their plan offers Medicaid) and evaluate options for auto-enrollment for Medicaid to QHP transitions.
- Design Exchange change reporting tools that are accessible and easy to use, and target consumer assistance to support consumers with changes in eligibility circumstances.

2. **Plan Participation in Medicaid Managed Care (MMC) and the Exchange:** Alignment of health plan participation in the public and private markets is a key strategy for smoothing coverage transitions for New Yorkers in 2014. Key recommendations to align available plans for lower-income New Yorkers include:
   - Complete work necessary to further assess and design a New York State Basic Health Program that provides more affordable coverage for low-income New Yorkers, and aligns health plans across the continuum of coverage for people up to 200% of the FPL.
   - Address Prepaid Health Services Plan (PHSP) licensure, tax-exemption, and accreditation issues to facilitate their participation in the Exchange as QHP issuers.

Approximately 30% of New Yorkers enrolled in Insurance Affordability Programs (IAPs) will experience year-to-year income fluctuations. In total, nearly 1.5 million New Yorkers, representing 529,000 families, will experience changes in income that potentially affect their eligibility for Medicaid or for health insurance Exchange subsidies. Given the magnitude of the population, it is essential to adopt policies and practices that mitigate any potential losses of coverage.

3. **Covered Benefits and Provider Networks in Medicaid and Qualified Health Plans:** To the extent that covered benefits and provider networks differ across New York's IAPs in 2014, consumers may experience disruptions to maintaining provider relationships and continuity of care. Key recommendations for ensuring benefit and network alignment in 2014 include:
   - Complete the study on benefit standardization in Q2 2012.
   - Evaluate QHP certification and MMC contracting strategies to drive provider network alignment.
   - Look to existing care transition policies and procedures in MMC to inform IAP transition policies.

4. **Administration of Medicaid Managed Care and QHP Products:** Administrative practices of the Exchange, New York's MMC program, and the health plans offering MMC and QHP products will have implications for continuity of coverage as consumers' eligibility changes. Exchange design and MMC and QHP administration may be leveraged and aligned to enhance continuity. Key recommendations to address potential barriers posed by administration of multiple Medicaid Managed Care and other health plans within the Exchange:

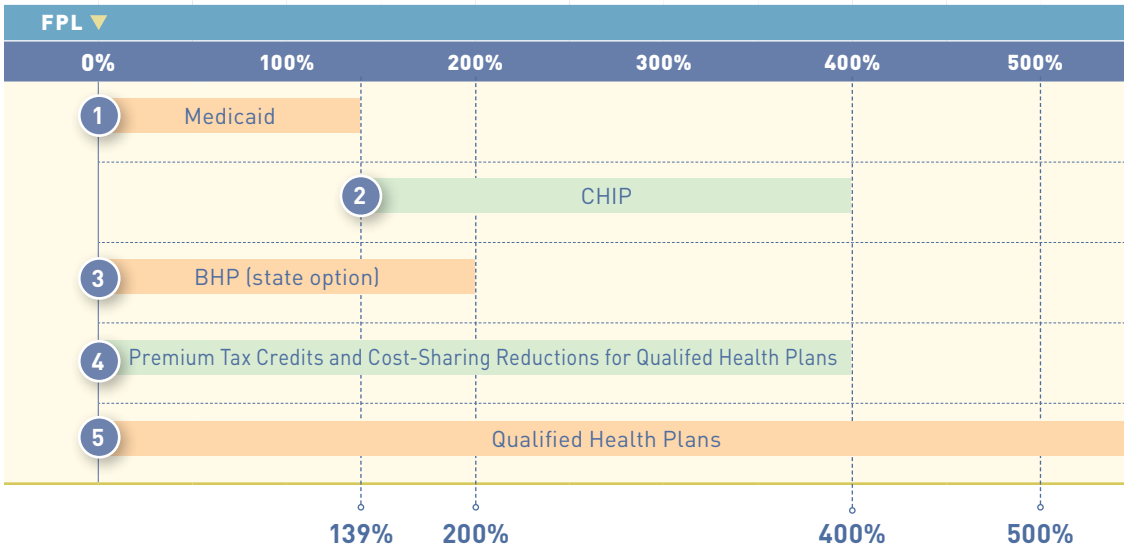
   - Create a health plan shopping functionality to serve consumers across all IAPs and provide targeted decision support for lower-income families.
   - Centralize premium billing through New York's Exchange to create a standard and uniform process for individual premium billing and payment for consumers even as they experience potential changes in their eligibility and health plans.
   - Align premium payment grace periods across IAPs.

While the continuity challenge will be a daunting one as coverage options expand for New Yorkers in 2014, the State and its partners have many tools at their disposal to facilitate continuity and realize New York's coverage vision.

Income Volatility Among Lower-Income New Yorkers

As a result of the Patient Protection and Affordable Care Act (ACA), New Yorkers will have access to a continuum of affordable coverage options in 2014. These coverage options, or "Insurance Affordability Programs"[15] (IAPs), will be available for individuals below 400% of the Federal Poverty Level (FPL) and include Medicaid;[16] Child Health Plus (CHPlus, New York's Children's Health Insurance Program); advance payments of premium tax credits (APTCs); and cost-sharing reductions (CSRs); as well as a Basic Health Program (BHP), should the State establish one.

FIGURE 2. Insurance Affordability Programs in 2014



Medicaid eligibility is determined based on the consumer's income at a point in time. Changes in income trigger a redetermination for Medicaid eligibility—in some cases resulting in loss of Medicaid coverage. Thus consumers who experience frequent changes in income from month to month (for example, self-employed individuals) and report these changes may be compelled to constantly reapply for different coverage programs for which they qualify, absent State policy to minimize such transitions.

[15] *CMS-9974-P*, "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," 76 FR 51202.

[16] This paper does not address individuals who may be eligible for Medicaid on a non-modified adjusted gross income (non-MAGI) basis (e.g., disability). However the non-MAGI population could also be subject to transitions in coverage that arise because of income and other eligibility factors. The ACA and proposed regulations require that the non-MAGI eligibility determination process is, at the very least, coordinated with simplified MAGI processes; however, it will also be critically important that solutions to maintain continuity of coverage for this population be considered in the design and implementation of New York's coverage continuum.

An evolving body of literature highlights the potential impact of income fluctuation on eligibility for IAPs in 2014 and beyond. Changes to consumer income could render families ineligible for the program in which they were enrolled at the beginning of their coverage year, and require transition to a new IAP (and potentially a new plan and new providers). National research found that within six months, more than 35% of all adults below 200% FPL will experience a shift in eligibility from Medicaid to Exchange coverage, or the reverse. Within 12 months, half of these adults, or 28 million people, will experience income changes that alter IAP eligibility.[17]

Gross Annual Income by FPL and Family Size (2012)[18]

	FPL %			
FAMILY SIZE	**100**	**139**	**200**	**400**
1	$11,170	$15,526	$22,340	$44,680
2	$15,130	$21,031	$30,260	$60,520
3	$19,090	$26,535	$38,180	$76,360
4	$23,050	$32,040	$46,100	$92,200
5	$27,010	$37,544	$54,020	$108,040
6	$30,970	$43,048	$61,940	$123,880

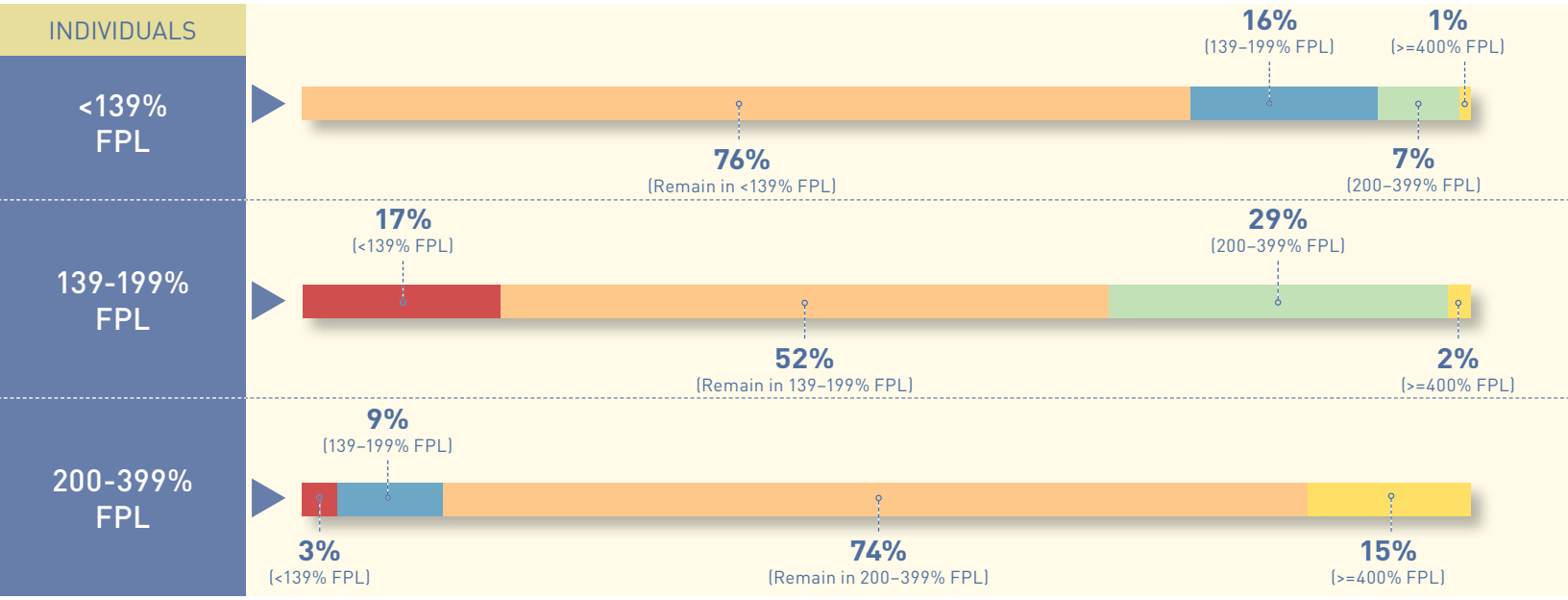
To estimate the potential scope and size of income-driven changes in eligibility in New York State in 2014, the authors conducted secondary analysis of income fluctuation by income and family composition for individuals and families in New York who are eligible for IAPs. Based on this analysis, an estimated 30% of non-elderly individuals below 400% FPL enrolled in Medicaid or subsidized Exchange coverage in New York State will experience annual income fluctuations that could alter their eligibility for their current coverage. In total, approximately 1.47 million non-elderly New Yorkers enrolled in these programs (representing 529,000 families with one or more family members enrolled) will experience annual changes in income that may influence their eligibility for their current coverage. See Appendix A for a detailed discussion of the data and methodology used to produce these estimates.

Additional analysis by income group estimated the proportion of individuals for which income fluctuations result in shifting to another income band. As illustrated in Figure 3, income fluctuation varies substantially by income group, with those between 139% and 199% FPL experiencing the greatest degree of fluctuation. Nearly half of those individuals are estimated to experience changes that have implications for their IAP eligibility.

[17] B.D. Sommers and S. Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid and Health Insurance Exchanges," Health Affairs, 30, no.2 (2011):228-236, February 2011.

[18] 2012 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia, available at http://aspe.hhs.gov/poverty/12poverty.shtml.

FIGURE 3. Income Fluctuation Rates
(Based on 2005–2006 Data and Additional PHP Coalition Analysis)



Given the significant economic instability today relative to 2005–2006 (the period at which income fluctuation rates were measured), the frequency and magnitude of fluctuations might be greater today or in 2014 and directionally different from the data used for this analysis would suggest. As such, the numbers reported here can be considered conservative estimates of: (1) the number of individuals and families likely to experience income fluctuations following implementation of the ACA; and (2) the directionality of such fluctuations (such that income may be more reasonably expected to fluctuate downward in a post-recessionary period than upward).

With nearly one-third of New York's population across IAPs estimated to experience income fluctuations, it is clear that concerns about frequent changes in coverage eligibility and the attendant risk for interruptions in coverage are well-founded. The extent to which this inevitable income fluctuation impacts consumers in New York's new coverage continuum depends on the success of the State, in partnership with the Federal government and health plans, in designing policies and implementing operational processes that minimize coverage transitions and align public and private market operations to mitigate the impact of transitions when they do occur.

Recommendations to Achieve Coverage Continuity

The following sections of this policy brief examine potential barriers to coverage continuity and propose recommendations to mitigate such barriers. These recommendations are targeted to minimizing and smoothing IAP transitions. Specific issues, implications, and recommendations to align public and private insurance market operations to facilitate continuity of coverage are discussed in the following areas:

- IAP Eligibility and Enrollment Rules
- Plan Participation in Medicaid Managed Care (MMC) and the Exchange
- Covered Benefits in Medicaid and Qualified Health Plans (QHPs)
- Administration of MMC and QHP Products

Insurance Affordability Program Eligibility and Enrollment Rules

In July 2011, the Centers for Medicare & Medicaid Services (CMS) issued proposed regulations related to Exchange functions and the administration of QHPs.[19] In August 2011, CMS and the Internal Revenue Service (IRS) issued proposed regulations providing further implementation detail on the seamless eligibility and enrollment processes envisioned under the ACA.[20] For the most part, proposed rules align the processes by which individuals will obtain and keep their health insurance coverage, and the requirements for IAP eligibility determinations. However, the proposed rules do not perfectly align and certain key eligibility policies diverge across coverage programs.

While at the time of the writing of this paper these policies are still in proposed form, the regulations taken together with the ACA and existing Federal and State Medicaid and CHIP rules highlight areas in which IAP rules may create barriers to continuity of coverage as consumer eligibility for these programs changes over time.

FAMILY/HOUSEHOLD, INCOME, AND REASONABLE COMPATIBILITY DEFINITIONS

ISSUE. Eligibility for IAPs is largely dependent on determining: (1) family/household composition and (2) countable income. However, proposed Federal regulations promulgate different definitions for family/household composition and income for Medicaid coverage versus

[19] *CMS-9989-P*, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 76 FR 41866.

[20] *CMS-9974-P*, "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," *CMS-2349-P*, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 76 FR 51148 and REG-131491-10, "Health Insurance Premium Tax Credit," 76 FR 50931.

publicly-subsidized private coverage purchased through the Exchange with refundable tax credits (APTCs). Proposed regulations use a "family" concept for APTC eligibility, defined as those individuals for whom a taxpayer properly claims a personal exemption for a taxable year. Medicaid proposed rules apply a "household" concept, which starts with a tax-filing unit (for those families that file taxes) but then makes several Medicaid-specific exceptions.[21]

With respect to income, the ACA requires all IAPs to use a modified adjusted gross income (MAGI) standard (which is defined in the Federal tax code) for the purposes of determining income eligibility.[22] But proposed Federal regulations stipulate two notable exceptions that misalign the MAGI income definition across Medicaid and APTCs. First, MAGI will be evaluated based on "point-in-time" or current monthly income for Medicaid, and on annual income for APTCs. Second, the proposed rules treat certain types of income (e.g., Social Security benefits) differently in the Medicaid MAGI and the APTC MAGI income-counting methodology.[23]

Finally, proposed Federal regulations introduce a new paradigm to be applied when determining eligibility for IAPs and QHPs which is especially relevant to evaluating consumer income changes: "reasonable compatibility." The reasonable compatibility standard is intended to strike a balance in consumer attestation, electronic verification, and paper documentation of income (and other eligibility criteria, excluding citizenship and immigration status). Simply stated, the State is prohibited from requesting additional documentation if the electronic data match returns information that is relatively consistent with the information provided by the applicant.[24] New York State has flexibility in interpreting this standard.

IMPLICATIONS. Divergent household and income definitions have the potential to: (1) confuse consumers regarding the information needed to determine or redetermine their eligibility (especially those consumers experiencing frequent income changes that may impact eligibility) and (2) impede New York's ability to design a single, streamlined, and paperless eligibility determination and redetermination process as envisioned by the ACA.

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[21] The proposed rule allows children living with caretaker relatives, such as grandparents, to apply for Medicaid without consideration of the relatives' income. When non-custodial parents claim children as tax dependents, the proposed rule maintains existing Medicaid policy, which considers children part of the households in which they reside. The Medicaid proposed rules also maintain the policy of counting pregnant women as two people. The proposed rule requires non-married parents living with their children, and all married couples living together, to be included in the household regardless of whether they file a joint return.

[22] As set forth in the proposed IRS rule at *REG-131491-10*, "Health Insurance Premium Tax Credit," 76 FR 50931, "modified adjusted gross income means adjusted gross income…increased by amounts excluded from gross income under section 911 and tax-exempt interest the taxpayer receives or accrues during the taxable year."

[23] *CMS-2349-P*, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 76 FR 51148, §435.603(e) and REG-131491-10, "Health Insurance Premium Tax Credit," 76 FR 50931, §1.36B-1(d)(2).

[24] *CMS-9974-P*, "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," *CMS-2349-P*, §§155.315 and 155.320.

The stakes are high for consumers and for New York State on several levels. First, consumer confusion regarding income and household information requirements may generate a high volume of manual determinations that require follow-up and paper documentation. Decades of research in New York State public health insurance programs document that paper-driven, manual processes are impediments to coverage for eligible consumers. Additionally, pursuant to the ACA, consumers are liable to repay APTC overpayments; to the extent that New York's consumers do not understand or cannot easily report household and income changes, they may reach year-end having received tax credits for which they were ineligible, and thus obligated to repay.[25]

Extensive manual processing, coverage gaps, and APTC-related liabilities would surely have a detrimental effect on insurance coverage rates for lower-income New Yorkers in the long-term. Consumers may determine that the complexity of the process combined with the financial exposure of maintaining health insurance coverage is simply more trouble than it is worth.

RECOMMENDATIONS. There are several options for addressing misalignment of eligibility rules to support New York's efforts to design an eligibility determination process that is transparent and accessible and minimizes coverage transitions and gaps. These recommendations focus in particular on policies and procedures related to the State's "reasonable compatibility" standard, electronic verification of eligibility data, and change reporting.

- **Devise a Reasonable Compatibility Standard that Minimizes Unnecessary Reporting and Documentation.** New York's "reasonable compatibility" standard can be a critical tool to minimize coverage gaps. New York State has a successful, time-tested self-attestation policy at Medicaid recertification. The State could base its reasonable compatibility standard on this experience to: (1) maximize automated eligibility determinations; (2) rely on consumer attestation and IRS data verification for all IAP determinations to the greatest extent possible; and (3) minimize circumstances where documentation and other manual processes are required. In doing so, New York would reduce documentation requirements and minimize loss of coverage for eligible consumers that fail to meet such requirements. As a simple example, the State's reasonable compatibility standard could stipulate that no verification (or even change reporting) is required for already Medicaid eligible consumers who experience income decreases (because such changes do not impact their Medicaid eligibility).
- **Design Underlying Eligibility Business Rules to Maximize Electronic Verification of Eligibility Data.** New York's 2014 eligibility information systems should be able to access robust data from a variety of sources to support automated income data analyses for all IAP eligibility determinations. Such sources of data should include Federal tax data, Social Security

[25] B.D. Sommers and S. Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid and Health Insurance Exchanges," Health Affairs, 30, no.2 (2011):228-236, February 2011.

Administration, and State wage data (e.g., Wage Reporting System, TALX Work Number, State unemployment data sources). In this regard, it is essential that New York's Federal partners develop a robust and accessible Federal data hub that is available to states beginning in 2014.

- **Take Predictable Income Changes into Account at Application and Renewal of IAP Coverage.** Proposed Federal rules give the State flexibility to take predictable increases or decreases in income into account when calculating an applicant's income for the purposes of Medicaid eligibility.[26] This practice is already employed by some New York counties in conducting Medicaid eligibility determinations, but its use and standards vary by county. New York would be able to minimize change reporting and coverage transitions related to predictable income changes by allowing consumers to take such changes into account at IAP application and redetermination.

- **Design and Promote Accessible and Easy–to-Use Consumer Change Reporting Tools.** As part of Exchange and Medicaid consumer assistance resources (e.g., Exchange website, call center, Navigators), the State should craft simple tools that enable consumers to report changes and receive real-time information regarding implications of changes for their IAP eligibility. Accessibility and ease of use of such tools will be essential for New York's consumers to determine when a change in income or other eligibility factors are material to their IAP eligibility.

- **Develop Targeted Customer Assistance and Navigator Capacity to Support Consumers When They Have Changes in Eligibility Circumstances.** Exchange and Medicaid customer service resources, including Navigators, should be well trained in, and specifically focus initial and ongoing customer interactions on, change reporting requirements, how to best mitigate year-end APTC reconciliation risk, and plan selection to minimize the impact of coverage transitions if they do occur. Consumer education regarding change reporting requirements should be consistent with the State's reasonable compatibility standard; for example, consumers should be given guidance to determine when income changes are likely to be material, and thus necessary to report.

ELIGIBILITY AND COVERAGE ACTIVATION/TERMINATION TIMEFRAMES

ISSUE. New York Medicaid/Family Health Plus (FHPlus) and Child Health Plus (CHPlus) have divergent policies with respect to coverage time periods and activation/termination of coverage. Federal guidance on QHP coverage timeframes creates a third framework for coverage activation and duration.

[26] CMS-2349-P, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 76 FR 51148, §435.603(h).

FIGURE 4. Comparison of Medicaid/CHPlus/QHP Coverage Eligibility and Enrollment Timeframes

	Medicaid	CHPlus	QHP
Application Acceptance	Rolling basis (consumers may apply for coverage at any time during the year).[27]	Rolling basis.	Annual open enrollment October 15 through December 7.[28]
Eligibility Determination and Enrollment[29]	Applicants may be determined eligible for and have their coverage activated at any time during the month, with fee-for-service coverage provided until MMC enrollment is activated at the first of the month.	Coverage in CHPlus is provided exclusively through health plans and therefore begins at the start of a month and is terminated on last day of month.[30]	First of the month. APTCs may only be provided for consumers enrolled at the beginning of the month.[31]
Coverage Activation[32]	For plan selections received within the first two weeks of the month, MMC enrollment is effectuated on the first of the following month. For plan selections/applications received after the first two weeks of the month, MMC enrollment is effectuated the first of the second following month.	CHPlus coverage starts on the first of the following month for applications received by the 20th, and the first of the second following month for applications received after the 20th.	According to proposed regulations, QHP coverage starts on the first of the following month for applications received by the 22nd of the month, and the first of the second following month for applications received after the 22nd. HHS has invited comment on whether there should be more flexibility in this coverage activation date for individuals who choose to forgo receipt of APTCs for a partial month.

IMPLICATIONS. Misalignments in coverage start and end dates may create structural gaps in coverage for individuals who experience eligibility changes as a result of income fluctuations. While structural gaps are implicit in all insurance models to some degree (e.g., many people who have changed employers or health plans have probably experienced a temporary gap in insurance), the potential loss of coverage is a particular risk for lower-income New Yorkers with frequent income changes. HHS acknowledges the potential for coverage gaps in regulatory commentary and invites feedback on whether HHS should promulgate a rule to require Medicaid coverage to extend to the end of the month of coverage termination (as opposed to mid-month terminations) in order to align with Exchange coverage rules.[33]

[27] NY Social Services Law §366-a.

[28] Proposed regulations stipulate that initial open enrollment for plan year 2014 run from October 1, 2013, through February 28, 2014. See *CMS-9989-P*, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 76 FR 41866, §155.410.

[29] Existing Medicaid and CHPlus policies allow for "presumptive eligibility" for pregnant women (Medicaid) and children (Medicaid and CHPlus). Qualified providers assist applicants in completing simple applications to gain immediate coverage, with 60 days to complete a full application for Medicaid or CHIP coverage.

[30] New York State Plan Amendment Application, Children's Health Insurance Program, submitted March 29, 2010, available at http://www.cms.gov/NationalCHIPPolicy/downloads/NYCurrentStatePlan.pdf.

[31] ACA Section 36B(c)(2)(A)(i).

[32] Existing Medicaid policy allows for coverage to be retroactive up to 90 days prior to the date of application.

[33] CMS-2349-P, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 76 FR 51148, Preamble.

ILLUSTRATIVE EXAMPLE
Coverage Gaps from Misalignment in Coverage Timeframes

SCENARIO 1

John is currently enrolled in Medicaid. When his coverage is up for renewal, he reports a new job that changes his eligibility from Medicaid to a QHP, for which he qualifies for refundable tax credits (APTCs) to subsidize the cost of premiums for a plan purchased through the Exchange. John's Medicaid eligibility ends on March 14th. John is eligible to enroll in a QHP and start receiving his APTCs on April 1st. If Medicaid is not extended to the end of the month, John would be uninsured for two weeks. If Medicaid coverage is extended to the end of the month, John would not experience a gap in coverage.

SCENARIO 2

John's Medicaid eligibility ends on March 24th and he isn't eligible for QHP enrollment or APTCs until May 1st. Even if John's Medicaid coverage is extended to the end of the month, John will have a four-week gap in his insurance coverage.

RECOMMENDATIONS. There are several possible remedies to misalignment of coverage periods that may be evaluated by plans and the Exchange.

- **Maintain 12-Month Continuous Coverage.** New York should maintain its 12-month continuous coverage policy beyond 2014 for adults and children in Medicaid. Twelve-month continuous coverage is an important tool for smoothing coverage transitions, particularly during initial Exchange implementation and operations. Doing so would ensure that a Medicaid-eligible consumer who has an income increase would have a predictable transition to QHP enrollment at a date certain: the end of his or her 12-month Medicaid coverage period. The Exchange and Medicaid Agency would be able to transition this consumer without a coverage gap.
- **Extend Medicaid Coverage to Month-end.** New York State could minimize coverage gaps at transition by supporting and implementing the proposed Federal option to extend Medicaid coverage to the end of the month.
- **Evaluate Extension of Medicaid Coverage Until QHP Coverage Activation.** The State may also extend Medicaid/CHPlus eligibility for consumers transitioning from Medicaid to subsidized QHP coverage until a consumer's new coverage is in effect, provided that the consumer has paid his or her QHP co-premium in a timely manner. Such strategy would require CMS partnership to ensure that New York receives Federal matching funds for such coverage extensions as well as a "safe harbor" for duplicate State/Federal premium payments in the initial implementation of this policy.
- **Enroll Consumers in Medicaid FFS Until Medicaid Managed Care Coverage Activation.** As a last option, the State may allow consumers transitioning from subsidized QHP coverage to Medicaid to be covered through Medicaid FFS until their MMC plan enrollment can be effectuated. Alternatively, the State may consider allowing these consumers to remain

enrolled in their QHP (or transition to a lower-cost QHP) and pay the full premium until their Medicaid plan enrollment can be effectuated. The majority of consumers who have experienced a decline in income and become Medicaid eligible will not be willing or able to pay full premium for their coverage, but some small number of consumers, particularly those with high health needs, may elect to do so for a time-limited period to avoid a coverage gap.

12-Month Continuous Medicaid Coverage for Adults

One important policy already in New York's continuity "tool box" is the State's ability to provide 12-month continuous eligibility for adults in Medicaid, approved through 2014 as part of the State's Section 1115 Waiver renewal.[34] Twelve-month continuous coverage supports coverage stability and predictability, enabling the State and consumers to anticipate and plan for transitions from Medicaid to other coverage when income or other family circumstances change. The State pursued this flexibility from CMS in light of the fact that most income changes for low-income people are "immaterial"—that is, do not make the individual or family ineligible for Medicaid. Additionally, processing redeterminations for every income change is administratively costly and results in eligible people losing coverage only to reenroll at a later date, driving even more administrative waste and cost.[35]

RENEWAL

ISSUE. In an effort to minimize the risk of consumers losing coverage, both the Medicaid and Exchange regulations set forth user-friendly redetermination (coverage renewal) processes that build on successful strategies states have used to increase retention rates, decrease churning, and reduce administrative burdens in Medicaid. Pursuant to draft Medicaid eligibility guidance, State Medicaid agencies are required to assess if the individual still qualifies for Medicaid based on the data already available from electronic databases. If that information is sufficient to make a determination of eligibility without requiring an in-person visit or paperwork documentation from the individual, coverage shall be renewed. This process is generally referred to as "administrative renewal."

Draft Exchange regulations provide that Exchanges must send consumers receiving APTCs an annual redetermination notice, including any APTC payments or level of cost-sharing reductions for which he or she appears to be eligible in the proceeding year based on updated eligibility information. The enrollee must sign and return the notice, including any corrections required. If the enrollee does not sign and return the notice, the Exchange will redetermine eligibility based on the eligibility information in the notice.

IMPLICATIONS. Proposed regulations specify that, if upon redetermination or renewal, consumers are found ineligible for their current IAP, they must be assessed for eligibility for

[34] N.Y. Pub. Health L. §2510(6).

[35] R. Seifert, G. Kirk, and M. Oakes, "Enrollment and Disenrollment in MassHealth and Commonwealth," Prepared for the Massachusetts Medicaid Policy Institute, April 2010, available at http://bluecrossfoundation.org/~/media/MMPI/Files/2010_4_21_disenrollment_mh_cc.pdf.

other IAPs and could be determined eligible for another IAP—Medicaid or APTCs. Guidance is not explicit with regard to the process by which the State may or must effectuate coverage transitions at redetermination; it would therefore appear that states have flexibility in this regard. Depending on coverage transition procedures implemented by the State, there are significant opportunities to mitigate coverage interruptions at renewal or because of mid-year changes in eligibility.

RECOMMENDATIONS. New York has the opportunity to take full advantage of administrative renewal in Medicaid and pursue auto-enrollment policies (with consumer opt-out) to help minimize potential enrollment gaps related to consumers being required to select and actively enroll in a new health plan:

- **Implement and Maximize Use of Administrative Renewal in Medicaid.** With the design of its new information technology infrastructure to support ACA-compliant eligibility determination and enrollment for Medicaid and APTCs, New York has the opportunity to maximize data storage and system interfaces to other human services programs to fully leverage administrative renewal in Medicaid.
- **Auto-Enroll Consumers Transitioning from APTC to Medicaid Eligibility.** New York State has long used auto-enrollment in Medicaid for consumers who do not select a health plan within a specified "choice period." The State should consider building on this experience to implement automatic enrollment into the Medicaid product of the health plan from which the consumer currently purchases a QHP using APTCs (to the extent the health plan offers both QHP and MMC products). If the carrier does not offer an MMC product and the consumer has prior enrollment history in MMC, the State may consider auto-enrolling the consumer into his or her previous MMC plan. At the time of auto-enrollment, the State could also notify consumers of their right to select an alternative health plan. In addition, the State could notify health plans of the consumer's change in IAP eligibility to enable plans to further support consumers by conducting outreach and education on the implications of the eligibility change.
- **Evaluate Options for Auto-Enrollment of Consumers Transitioning from Medicaid to APTC Eligibility.** The State may also be well served by evaluating auto-enrollment in a QHP offered by the same carrier of individuals transitioning from Medicaid to APTCs. However, such auto-enrollment is decidedly more complicated than Medicaid auto-enrollment. First, these consumers would be transitioning from a zero co-premium coverage to a product requiring co-premiums (in some cases, substantial) and would need to pay their new co-premiums in order to effectuate coverage. These consumers would also have a potentially expansive range of QHP products from which to choose across and within the precious metal tiers of coverage. Nevertheless, the State may consider potential auto-enrollment strategies for these consumers, perhaps defaulting to auto-enrollment in the second-lowest cost Silver

Tier product (thus enabling them to access cost-sharing reductions) and making coverage activation conditional on payment of a co-premium.

Plan Participation in Medicaid Managed Care and the Exchange

There is broad consensus that states can help ensure coverage continuity in the face of income-driven eligibility changes by maximizing health plan participation across Medicaid and the Exchange. By doing so, states can align plan options in both the government (Medicaid/CHIP) and private (QHP) markets.[36] The extent to which Medicaid/CHIP and QHPs are siloed, with a unique universe of offering plans in each market, creates complexities for families with split IAP eligibility (making it impossible to enroll in a "family" health plan) and creates barriers to smooth coverage transitions across the continuum of coverage, requiring consumers to change health plans and possibly providers with each shift in subsidy eligibility. Simply put, lack of alignment in health plan participation across the public and private markets creates barriers to continuity in coverage and continuity in care.

ILLUSTRATIVE EXAMPLE
Split Eligibility

SCENARIO

The Smiths are a family of four living in New York. The family earns $50,000 a year, which equates to 270% of the Federal Poverty Level (FPL) for a family of four. At that income level, the parents will be eligible for APTC subsidies to purchase QHP coverage through the Exchange while the children, who are under age 19, will be eligible for CHPlus. Depending on the level of alignment across New York's public and private insurance markets, members of Smith family may be required to enroll in and manage separate health insurance plans.

In New York, nearly 75% of public insurance beneficiaries are enrolled in managed care plans,[37] and the State's Medicaid Redesign initiative intends to enroll almost all Medicaid members in care management by the end of 2014, relying extensively on the existing managed care infrastructure to do so. New York's Medicaid Managed Care marketplace is served by 18 plans statewide. Prepaid health services plans (PHSPs) serve three-quarters of total MMC and Family Health Plus (FHPlus) members statewide, including more than 1,800,000 in New York City.[38]

It will be essential to continuity of coverage for low-income New Yorkers that New York State develop policies geared toward alignment of health plans, commercial and Medicaid, across

[36] D. Bachrach, P. Boozang, and M. Dutton, "Medicaid's Role in the Health Benefits Exchange: A Road Map for States," NASHP, March 2011, available at http://www.maxenroll.org/files/maxenroll/file/maxenroll%20Bachrach%20033011.pdf.

[37] Manatt analysis of August 2010 NYS Department of Health managed care enrollment data.

[38] Coalition analysis of NYS Department of Health data, November 2011.

the continuum of coverage options in 2014. As part of such an alignment strategy, New York may seek to address barriers to entry for public health plans into the BHP and QHP markets. Indeed, there are unique considerations for these plans with regard to Exchange participation. The following section provides analysis of these issues, including recommendations to reduce barriers to participation in the State's new Exchange and facilitate MMCs' continued role in serving low-income New Yorkers. In conjunction, New York should ensure that the BHP and QHP markets remain attractive to commercial plans.

BASIC HEALTH PROGRAM

ISSUE. The ACA offers states the option to implement an additional coverage option targeted to citizens between 139% and 200% FPL and legal immigrants under 200% FPL through the BHP. The BHP is a State-administered program funded by 95% of the APTCs and cost-sharing reductions that would have been available for these individuals had they been enrolled in coverage through the Exchange. The BHP may offer the opportunity to enhance affordability of coverage for lower-income New Yorkers and substantially align health plans for consumers from 0–200% FPL.

IMPLICATIONS. Without additional support or adjustments in the affordability standard,[39] Federal subsidies for premiums and cost-sharing may not be sufficient to make coverage affordable for New York's lower-income individuals and families. Through the BHP, New York may be able to leverage Federal subsidies and government purchasing power to secure more affordable comprehensive benefit packages for the targeted population below 200% FPL. In doing so, New York State would be able to save significant State dollars by transitioning from Medicaid certain immigrants, including those who have resided in the country for less than five years and are thus ineligible for Federal matching funds.[40] Additionally, a BHP is a natural progression of the State's current Family Health Plus program, which covers adults up to 150% of the FPL. FHPlus is served now by the State's MMC plans, which could continue to serve their current enrollees through a New York BHP; as such, a BHP would create significant alignment of health plans for consumers from 0–200% FPL.

From a continuity perspective, the implementation of a BHP would create an additional coverage transition point at 200% FPL, where income fluctuations also occur and (as reflected in the volatility data reviewed in the second section of this paper) may be even more prevalent depending on the economic conditions. Additionally, several policy analyses on

[39] Coverage under an employer-sponsored plan is affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year. http://www.irs.gov/pub/irs-drop/n-11-73.pdf.

[40] E. Benjamin and A. Slagle. "Bridging the Gap: Exploring the Basic Health Insurance Option for New York," New York State Health Foundation, June 2011.

the BHP raise concern regarding the implications of a BHP for the Exchange risk pool, as the BHP is estimated to potentially draw a significant proportion of subsidized and possibly healthier individuals out of the Exchange.[41] Finally, the BHP is a complex program for which HHS has released limited information that is inadequate to truly evaluate its fiscal feasibility for consumers or the State.[42]

RECOMMENDATIONS. The creation of a BHP will more than likely mitigate coverage gaps for the lowest-income New Yorkers both by creating a more affordable coverage option for consumers who exceed Medicaid eligibility levels and aligning health plans for New Yorkers with income fluctuation up to 200% FPL. Given the potential compelling benefits of a BHP, the State should continue to dedicate policy and planning resources to assess and implement a New York State BHP, including:

- **Complete the Study on the BHP Option for New York in Q2 2012.** To position itself for BHP decision-making and related critical Exchange design decisions this year, the State would be well served by completing the study and review of the BHP option as authorized under the Governor's proposed budget and pending Exchange legislation (S5849/A8514) in the second quarter of 2012. This study would assess affordability and coverage continuity implications for consumers; financial feasibility for the State and potential State fiscal relief; the impact on the Exchange risk pool and Exchange sustainability; delivery model options; required State administrative resources; and key unknowns with respect to modeling a New York State BHP. Completion and review with stakeholders of this study in the second quarter of 2012 will support State decision-making regarding the BHP soon thereafter; the decision is central to the design of the State's Exchange as well as carrier decisions with respect to QHP product development and operational readiness for Exchange implementation in 2014. Health plan participation will be critical to the State's success in implementing a BHP, and the State should engage actively with plans in the design of the BHP.
- **Monitor and Engage in Federal Rulemaking with Respect to the BHP.** Many BHP design issues require Federal guidance, including calculation of Federal financing available for the BHP, ability for states to use Federal funding for program administration costs, and the

[41] R. Carey, "Health Insurance Exchanges: Key Issues for State Implementation," State Coverage Initiatives, September 2010, available at http://www.rwjf.org/files/research/70388.pdf and S.Dorn, "The Basic Health Option under Federal Health Reform: Issues for Consumers and States," State Coverage Initiatives, March 2011, available at http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf.

[42] D. Bachrach, P. Boozang, and M. Dutton, "Medicaid's Role in the Health Benefits Exchange: A Road Map for States," NASHP, March 2011, available at http://www.maxenroll.org/files/maxenroll/file/maxenroll%20Bachrach%20033011.pdf, S.Dorn, "The Basic Health Option under Federal Health Reform: Issues for Consumers and States," State Coverage Initiatives, March 2011, available at http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf and E. Benjamin and A.Slagle, "Bridging the Gap: Exploring the Basic Health Insurance Option for New York," New York State Health Foundation, June 2011, available at http://www.nyshealthfoundation.org/content/document/detail/12952/.

application of risk adjustment on Federal funding. The State should engage with Federal officials to inform policymaking and promote issuance of additional Federal guidance in the near term. In addition to providing further design and implementation detail in the areas noted above, Federal guidance should be crafted to reduce financial exposure to states caused by consumer income volatility that may result in substantial year-end reconciliations.

LICENSURE

ISSUE. PHSPs are licensed under a special provision of the New York Public Health Law that authorizes them to serve a population "substantially composed" of persons eligible to receive benefits under Medicaid "or other public programs."[43] PHSPs must operate within this licensing restriction; they may not enroll an unlimited number of commercially insured individuals. Unfortunately, neither the language of the PHSP licensing law nor its legislative history provides clear guidance on the definition of the terms "public program" or "substantially composed."

IMPLICATIONS. PHSPs may face uncertainty regarding the extent to which they may participate in New York's Exchange, enrolling members through (1) QHPs offered in the individual and, possibly, small group markets and (2) a BHP, to the extent New York establishes one.

RECOMMENDATIONS. There are two approaches to eliminate the uncertainty related to PHSP enrollment limitations:

- **Define "Substantially Composed" to Mean No Less than 50% of a Plan's Population.** The State Department of Health (SDOH) should interpret the term "substantially" to mean no less than 50% of the population served by the plan are persons eligible to receive benefits under Medicaid or other public programs. This interpretation is a reasonable one absent any guidance in the statute. It would ensure that PHSPs continue to focus at least a majority of their activities on serving Medicaid beneficiaries and other individuals enrolled in traditional government-run health insurance programs. And it would at least authorize PHSPs to serve a significant number of individuals through New York's Exchange and/or a BHP. However, an enrollment cap would likely be difficult to implement without impeding continuity of care.
- **Classify Subsidized QHPs Sold Through the Exchange and the BHP as "Public Programs" for Licensure Purposes.** Alternatively, for the purposes of PHSP licensure, the SDOH could classify subsidized QHPs sold through the Exchange and a BHP to be "public programs." There are compelling arguments in support of this position. The Exchange is a publicly organized marketplace in which State and Federal regulators play significant roles in determining the terms of coverage and the manner in which insurance is sold. Indeed, the State may select a subset of licensed insurers to participate in the Exchange. Moreover, QHP

[43] N.Y. Pub. Health L. § 4403-a.

coverage obtained by individuals through a BHP or with government subsidies in the form of tax credits is particularly analogous to the government health insurance coverage currently provided by PHSPs.

This second approach is preferable for PHSPs, as it would authorize PHSPs to enroll individuals into QHPs without any prospect of an enrollment cap. However, it is not clear if deeming Qualified Health Plans as "public programs" creates a market barrier to commercial plans, including commercial HMOs that currently provide Medicaid managed care, from entering products in the Exchange.

TAX-EXEMPT STATUS

ISSUE. Many PHSPs are exempt from taxation under either Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code. But, as required by Section 501(m) of the Code, their tax-exempt status hinges on the assumption that "no substantial part" of their activities consist of offering "commercial-type insurance."[44]

IMPLICATIONS. The tax-exempt status of PHSPs would be jeopardized if the sale of QHPs through New York's Exchange is deemed inconsistent with this assumption. It is unclear what constitutes a "substantial part" of an organization's activities. When considering whether offering commercial-type insurance constitutes a substantial part of an exempt organization's activities, the IRS will consider the relevant facts and circumstances for that entity, rather than apply a bright-line test.[45] That said, there is case law and guidance suggesting that an organization will not lose its tax-exempt status if less than 15% of its activities are related to offering commercial-type insurance.[46] A 15% limitation is likely to serve as a significant impediment to the full and effective participation of tax-exempt PHSPs in the Exchange. Therefore, reliance by PHSPs on the position that such participation is not a "substantial part" of their activities is not an ideal approach to maintaining tax-exempt status.

RECOMMENDATIONS. To promote tax-exempt PHSP participation in the Exchange, the State and plans should collaborate to address potential tax status limitations through one of two alternatives:

- **Seek IRS Guidance that "Commercial-type Insurance" Excludes QHPs.** The State and plans could seek guidance from the IRS indicating that "commercial-type insurance" excludes QHPs sold by tax-exempt PHSPs through the Exchange. The rationale for this position would

[44] 26 U.S.C. § 501(m).

[45] See Internal Revenue Manual § 7.25.41.1.1.

[46] *See* Internal Revenue Manual § 7.25.41.1.1.

be similar to the reasoning behind the position that coverage offered through the Exchange is a "public program" under the PHSP licensing law.

- **Define "Commercial-type Insurance" to Exclude HMOs.** Alternatively, PHSPs could rest on the fact that, under 501(m), the term "commercial-type insurance" does not include "incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations."[47] While the IRS has not taken a clear position on what constitutes this type of incidental health insurance, as a general matter, the IRS has indicated that HMOs provide only incidental insurance if they shift significant financial risk to their providers.[48] HMOs may shift risk to providers through capitation or other means.[49] The IRS has stated that, by shifting risk to providers, HMOs deliver services—arranging for health care—rather than offer insurance. Because many PHSPs share risk with their participating physicians and sometimes their hospitals, they may have an argument that they are offering "incidental health insurance" through the Exchange and are acting in accordance with their tax-exempt status.

ACCREDITATION

ISSUE. Under the proposed rule, insurers offering QHPs must be accredited by an accrediting entity recognized by HHS.[50] New York State does not currently require health plans participating in public health insurance programs to be accredited. As a result, few PHSPs have sought accreditation. Conversations with the national association of Medicaid plans point to a similar experience for these plans across the country. Only about one-third of the member plans have pursued or are pursuing accreditation through organizations such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC). The process is lengthy—about one to two years from preparation to completion—and costly. More often than not, plans secure the assistance of outside consultants to help navigate the complex accreditation process.

IMPLICATIONS. The cost of obtaining and maintaining accreditation could serve as a significant barrier to PHSP entry into New York's Exchange. PHSPs rely exclusively on revenue from government programs; many plans are financially strained because of substantial Medicaid premium cuts.

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[47] 26 U.S.C. § 501(m)(3)(b).

[48] *See* Internal Revenue Manual § 7.25.41.1.1; *see also* General Counsel Memorandum 39829 (1990); *cf.* Rev. Rul. 68-27, 1968-1 C.B. 315.

[49] *See* General Counsel Memorandum 39829 (1990).

[50] *CMS-9989-P*, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 76 FR 41866, §156.275.

RECOMMENDATIONS. New York State would do well to exercise its flexibility in implementing this requirement and may consider seeking additional flexibility from HHS to establish its own accreditation standard. In its considerations, New York may specifically:

- **Seek HHS Approval for New York State-Specific Accreditation.** The State could seek HHS approval of a New York-specific accreditation that would leverage the State's existing, rigorous plan certification processes. Plans complying with the State's existing certification could be deemed QHP-certified. As one example, all licensed HMOs and PPOs in New York State participate in the State's Quality Assurance Reporting Requirements (QARR) program. The QARR program is State-specific, based on New York's public health priorities, and as such is arguably a better indicator of plan quality than national accreditation, with the added benefit of minimizing State and plan administrative burdens.
- **Establish Sufficient Lead Time for Plan Accreditation.** New York could also exercise the flexibility afforded by HHS to determine when the Exchange will implement the accreditation standard to afford plans a sufficient period of time to prepare for and obtain accreditation.[51]

SHOP EXCHANGE PARTICIPATION AND MARKET MERGER

ISSUE. The ACA requires insurers participating in the individual market to "take all comers" in the individual market within the Exchange, but does not require plans to participate in the SHOP (Small Business Health Options Program) or in any markets outside the Exchange. States have the flexibility to impose additional requirements on carriers seeking to offer QHPs in the Exchange, such as mandatory insurer participation in the SHOP.[52] States also have considerable flexibility in implementing other market reforms with implications for carriers offering individual products inside and outside of the Exchange, including merger of the individual and small group markets for rating purposes.

IMPLICATIONS. Different issuer infrastructure, experience, and product offerings are required to meet the needs of the individual versus the small group markets. Should New York State require carriers to participate in both the individual and SHOP markets, it could be a barrier to participation by traditional MMC plans, which possess deep experience in providing individually-focused coverage, but little experience or infrastructure serving the group market. As one of the five states that already has guaranteed issue in the individual

[51] *CMS-9989-P*, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 76 FR 41866, §155.1045.

[52] ACA §1311(e)(1)(B) and *CMS-9989-P*, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 76 FR 41866, §155.1000.

market, New York is evaluating the merger of the individual and small group markets for rating purposes and may decide to merge risk pools, but such action would not compel the State to require carriers to participate in all products.[53]

However, a market merger may create selection issues for plans offering QHPs solely in the individual market. Various studies validate that the small group market generally comprises healthier consumers than the individual market. Merging and pooling risk across these two markets is intended to result in premiums that are slightly higher than current experience for the small group market and lower than current experience for the individual market.[54] To the extent that a plan participates only in the individual market (and therefore cannot spread premium risk across the two markets), the carrier would likely have higher than average costs for its QHP members, requiring higher than average premiums to meet those costs, and thus be at a competitive disadvantage in the Exchange as compared to carriers participating in both markets. Finally, public health plans in particular are likely to attract a disproportionate number of subsidized individual members, who are generally believed to have greater health needs and costs than higher-income individuals.[55]

RECOMMENDATIONS. In designing New York's Exchange, the State should explore options to:

- **Permit Carriers to Offer QHPs in the Individual Exchange Only.** New York's Exchange should avoid requiring plans to participate in both the individual and small group markets, even if it should pursue a merged market.
- **Study the Implications of Market Merger for Plans Participating Only in the Individual Market.** New York has commissioned a study of a potential merger of the individual and small group markets. As part of that study, or as a follow-up, the State may consider evaluating

[53] An illustrative example is the Massachusetts market, which merged the individual and small group risk pools, but maintains separate treatment of the individual and small group markets in the Connector, allowing for participation of different issuers and different products in the two Exchanges.

[54] L.J. Blumberg, A.B. Garrett, M. Buettgens, L. Clemans-Cope, J. Holahan, A. Lucas, P. Masi, and B. Shang, "Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options." Final Report to the NYS Department of Health and the NYS Department of Insurance., July 2009, available at: http://www.urban.org/UploadedPDF/411925_ny_health_insurance.pdf and J. Herbold, Milliman, "Merging the Individual and Small Group Markets: Health Care Exchange Issue Brief: Indiana Exchange Policy Committee," May 2011, available at http://www.in.gov/aca/files/Merge_Ind_SG.PDF.

[55] J.M. Sutherland, E.S. Fischer, and J.S. Skinner, "Getting Past Denial—The High Cost of Health Care in the United States," *New England Journal of Medicine* 361:1227-1230, September 2009, available at http://www.nejm.org/doi/full/10.1056/NEJMp0907172, Congressional Budget Office, "Designing a Premium Support System," December 2006, available at http://www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf, T. Rice and K. Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," *Journal of Health Politics, Policy, and Law*, December 2004, available at http://www.kff.org/medicare/upload/The-Distributional-Consequences-of-a-Medicare-Premium-Support-Proposal.pdf and Medicare Payment Advisory Commission, "Report to the Congress: Promoting Greater Efficiency in Medicare," June 2007, available at http://www.medpac.gov/documents/jun07_entirereport.pdf.

the implications of a market merger and risk selection for plans that participate only in the individual Exchange, particularly PHSPs that are likely to attract primarily lower-income members who qualify for subsidized QHPs.

- **Evaluate Inclusion of Enrollee Income as Part of the State's Risk Adjustment Mechanism.** HHS is developing and will propose a federally-certified risk adjustment methodology for state implementation. New York State has the option of proposing to use an alternative risk adjustment methodology. The State may consider evaluating the possibility of advocating with HHS for consumer income to be a variable in the federally-certified methodology and/or for inclusion in the State proposed methodology should New York pursue one.

Covered Benefits and Provider Networks in Medicaid and Qualified Health Plans (QHPs)

ISSUE. The ACA mandates that QHPs provide an Essential Health Benefit with minimum standard covered benefits that all QHPs must cover,[56] and cost-sharing obligations that vary by subsidy level and precious metal tier.[57] The ACA also provides that the newly eligible Medicaid population will receive a benchmark benefit package that must be at least as generous as the Essential Health Benefit, with nominal levels of cost-sharing.[58] Should the State decide to establish a BHP, the covered benefits must also be at least as generous as the Essential Health Benefit package.[59] A recent Federal "pre-rule" suggests that New York will have significant flexibility in defining the Essential Health Benefit, including flexibility to define essential benefits generously.[60]

With respect to provider networks, the ACA and implementing guidance establish provider network adequacy requirements as a condition of QHP certification, including ensuring that enrollees have a sufficient choice of providers and information regarding the availability of both in-network and out-of network providers. Proposed implementing regulations also require that QHPs include in their networks "sufficient" numbers of essential community providers that serve predominantly low-income, medically underserved individuals.

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[56] ACA, §1302.

[57] ACA, §§1401, 1402, 1411, 1412.

[58] ACA, §2001(c).

[59] ACA, §1331.

[60] HHS, Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," December 16, 2011, available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

IMPLICATIONS. To the extent that covered benefits (including the current standard Medicaid benefit, the new Medicaid benchmark benefit, a BHP, and QHPs) and provider networks differ across New York's IAPs in 2014, consumers may experience barriers to continuity of coverage and care. Implications for consumers transitioning between coverage programs (and possibly different health plans participating in those programs) may include disruptions to provider relationships and/or their ongoing courses of medical care, mental health treatment, and pharmaceutical therapies.

The Essential Health Benefit pre-rule appears to give New York discretion to drive alignment of benefits across the coverage continuum. A variety of considerations, including affordability of QHP (and possibly BHP) coverage for consumers and fiscal feasibility for State Medicaid, will be implicit to State decisions regarding benefit alignment.

In terms of provider network alignment, there is a strong degree of provider network alignment in New York's public insurance market; plans commonly negotiate all-program—Medicaid, FHPlus, CHPlus, and Medicare—contracts. However, similar consistency has not been achieved for provider networks across the public and commercial insurance markets.[61] The ACA will drive some alignment by requiring that QHP networks include essential community providers, but the ability to ensure that a consistent set of providers is available across Medicaid, the BHP, and QHPs will depend on a number of additional factors, including provider price sensitivity in evaluating participation in a BHP and QHP products offered by traditional MMC plans.

RECOMMENDATIONS. Although full analysis of implications and continuity strategies related to benefit and provider alignment are beyond the scope of this paper, we suggest that New York may pursue the following recommendations:

- **Complete the Study on Benefit Standardization in Q2 2012.** To position its decision-making regarding the alignment of benefits across the public and private markets, the State would be well served by completing the study on benefit standardization as authorized under pending Exchange legislation (S5849/A8514) in the second quarter of 2012. This study would assess the potential fiscal implications of standardizing benefits—including the impact of defining an Essential Health Benefit to include New York's mandated benefits, implications for State Medicaid costs, and BHP costs. Completion and review with stakeholders of this study in the second quarter of 2012 is central to the design of the State's Exchange, implementation of the Medicaid expansion, and health plan decisions with respect to QHP product development and Medicaid and Exchange operational readiness by 2014.

[61] D. Holahan, "Coordinating Medicaid and the Exchange in New York," United Hospital Fund, May 2011, available at http://www.uhfnyc.org/publications/880749.

- **Evaluate QHP Certification and MMC Contracting Strategies that Drive Provider Network Alignment.** The State may consider evaluating and modeling strategies to incentivize plans that participate in MMC, BHP (if the State establishes one), and QHPs to align provider networks across these products. Such alignment will have implications for provider reimbursement and costs, including Medicaid program costs, which should be modeled as part of such evaluation.
- **Look to Existing Care Transition Policies and Procedures in Medicaid Managed Care to Inform IAP Transition Policies.** To the extent that New York is not able to perfectly align benefits across IAPs in 2014, it will be essential to develop care transition policies for consumers in ongoing courses of care that are impacted by their transition to a new program. All licensed HMOs in New York, including those in the MMC program, have tested and implemented successful policies regarding care transitions that may be evaluated for implementation across IAPs in 2014.[62]

Administration of Medicaid Managed Care and QHP Products

Administrative functions and operational practices of the Exchange, New York's MMC program, and the health plans offering MMC and QHP products will have implications for continuity of coverage as consumers transition across IAPs. As such, Exchange design and MMC and QHP administration may also be leveraged and aligned to enhance continuity for lower-income consumers most likely to experience transitions. Below, we discuss recommendations that promote a single, supportive infrastructure through the Exchange and participating health plans to facilitate a consistent and standardized experience for consumers regardless of the IAP for which they are determined eligible at any given point in time.

SHOPPING, ENROLLMENT, AND CUSTOMER SERVICE

ISSUE. The ACA and proposed regulations stipulate that the Exchange and the State Medicaid Agency maintain websites for current and prospective IAP enrollees; these sites will provide information about IAPs and enable application, enrollment, and renewal in coverage. The ACA further mandates detailed, standard, and transparent consumer information regarding QHPs—including benefit information, standardized quality ratings, and cost-sharing responsibilities. Similar information requirements do not exist for Medicaid or CHPlus. Further, while Exchanges are not required by the law to enroll consumers in Medicaid/CHIP coverage, draft Medicaid eligibility guidance notes that Medicaid agencies may delegate to state Exchanges

[62] N.Y. Pub. Health L. § 4403(6)(f) requires all licensed HMOs to permit ongoing treatment during a transitional period of up to 60 days if the new enrollee has an existing relationship with non-participating health care provider, elects to continue to receive care from the non-participating provider, and has a life-threatening disease or condition or a degenerative and disabling disease or condition. For new enrollees receiving care from a participating provider, plans in the New York State MMC program are required to have policies and procedures to ensure new enrollees continue receipt of medically necessary services authorized under a prior managed care plan or Medicaid fee-for-service until an approved care plan is put in place.

responsibility for health plan enrollment for Medicaid beneficiaries.[63] Today, enrollment in Medicaid and CHPlus health plans in New York State is fragmented between programs and regions of the State. CHPlus health plan enrollment is effectuated by health plans. Medicaid eligible consumers select health plans through local district offices or through an enrollment broker, depending upon the region of the State. Health plan and community-based facilitated enrollers smooth much of the fragmentation in New York's eligibility and enrollment processes by providing "one-stop" consumer assistance in applying for Medicaid and CHPlus.

IMPLICATIONS. Consumers transitioning from QHP coverage to New York Medicaid/FHPlus/CHPlus, or vice versa, may confront radically different health plan selection and enrollment processes in 2014. Absent alignment of enrollment processes, consumers will be required to access variable plan information through different websites, seek telephonic assistance through different call centers, and effectuate enrollment through different processes. Such fragmentation of enrollment processes may create barriers to continuity of coverage for these consumers.

RECOMMENDATIONS. Fostering consumer reliance on a single, trusted source of information regarding all insurance coverage options in the State, subsidized and unsubsidized, can be an effective and valuable tool in promoting continuity of coverage in 2014 and beyond.

New York State could enhance continuity of coverage by providing all consumers, regardless of the IAP for which they are eligible, with a single, standard, web-enabled shopping, enrollment, and consumer assistance experience. Specifically:

- **Create a Health Plan Shopping Functionality to Serve All Consumers, Regardless of Income.** The State Exchange could enhance continuity by providing shopping and enrollment functionality to all consumers, regardless of the IAPs for which they are eligible, including Medicaid.
- **Provide Targeted Decision Support for Lower-Income Families.** New York's Exchange should provide consumer decision support functionality on its website and through Navigator and consumer service call centers targeted to assisting lower-income consumers in selecting a health plan. This may include generating plan recommendations, highlighting or prioritizing plans that participate in all IAPs, for consumers with incomes below 200% FPL.
- **Consolidate Call Center/Customer Service for all IAPs in the State.** The State should consider consolidation of call center/customer service functionality for all IAPs. In doing so, New York could provide a single, integrated, best-in-class capability for consumers seeking information or assistance with subsidized health insurance coverage in the State, including Medicaid, CHPlus, BHP, and APTCs.

[63] *CMS-2349-P*, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 76 FR 51148.

- **Leverage New York's Successful Facilitated Enrollment Infrastructure.** New York has a tried and true facilitated enrollment program that has been successful in connecting with low-income and hard-to-reach populations and smoothing the complexities and fragmentation of New York's public insurance eligibility and enrollment system for eligible consumers. Today, facilitated enrollment is the primary way in which consumers are connected to public health insurance coverage in New York. In leveraging this existing consumer assistance infrastructure, the State could inform development of and supplement the Exchange Navigator program. At a minimum, the State would do well to maintain facilitated enrollment capacity until New York's full eligibility and enrollment IT infrastructure and its Navigator program are operating successfully.

PREMIUM BILLING / PAYMENT

ISSUE. Proposed ACA implementing regulations released in July 2011 mandate that Exchanges perform billing for the small group (or SHOP) market.[64] Exchanges also have the option to perform premium billing for individual consumers; the ACA grants individual consumers the option to pay their premiums directly to carriers even in cases where the State Exchanges provide premium billing functionality.[65] In short, New York's Exchange must determine the level of premium billing functionality that it will provide: SHOP-only or individual and SHOP premium billing.

IMPLICATIONS. Lack of standardization in premium billing practices may create particular confusion for consumers with implications for their access to coverage. For example, consumers transitioning across IAPs could be confronted with learning new premium payment procedures and familiarizing themselves with different administrative entities as they change programs and/or health plans. Consumers in split IAP eligibility families could also be challenged with tracking differing payment procedures for family members in different IAPs. These unnecessary complexities could lead to consumers' unintended noncompliance with premium payments and potential interruptions in coverage.

RECOMMENDATIONS. The State should create a standard and uniform process for premium billing and payment for consumers even as they experience potential changes in their eligibility and health plans. In addition, the State should consider centralization of the function under the Exchange, which would ease premium payment for families with mixed IAP eligibility, and thus family members with multiple plans.

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[64] *CMS-9989-P*, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 76 FR 41866, §155.705.

[65] ACA §1312(b) and *CMS-9989-P*, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 76 FR 41866, §155.240.

- **Design New York's Exchange to Provide Individual Premium Billing as a Core Function.** The State should consider providing both individual and small business premium billing as a core function of the Exchange. In designing premium billing capacity, the State should evaluate and implement Electronic Funds Transfer (EFT) capacity to enable consumers to pay premiums at the time their eligibility is determined. EFT could also promote smooth enrollment and transitions in coverage, and may provide a potential mechanism to effectuate immediate coverage.

CO-PREMIUM PAYMENT AND NON-PAYMENT POLICIES

ISSUE. The ACA requires that Exchanges provide a three-month payment grace period for those consumers receiving APTCs. Proposed rules codify this requirement and further stipulate that the individual must have paid previously at least one month's premium to be afforded the payment grace period.[66] In New York, CHPlus members above 160% FPL are subject to co-premiums. Currently, CHPlus policies provide for a 60-day premium payment grace period. In addition, program rules provide for a mandatory 30-day payment grace period for populations up to 400% FPL.

IMPLICATIONS. Misalignments in co-premium payment rules may cause consumer confusion, create another barrier to seamless transitions in coverage, and add administrative cost and complexity. Additionally, failure to pay co-premiums may indicate a change in consumer eligibility that, if identified by the Exchange, could promote coverage continuity.

RECOMMENDATIONS. Options for the State's consideration with regarding to aligning co-premium payment rules include:

- **Align Premium Payment Grace Periods Across IAPs.** The State should align premium payment grace periods for those failing to pay premiums in CHPlus, the BHP (should the State establish one), and the Exchange.
- **Develop Mechanisms to Support Coverage Retention for Consumers Failing to Pay Premiums.** The State should also evaluate potential mechanisms to continue coverage for consumers who receive CHPlus, BHP coverage, or APTCs and fail to pay premiums. Such policies may include automatic screening for Medicaid eligibility or more generous APTCs, outreach to consumers to increase the percentage of subsidy they are taking advantage of on a month-to-month basis, or encouraging consumers to enroll into a lower-cost QHP, as appropriate.

[66] *CMS-9989-P*, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," 76 FR 41866, §156.270.

Conclusion

As the cornerstone of its universal coverage vision for lower-income Americans, the ACA assembles traditional government-sponsored insurance programs for non-elderly Americans together with federally subsidized, private market-based coverage to create the continuum of Insurance Affordability Programs. With a subsidized coverage continuum that now straddles the public and private insurance markets, New York State strategies to ensure continuity must also span the two insurance marketplaces. In short, alignment of access to and administration of coverage in the public and private insurance markets will be essential to ensuring continuity of health insurance coverage for lower-income New Yorkers in 2014.

The continuity challenge is a daunting one with which New York will grapple from now through 2014 and beyond. First and foremost, the State can tackle the challenge by aligning eligibility and enrollment rules across IAPs to minimize the volume and frequency of coverage transitions, leveraging new tools to eliminate paperwork, and maximizing technology to simplify and streamline necessary verification. When coverage transitions do occur, New York State Medicaid, the Exchange, and health plans have myriad policy solutions at their disposal to make transitions nearly transparent to consumers—including and beyond the recommendations included in this report. Evaluating, implementing, and assessing the value of these solutions on an ongoing basis will require partnership among State stakeholders and Federal officials to achieve the ACA's and New York's coverage vision.

Appendix A

Income Volatility Analysis: Methodological Approach

The following summarizes the methodological approach for the income volatility analysis discussed in the second section of the paper.

BASELINE POPULATION IN INSURANCE AFFORDABILITY PROGRAMS POST-ACA

Baseline estimates of post-ACA new enrollment in Medicaid and non-group Exchanges are drawn from the widely-cited March 2011 Robert Wood Johnson Foundation report by Buettgens, Holahan and Carroll of the Urban Institute, which presents estimates of post-ACA coverage in all 50 states using the Urban Institute's HIPSM model.[67] These estimates reflect new enrollment levels in 2011 if the ACA were implemented immediately; no adjustment is made for possible population growth or population changes between 2011 and 2014. This analysis also assumes no changes to New York's CHPlus program through 2019. Where necessary, the population of estimated new enrollees is further distributed based on an analysis of 2008–2010 data from the Current Population Survey, Annual Social and Economic Supplement (CPS ASEC) on the demographics and family composition of non-elderly New Yorkers.[68] Specifically, distributions are based on the population of adults ages 19–64 with or without related children under 18 living in their home (as a proxy for parents) and the population of children ages 0–18. The data are further limited to those without ESI coverage (i.e., those who are currently uninsured, enrolled in Medicaid, or with other small categories of coverage such as Direct Pay). These data are used to estimate distributions of the population of new Medicaid and Exchange enrollees by age and family composition; the baseline count of new enrollment is drawn directly from Buettgens et al., as described above.

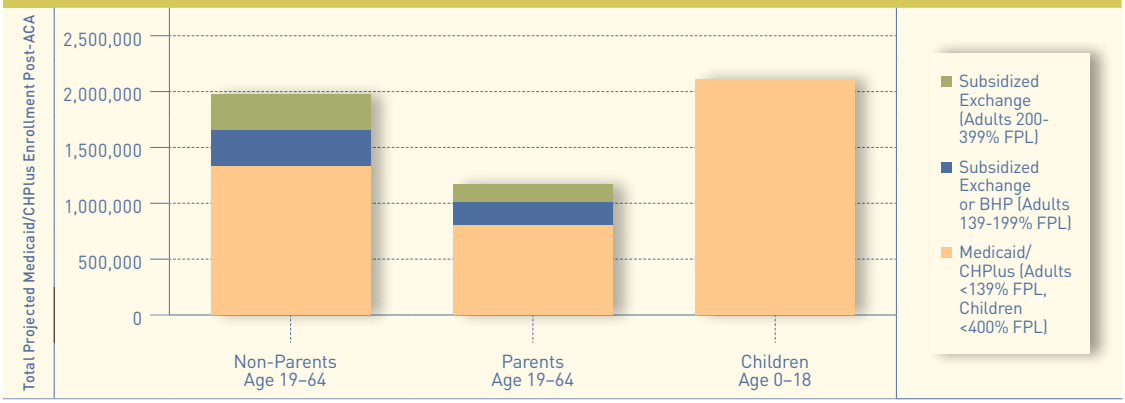
TABLE 1: Post-ACA New York State Non-Elderly, Medicaid or Exchange Coverage with Subsidies, Population <400% FPL (2011)

	Non-Parents Age 19–64	Parents Age 19–64	Children Age 0–18	Total Non-Elderly
<139% FPL	1,334,000	809,000	1,335,713	3,478,713
139–199% FPL	313,218	201,842	330,722	845,782
200–399% FPL	322,464	158,636	441,565	922,665
Total 0–399% FPL	**1,969,682**	**1,169,478**	**2,108,000**	**5,247,160**

[67] M. Buettgens, J. Holahan, and C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," prepared for the Robert Wood Johnson Foundation State Coverage Initiatives by the Urban Institute, March 2011.

[68] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement. 2008-2010.

FIGURE 1: Post-ACA New York State Medicaid/CHPlus and Subsidized Exchange Enrollment by Age, Parent/Non-Parent Status, and Income (2011)



SOURCES: Buettgens et al. (2011); 2008-2010 CPS ASEC three-year blend, custom tabulation by Manatt Health Solutions

As outlined in Table 1 and Figure 1 above, more than 5.2 million non-elderly New Yorkers below 400% FPL are estimated to be covered by Medicaid (3.5 million) or through subsidized coverage in non-group Exchanges (1.7 million) under the ACA. Of these, 2.1 million are children, all of whom would be covered by Medicaid or CHPlus (at least through 2019). The remaining 3.1 million are adults, of whom more than one-third (1.2 million) are parents. Among both parents and adults without children, slightly less than one-third have incomes between 139% and 400% FPL, with half of these falling into the 139%–200% FPL group (the income group that would be eligible for a Basic Health Program, if New York elects to establish one).

BASELINE COUNT OF FAMILIES, ONE OR MORE MEMBERS IN MEDICAID OR EXCHANGES POST-ACA

Based on data above and additional information on family composition derived from the 2008–2010 Current Population Survey, we estimate that roughly 2.1 million New York State families below 400% FPL have one or more family members who are not covered by employer-sponsored insurance. While many of these will take up coverage under the ACA, a small number of families in this circumstance will likely forgo coverage and pay penalties, take up existing ESI offers, or obtain coverage through some other means.

Extrapolating from Buettgens et al. and previous analysis conducted for the New York State Health Foundation,[69] we estimate that roughly 15% of New Yorkers eligible for Medicaid or subsidized Exchange coverage will not enroll in one of these programs following

[69] D. Bachrach, P. Boozang, M. Dutton, A. Lam. "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010. nyshealthfoundation.org/resources-and-reports/resource/implementing-federal-health-care-reform-a-roadmap-for-new-york-state

implementation of the ACA. While some number of these New Yorkers are likely to obtain coverage outside of Medicaid or Exchanges, this effect is relatively small. For purposes of estimation, we apply this same rate for families where one or more family members will be eligible for Medicaid or subsidized Exchange coverage under the ACA, with no adjustment for family size or composition.

TABLE 2: Post-ACA New York State Families, One or More Non-Elderly Family Members Holds Medicaid or Exchange Coverage, Population <400% FPL (2011)

	Families with No Children Under Age 18	Families with One or More Children Under Age 18	Total Families
<139% FPL	621,735	476,748	1,098,483
139–199% FPL	237,051	128,670	365,722
200–399% FPL	122,544	180,812	303,356
Total 0–399% FPL	**981,330**	**786,230**	**1,767,561**

In total, we estimate that 1.8 million New York State families with income below 400% FPL, and almost 800,000 families with children, will have one or more members enrolled in Medicaid or subsidized Exchange coverage. Of these, 1.1 million will be families below the Medicaid income eligibility threshold of 139% FPL.

ESTIMATES OF ANNUAL INCOME FLUCTUATION BY BASELINE INCOME AND FAMILY COMPOSITION

Several recent studies have explored the likelihood and frequency of income fluctuations affecting coverage continuity in the context of the ACA. The most directly applicable, by Pamela Short and colleagues,[70] provides estimates of annual income fluctuation by ACA income eligibility group. Specifically, for each baseline income group, the authors describe the share of that group who fall into a different Insurance Affordability Program income eligibility group one year later.

Overall, the authors find that in lower-income and moderate-income groups, a larger share of the population transitioned to a higher-income group than to a lower-income group, though this may be an artifact of prevailing economic conditions during the 2005–2006 time period that could be unrealistic in the current climate of economic recession.

Monthly vs. Annual Income Fluctuation

Findings from another study, by Benjamin Sommers and Sara Rosenbaum, indicate that these annual estimates understate the extent of monthly income fluctuation and churning.[71]

[70] P. Short, K. Swartz, N. Uberoi, and D. Graefe. "Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change." Commonwealth Fund, May 2011.

[71] B.D. Sommers and S. Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid and Health Insurance Exchanges," Health Affairs, 30, no.2 (2011):228-236, February 2011.

For example, Sommers and Rosenbaum find that during the same time period (2005–2006), more than half of the adult non-elderly population (age 19–60) with baseline income below 133% FPL were above 133% FPL for at least one month—double the fluctuation rate indicated in the annual estimates by Short and colleagues. For the population with baseline income between 133% and 200% FPL, Sommers and Rosenbaum find that more than 40% drop below 133% FPL for at least one month, compared to the annual downward fluctuation of 17% which Short and colleagues report for this group. At least for the comparable income groups it appears that annual fluctuations may understate by half the incidence of at least one monthly fluctuation during that year, though it is unclear whether it would be appropriate to apply this observation to the higher-income groups where there is no comparable monthly estimate.

As a policy matter, while there has been significant focus on monthly fluctuation in the literature, in fact annual fluctuation will be more relevant to understanding continuity of coverage and churning. Currently, New York State has 12-month continuous eligibility in Medicaid, and eligibility for Exchange subsidies is also likely to be determined on an annual basis. As such, monthly fluctuations will be largely moot, and year-over-year income changes are more appropriate as a measure of potential eligibility transitions.

Relative Hazard Adjustments

In addition to providing an analysis of monthly fluctuation, Sommers and Rosenbaum's analysis provides additional nuance about the variation in income fluctuation rates by various demographic categories for the non-elderly adult population (age 19–60) below 200% FPL. These relative hazard rates reflect the fact that different demographic groups may experience comparatively higher or lower income fluctuation rates than others (i.e., younger workers may have less stable income than older workers, which would be reflected in a higher relative hazard for young workers). Although the links are less direct, we might expect (as Sommers and Rosenbaum's findings suggest) that relative hazard for parents would be lower than that for non-parents. While causality is unclear, parenthood is correlated with a number of measures of income and job stability, including greater likelihood of being in partnered relationships, less likelihood to be in the youngest age groups where fluctuation is greatest, and higher rates of insurance coverage, including employer-sponsored insurance.

For purposes of this analysis we considered applying two of the relative hazards reported by Sommers and Rosenbaum, one for family composition and one for baseline health insurance coverage. However, because of data limitations, we opted to make only one adjustment, for family composition. To adjust for somewhat lower risk of fluctuation for parents, we have incorporated the authors' reported 0.92 relative hazard ratio for parents with children in the

home, and have applied this modifier to children as well, given that their family income would fluctuate directly with that of their parent(s).[72]

Adjusted Fluctuation Rates by Income

Finally, after applying the relative hazard ratios for families vs. adults without children, we estimate the following income fluctuation rates by family composition group:

TABLE 3A
Annual Income Fluctuation by Baseline ACA Income Eligibility Group Modified by Family Composition Hazard, Non-Elderly Adult Non-Parents (2005–2006)

BASELINE INCOME LEVEL (2005)	ANNUAL INCOME FLUCTUATION RESULT (2006)			
	<139% FPL	139–199% FPL	200–399% FPL	>=400+ FPL
<139% FPL	74%	17%	8%	1%
139–199% FPL	18%	48%	32%	2%
200–399% FPL	3%	10%	71%	16%
>= 400% FPL	1%	1%	13%	85%

TABLE 3B
Annual Income Fluctuation by Baseline ACA Income Eligibility Group Modified by Family Composition Hazard, Non-Elderly Adult Parents and Children (2005–2006)

BASELINE INCOME LEVEL (2005)	ANNUAL INCOME FLUCTUATION RESULT (2006)			
	<139% FPL	139–199% FPL	200–399% FPL	>=400+ FPL
<139% FPL	78%	15%	6%	1%
139–199% FPL	16%	55%	28%	2%
200–399% FPL	3%	8%	75%	14%
>= 400% FPL	1%	1%	11%	87%

* Percentages in bold indicate the share of the baseline population which "holds constant," i.e., does not experience annual fluctuation.

[72] It is important to note that in Sommers and Rosenbaum's relative hazard table, parents with children in the home is not compared against single adults, but against parents without children in the home. As such, the .92 hazard ratio reported almost certainly understates the difference in relative hazard between parents and non-parents. For purposes of preliminary analysis, we have applied a 1.08 fluctuation hazard for single adults to address this issue, effectively assuming double the effect to account for presumably higher instability among childless adults than among non-custodial parents.

FINAL RESULTS OF INCOME FLUCTUATION ANALYSIS, NEW YORK STATE INDIVIDUALS AND FAMILIES

In the final table, we average the resulting fluctuation rates and report the resulting shifts for New York State's non-elderly Medicaid and Exchange enrolled post-ACA population.

TABLE 4
Final Annual Income Fluctuation Counts and Rates by Baseline ACA Income Eligibility, Non-Elderly Individuals and Affected Families, FPL <400%

Baseline Income Level	Post-ACA Medicaid and Exchange Enrollees	Annual Income Fluctuation and Resulting Income Group (Values in bold indicate no fluctuation)									
		<139% FPL		139–199% FPL		200–399% FPL		>=400+ FPL		TOTAL FLUCTUATING	
		Count	Share of Baseline Income Group	Count	Share of Baseline Income Group	Count	Share of Baseline Income Group	Count	Share of Baseline Income Group	Count	Share of Baseline Income Group
INDIVIDUALS											
<139% FPL	3,478,713	**2,658,320**	**76%**	542,482	16%	244,840	7%	33,071	1%	820,393	24%
139–199% FPL	845,782	139,672	17%	**442,829**	**52%**	247,217	29%	16,064	2%	402,953	48%
200–399% FPL	922,665	26,239	3%	81,943	9%	**680,061**	**74%**	134,422	15%	242,604	26%
TOTAL	**5,247,160**	**2,824,232**		**1,067,254**		**1,172,117**		**183,557**		**1,465,950**	**28%**
FAMILIES											
<139% FPL	1,098,483	**831,566**	**76%**	175,872	16%	80,441	7%	10,603	1%	266,917	24%
139–199% FPL	365,721	62,793	17%	**184,450**	52%	111,369	29%	7,109	2%	181,271	50%
200–399% FPL	303,356	8,667	3%	27,226	9%	**222,905**	**74%**	44,559	15%	80,451	27%
TOTAL	**1,767,560**	**903,026**		**387,548**		**414,715**		**62,271**		**528,639**	**30%**

NOTE: Numbers may not sum up exactly as a result of rounding.

Appendix B

Interviewees

HEALTH PLANS

MAURA BLUESTONE
Affinity Health Plan

PAMELA HASSEN
Fidelis Care New York

HAROLD ISELIN
New York Health Plan Association

MARK SANTIAGO
Hudson Health Plan

ROBERT THOMPSON
Excellus

PATRICIA WANG
Healthfirst

DAVID ZEH
Healthfirst

CONSUMER ADVOCATES

JOSEPH BAKER
Medicare Rights Center

ELISABETH BENJAMIN
Community Service Society

TRILBY DE JUNG
Empire Justice Center

NEW YORK STATE OFFICIALS

JUDITH ARNOLD
New York State Department of Health

DONNA FRESCATORE
New York State Executive Chamber

DANIELLE HOLAHAN
New York State Health Insurance Exchange

LISA SBRANA
New York State Health Insurance Exchange

BETH OSTHEIMER
New York State Department of Health

FEDERAL OFFICIALS

ANNE MARIE COSTELLO
Centers for Medicare & Medicaid Services, Center for Medicaid, CHIP, and Survey & Certification

MICHELLE STROLLO
Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight

BEN WALKER
Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight

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