Saint Louis University Journal of Health Law & Policy

Volume 5
Issue 1 *Implementing Health Reform: Fairness, Accountability & Competition*

Article 8

2011

Rethinking Medicaid in the New Normal

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RETHINKING MEDICAID IN THE NEW NORMAL

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I. INTRODUCTION

For nearly a half century, Medicaid has been a shock absorber for a system characterized by its strong commitment to market-based solutions to health care financing. To understand Medicaid simply as health insurance for the poor is to miss the point. Unmatched in its ability to compensate for the limitations inherent in the design of private health insurance, Medicaid extends far beyond its role as a health insurance subsidy for certain groups of poor people.[1] Devoid of the exclusionary qualities that traditionally have characterized the private insurance market,[2] as well as Medicare's lengthy statutory waiting period in the case of persons with disabilities,[3] Medicaid is explicitly designed to finance health care for the sick.[4] This singular ability

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1. MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 9-10 (Mar. 2011) [hereinafter MACPAC]. In FY 2010, Medicaid provided either primary or secondary coverage for 68 million people. *Id*. at 10, Box 1-1. Its coverage reached 33 million children, 11 million children and adults with disabilities, 17 million non-disabled adults (pregnant women and caretakers of minor children), and 6 million elderly persons. *Id*.

2. For perhaps the finest insight into the fundamentally discriminatory nature of a private health insurance market built on concepts of actuarial risk see Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y. & L. 287, 290 (1993). The seminal contribution of the Patient Protection and Affordable Care Act is the virtual elimination of insurers' discretion to exclude or discriminate against access to coverage based on health status. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1201, 124 Stat. 119, 154 (2010) (to be codified at 42 U.S.C. § 300gg) (amending Public Health Services Act ("PHSA") § 2704).

3. 42 U.S.C. § 426(b) (2006). For an explanation of the two-year waiting period, which affects some 1.8 million persons with disabilities see MEDICARE RIGHTS CTR., END THE TWO-YEAR WAIT FOR MEDICARE, *available at* http://www.medicarerights.org/pdf/two_year_waiting_period_fact_sheet.pdf (last visited Sep. 28, 2011).

4. *See generally* 42 U.S.C. § 1396a(a) (2006) (describing the benefits which Medicaid is required to supply). Medicaid eligibility is conditioned strictly on whether an individual falls within one of the statute's recognized eligibility categories and meets the program's financial

to aid people in the poorest health as a result of its unique benefit design structure allows Medicaid to extend into areas of health care that lie well beyond the limits of private insurance.[5]

The Patient Protection and Affordable Care Act[6] (hereinafter referred to as the Affordable Care Act, ("ACA")) tackles the problem of discriminatory exclusion from insurance but does not address Medicaid's other roles. Indeed, even where the threshold matter of insurance access is concerned, the ACA builds on rather than replaces Medicaid, expanding its reach while limiting eligibility for insurance affordability subsidies secured through state health insurance Exchanges to persons ineligible for Medicaid or another form of "creditable coverage."[7]

This decision to preserve Medicaid reflects many considerations. For the country's poorest children and adults who are entitled to its benefits, Medicaid finances a range of health care that goes well beyond the limits of private health insurance, covering clinical interventions for children with developmental disabilities,[8] long term institutional services furnished in nursing homes or intermediate care facilities,[9] and community-based services of personal attendants and home care aides whose work makes it

and other requirements. *Id.* § 1396a(a)(10). No health status test is used other than to *make* people eligible based on health status (e.g., pregnancy, disability). *Id.* § 1396a(a). Eligibility can be retroactive to the date of application in order to cover previously incurred health care costs. *Id.* § 1396a(a)(34). Many eligibility categories are linked to health care need at the time of enrollment (e.g., pregnancy, disability, age). *Id.* § 1396a(a)(10).

5. *See* MACPAC, *supra* note 1, at 9-10.

6. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). The two preceding laws will be hereinafter cited together as "ACA."

7. ACA § 1413 (to be codified at 42 U.S.C. § 18083).

8. *See* MACPAC, *supra* note 1, at 10. The contrast between Medicaid and commercial insurance can be best seen in the striking facts of *Mondry v. Am. Family Mut. Ins. Co.*, 557 F.3d 781 (7th Cir. 2008), *cert. denied*, 130 S. Ct. 200 (2009). *Mondry*, which arose under the Employee Retirement Income Security Act ("ERISA"), involved the denial of speech therapy for a child covered under the employer's health benefit plan and born with developmental disabilities. Despite the clinical appropriateness of the treatment, the plan administrator denied coverage on the ground that in this child's case, treatment was merely "educational." *Id.* at 783-84, 799. Ultimately the child was able to successfully receive these services through BadgerCare, Wisconsin's name for Medicaid. *See id.* at 786. *Mondry* offers a remarkably clear example of the subtle ways in which private insurers discriminate against persons with disabilities while Medicaid does not. For a broader discussion of insurance design practices that discriminate against persons with disabilities. *See* Sara Rosenbaum et al., *Crossing the Rubicon, the Impact of the Affordable Care Act on the Content of Coverage for Persons with Disabilities*, 25 NOTRE DAME J. L. ETHICS & PUB. POL'Y 527, 532-39 (2011) [hereinafter Rosenbaum et al., *Crossing*].

9. *See* MACPAC, *supra* note 1, at 156-57.

possible for children and adults with disabilities to grow, live, and work in integrated community settings.[10] Medicaid compensates for Medicare's limitations for the poorest beneficiaries, paying program premiums and cost-sharing and covering Medicare-excluded services ranging from eyeglasses and hearing aids to long-term care.[11] Furthermore, because it not only insures the poor but also pays special enhanced rates[12] to certain health care safety net providers,[13] Medicaid financially enables health care

10. *Id.* at 12; *see, e.g.*, KAISER COMM'N ON MEDICAID & THE UNINSURED, NO. 7720-04, MEDICAID HOME AND COMMUNITY-BASED SERVICES PROGRAMS: DATA UPDATE 1-2 (Feb. 2011) [hereinafter MEDICAID HOME], *available at* http://www.kff.org/medicaid/upload/7720-04.pdf (reporting on the growth of home and community based services funding under Medicaid and opportunities for further growth under the ACA). So important is Medicaid to community-based care for persons with disabilities that on numerous occasions Congress has amended Medicaid to expand its availability to both children and adults with disabilities. *See, e.g.*, Ticket To Work and Work Incentives Improvement Act of 1999, Pub. L. No. 106-170, § 2, 113 Stat. 1860, 1863 (1999) (codified at 42 U.S.C. § 1305) (allowing states to extend Medicaid to adults with disabilities whose ability to work threatens their continued eligibility for Social Security disability benefits and thus both Medicare and Medicaid); *see also* The Family Opportunity Act, Pub. L. No. 109-171, § 6062, 120 Stat. 4, 96 (2005) (codified at 42 U.S.C. § 1305) (allowing states to provide Medicaid to moderate income families whose children otherwise would not qualify for Medicaid under a state plan but whose disabilities have exhausted the limits of private health insurance coverage).

11. *See* MACPAC, *supra* note 1, at 26, 33, Table 2-1. For a discussion of dual eligibles, the common name for persons entitled to both Medicare and Medicaid see *id.* at 27-45.

12. MACPAC, *supra* note 1, at 10. Community health centers are paid on the basis of a prospective payment system tied to patient costs. PETER SHIN, LEIGHTON KU, EMILY JONES, BRAD FINNEGAN & SARA ROSENBAUM, FINANCING COMMUNITY HEALTH CENTERS AS PATIENT- AND COMMUNITY-CENTERED MEDICAL HOMES 17-22 (2009) [hereinafter FINANCING COMMUNITY HEALTH CENTERS], *available at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A186E838-5056-9D20-3D9EA92EB75DAC24.pdf. Public hospitals frequently receive "disproportionate share" payments under Medicaid because of the high volume of services furnished to low-income patients. In addition, as public health care institutions, public hospitals may qualify for higher Medicaid payments than rates paid to private hospitals under special Medicaid "upper payment limit" rules. OBAID ZAMAN ET AL., NAT'L ASS'N OF PUB. HOSP. & HEALTH SYS., AMERICA'S PUBLIC HOSPITALS & HEALTH SYSTEMS, 2009 at 16-19 (2010) [hereinafter NAPH], *available at* http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2009-Public-Hospital-Financial-Characteristics-.aspx?FT=.pdf.

13. MACPAC, *supra* note 1, at 2, 10, 132. The health care safety net accounts for a disproportionate percentage of all primary health care. *Id.* at 10. Medicaid a substantial provider to health care financing for community health centers. SARA ROSENBAUM ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, NO. 8098, COMMUNITY HEALTH CENTERS: OPPORTUNITIES & CHALLENGES OF HEALTH REFORM 4 fig. 5 (2010) [hereinafter ROSENBAUM ET AL., OPPORTUNITIES], *available at* http://www.kff.org/uninsured/upload/8098.pdf (Medicaid accounted for more than 37% of all health center revenues in 2008); *see also* NAPH, *supra* note 12, at 36, app. C Table 6 (showing Medicaid's dominant role as a payer source).

access in impoverished and medically underserved communities and markets in which unsubsidized practices are an impossibility.[14]

Beginning January 1, 2014,[15] the ACA rectifies Medicaid's most basic failing by eliminating the restrictions that historically have excluded from coverage low-income nonelderly adults other than those who can claim an attachment to the program on the basis of disability, pregnancy, or status as caretaker relatives of minor children eligible for cash welfare benefits.[16] At the same time, the ACA builds a companion system of subsidized insurance for people without another form of creditable coverage (including Medicaid).[17] From the perspective of low and moderate-income people therefore, the Exchange system picks up where Medicaid leaves off. Thus, because the Act tackles the problem of affordable coverage for lower income people through two distinct pathways, the law also divides the population into two groups: those who meet Medicaid's financial eligibility requirements; and those who qualify for Exchange subsidies. In so doing, the Act eliminates the historic "cliff" from which people no longer eligible for Medicaid previously would have fallen. But this bifurcated approach—built in part to preserve the status quo and in part to shield the federal government from the full cost of insuring low-income people[18]—comes with its own set of challenges.

14. MACPAC, *supra* note 1, at 131-32. By contrast, private insurance is a poor payer. One study that has compared Medicaid revenues to those received by community health centers from commercial payers has found that over an eight year period, cumulative losses experienced from serving patients with private insurance approached $4 billion, a cost that shifted onto health centers' federal grants. PETER SHIN, BRAD FINNEGAN, JESSICA SHARAC & SARA ROSENBAUM, KAISER COMM'N ON MEDICAID & THE UNINSURED, NO. 7738, HEALTH CENTERS: AN OVERVIEW AND ANALYSIS OF THEIR EXPERIENCE WITH PRIVATE HEALTH INSURANCE 8 fig. 13 (2008) [hereinafter HEALTH CENTERS], *available at* http://www.kff.org/ uninsured/upload/7738.pdf.

15. ACA § 1101 (2010) (to be codified at 42 U.S.C. § 18001). States may implement Medicaid coverage earlier at their option. *Id.* § 2001(a)(4)(B).

16. For an explanation of Medicaid's traditional eligibility rules see KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: A PRIMER 7-14 (2010), *available at* http://www.kff.org/ medicaid/upload/7334-04.pdf.

17. ACA § 1331 (to be codified at 42 U.S.C. § 18051).

18. A major point of discussion in designing the new law was whether to cover all low income persons through health insurance exchanges, with state Medicaid programs responsible for coverage of supplemental Medicaid services only. This approach was rejected because of the increase cost associated with the federal government's entire assumption of the cost of coverage, in contrast to Medicaid, in which the cost of coverage is borne by both the federal and state governments. Discussion with Mark Hayes, former Staff Dir., Senate Finance Comm., Subcomm. on Health, and David Schwartz, Majority Staff, Senate Finance Comm., Subcomm. on Health (May 6, 2011). Mr. Hayes, Mr. Schwartz, and Professor Rosenbaum held many discussions on this issue throughout the creation of the ACA during 2009. Mr. Hayes reported that the initial price tag given the Committee staff for creating a unified

Of course, even if Congress had taken a more unified approach to insuring lower income people, Medicaid's continuation would have been essential because of the multiple roles it plays. These roles persist, despite the ACA's own coverage improvements. The Act establishes new preventive coverage standards in the individual and employer-sponsored health plan markets,[19] prohibits the use of annual and lifetime coverage caps,[20] extends mental health and substance use disorder parity protections into the new Exchange market,[21] and brings more standardization and potentially greater scope of coverage in the individual and small group markets through the application of "essential health benefit" criteria.[22] But these coverage improvements fall well short of Medicaid's scope of health care financing. With the exception of the law's CLASS Act provisions,[23] whose

coverage system for all low income non-elderly Americans approached $100 billion over ten years over and above what it would cost to expand Medicaid to cover all low income persons.

19. ACA § 1001 (to be codified at 42 U.S.C. §300gg-13) (adding PHSA § 2713). Grandfathered plans are exempt. *See* ACA § 1251 (to be codified at 42 U.S.C. § 18011). These services consist of evidence-based items or services that have an effective rating of "A" or "B" from the U.S. Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and additional preventive services recommended for children, infants, adolescents and women by the Health Resources and Services Administration of the United States Department of Health and Human Services. *See* Group Health Plan and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46,621-26 (Aug. 3, 2011) (defining preventive services generally and additional preventive services for women, respectively); Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726-60 (July 19, 2010); Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538-70 (June 17, 2010) (explaining grandfathering rules).

20. ACA § 1001 (to be codified at 42 U.S.C. § 300gg-11) (adding PHSA § 2711). The annual lifetime limit is phased in beginning with plan years after the date of passage. As of Summer 2011, Health & Human Services ("HHS") had granted numerous waivers of the annual coverage limit restrictions. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-725R, PRIVATE HEALTH INSURANCE: WAIVERS OF RESTRICTIONS ON ANNUAL LIMITS ON HEALTH BENEFITS 1-2 (2011), *available at* http://democrats.energycommerce.house.gov/sites/default/files/documents/GAOReport_06.14.11.pdf (finding that HHS had waived 95% of 1,415 requests for waivers of the limit restrictions received to date).

21. ACA § 1311(j) (to be codified at 42 U.S.C. § 18031). Mental health parity regulations implementing legislation strengthening previous parity requirements were issued in 2009. 45 C.F.R. § 146.136 (2010).

22. ACA § 1302 (to be codified at 42 U.S.C. § 18022). As of January 1, 2014, all health plans sold in the individual and small group markets will be required to cover certain "essential health benefits." *Id.*

23. ACA § 8002 (to be codified at 42 U.S.C. § 300*ll*). The CLASS Act would have established the CLASS program, a system of private long-term care coverage that could have been purchased during work years. *Id.* Medicaid would have continued to supplement the

implementation has been halted (at least for the foreseeable future) as a result of aspects of its statutory design that create financial sustainability challenges, [24] the Act does not fund long-term care. Similarly, nothing in the Act bars classic coverage exclusions such as educational exclusions aimed at denying otherwise covered treatments for children and adults with developmental disabilities;[25] indeed, the law contains a sweeping provision barring the Secretary of HHS from promulgating "regulations that prohibit . . . a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of the date of enactment of this Act."[26] This limitation on Secretarial power had not yet been interpreted as of the Summer of 2011. But the assumption is that in view of the price of health insurance and therefore, the cost of subsidies, essential health benefit regulations (which are expected in winter 2012)[27] will give insurers broad leeway to impose coverage limitations (subject to mental health parity rules where applicable) that utilize strict standards of medical necessity and apply coverage and medical management guidelines that impede the full reach of coverage in ways that Medicaid does not in view of its historic mission.[28]

Nor does the Act provide a full shield against high cost-sharing at the point of service. The law makes cost-sharing assistance available to lower income people who purchase "qualified health plans" sold through state health insurance Exchanges.[29] At the same time however, qualified health plan offerings are required by law to use a cost-sharing framework that essentially locks in considerable financial exposure, even among those who are not well off. Cost-sharing subsidies are tied to "silver plans" whose

more limited CLASS benefits, which had, not yet been defined by the Administration. *See* KAISER FAMILY FOUND., NO. 8069, HEALTH CARE REFORM AND THE CLASS ACT 1, 4 (Apr. 2010) [hereinafter REFORM AND CLASS ACT], *available at* http://www.kff.org/healthreform/upload/8069.pdf.

24. Robert Pear, Health Law to be Revised by Ending a Program., N.Y. TIMES, Oct. 14, 2011, at A10. Gardiner Harris & Robert Pear, Still No Relief in Sight for Long Term Care Needs, N.Y. Times, Oct. 25, 2011, at D1.

25. *See Mondry*, 557 F.3d at 790.

26. ACA § 1562(d)(1) (to be codified at 42 U.S.C. § 18120). Subsidies will increase the actuarial value of the silver plan to 94% for persons with incomes below 150% of the federal poverty level and 87% for persons with incomes between 150% and 200% of the federal poverty level. ACA § 1331(a)(2) (to be codified at 42 U.S.C. § 18051). For a discussion of how insurance limits discriminate against people with disabilities, see Rosenbaum et al., *Crossing*, *supra* note 8, 531.

27. *See* REFORM AND CLASS ACT, *supra* note 23, at 4.

28. *See* discussion of children with developmental disabilities *supra*, note 8; *Mondry,* 557 F.3d at 789 n. 3.

29. ACA § 1402(c) (to be codified at 42 U.S.C. § 18071).

actuarial rating equals only 70% of full actuarial value.[30] Although the law's cost-sharing subsidies reduce this financial exposure, they by no means eliminate it, and subsidies undergo a steep phase-out, ending entirely at four times the federal poverty level.[31] This level of financial support is well below that offered by Medicaid, which requires that cost-sharing be nominal and bars the use of cost-sharing entirely for certain populations.[32]

In terms of support for the health care safety net, the Act makes fundamental contributions by insuring millions of low-income people. At the same time however, these contributions pale next to Medicaid's power as an ongoing engine of health care services in medically underserved communities. Medicaid remains central to the safety net not only because it insures the poor, but also because of its special payment rates that shield safety net providers from losses to which they otherwise would be exposed because of low insurer payments in relation to the cost of caring for clinically complex patients.[33] To be sure, the Act makes a historic investment in the expansion of community health centers.[34] But these expansion funds are time-limited, ending in 2015,[35] after which the assumption is that public and private health insurance (along with discretionary grant subsidies to help offset costs associated with those who remain uninsured)[36] will pick up ongoing operational costs. Historically however, health centers and other safety net providers have experienced significant losses under private health insurance as a result of low payment rates, high patient cost sharing, and coverage disallowances.[37] Although the Act requires qualified health plans sold in Exchanges to pay community health centers at their enhanced Medicaid payment rates,[38] early signals are that the federal government is approaching enforcement with skepticism,

30. ACA § 1302(d)(1)(B) (to be codified at 42 U.S.C. § 18022).

31. ACA § 5601 (amending PHSA § 254b(r)). The actual funding amount allocated to this expansion is found in ACA §§ 18121, 1201, 1204, 1303.

32. 42 U.S.C. § 1396o(a)(1)(3) (2006).

33. HEALTH CENTERS, *supra* note 14, at 7.

34. MEDICAID HOME, *supra* note 10, at 15.

35. ACA § 5601 (amending PHSA § 330(r)).

36. HEALTH CENTERS, *supra* note 14, at 6; *see also* FINANCING COMMUNITY HEALTH CENTERS, *supra* note 12, at 8. Federally funded community health centers receive annual operating funding through the Congressional appropriations process. Discretionary grant funds for the uninsured represent approximately 21% of health centers' operating revenue. KAISER COMM'N ON MEDICAID & THE UNINSURED, NO. 7877, COMMUNITY HEALTH CENTERS fig. 4 (Mar. 2009), *available at* http://www.kff.org/uninsured/upload/7877.pdf.

37. HEALTH CENTERS, *supra* note 14, at 8-10, fig. 13.

38. 42 U.S.C. § 18022, *added by* ACA §1302(g).

leaving the safety net vulnerable to cost-shifting by private health insurers against grant funds intended for treatment of the uninsured.[39]

39. Proposed rules implementing state health insurance exchanges illuminate the quandary that federal agencies can find themselves in when they attempt to implement a clear congressional directive that, in an agency's view, may raise unintended consequences. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,899-41,900 (July 15, 2011) [hereinafter Establishment of Exchanges].

HHS' discussion of the difficulties associated with implementing the FQHC payment system is fascinating both for its frankness and for the extent to which, in this instance, the federal government may be willing to allow private health insurers to cost-shift onto federal grants intended to keep the health care safety net afloat for the remaining uninsured (approximately 24 million people). The enactment of special payment rates in Medicaid and Medicare was intended to stop cost-shifting by public insurers against appropriated programs as well as based on evidence of the overall cost effectiveness of community health centers. LEIGHTON KU ET AL., GEIGER GIBSON /RCHN COMTY. HEALTH FOUND. RESEARCH COLLABORATIVE, POLICY RESEARCH BRIEF NO. 16, USING PRIMARY CARE TO BEND THE COST CURVE: THE POTENTIAL IMPACT OF HEALTH CENTER EXPANSION IN SENATE REFORMS 5 (Oct. 14, 2009).

Apparently where private insurers are concerned however, this cost shift may be acceptable to HHS if the consequences are more limited access to health centers as network members.

> [T]wo provisions of the Affordable Care Act regarding payment of essential community providers and payment of Federally Qualified Health Centers (FQHCs) may conflict. Section 1311(c)(2) of the Affordable Care Act states that nothing shall be construed to require a QHP to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the plan. This requirement may conflict with section 1302(g) of the Affordable Care Act, which requires that a QHP issuer reimburse FQHCs at each facility's Medicaid prospective payment system (PPS) rate. . . . One approach to reconciling these provisions would be to require QHP issuers to pay at least the Medicaid PPS rate to each FQHC that participates in the issuer's QHP network. . . . However, if FQHC Medicaid PPS rates are greater than comparable amounts paid to other providers, and if many of the enrollees in a QHP receive care at FQHCs, the costs of these QHPs may be greater than the costs of QHPs that do not have many enrollees who are seen at the centers. Also, if Medicaid prospective payment rates exceed QHPs' generally applicable payment rates, requiring QHP issuers to pay the full FQHC Medicaid PPS rate could lead insurers to minimally contract with FQHCs. . . . Another potential approach to reconciling these two payment provisions would be to permit issuers to negotiate mutually agreed-upon payment rates with FQHCs, as long as they are at least equal to the issuer's generally applicable payment rates. Such an interpretation may furnish FQHCs with a degree of negotiating leverage with issuers to obtain payment rates higher than the issuer's generally applicable payment rates but not tie issuers to the full Medicaid PPS rate for in-network FQHCs. This approach would decrease the incentive to drive patients away from providers that may be best suited to their needs, while providing FQHCs with leverage to be able to negotiate payments that will allow them to continue providing the comprehensive services that are particularly valuable to the individuals they serve. However, this approach may result in FQHCs receiving less than their Medicaid PPS rates for in-network participation. We invite comment.

For all of these reasons, the preservation of Medicaid for the poor and the medically vulnerable is vital. At the same time, this decision to use Medicaid as a primary source of insurance rather than as a supplemental payer to expand and complement on basic coverage for certain populations and health care systems was hardly without controversy. The source of this controversy is both political and operational. On the political front, state opposition to Medicaid expansion has been widespread and has spilled over into the general legal attacks on the law.[40] This state opposition has persisted despite the availability of heavily enhanced federal contributions to the cost of covering the expansion population,[41] in part because of the general state of high state stress over Medicaid, and in part because new outreach and enrollment requirements,[42] discussed *infra,* are also expected to result in the enrollment of potentially millions of children and adults who are entitled to coverage under current law but remain unenrolled.[43] No enhanced contributions are available for this population of "traditionally eligible" beneficiaries however.

The second cause of controversy is Medicaid's inability to assure appropriate access to care for the poor. Medicaid historically suffered under serious limitations owing to the widespread physician non-

Establishment of Exchanges, 76 Fed. Reg. at 41,899-41,900. In fact, there is no evidence that health plans have avoided health centers as primary care network members, particularly in medically underserved communities where access to primary care is very limited to begin with.

40. *See* Florida v. U.S. Dep. of Health % Human Serv., 648 F.3d 1235 (11th Cir. 2011) (rejecting claims of unconstitutional commandeering of state Medicaid programs); *see generally* Benjamin Sommers & Arnold Epstein, *Why States are So Miffed About Medicaid*, 365 NEW ENG. J. MED. 100 (2011) (discussing Medicaid's effects on state budgets and examining the political challenges which expanding Medicaid presents).

41. ACA § 2001(a)(3) (to be codified at 42 U.S.C. § 1396d(y)). Normal federal contributions to the state cost of medical assistance range from 50% to approximately 77%. Federal contributions to the expansion populations added by the Act begin at 100% (the federal government assumes the entire cost) and gradually drop down to 90%. Even at this slightly lower federal payment level, the Medicaid expansions turn out to be a bargain according to at least one highly regarded cost estimate, finding state savings of $12 to $19 billion in 2020 alone, after the federal contribution rate falls. Matthew Buettgens et al., *Consider Savings as Well as Costs*, THE URBAN INSTITUTE (August 13, 2001), http://www.urban.org/uploadedpdf/412361-consider-savings.pdf.

42. ACA § 2201 (to be codified at 42 U.S.C. § 1396w-3).

43. The problem of low-income people who are eligible for public insurance but not enrolled is longstanding and is attributed to many factors, one of which is the failure of states to simplify the enrollment process and thereby remove artificial barriers to access. There is much literature on Medicaid enrollment barriers. *See, e.g.*, Amy Davidoff et al., *Medicaid-Eligible Children Who Don't Enroll: Health Status, Access to Care, and Implications for Medicaid Enrollment*, 37 INQUIRY 203 (2000); Jennifer Stuber & Elizabeth Bradley, *Barriers to Medicaid Enrollment: Who is At Risk?*, 95 AM. J. PUB. HEALTH 292 (2005).

participation, particularly in the case of specialty care.[44] In the case of primary care, the existence of the health center programs helps offset the lack of access.[45] Although free choice of medical providers has been a hallmark of Medicaid almost since its 1965 enactment,[46] access remains seriously constrained. Whether, in fact, raising Medicaid's low provider payment rates would result in access improvements is a matter of debate in view of the fact that access to care is a reflection not just of payment rates but also of availability and utilization.[47] At the same time, low payment rates have generally been regarded as an *ipso facto* barrier to Medicaid's ability to better assure appropriate care for covered populations.

II. ADDRESSING THE CHALLENGES CREATED BY MEDICAID'S PRESERVATION

Assuming that the Affordable Care Act survives constitutional challenges mounted against it,[48] in the "new normal" that will characterize the American health care financing system for nonelderly people circa 2015, Medicaid will effectively serve as the platform on which an expanded, subsidized individual market will rest. Workers and their families will continue to receive coverage through employer-sponsored health benefit plans (the Congressional Budget Office has projected that employment based coverage arrangements will remain stable, at least in the near-term).[49] People who qualify for Medicare on the basis of disability will

44. MACPAC, *supra* note 1, at 132.

45. In 2008 health centers served 17.1 million patients. *See* ROSBENBAUM ET AL., OPPORTUNITIES, *supra* note 13 at 2.

46. The free choice of provider provision of Medicaid, 42 U.S.C. § 1396a(a)(23), was not part of the original statute. H.R. REP. NO. 89-682, at 17 (1965) (Conf. Rep.), *reprinted in* 1965 U.S.C.C.A.N. 2228, 2246; ("Amendment No. 267: This amendment provided that an individual entitled to medical assistance under an approved State plan (under the new title XIX) might obtain such assistance from any institution, agency, or person qualified to perform the service or services required. The House bill contained no comparable provision. The Senate recedes."). *Id.* Instead it was added to the law in 1967 in the wake of evidence of efforts to limit Medicaid beneficiaries to government health care facilities, whose survival of course was at stake in the wake of what was to be an access enabling reform. Social Security Amendments of 1967, Pub. L. No. 90-248, § 227, 81 Stat. 821, 903-04 (1968). It is no small irony that a half century later, the health care safety net provides the plurality of health care access.

47. MACPAC, *supra* note 1, ch. 4.

48. *See Court Schedules and Documents*, HEALTH LAW & LITIGATION, http://www.healthlawandlitigation.com/courts/index.php (last visited Sep. 29, 2011) (providing full inventory of pending cases regarding the ACA maintained by the O'Neill Institute in Global Health Law and Policy and the National Health Law Program).

49. For a complete presentation of all CBO analyses related to the Act, see DOUGLAS W. ELMENDORF, CONG. BUDGET OFFICE, CBO'S ANALYSIS OF THE MAJOR HEALTH CARE LEGISLATION ENACTED IN MARCH 2010 (2011), *available at* http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf. CBO's budget projects are made in ten-year windows.

continue to do so.[50] Everyone else will secure coverage through one of two basic pathways: Medicaid for the poorest people with family incomes below its new financial eligibility cutoff point;[51] or state health insurance Exchanges for low, moderate, and high income individuals without access to employer coverage or another form of creditable coverage.[52] Coverage subsidies thus will flow through Medicaid for the poorest individuals and families, and through premium tax credits for qualified individuals.[53]

This all sounds simple enough. But getting to the new normal entailed tackling three major challenges within the scope of the Act. First, Medicaid eligibility rules needed to be changed in order to end the program's historic exclusion of poor adults without disabilities. Second, Medicaid enrollment needed to be simplified given the long history of barriers to entry into, and retention of, coverage. Third, processes needed to be adopted to ensure a smooth transition between the two subsidized markets in light of the impact of constant income fluctuation on their joint and several operations.

This third challenge takes on added urgency that goes beyond simply the question of assuring appropriate connection to the correct source of financial subsidy; that is, this is more than an accounting problem. Modern health insurance products are characterized by coverage that in turn is tied to provider networks.[54] As a result, one's source of coverage effectively becomes one's source of health care for all but emergency medical

What happens to people after that is anyone's guess, although CBO anticipates very small changes in employer behavior as a result of the Act. *See* PAUL D. JACOBS, CONG. BUDGET OFFICE, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S EFFECTS ON EMPLOYERS' DECISIONS TO OFFER HEALTH INSURANCE (July 13, 2011), *available at* http://www.cbo.gov/ftpdocs/123xx/doc12374/07-13-2011-Jacobs_IHEA-presentation_CBO-analysis-employer-responses.pdf. It is also anyone's guess as to whether the establishment of state health insurance Exchanges and federally subsidized coverage will in fact trigger entirely different behavior on the part of all but, perhaps, the very largest or wealthiest of employers. But this is another law review article.

50. ACA § 3601 (to be codified at 42 U.S.C. § 1395).

51. Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228, 228 (2011) [hereinafter *Issues in Health Reform*] (citing ACA § 1401(a) (to be codified at 26 U.S.C. § 36)).

52. *Id.*

53. Medicaid is referred to explicitly as a state health subsidy program under the law. ACA § 1413(a) (to be codified at 42 U.S.C. § 18083).

54. *See* KAISER FAMILY FOUND. & HEALTH RESEARCH & ED. TRUST, NO. 8085, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY ex. 4.3 (2010), *available at* http://ehbs.kff.org/pdf/2010/8085.pdf. As of 2010, only 3% of firms offered "conventional" insurance, that is, insurance in which coverage is fully available up to plan limits regardless of the provider from whom care is obtained. *See id.*

conditions.[55] Unstable coverage thus raises the specter of disruption in health care itself, a significant consequence in view of the important role that continuity in care plays in assuring access, health care quality, and administrative efficiency, another basic aim of the Act.[56]

The Affordable Care Act addressed the first two issues,[57] while leaving the third essentially untouched. Although it falls largely to states to address the problem, we argue below that there are steps the federal government might take, as part of implementation, to ease matters.

A. Coverage of the Poorest Americans

The hallmark of pre-ACA Medicaid eligibility was its discrimination against poor adults who were neither pregnant, disabled nor parents of minor children. Conceived as an outgrowth of the cash welfare programs to which it was connected,[58] Medicaid historically was limited in its scope of eligibility to those categories of persons who qualified for welfare assistance: parents of minor children whose incomes and resources placed them below their state's welfare eligibility standards under Aid to Families with Dependent Children ("AFDC");[59] and recipients of aid to the aged, blind and disabled, recodified in 1972 as Supplemental Security Income.[60] Over nearly fifty years, Congress added numerous mandatory and optional eligibility categories, extending coverage to millions of additional poor people, chief among them, all pregnant women, infants and children up to age six with family incomes up to 133% of the federal poverty level, and all

55. The Act extends coverage for emergency medical care on an out-of-network basis to all insured persons. ACA § 10101(h) (to be codified at 42 U.S.C. § 300gg-19A) (adding PHSA § 2719A).

56. Shana Alex Lavarreda et al., *Switching Health Insurance and its Effects on Access to Physician Services*, 46 MED. CARE 1055, 1060 (2008); Sharon K. Long, Teresa Coughlin & Jennifer King, *How Well Does Medicaid Work in Improving Access to Care?*, 40 HEALTH SERVICES RES. 39, 54-55 (2005); *Issues in Health Reform*, *supra*, note 51 at 229; Joel S. Weissman et al., *Delayed Access to Health Care: Risk Factors, Reasons and Consequences*, 114 ANNALS INTERNAL MED. 325, 329 (1991).

57. ACA § 2001 (to be codified at 42 U.S.C. § 1396(a)) (providing Medicaid coverage for the lowest income populations); ACA § 2202 (to be codified at 42 U.S.C. § 1396(w)(3)) (simplifying Medicaid enrollment and coordination with State Health Insurance Exchanges).

58. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID chs. 1, 4 (Transaction Publishers 2003) (1974). For a history of the evolution of Medicaid eligibility categories see MACPAC, *supra* note 1, at 27-45.

59. The AFDC program was repealed in 1966 and replaced with the Temporary Assistance to Needy Families Program ("TANF"). Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105. Medicaid eligibility on a mandatory basis remains tied to states' historic 1996 AFDC eligibility standards. Social Security Act, 42 U.S.C. § 1396n (2006).

60. 42 U.S.C. § 1396a(a)(10)(A)(i).

children ages 6-18 with family incomes up to 100% of the federal poverty level.[61]

As important as they were, these expansions failed to address two separate issues, the first being the lack of a recognized eligibility "category" for nonelderly adults who were neither caretakers of dependent children nor disabled, and the second being the program's link in the case of adults with children to states' historic AFDC eligibility standards which as of 2009 were as low as 20% of the federal poverty level.[62] Under federally sanctioned arrangements authorized by the Social Security Act's special demonstration authority[63] a handful of states covered additional low-income adults.[64] As of 2009 however, no federal law either required or allowed such coverage as a matter of state Medicaid plan administration.

The Affordable Care Act restructured Medicaid eligibility, breaking its last link to its old welfare eligibility categories. The Act added a new mandatory categorical eligibility group to Medicaid consisting of nonelderly adults with family incomes below 133% of the federal poverty level[65] and who otherwise would be ineligible for coverage based on pregnancy, disability, or as the caretaker of a dependent child.[66] The medical assistance entitlement for this newly eligible population consists of "benchmark benefits," which were modified by the Act to parallel the essential benefit requirements of the Act.[67] The Act further creates a state option, beginning January 1, 2014, to extend Medicaid coverage to adults with higher incomes that exceed 133% of the federal poverty level.[68] In the case of adults made eligible for Medicaid on a mandatory basis, the federal medical assistance percentage (that is, the federal contribution toward state

61. *Id.* § 1396a(a)(10)(A)(i)(IV), (VI).

62. *See* Sara Rosenbaum, *Medicaid and National Health Reform*, 361 NEW ENG. J. MED. 2009, 2009-10 (2009).

63. Social Security Act § 1115, 42 U.S.C. § 1315 (2006).

64. KAISER FAMILY COMM'N ON MEDICAID & THE UNINSURED, NO. 7874, THE ROLE OF SECTION 1115 WAIVERS IN MEDICAID AND CHIP, LOOKING BACK AND LOOKING FORWARD 1, 6-7 (2009) [hereinafter SECTION 1115 WAIVERS], *available at* http://www.kff.org/medicaid/upload/7874.pdf.

65. ACA § 2001(a) (amending 42 U.S.C. § 1396a). In reality the income eligibility standard is 138% of the federal poverty level because of an additional 5% income disregard added to the eligibility calculation methodology under HCERA. ACA § 1004(e) (amending 42 U.S.C. § 1396a(e)(14)).

66. ACA § 2001(a) (amending Social Security Act § 1902(a)(10)(A)(i), 42 U.S.C. § 1396a).

67. ACA § 2001(c) (amending 42 U.S.C. § 1396u-7(b).

68. ACA § 2001(e)(1)(A)(iii) (amending Social Security Act § 1902(a)(10)(A)(ii), 42 U.S.C. § 1396a).

expenditures) was increased to 100% for calendar years 2014-2016, dropping to 90% by 2020 and years thereafter.[69]

In addition, the Act further eliminated states' use of a Medicaid asset test and revised the methodology used to evaluate income to conform with that used when determining eligibility for premium tax credits and cost sharing assistance in the case of Exchange qualified individuals,[70] thereby harmonizing the income calculation methodology between the two basic subsidy systems.

B. Enrollment in Medicaid

Enrollment in Medicaid traditionally has been a horror. In part to conform to the law's intricate eligibility requirements (including verification procedures required by law) and in part in order to keep people off the rolls for budgetary reasons, states typically utilized Byzantine enrollment procedures that were seemingly designed to be as difficult as possible. Applications could run thirty pages; were available only by physically going to a welfare office and picking the application up; welfare offices were open for application pickup only at odd hours; applications were written only in English; the English that was used would defeat comprehension by most law students, not to mention lawyers; masses of unnecessary and irrelevant information were required as part of the application; applications would be accepted only on certain days; only completed applications would be accepted; incomplete applications would be mailed back at some future date with an explanation that they could not be processed; an in-person interview would be required; in-person interviews could happen only on certain days, typically in the middle of work; and on and on.[71] And then the process would begin anew at the point of eligibility redetermination, conducted at least once annually and as frequently under federal law as monthly, at a state's option.[72]

Over the years a tremendous amount of determined advocacy shone a light on this problem, and Congress, along with a number of enlightened states, began to respond in recognition of Medicaid as a health care

69. ACA § 2001(a)(3) (amending Social Security Act § 1905, 42 U.S.C. § 1396d).

70. ACA § 2002 (amending Social Security Act § 1902(e), 42 U.S.C. § 1396a(e)).

71. *See* Davidoff, *supra* note 43; Stuber, *supra* note 43 for studies of Medicaid enrollment barriers. Professor Rosenbaum finds it instructive to recite the adventure of Medicaid applications from memory.

72. 42 C.F.R. § 435.916 (2009). In addition to this periodic redetermination process, individuals must report any interim change in circumstances that might affect their eligibility, which can also result in the loss of coverage. *Id.*

program rather than as a welfare benefit to be "churned."[73] Steps taken have included many changes to reduce barriers to both initial enrollment and retention of coverage. These steps included shortened and far more accessible applications, elimination of eligibility criteria and verification procedures not required under federal law, online enrollment and out stationed enrollment assistance, longer enrollment periods before eligibility needed to be redetermined, "passive" redeterminations that allow individuals to retain coverage in the absence of any change in circumstances, the elimination of in-person interviews, and more. Most of these changes took place in the context of pregnant women and children.[74] The Children's Health Insurance Program Reauthorization Act of 2009 went so far as to create financial bonuses for states that simplified enrollment and retention of coverage.[75]

The Affordable Care Act took matters further. The ACA essentially eliminates state flexibility to make enrollment difficult, either for persons made newly eligible by the Act or for those falling into traditional Medicaid eligibility categories. The ACA requires that as a condition of federal financial participation, states assure enrollment simplification and coordination with state health insurance Exchanges.[76] Enrollment simplification must include initial enrollment and renewal activities, online application and electronic signature, the use of a secure electronic interface between state Medicaid agencies and state Exchanges to assure full screening without repeat visits under all potential subsidy sources, outreach to find underserved populations not enrolled, and other steps.[77] Most significantly perhaps, individuals can enroll in Medicaid through their state health insurance Exchanges, which have a parallel duty to screen individuals for eligibility for premium tax credits or any other state subsidy (including Medicaid) and to enroll individuals if they are determined to be eligible.[78]

73. Welfare churning is a classic term of art used by legal services attorneys and scholars alike. It denotes knocking people off the program for no really good reason. *See generally* David J. Kennedy, *Due Process in a Privatized Welfare System*, 64 BROOK. L. REV. 231 (1998).

74. *See, e.g.*, DONNA COHEN ROSS, ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, NO. 7608, RESUMING THE PATH TO HEALTH COVERAGE FOR CHILDREN AND PARENTS: A 50 STATE UPDATE ON ELIGIBILITY RULES, ENROLLMENT AND RENEWAL PROCEDURES, AND COST-SHARING PRACTICES IN MEDICAID AND SCHIP IN 2006, at 1, 5, 15 (2007), *available at* http://www.kff.org/medicaid/upload/7608.pdf.

75. Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 104, 123 Stat. 17, 17-23.

76. ACA § 2201 (to be codified at 42 U.S.C. § 1396w-3) (adding Social Security Act § 1943).

77. *Id.*

78. ACA § 1311(d)(4)(F) (to be codified at 42 U.S.C. § 18031).

C. *Transitioning Between Medicaid and the Exchange*

This brings us to the third issue, the problem of market transitions created by the fact that the subsidy system comprised of Medicaid and premium tax credits available through state health insurance Exchanges are income sensitive. Each has a hard stop. Medicaid eligibility terminates at 138% of the federal poverty level, and the Exchanges pick up at this point.[79] When family income drops back below this threshold, Medicaid eligibility resumes; furthermore, under the express terms of the ACA, any coverage month for which an individual is eligible for Medicaid is a coverage month for which the individual is *not* eligible for premium assistance.[80]

The mechanics of implementing this system (i.e., catching up with people whose incomes fluctuate from month-to-month and transitioning them between subsidy sources) are daunting. To make matters more complex, the Exchange subsidies (i.e., tax credits) and Medicaid coverage are under the control of two very different types of governmental entities—the IRS on one side with state Medicaid agencies and HHS on the other.[81] Each of the parties in this uneasy relationship has every interest in strict enforcement against the other (HHS aligned with state Medicaid agencies against the IRS) in order to assure cost avoidance against the agency's financial obligations. All three agencies will have to put into place a previously untested type of information sharing arrangement.

Worse still is the fact that this problem of market transition is not a small one. Where the poor are concerned, the great advance of the ACA is its elimination of the Medicaid cliff. In the pre-ACA days (meaning now, of course, since the Exchange reforms do not begin until January 1, 2014), people who lost Medicaid lost their insurance entirely.[82] There were many reasons why this happened, income fluctuation being one of them, failure to comply with program requirements or make it through the redetermination maze being another, and the effects on coverage and access were severe. One study showed that by the end of twenty-three months, 55% of adults initially enrolled in Medicaid were disenrolled, and half of those who lost coverage remained uninsured six months later.[83] Another study examining insurance over a four-year time period found that over this time span, 41%

79. ACA § 1004(e) (to be codified at 42. U.S.C. § 1396a).

80. ACA § 1401 (amending I.R.C. § 36B(c)(2)(B)).

81. *HHS, IRS Issue Proposed Rules on Health Exchange Enrollment, Subsidies, Credits*, NAT'L ASS'N OF PUB. HOSP. & HEALTH SYS. (Aug. 17, 2011), http://www.naph.org/Homepage-Sections/News/Latest-From-Newsline/HHS-IRS-Issue-Proposed-Rules-on-Health-Exchange-Enrollment-Subsidies-Credits.aspx.

82. *See* Benjamin D. Sommers, *Loss of Health Insurance Among Non-elderly Adults in Medicaid*, 24 J. GEN. INTERNAL MED. 1, 4 (2009).

83. *Id.* at 4.

of adults experienced repeated cycles of Medicaid coverage interspersed with being uninsured.[84]

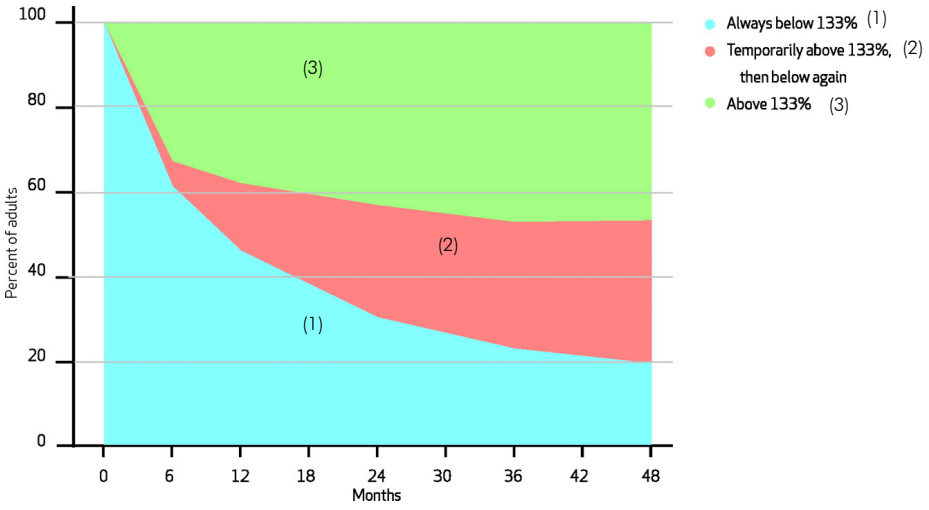
The ACA's seminal contribution in this regard is the creation of a continuous source of coverage for people who lose Medicaid. In this sense, the old churning problem—that is, being churned on and off the program and left without coverage—is structurally eliminated. Nonetheless, a new problem, which might be called transitional churning, arises in its stead. How this transition across the two markets occurs becomes central to the success of the program for lower income families, not only because of the potential for disruption in financial subsidies, but because the disruptions will affect both coverage and care.

In order to examine the magnitude of this challenge more closely, we analyzed data from the Survey of Income and Program Participation, a nationally representative longitudinal survey carried out by the U.S. Census Bureau.[85] The study collects detailed information from participants every four months over four twelve-month waves, thereby providing an incomparable look at changes in income and participation in programs such as Medicaid. Our study period spanned the 2004-2008 time period and focused on adults. We sought to measure the extent of income fluctuations within the population at the edge of the transitional churn—that is, people with incomes below 200% of the federal poverty level. What we found is presented in Figures 1-2 reproduced from our earlier study:

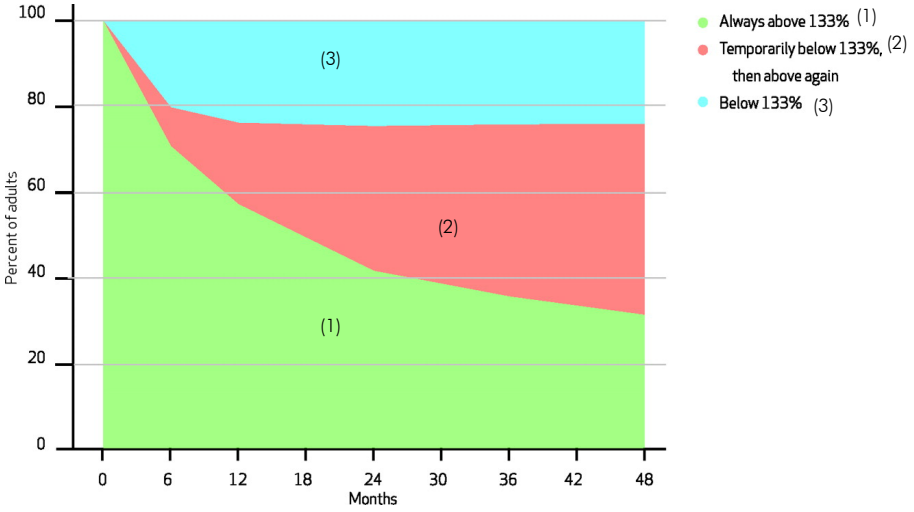
84. Pam Farley Short & Deborah R. Graefe, *Battery Powered Health Insurance? Stability in Coverage of the Uninsured*, HEALTH AFF., Nov.-Dec. 2003, at 244, 251.

85. The full methodology for our analysis can be found in *Issues in Health Reform*, *supra* note 51.

Income Changes Over Time Among Adults Ages 19–60 With Incomes Initially Under 133 Percent Of The Federal Poverty Level.[86]



Income Changes Over Time Among Adults Ages 19-60 With Incomes Initially Between 133 Percent And 200 Percent Of The Federal Poverty Level.[87]



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What the figures show is that as time passes, fluctuations in income translate into a high level of movement across the Medicaid-Exchange market divide, among both those originally eligible for Medicaid (Figure 1) and those originally eligible for Exchange subsidies (Figure 2). The cumulative effects of income fluctuations on market movement over time are shown in Figure 3. A full 50% of adults with incomes initially under 200% of the federal poverty level would have experienced at least one movement across the divide within a year, while 24% would have experienced at least two eligibility changes within a year. By the end of forty-eight months, over 38% of adults ages 19-60 falling within the income range we tested would have experienced four or more changes.

HEALTH REFORM

EXHIBIT 3

Frequency Of Income Fluctuation Across Medicaid-Exchange Eligibility Threshold, Among Adults Ages 19–60 Initially Under 200 Percent Of The Federal Poverty Level

	Number of changes					
Month	0 changes (%)	1 change (%)	2 changes (%)	3 changes (%)	4 or more changes (%)	Sample size
0	100.0	0.0	0.0	0.0	0.0	19,248
6	64.5	26.9	6.7	1.6	0.3	17,227
12	49.8	26.6	14.8	5.9	2.9	15,274
24	34.1	19.9	18.7	11.9	7.8	11,937
36	27.2	16.4	15.6	11.5	29.3	4,855
48	23.6	13.8	14.5	9.7	38.4	4,101

SOURCE Authors' analysis of data from the 2004–08 Survey of Income and Program Participation. NOTES "Changes" refers to monthly income moving across the Medicaid-exchange eligibility threshold of 133 percent of the federal poverty level (plus an additional 5 percent income disregard, yielding an effective threshold of 138 percent of the poverty level). In each time frame, only people with monthly income reported for the full survey to that point are included; people who dropped out of the survey at any prior point are excluded.[88]

Further analysis of the transitional churners, who totaled an estimated 28 million just in the first year of churning, shows that they are more likely to be younger, white, married, male, with a high school education or greater.[89] In other words, they are exactly the young workers with spouses and families

88. Copyrighted and published by Project HOPE/*Health Affairs* as Benjamin D. Sommers and Sara Rosenbaum, Issues in Health Reform: How Changes In Eligibility May Move Millions Back and Forth Between Medicaid And Insurance Exchanges, Health Aff (Millwood). 2011; 30(2):232. The published article is archived and available online at www.healthaffairs.org.

89. *Id*. at 230, 233 ex. 4.

(the number of churned adults translates into an estimated 17-18 million children affected)[90] whose participation in coverage is so critical to the success of the ACA. Indeed, this population at risk for what might be thought of as enrollment fatigue, is exactly the group (along with older workers forced out of the job market by illness or unemployment) whose image comes to mind when one thinks about the achievements of the Act.

III. ADDRESSING THE PROBLEM OF TRANSITIONAL CHURNING IN THE NEW NORMAL

The ACA essentially leaves this issue of transitional churning unaddressed and a major challenge for the implementation process. The law might have offered one basic tool that would have mitigated (but by no means fixed) the problem, namely, a subsidy structure utilizing annual enrollment periods. Under this model, people's subsidy eligibility (tax premiums or Medicaid) would have been determined for a plan year, allowing the equivalent of the open enrollment process used in the workplace. Individuals would sign up for coverage, say, on November 1, their incomes as of November 1 would have been compared to the subsidy scale as of that date, and the subsidy would have been locked in for the next twelve months. In the short run, this would have, at least on paper, cost one subsidy source or another extra money, since the payer for the year potentially would be paying for months in which the individual or family technically did not qualify for coverage. But income fluctuation being what it is, the additional cost would have washed out in following years, when the subsidy's recipient's income shifted to the other source of funding. Using an annual enrollment process and a twelve-month projected income approach, the law could have offered far more stability in enrollment.

Unfortunately, the federal policymaking process is about nothing if not "on paper" cost projections and short term cost avoidance. Because a stabilization strategy to enrollment would have cost the federal government additional money in the short term in the form of "excess" advance premium tax credits, the proposal was not considered beyond the initial cost estimation phase.[91] Of course a state might take matters into its own hands and, utilizing state funding, provide the additional resources needed to stabilize enrollment on an annual basis. The administrative efficiencies to be gained from such a model, as well as the incentives that it conceivably creates for strong take-up among healthy young workers and their families who are drawn to its simplicity and parallelism with the workplace

90. *Id.* at 232. The total sample in Sommers and Rosenbaum corresponds to 56 million adults with 35 million children. *Id.* If roughly half of parents churn in a single year, this translates into 17.5 million children potentially affected. *Id.*

91. In the interest of disclosure, Professor Rosenbaum was involved in the development of the proposal.

enrollment process, are considerable. Yet with state economies being what they are, in the absence of a federal partnership, such an outcome is highly unlikely.

One possibility for moving toward this model is the federal State Innovation Waiver or Basic Health Program options.[92] Both pathways (the former for all populations, the latter for the low income population) permit states to replace the existing structure envisioned in federal law with one of their own making. States opting for this approach would receive federal payments in relation to the size of their subsidy-eligible populations, along with special waivers under Medicaid, to fashion alternative models of coverage.[93] In such a structure, testing an annual enrollment period might be feasible, although again, the problem would arise as to how to offset the initial short-term costs in order to achieve longer-term gains. Here the federal Office of Management and Budget, whose job it would be to certify the budgetary soundness of state models against otherwise-anticipated federal outlays, might play a key role by utilizing a longer timeframe for determining budget neutrality, thereby allowing short term investments to be realized through back-end savings.[94]

Even with the establishment of annual enrollment periods however, the problem is only partially resolved, since the potential for disruption in care is possible if the Medicaid and Exchange markets utilize two different groups of insurance plans. Traditionally, the Medicaid managed care market (70% of all beneficiaries are enrolled in managed care arrangements, and this proportion is expected to grow)[95] has been relatively specialized, consisting either of companies that sell only in this market or of Medicaid subsidiaries of larger health benefit services corporations that sell in multiple markets.[96] This specialty has developed for good reason: the Medicaid benefit package is unique in relation to commercial products, as this article suggests. Medicaid beneficiaries tend to be concentrated in medically underserved communities where special networks heavily emphasizing safety net providers must be utilized; and Medicaid beneficiaries may be more likely to present social and clinical challenges requiring providers such as health centers and safety-net hospital clinics whose staff providers have relevant experience, particularly in furnishing primary care in a broader social

92. ACA §§ 1331, 1332 (to be codified at 42 U.S.C. §§ 18051, 18052).

93. ACA §§ 1331, 1332.

94. There is precedent for such a long term approach to cost estimation in state experiments, since the OMB has used longer term windows in the past in approving Medicaid section 1115 demonstrations, which must be budget neutral. *See* SECTION 1115 WAIVERS, *supra* note 64, at 4.

95. MACPAC, *supra* note 1, at 42.

96. *See* MACPAC, *supra* note 1, at 48.

welfare context. Medicaid providers often are entry points not only in relation to clinical treatment for immediately presenting preventive needs or acute conditions, but also for nutritional assistance and patient support services. In the best models, the health care safety net is a point of contact for a full range of social interventions including education, child care, housing supports, and jobs programs.

While persons with fluctuating incomes related to work do not face impoverishment as deep as that which confronts millions of Medicaid beneficiaries, the experience of a deeply distressed economy highlights just how many families are barely making it and are only a step away from economic and personal catastrophe. For this reason, families would be advantaged were states to develop a market of health plans that are certified to participate in both Medicaid and health insurance Exchanges and whose provider networks remain completely in place, regardless of which subsidy source happens to be paying the enrollment fee for any given month. Because Exchange premiums are risk-adjusted,[97] the potential for this market to attract both higher-cost cases as well as younger families with variable incomes would be mitigated by the risk-adjusted payments to offset the cost of more clinically challenging members.

From families' perspectives, the ability to remain with one's pediatrician, internist, obstetrician, or nurse practitioner and not have to change clinicians every year is of major importance. The importance of continuity and stability grows even more so in families with children or adults who have serious health care needs. Families' interests in stable care, even when health care choices open up, at least in theory, is reflected in a study of patient use of safety net providers after universal health reform in Massachusetts. That study found that safety net providers retained and even grew their patient populations in the wake of Massachusetts' health reform implementation.[98]

In the absence of continuous enrollment subsidies that permit stable enrollment in a single plan over time, the unification of the health plan market should be an even greater focus on the part of HHS and states. The ACA specifies cooperation between Exchanges and Medicaid programs on matters of enrollment.[99] It does not do so on matters of market alignment, leaving this issue instead to the federal and state governments to identify and resolve on their own. The importance of this challenge is such that it represents a major issue on which the federal government should take a lead through creation of tools that foster market harmonization. Extensive

97. ACA § 1312 (to be codified at 42 U.S.C. § 18032).

98. Leighton Ku et al., *Safety-Net Providers After Health Care Reform: Lessons From Massachusetts*, 171 ARCHIVES INTERNAL MED. 1379, 1379-83 (2011).

99. ACA § 1943 (amending 42 U.S.C. § 1396w-3).

federal regulations govern the Medicaid managed care market.[100] An HHS-led initiative to align these requirements with federal requirements applicable to qualified health plans operating in state health insurance Exchanges would be enormously productive, as would a federal process of joint certification in both markets. While as is inevitable in laws, the operational requirements for Medicaid managed care and qualified health plans are somewhat differently expressed in statute, both the federal Medicaid statute and the ACA leave plenty of room for HHS to adopt plan certification standards governing both programs. Plans with dual certification could then be marketed as such to families so that the benefits of stability over time (regardless of changes in family income) would be clear. At the very minimum, federal standards are essential to guide the process of transitioning families between markets, particularly in the case of patients with significant health needs, whose source of care must change because of a change in the source of subsidy enrollment.

IV. CONCLUSION

For reasons both expedient and compelling, the Affordable Care Act maintains Medicaid as an independent source of health insurance coverage, extending its reach to nearly all non-elderly poor people and using it as a platform to build a companion state-based coverage arrangement that essentially picks up where Medicaid leaves off. This approach preserves all that is vital about Medicaid while assuring that the end of Medicaid eligibility does not equate with the loss of access to subsidized coverage. Many improvements to Medicaid identified over decades—simplified categorical eligibility, a simplified set of methods for determining financial eligibility, and vastly simplified enrollment and retention—are signature features of the ACA.

At the same time, however, by employing a layered approach to subsidized coverage without paying real attention to the consequences of layering, the Affordable Care Act has the potential to push millions of younger, healthier adults and their families between two subsidy worlds in a constant churning motion. Given the daily pressures that face lower income working families and their relative good health, the very younger workers and their families whose aid is such a central feature of the ACA may experience multiple breaks in coverage. Ultimately they simply may walk away from coverage entirely, victims of what might be thought of as enrollment fatigue. To be sure, periods of coverage lapses may be shorter given the constant availability of an alternative subsidy system. But if families exposed to churning get tired of the whole thing and effectively

100. *See* 42 C.F.R. § 438 (2010).

wander off, the very people whose participation is most important to the risk solidarity aspect of health reform may be lost to the system. Ironically, many of these people may never experience a tax penalty for walking away, since their annual family incomes may place them below the taxpayer penalty threshold. The real loss is the chance for stable coverage, which ultimately may affect their health and well-being, as well as the chances for a more stable and efficient health care system along the way will erode.

The simplest way to mitigate at least some of the risk would have been annual enrollment periods. This reform probably is a non-starter for now, in the absence of convincing economic analyses showing that the cost of stable enrollment would be offset by its economic benefits. Designing and carrying out such a study is difficult; convincing the Congressional Budget Office that such measurable cost savings really do exist, if found, is even more so in our experience, because of CBO's natural skepticism regarding the value of health care investments.[101] Without CBO-scored cost savings on one's side, reforms to make the health care system work better are unlikely. States could of course create subsidies of their own, but this is also unlikely in today's economic climate.

The more realistic solution may be unification of the seller market of Medicaid managed care plans and Exchange qualified health plans. In this way, the same products could be offered in both markets, using common networks, common terms of coverage (additional Medicaid benefits could offered as a supplement for those whose financial circumstances place them on the Medicaid side of the subsidy line), and at least compatible payment systems. Common performance measures could also be utilized for a standard market basket of preventive, acute care, and ongoing health management activities, such as management of diabetes or cardiovascular disease. Indeed, the emphasis in the ACA on national quality of care standards across all health plans moves performance measurement in this direction already.[102]

Of course, Medicaid also will continue to serve a core group of beneficiaries who are deeply impoverished and whose disabilities put them outside a sufficiently significant enough level of work to trigger constant income swings. For this population, Medicaid will remain the primary health insurer and will out of necessity play a role that has no real counterpart in the Exchange system. Because health care for people who face the greatest burdens of illness is perhaps Medicaid's highest aim, the program's continuation in this capacity was crucial to the shaping of the Affordable Care Act. At the same time, however, Medicaid needs to be

101. For a superb article underscoring this paradox, see Tim Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 GEO. L.J. 1555 (2007).

102. ACA § 3012 (to be codified at 42 U.S.C. § 280j).

able to grow into a financing system that can serve as a fully integrated companion to the new market created through state health insurance Exchanges. Indeed, if Medicaid does not achieve this result, the full participation by individuals and families whose coverage is central to the ACA's ultimate goals of affordable care for everyone may be jeopardized.

Using the tools of Basic Health Program and State Innovation Waivers, as well as the technique of market harmonization to promote compatibility of product design and regulatory oversight, the federal and state governments, working in close companionship, should be able to alleviate the impact of bifurcation. Future research efforts should be structured to focus on this process of alignment, developing alignment benchmarks and measurable outcomes, so that future Congresses in a potentially stronger position to attend to this set of challenges will have the benefit of a strong empirical basis on which to act.