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Helping New Jersey Families Coordinate Transitions and Maintain Coverage When Changing Health Plans

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March 2012

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Acknowledgments

Funding for this report was provided by the New Jersey Department of Banking and Insurance under a grant from the US Department of Health and Human Services.

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Executive Summary

The purpose of this Issue Brief is to examine how to coordinate and transition enrollees between Medicaid/Children's Health Insurance Plan (CHIP), employer-sponsored coverage, and the proposed health insurance exchange products, while promoting continuity of coverage. We highlight applicable Affordable Care Act (ACA) provisions and proposed rules, and discuss policy options that could reduce the impact of "churning" of low-income individuals who lose and regain coverage in a short period of time because of changes in family income or eligibility.

Research has established the hazards of losing health coverage and the harm that results from the disruptions in care that occur when consumers have to shift providers due to a plan change, even without any period of being uninsured. The ACA promises to offer more choices of coverage for individuals, but it also poses coordination challenges for states. There are many outstanding questions in the proposed implementing regulations specifically regarding the exchanges and Qualified Health Plans (QHPs). This brief outlines the issues that New Jersey will need to consider, given the information available, as it tries to maximize continuity of care and maintain seamless coverage among different types of health insurance coverage once health reform is implemented.

Possible strategies include: 1) a minimum Medicaid eligibility or renewal period of at least one year; 2) dually certifying plans and/or providers; 3) offering a Basic Health Plan (covered in detail in a separate brief); 4) combining the individual and small group (SHOP) exchanges; 5) offering providers increased incentives to participate in Medicaid; 6) addressing issues with the timing of coverage; 7) allowing a transitional period for completion of treatment in progress; 8) designing and supporting comprehensive outreach and education programs; and 9) establishing a consolidated provider directory to facilitate identification of providers participating in multiple plans. These strategies are not mutually exclusive and the state could pursue some or all of the choices.

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Introduction

The purpose of this Issue Brief is to discuss how to coordinate coverage transitions between different types of coverage after implementation of the Affordable Care Act (ACA), while promoting continuity of care. Though the ACA greatly expands insurance coverage, some people will remain uninsured even though they are eligible for coverage (Sommers and Rosenbaum 2011). Prior to the implementation of the ACA, many people eligible for free or low-cost government coverage did not enroll or did not renew, sometimes due to administrative barriers (Kenney and Haley 2001). In addition to failing to renew public coverage, changes in life and/or economic circumstances may cause individuals to lose coverage. Gaps in health coverage may occur because of job loss, reduction in work hours, divorce, widowhood, relocation, and aging off of parental health insurance (Jacobs et al. 2011). People transitioning out of employer coverage due to a job change or loss may decide to remain uninsured if enrollment into exchange plans is complicated (Short et al. 2011).

Extensive research has documented the problems caused by an absence of health coverage due to loss of Medicaid/CHIP eligibility or failure to renew enrollment in circumstances when eligibility remains intact. Many states, including New Jersey, have implemented streamlining measures to facilitate the enrollment and retention of those eligible for coverage (Heberlein et al. 2011). Being uninsured due to loss of Medicaid coverage results in suboptimal utilization patterns (i.e., higher cost emergency care that may drive consumers toward bankruptcy and/or increase government charity care costs as well as decrease health for the uninsured). This is true for both adults (Sommers 2009) and children (Rimsza, Butler, and Johnson 2007). Similar findings exist regarding continuity of health coverage generally—i.e., not just among current or former Medicaid recipients (Christakis et al. 2001; Hadley 2002). However, disruptions in coverage are more likely for people with low incomes (Ku and Ross 2002). Even without an uninsured period, switching between plans can delay needed care (Lavarreda et al. 2008).

The implementation of the ACA will greatly expand coverage eligibility, but enrollment and continued coverage will depend on financial incentives, as well as the quality of information provided to consumers. Some consumer behavior is driven not by actual costs and

penalties, but rather by people's perceptions of costs and penalties, whether accurate or not (Short et al. 2011). In addition to being affected by financial incentives (in the form of subsidies and penalties), consumers are influenced by “time costs,” such as how difficult it is to enroll or redetermine eligibility, and whether clear and useful information is readily available to them.

With the implementation of ACA, the number of people likely to move in and out of Medicaid eligibility is huge. On a national level, Sommers and Rosenbaum (2011) calculated that "within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will."

In addition, many individuals who have affordable employer-sponsored coverage are likely to shift between that coverage and Medicaid or exchange products because of employment changes (Jacobs et al. 2011). The exchange provides an alternative to COBRA continuation of benefits for those facing the loss of employment-based coverage.

Maintaining seamless coverage is likely to be more difficult for those individuals living in complex family situations. Nationally, 28 million children live apart from at least one parent, and 3.7 million live with neither parent. Individuals in such families may have a mix of coverage types, and not all family members may change coverage eligibility at the same time. In New Jersey, as in other states, children in NJ FamilyCare with family incomes above 138% of the federal poverty level (FPL) will have parents enrolled in coverage through employer or exchange plans. In addition, many citizen and legal resident children may have a parent who is undocumented, creating additional barriers to enrolling and maintaining coverage for these families.

Policy and Legal Context

Applicable ACA Law and Rules

The ACA and proposed implementing regulations have several provisions designed to ease enrollment and help coordinate transitions between health plans. The ACA seeks to ensure that consumers have a single point of entry and seamlessness between public programs and exchange plans, including access to information needed to understand plan options and make an enrollment choice or change plans. Some of those provisions related to coordinating coverage transitions include:

- ACA requires a single application for Medicaid, CHIP, the Basic Health Plan (if applicable), and exchange plans. The exchange will determine eligibility for tax credits and cost-sharing reductions. The application may be accepted in person, via telephone, mail, or over the Internet.[1] Proposed rules require that exchanges operate a call center

[1] ACA Section 1413 and proposed rule §155.405.

and a website that provide information to the public regarding enrollment (plan and provider information), eligibility (including making determinations), plan quality, and exchange transparency (disclosure of fees, etc.).[2] The exchange must provide a calculator tool to help prospective applicants compare plans given the tax credit and cost-sharing measures that will apply to them. The information must be accessible to people with disabilities and people with limited English proficiency.

- The proposed rules limit requests for information to those which are essential for plan enrollment or renewal. Families cannot be required to provide Social Security Number and immigration status of family members who are not seeking coverage. Under the ACA, states must rely on electronic verification of data to the “maximum extent practicable” when evaluating eligibility. In proposed rules for both Medicaid and exchange eligibility, states must verify eligibility first by gathering data from electronic sources (Rosenbaum 2011b). Federal and state databases will be established to facilitate electronic verification; if implemented as intended, these provisions would minimize the need to provide copies of pay stubs and other documents at the time of enrollment or renewal. However, the final rules may provide additional guidance on what will be considered “reasonably compatible” confirming data.
- The exchange must conduct outreach and education separately from the programs mentioned elsewhere, to educate consumers and encourage participation. Proposed rules "encourage exchanges to conduct outreach broadly as well as in ways that are accessible to people with disabilities, individuals with low literacy, and those with limited English proficiency" and also to "target specific groups including hard to reach populations and populations that experience health disparities due to low literacy, race, color, national origin, or disability, including mental illnesses and substance use disorders."[3]
- The ACA provides for grants to states or exchanges for consumer assistance programs to educate consumers, assist with complaints, and collect data.[4] Exchanges are to establish grants for "navigators" to provide public education, information on plans and tax credits, facilitate enrollment, and refer complaints and questions in a culturally and linguistically appropriate manner.[5] At least two navigators are to come from a list that includes various business and trade-oriented groups, licensed agents/brokers,

[2] Proposed rule §155.205, implementing parts of ACA Section 1311.
[3] US Department of Health and Human Services (DHHS), 45 CFR Parts 155 and 156, [CMS-9989-P], RIN 0938-AQ67, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, pp.44–45.
[4] ACA Section 1002.
[5] ACA section 1311(i) and proposed rule §155.210.

community and consumer-focused organizations, and government agencies.[6] Comment is sought about the need for navigators to include those who can demonstrate the ability to work successfully with vulnerable community groups.[7]

- Proposed rules require plans to have a provider directory that notes whether or not the provider is accepting new patients.[8] The Centers for Medicare & Medicaid Services (CMS) notes that "Exchanges will have discretion to determine the best way to give potential enrollees access to the provider directory for each QHP, including through a link from the Exchange's website to the issuer's website, or by establishing a consolidated provider directory through which a consumer may search for a provider across QHPs."[9]
- Plans must offer consumers sufficient choice of providers and give information on their availability, and that they "include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically underserved individuals."[10]

The ACA seeks to ensure consumer choice in the following ways:

- It authorizes the Basic Health Plan option (covered in a separate brief), which is a state-run plan for low-income consumers (between 138% and 200% FPL) that can potentially help to bridge the affordability gap between public programs and exchange products.[11]
- It allows states to offer a merged individual and small employer group (SHOP) exchange, which could offer better continuity for consumers who may be moving back and forth between small group and individual coverage with employment changes (Ingram, Gore, and McMahon 2011; Short et al. 2011).[12]

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[6] The full list is "(i) Community and consumer-focused nonprofit groups; (ii) Trade, industry, and professional associations; (iii) Commercial fishing industry organizations, ranching and farming organizations; (iv) Chambers of commerce; (v) Unions; (vi) Resource partners of the Small Business Administration; (vii) Licensed agents and brokers; and (viii) Other public or private entities that meet the requirements of this section. Other entities may include but are not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies." §155.220 notes that states may permit agents and brokers to assist people with enrollment and application for tax credits. However, if they are compensated by issuers for this, they may not be a navigator (DHHS, 45 CFR Parts 155 and 156, [CMS-9989-P], RIN 0938-AQ67, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, p.49).

[7] DHHS, 45 CFR Parts 155 and 156, [CMS-9989-P], RIN 0938-AQ67, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, p.46.

[8] §156.230.

[9] DHHS, 45 CFR Parts 155 and 156, [CMS-9989-P], RIN 0938-AQ67, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, p.126.

[10] ACA Section 1311(c)(1).

[11] ACA Section 1331.

[12] ACA Section 1311(b)(2).

New Jersey Context and Practice

New Jersey has generally adopted many recommended practices to maximize retention in public insurance. Both Medicaid and NJ FamilyCare offer continuous 12-month eligibility before a renewal is required. New Jersey offers presumptive eligibility and was an early adopter of the “express lane” eligibility option, where states use information already possessed by government agencies (e.g., income) rather than requiring applicants to provide documentation (Heberlein et al. 2011).

New Jersey's provider network rules for HMOs, codified in N.J.A.C. 11:24-6 et seq., do not currently mention essential community providers. The state's Medicaid HMO contract, however, requires contracting with "at least one federally qualified health center (FQHC) within each enrollment area based on the availability and capacity of the FQHCs in that area.” [13] FQHC providers are required to meet the contractor’s credentialing and program requirements.[14] Both commercial issuers offering managed care plans and Medicaid HMOs must comply with detailed provider directory requirements, including maintenance of a web-based directory.[15,16] In focus groups conducted by the Rutgers Center for State Health Policy, stakeholders noted the importance of ascertaining the accuracy of advertised provider networks, alleging that plans have engaged in a variety of strategies to artificially inflate the number of providers they offer (Michael et al. 2011).

New Jersey, like other states, faces budgetary pressures with Medicaid expenditures and struggles to find a balance among the various ways of addressing costs: eligibility restrictions, service reductions, provider reimbursement amounts, and administrative streamlining. Setting provider reimbursement too low can reduce enrollees' access to care by reducing the number of providers who are willing to participate in public programs. New Jersey's fee-for-service provider reimbursement rates were the lowest in the nation overall in 2008 at 58% of the national average,[17] though the state improved quite a bit by 2010 to 93% of the national rate.[18] Managed care rates are less well known—2001 data show New Jersey ranked 13th out of 36 states in generosity of payment.[19] The planned increase in Medicaid

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[13] NJ Medicaid HMO contract, *see* http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-vol1.pdf, accessed August 2, 2011.
[14] NJ Medicaid HMO contract, section 4.8.1, p.124.
[15] NJ Medicaid HMO contract, section 4.8.4, p.127.
[16] N.J.A.C. 11:24A-4.2 and 4.3.
[17] Kaiser State Health Facts, Medicaid Physician Fee Index, 2008; *see* http://www.statehealthfacts.org/comparetable.jsp?ind=195&cat=4, accessed August 10, 2011.
[18] In 2010 NJ was the 7th-lowest state, but was much higher than many of the lower-ranked states. Medicaid and CHIP Payment and Access Commission, Report to the Congress on Medicaid and CHIP, March 2011, Table 5-1, p.169.
[19] Kaiser State Health Facts, Statewide Adjusted Medicaid Managed Care Rates, 2001, *see* http://www.statehealthfacts.org/comparemaptable.jsp?ind=221&cat=4, accessed August 10, 2011. (39 states offered Medicaid managed care and 36 responded to the survey.)

beneficiaries covered by managed care will challenge managed care plans to expand provider networks to insure needed levels of care for these new members.

Policy Options

Many options are available to states to increase provider continuity or reduce the likelihood that people will become uninsured. The policy options described below are not mutually exclusive.

- **Minimum eligibility or renewal period, generally at least one year**
  Medicaid and CHIP regulations allow for a 12-month minimum eligibility period for children, where enrolled children remain eligible for 12 months regardless of circumstances. Regulations do not allow for such continuous eligibility for adults, though Heberlein et al. (2011, 24) note: "it is possible that states could achieve a similar result for adults through a waiver from CMS or possibly through use of less restrictive income methodologies (e.g., a state could disregard changes in income that occur during the course of a 12-month renewal period)." New Jersey Medicaid has a 12-month renewal period for adults. Enrollees are expected to notify the state of changes that affect eligibility during this period, but the state will not ask for updated information for 12 months. Medicaid Health Plans of America, a trade association of health plans contracting with Medicaid programs, recommends synchronizing Medicaid redetermination with exchange open enrollment periods to make it easier for consumers to shift if necessary (Johnson 2010).

  Researchers who have looked at the frequency with which people with low incomes move above and below the eligibility guidelines believe that the administrative cost of disenrolling and reenrolling people may exceed the savings from immediately terminating enrollment of those who become ineligible (Sommers and Rosenbaum 2011).

- **Dual certification of plans and/or providers**
  It has been suggested that states could provide incentives or mandate plans to participate in both Medicaid and the exchange, allowing consumers to keep the same plan and provider network when switching from Medicaid to the exchange (or vice versa), which would be less disruptive (Short et al. 2011; Sommers and Rosenbaum 2011). The National Governor's Association held two meetings in September 2010 in which mandatory participation in Medicaid and the exchange was discussed among state representatives who were concerned about churning issues. A spokesperson from Minnesota Department of Human Services noted that HMOs are currently required to participate in Medicaid as a condition of being licensed in Minnesota, but could not say

what requirements the state would make of plans under health reform. A Delaware representative said that the state was considering the issue of mandatory participation (Trompeter and Davis 2011). Medicaid Health Plans of America supports voluntary participation in both arenas, but notes that some Medicaid plans have specialized in serving low-income populations and may not be able to offer a competitive exchange product (Johnson 2010). National research shows that Medicaid managed care plans have become more specialized, with the percentage of plans dominated by publicly insured individuals increasing from 43% of managed care plans in 2003 to 56% in 2008 (Kaiser Commission on Medicaid and the Uninsured 2010). A national survey of state Medicaid directors showed that while most states are planning to increase the use of managed care in Medicaid, they are uncertain about the landscape of managed care under health care reform—most did not know if dual participation in Medicaid and the commercial market, or any participation in the exchange, would be required. Some 13 of 30 states reported managed care interest in the exchange (Gifford et al. 2011).

Even if the same plans weren't offered, broad provider participation across plans could ensure continuity of care if consumers switched plans. The ACA and proposed regulations suggest that all plans contract with essential community providers, but does not require this (see discussion above in the section on Policy and Legal Context). The proposed regulations also allow FQHCs to negotiate higher compensation than other providers, which may prove a disincentive for health plans to offer contracts with them. The number of plans offered in New Jersey Medicaid has decreased from six in 2009 to four in 2010 (New Jersey Department of Human Services, Division of Medical Assistance and Health Services 2010). Two carriers covering 84% of the Medicaid managed care population currently offer both commercial and Medicaid plans in the state; the others are Medicaid only (Gifford et al. 2011). New Jersey is planning to update Medicaid managed care network adequacy standards in light of the large number of additional people with special health care needs moving into managed care before ACA implementation.

It is unclear whether mandating plan participation would increase consumer choice in a meaningful way. It is possible that if plans are not competitive or decide to withdraw from the market, consumers might be worse off.

- **Basic Health Plan**

  With the Basic Health Plan (BHP), states can design a special program for low-income people from the maximum level of Medicaid eligibility (138% FPL) up to 200% FPL. Though some details remain to be clarified by the federal government, many experts believe that this approach has promise for offering better services to low-income consumers while potentially offering more continuity with Medicaid and/or exchange products (Benjamin and Slagle 2011; Palmer 2011; Rosenbaum 2011a; Short et al. 2011).

A separate Issue Brief on this topic prepared by CSHP is available at http://www.cshp.rutgers.edu/Downloads/9120.pdf. A more complete analysis of the costs of this option will be required to determine the impact of operating a BHP in New Jersey.

As an alternative to a BHP, Tennessee has expressed interest in having the option to allow Medicaid managed care organizations to offer a product in the insurance exchange (the Medicaid "bridge"). MCOs might limit the availability of the product only to persons who have a dependent in their immediate family who is enrolled in Medicaid or CHIP or has been enrolled with the past 6-12 months. This would enable members of a nuclear family to hold coverage through a common insurer/provider network, regardless of their eligibility status. MCOs would provide a single card for use by the entire family while a dependent is enrolled in the Medicaid/CHIP program and for a defined period thereafter. Correspondence from TN policymakers has suggested that the bridge product(s) might be modeled after silver level QHPs, so that family members not covered by Medicaid/CHIP could qualify for premium tax credits and cost-sharing subsidies.[20] Since Tennessee covers CHIP enrollees in families with incomes up to 250% FPL, it appears that the bridge plan could benefit families up to this level. Bridge products might pay more than Medicaid reimbursement levels to providers but likely less than commercial or QHP levels. Tennessee has requested CMS' Center for Consumer Information and Insurance Oversight (CCIIO) to confirm that within the health reform law the state has the authority to have such a plan option, but CCIIO has interpreted the ACA guaranteed issue provisions as prohibiting exchange plans from limiting eligibility to current or former Medicaid/CHIP enrollees and their nuclear families. Tennessee has provided legal basis for their policy, but it is unclear currently whether the bridge option will be deemed within the statutory limits of the ACA.

- **Combined individual and small group (SHOP) exchange**
  Lower-income people are more likely than others to work for smaller firms. In 2006, 57% of those below 133% FPL worked at firms with fewer than 100 workers, while only 32% of those above 400% FPL worked in similar sized businesses (Short et al. 2011). There is also some evidence of greater employment churning at lower income levels. This "will add to movement among small-business exchanges, subsidized participation in individual exchanges, and Medicaid under health reform" (Short et al. 2011, 6). A combined exchange could simplify transitions between small group and individual

[20] Letter to CMS from Darin J. Gordon: Re: File CMS-9989-P (Comments on Proposed Rules for Exchanges and QHPs), October 31, 2011. Available at: http://www.tn.gov/nationalhealthreform/forms/cmtsonexchangeregs.pdf, accessed February 8, 2012.

coverage, as people might be able to stay in the same plan when their type of coverage changed (Ingram, Gore, and McMahon 2011).

- **Increase provider incentives to participate**
  Low reimbursement rates in Medicaid are widely blamed for low provider participation (Legal Services of New Jersey Poverty Research Institute 2011). Research shows that reimbursement is the most important factor in providers' decisions to participate, but also important are the administrative burdens of billing and documentation and delays in receiving payment (Cunningham and May 2006). New Jersey has recently raised reimbursement rates for some providers, and the ACA requires a temporary increase in rates for primary care providers. Reducing administrative burdens and payment times would make the program more attractive to providers.

- **Address issues with coverage timing**
  Proposed regulations give the exchange up to approximately 10 weeks for coverage to take effect for those enrolling outside open enrollment periods, depending on when enrollment occurs.[21] States could extend Medicaid for those transitioning to the exchange or require exchange plans to cover people sooner (Short et al. 2011; Sommers and Rosenbaum 2011). The proposed rules leave unclear whether states can continue to impose waiting periods for CHIP coverage (Rosenbaum 2011b). New Jersey currently imposes a three-month waiting period during which children must be uninsured before CHIP enrollment, with exceptions for loss of employment due to company closure or layoff. Now, under the ACA, families may face financial penalties if they do not maintain insurance coverage for their children.

- **Allow a transitional period for completion of treatment underway**
  Medicaid Health Plans of America suggests that policy could "establish a transition period where beneficiaries can complete treatments in progress for an allotted period of time, allowing a smoother transition between plans and maintaining access to care" (Johnson 2010). New Jersey Medicaid has extended benefits to allow those losing eligibility to complete treatments in progress in the past.

- **Conduct outreach and education**
  The ACA and proposed rules offer several routes for states or exchanges to provide outreach and education. Successful outreach and education can help consumers enroll in plans that fit their needs, minimizing uninsurance and churning.

  States are to "conduct outreach broadly as well as in ways that are accessible to people with disabilities, individuals with low literacy, and those with limited English

[21] §155.420 in DHHS, 45 CFR Parts 155 and 156, [CMS-9989-P], RIN 0938-AQ67, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans.

proficiency" and also to "target specific groups including hard to reach populations and populations that experience health disparities due to low literacy, race, color, national origin, or disability, including mental illnesses and substance use disorders."[22] CMS grants for exchange establishment can be used for stakeholder engagement (Ingram, Gore, and McMahon 2011), which could help define a general outreach strategy and tactics, as well as shaping the specific programs discussed below.

Consumer assistance programs. ACA Section 1002 provides for grants to states or exchanges for consumer assistance programs to educate consumers, assist with complaints, and collect data. Initial funding has been disbursed to 35 states, including New Jersey, although New Jersey ceased participating in the grant as of September 30, 2011.[23] The federal government anticipates future funding to focus on expansions rather than supporting existing services.[24]

New York may provide examples of other ideas approaches to consumer assistance. The city and state fund "Community Health Advocates" in 24 organizations around the New York City metropolitan area (Jones, Benjamin, and Mendon 2010), and the state has drawn on its CMS State Health Insurance Assistance Program (SHIP) funding to expand counseling about managed care around the state.[25] The Community Service Society of New York conducted an analysis of more than 100 consumer assistance programs around the country and profiles several models of organization (Tracy, Benjamin, and Barber 2010).

O'Leary et al, 2011 point out that identifying key institutions that connect to individuals when they are going through a life transition may be helpful in raising awareness about health exchanges and connecting individuals to coverage, similar to efforts undertaken by CHIP and Medicaid programs to partner with school lunch programs, schools, and community organizations to reach eligible children. It is possible that exchanges could work with existing institutions such as unemployment insurance agencies, educational institutions, employers, family courts, or motor vehicle departments to notify individuals of opportunities for affordable coverage made possible through the ACA.

Hospital presumptive eligibility determinations. ACA Section 2202 permits hospitals that are participating providers under the state plan to make presumptive eligibility determinations for Medicaid-eligible populations.

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[22] DHHS, 45 CFR Parts 155 and 156, [CMS-9989-P], RIN 0938-AQ67, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, pp.44-45.

[23] *See* http://www.healthcare.gov/news/factsheets/CAPGrants/States.html, accessed July 31, 2011.

[24] *See* http://cciio.cms.gov/resources/files/consumer_grants_qa.html, accessed July 31, 2011.

[25] *See* http://www.aging.ny.gov/NYSOFA/Programs/EconSecurity/MCCAP.cfm, accessed September 16, 2011. In New Jersey, SHIP counseling is managed by the Department of Health and Senior Services, Division of Aging and Community Services; *see* http://www.state.nj.us/health/senior/sashipsite.shtml, accessed September 16, 2011.

New Jersey has a process in place for presumptive eligibility determinations for pregnant women and children by approved Medicaid providers (not just hospitals), and may be able to modify this process for all Medicaid-eligible populations.[26] Stakeholders have expressed an interest in this option, but are uncertain how this would work with the existing county-level determination system.[27] As the exchange will have to be able to determine eligibility, the existing system will need to be redesigned in any case. New York recently decided to centralize its eligibility determination system after examining other states' experiences (Holahan 2011; Edwards, Smith, and Moody 2008).

Navigator programs and community-facilitated enrollment. ACA section 1311(i) and proposed rule §155.210 require that exchanges establish grants for navigators to provide public education, information on plans and tax credits, facilitate enrollment, and refer complaints and questions in a culturally and linguistically appropriate manner.

Since many exchange participants will be low- to moderate-income people, advocates have argued that community and consumer-focused groups will be best able to communicate with this population (Community Catalyst 2011). The president of the New Jersey Primary Care Association (which represents providers and affiliates of community-based health care) noted that there are community groups in the state that have been doing this type of work for years (Roman 2011).

New Jersey stakeholders in CSHP's forums thought that the navigator role was key and required some kind of certification to ensure both competence with respect to insurance products (particularly important to brokers and employers) and impartiality and knowledge of the people they were assisting (particularly important to providers and consumers). See Michael et al. (2011) and Cantor et al. (2011). In a subsequent forum, the president of the New Jersey Primary Care Association (representing providers/affiliates of community-based health care) suggested that while there should be standards, navigators should not have to be licensed (Roman 2011).

New York's Facilitated Enrollment program may be a model to consider. It is designed to enroll people into Medicaid and CHIP by using community-based organizations that engage potential enrollees in their own language and in local public spaces such as schools, libraries, laundromats, community health centers, hospitals, and tax preparation sites (Lawler and Costello 2005). An evaluation of enrollments in New York found that community-facilitated enrollment cost $119 per child, compared with $282 when done by managed care organizations (Fairbrother et al. 2004).

[26] *See* "HealthStart" page at New Jersey Department of Health and Senior Services, http://www.state.nj.us/health/fhs/professional/healthstart.shtml, accessed August 29, 2011.
[27] Discussion from Expert Panel, "Preparing the New Jersey Public for Implementation of the Affordable Care Act" on Tuesday, June 21, 2011, at the Rutgers Center for State Health Policy.

California also has similar experience with community-facilitated enrollment (Teare 2011; Paredes and Galloway-Gilliam 2010) and has legislation underway related to navigators (Weinberg and Sarkin 2011a, 2011b). An analysis of the California program showed the cost of the program was less than 1% of the program budget, and that insurance brokers and tax preparers, in addition to various nonprofit and/or public community agencies, played an important role in enrollment (Jacobson and Buchmueller 2007).

Funding levels have been an issue for navigator-like programs in New York and California. In both states, enrollments have increased when funding was provided or reinstated but dropped off dramatically when funding was cut (Jacobson and Buchmueller 2007; Lawler and Costello 2005; Teare 2011). Program administrators in California noted that when funding for assistance was cut, application errors and thus administrative costs went up (Jacobson and Buchmueller 2007).

- **Establish a consolidated provider directory so that consumers and those helping them can identify providers who participate in multiple plans**
  Proposed rules require plans to have a provider directory that notes whether or not the provider is accepting new patients. In the discussion of the rules, CMS notes that "Exchanges will have discretion to determine the best way to give potential enrollees access to the provider directory for each QHP, including through a link from the Exchange's website to the issuer's website, or by establishing a consolidated provider directory through which a consumer may search for a provider across QHPs."[28]

Conclusions

Research has established the hazards of uninsurance and the harm that results from the disruptions in care created when consumers have to shift providers due to a change in plan even without any period of being uninsured. The Affordable Care Act promises to offer more choices of coverage for individuals, but it also poses coordination challenges for states. There are many open questions posed in proposed implementing regulations regarding the exchanges and Qualified Health Plans, for which comments were due at the end of September 2011. This brief frames issues that New Jersey may want to consider as it tries to maximize continuity of care and reduce churning among plans once health reform is implemented. We have offered an explanation of several options that we believe can increase enrollment, reduce churning among plans, or increase the willingness of providers to participate across plans. It is likely that finding

[28] DHHS, 45 CFR Parts 155 and 156, [CMS-9989-P],vvRIN 0938-AQ67, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, p.126.

providers to participate in Medicaid will continue to be a challenge for New Jersey and across the nation.

References

Benjamin ER, and A Slagle. 2011. *Bridging the Gap: Exploring the Basic Health Insurance Option for New York*. New York: Community Service Society.

Cantor JC, M Koller, S Brownlee, M Michael, D Belloff, and R Hughes. 2011. *Stakeholder Views about the Design of Health Insurance Exchanges for New Jersey: Volume I: Findings from Stakeholder Forum Discussions & Survey*. New Brunswick, NJ: Rutgers Center for State Health Policy.

Christakis DA, L Mell, TD Koepsell, FJ Zimmerman, and FA Connell. 2001. "Association of Lower Continuity of Care with Greater Risk of Emergency Department Use and Hospitalization in Children." *Pediatrics* 107 (3): 524–29.

Community Catalyst. 2011. *Navigators: Guiding People Through the Exchange*. Boston: Community Catalyst. http://www.communitycatalyst.org/doc_store/publications/Navigators_June_2011.pdf.

Cunningham P, and J May. 2006. *Medicaid Patients Increasingly Concentrated Among Physicians*. Tracking Report, no. 16. Washington, DC: Center for Studying Health System Change.

Edwards BC, VK Smith, and G Moody. 2008. *Reforming New York's Medicaid Eligibility Process: Lessons From Other States*. New York: Medicaid Institute at United Hospital Fund.

Fairbrother G, MJ Dutton, D Bachrach, KA Newell, P Boozang, and R Cooper. 2004. "Costs of Enrolling Children in Medicaid and SCHIP." *Health Affairs (Millwood)* 23 (1): 237–43.

Gifford K, VK Smith, D Snipes, and J Paradise. 2011. *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Hadley J. 2002. *Sicker and Poorer: The Consequences of Being Uninsured*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Heberlein M, T Brooks, J Guyer, S Artiga, and J Stephens. 2011. *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Holahan D. 2011. *Coordinating Medicaid and the Exchange in New York*. New York: United Hospital Fund.

Ingram C, S Gore, and S McMahon. 2011. *Ten Considerations for States in Linking Medicaid and the Health Benefit Exchanges*. Hamilton, NJ: Center for Health Care Strategies.

Jacobs K, L Lucia, A O'Leary, and AM Marciarille. 2011. *Maximizing Health Care Enrollment through Seamless Coverage for Families in Transition: Current Trends and Policy Implications*. Berkeley, CA: University of California, Berkeley, Center for Labor Research and Education; Berkeley, CA: Berkeley Center on Health, Economic & Family Security.

Jacobson M, and TC Buchmueller. 2007. "Can Private Companies Contribute To Public Programs' Outreach Efforts? Evidence from California." *Health Affairs (Millwood)* 26 (2): 538–48.

Johnson TL. 2010. "Medicaid Health Plans of America's comment on the Office of Consumer Information and Insurance Oversight's request for comments on the Planning and Establishment of State-Level Exchanges and Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act published in the Federal Register on August 3, 2010, at 45 CFR Part 170 (OCIIO-9989-NC)."Correspondence to the Centers for Medicare & Medicaid Services. http://www.mhpa.org/_upload/10-4-10 MHPA Exchange Comments (2).pdf.

Jones DR, E Benjamin, and P Mendon. 2010. *Community Health Advocates 2010 Annual Report*. New York: Community Service Society.

Kaiser Commission on Medicaid and the Uninsured. 2010. *Medicaid and Managed Care: Key Data, Trends, and Issues*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/upload/8046.pdf.

Kenney G, and J Haley. 2001. *Why Aren't More Children Enrolled in Medicaid and SCHIP?* New Federalism: National Survey of America's Families, no. B-35. Washington, DC: Urban Institute.

Ku L, and DC Ross. 2002. *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*. New York: The Commonwealth Fund.

Lavarreda SA, M Gatchell, N Ponce, ER Brown, and YJ Chia. 2008. “Switching Health Insurance and Its Effects on Access to Physician Services.” *Medical Care* 46 (10): 1055–63.

Lawler K, and AM Costello. 2005. *Community-based Facilitated Enrollment: Meeting Uninsured New Yorkers Where They Are.* New York: Children's Aid Society; New York: Children's Defense Fund.

Legal Services of New Jersey Poverty Research Institute. 2011. *Poverty Benchmarks 2011: Assessing New Jersey's Progress in Combating Poverty*. Edison, NJ: Legal Services of New Jersey.

Michael M, R Hughes, D Belloff, M Koller, and JC Cantor. 2011. *Stakeholder Views about the Design of Health Insurance Exchanges for New Jersey: Volume II: Proceedings from Stakeholder Forum Discussions*. New Brunswick, NJ: Rutgers Center for State Health Policy.

New Jersey Department of Human Services, Division of Medical Assistance and Health Services. 2010. *2009 NJ FamilyCare/Medicaid HMO Performance Report*. Trenton, NJ: New Jersey Department of Human Services.

Palmer J. 2011. *Healthcare Reform and the Basic Health Program Option: Modeling Financial Feasibility*. Seattle, WA: Milliman. http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf.

Paredes M, and L Galloway-Gilliam. 2010. *Bridging the Health Divide: California’s Certified Application Assistants*. Los Angeles: Community Health Councils.

Rimsza ME, RJ Butler, and WG Johnson. 2007. “Impact of Medicaid Disenrollment on Health Care Use and Cost.” *Pediatrics* 119 (5): e1026–32.

Roman V. 2011. “Taking the First Steps Toward a New Jersey Health Exchange.” NJ Spotlight. Accessed September 15. http://www.njspotlight.com/stories/11/0915/0115/.

Rosenbaum S. 2011a. “The Basic Health Program.” Health Reform GPS. Accessed July 6. http://www.healthreformgps.org/resources/the-basic-health-program/.

———. 2011b. "Update: Medicaid Program Eligibility Changes under the Affordable Care Act." Health Reform GPS. Accessed September 14. http://www.healthreformgps.org/resources/update-medicaid-program-eligibility-changes-under-the-affordable-care-act/.

Short PF, K Swartz, N Uberoi, and D Graefe. 2011. *Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change*. New York: The Commonwealth Fund.

Sommers BD. 2009. "Loss of Health Insurance Among Non-Elderly Adults in Medicaid." *Journal of General Internal Medicine* 24 (1): 1–7.

Sommers BD, and S Rosenbaum. 2011. "Issues in Health Reform: How Issues in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." *Health Affairs (Millwood)* 30 (2): 228–36.

Teare C. 2011. *A Trusted Voice: Leveraging the Local Experience of Community Based Organizations in Implementing the Affordable Care Act*. Sacramento, CA: California Children's Health Initiatives.

Tracy C, ER Benjamin, and C Barber. 2010. *Making Health Reform Work: State Consumer Assistance Programs.* New York: Community Service Society; Boston: Community Catalyst.

Trompeter E, and S Davis, eds. 2011. *Health Insurance Exchanges: Strategies and Stakeholders*. Washington, DC: Atlantic Information Services.

Weinberg M, and C Sarkin. 2011a. "Envisioning the Role of Navigators in the California Health Benefit Exchange." Draft manuscript, last modified March 2. Portable Document Format (PDF) file. http://www.statereforum.org/system/files/navigator_backgrounder_march_2_2011.pdf.

———. 2011b. *Health Reform's Navigator Program: Ideals, Ideas & Recommendations*. Washington, DC: New America Foundation; Santa Monica, CA: Insure the Uninsured Project. http://www.statereforum.org/system/files/ca_navigator_grant_program_32911.pdf.

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