CURRENT PROGRAMS AND INTEGRATION OPPORTUNITIES

ALABAMA DEPARTMENT OF INSURANCE

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OVERVIEW

In January 2014, lower- and middle-income Alabamians with income up to four times the federal poverty level (FPL) may become newly eligible for subsidized health coverage through the expansion of Medicaid and through the Health Insurance Exchange.[1] Non-elderly residents with modified adjusted gross income (MAGI) up to 138 percent of the FPL will be eligible for Medicaid, while residents with income between 139 and 400 percent FPL may become newly eligible for premium subsidies for health insurance purchased through the Exchange.[2] In addition, legal residents of Alabama who have not resided legally in the United States for at least 5 years and may not eligible for Medicaid or ALL Kids, the state's Children's Health Insurance Program (CHIP), may be eligible to purchase subsidized coverage through the Exchange.

Tables 1 and 2 display the income limits for Medicaid and the Exchange, using calendar year 2011 FPL levels and premium percentages, for a single household and for a family of four. The tables show members' share of monthly premiums purchased through the Exchange for individual and family health coverage.

Table 1. Exchange Monthly Premiums for Individual Coverage (Household Size = One)

Federal poverty level percent	Annual income ($)	Premium as percent of income	Member's share of monthly premium ($)
100	10,890	2.00	18
133	14,484	3.00	36
150	16,335	4.00	54
200	21,780	6.30	114
250	27,225	8.05	183
300	32,760	9.50	259
350	38,115	9.50	302
400	43,560	9.50	345

[1] The term "may" be eligible for premium subsidies is used because the eligibility criteria prohibit residents who meet the income thresholds but have access to "affordable" employer-sponsored insurance from receiving subsidized insurance through the Exchange.

[2] While the law expands Medicaid eligibility to non-elderly individuals with income up to 133 percent FPL, because there is a 5 percent income disregard, the income limit is effectively set at 138 percent FPL.

Individuals and families eligible for Medicaid will not be charged a monthly premium, while ALL Kids charges a modest premium. Coverage through the Exchange will require enrollees to pay a premium ranging from 3 percent of MAGI for individuals and families at 139 percent of FPL to 9.5 percent of MAGI for households at 300 to 400 percent of FPL.[3] Individuals and families with income between 100 and 138 percent of FPL who are not eligible for Medicaid or ALL Kids due to the legal residency requirement will be responsible for premiums that equal 2 percent of MAGI.[4]

Table 2. Exchange Premiums for Family Coverage (Household Size = Four)

FPL level percent	Annual income ($)	Premium as percent of income	Member's share of monthly premium ($)
100	22,350	2.00	37
133	29,726	3.00	74
150	33,525	4.00	112
200	44,700	6.30	235
250	55,875	8.05	375
300	67,050	9.50	530
350	78,225	9.50	619

As Alabama continues to plan for implementing the 2014 requirements of the Patient Protection and Affordable Care Act (ACA), expanding the state's Medicaid program, and establishing the Exchange, the state will need to coordinate a number of activities across Medicaid, ALL Kids, and the Exchange. This report focuses on seven key areas of potential program integration:

1. Eligibility
2. Appeals of eligibility
3. Outreach, education, and enrollment
4. Call center and customer service
5. Covered benefits

[3] Individuals and families with income in excess of 400 percent FPL will also be eligible to purchase coverage through the Exchange but will not have access to federally funded premium subsidies.

[4] Premium subsidies that are available through the Exchange will be provided by the federal government in the form of advanced premium tax credits that will be sent directly on the member's behalf to the issuer of the qualified health plan.

6. Provider networks

7. Health insurers.

In addition to integrating program elements of the Alabama Medicaid Agency and the Alabama Department of Public Health (ADPH), which administers ALL Kids, the Exchange will need to work closely with the Department of Insurance (DOI), which regulates health insurers in the state. Depending upon which governance model the state selects for the Exchange and how this entity relates to DOI, the state will need to determine how best to resolve a number of related regulatory issues across the individual, small group, and large group insurance markets, including

- rate review and approval;
- certification, recertification, and decertification of qualified health plans;
- network adequacy standards;
- marketing standards; and
- risk adjustment and reinsurance.

ELIGIBILITY

The ACA calls for a streamlined, simplified, user-friendly approach to eligibility and enrollment, and for a comparable consumer experience regardless of the program for which a person is eligible. One key tenet of the law is to enable consumers to use a single application for Medicaid, CHIP, and the Exchange, instead of requiring them to submit separate or different applications for each program.

States must offer consumers multiple access points to apply for coverage—web-based, phone, paper, in person—with eligibility for all publicly subsidized medical assistance programs based primarily on the applicant's MAGI. Alabama has already established a single application form for determining eligibility for Medicaid and ALL Kids. People can complete the application manually and mail it to Medicaid or ALL Kids, fill it out and drop it off at district offices or county health departments across the state, or complete it online and submit it electronically.

In addition, over the next 18 months, Alabama's Medicaid Agency plans to develop 17 customer service centers that will allow residents to apply for Medicaid and ALL Kids at remote locations across the state; and the state is establishing 120 kiosks statewide that will allow more applicants to complete the eligibility process through the Web. These access points can be leveraged by the Alabama Exchange to provide residents with a one-stop shop for all medical coverage programs.

Although the state has established a single application that applies to both programs, each program has its own eligibility process and rules. That is, no single system determines eligibility for both Medicaid and ALL Kids. An application may first be processed by the Medicaid Agency to determine eligibility under Medicaid, then sent to ADPH to determine eligibility for ALL Kids, or vice versa. Centers for Medicare and Medicaid Services has informed the state that the current application process does not appropriately address the MAGI rules or the requirement that eligibility determinations be made in a single, streamlined manner. As a result, the state will need to modify its eligibility processes.

APPEALS OF ELIGIBILITY

Alabama will need to establish a process for handling complaints and appeals by individuals and families found ineligible for Medicaid, ALL Kids, or premium subsidies through the Exchange, or those who disagree with the determination of eligibility for a particular program or the amount of their subsidy. How the state chooses to process eligibility for all of its medical assistance programs, including the Exchange, will affect how best to handle eligibility complaints and appeals.

Currently, the Medicaid and ALL Kids programs employ separate in-house staff to handle eligibility complaints and appeals. Information on Medicaid appeal rights is included in the notice of determination sent to an applicant who is denied enrollment. If the applicant disagrees with the decision, the case is initially reviewed by a caseworker; if this initial review does not resolve the matter, the case is forwarded to a supervisor for review. The supervisor meets with the applicant, and if this meeting does not resolve the issue, the applicant can request a fair hearing before an administrative law judge.

The ALL Kids procedure is similar. ALL Kids staff reviews the case to verify that the determination was appropriate, and if that review does not resolve the appeal, the applicant can request an administrative review. The administrative review is also conducted by ALL Kids staff. Applicants can then request a final appeal with the state health officer or their designee.

The process for resolving eligibility appeals in the future will largely depend on the process and the entity that determines eligibility for coverage and subsidies through the Exchange. If Alabama's Exchange leverages the Medicaid eligibility system and staff, it may be cost-effective and administratively efficient to have one entity handle appeals and complaints. As the state looks to establish a "no-wrong-door" approach with regard to eligibility, it may also want to consider instituting a centralized appeals process across all programs.

In addition, because some people will move between the Exchange and the Medicaid program over the course of a year as their circumstances change (e.g., marital status, birth of a child, change in income), the state will need to closely coordinate the activities of these programs. The Exchange could set up its own appeals process, with Exchange staff accessing the eligibility system to review

information submitted by the applicant and the federal and state data sources used to determine eligibility.

Alabama could modify and consolidate eligibility systems so that applications are handled by one system, which could determine eligibility for Medicaid, ALL Kids, and the Exchange. If, for example, the state were to have the Medicaid agency review eligibility for all three programs, the Exchange could contract with the Medicaid agency to handle eligibility on its behalf. The state needs to determine whether changes to the Medicaid eligibility system required to perform this function for all three programs could occur by mid-2013. According to the recently released Notice of Proposed Rulemaking, the updated eligibility system will need to be operational by October 1, 2013, in order to process applications for coverage that will take effect starting January 1, 2014.

Alternatively, the Exchange could set up its own eligibility system. To meet ACA requirements that the state establishes a "no-wrong-door" approach to applications for all medical assistance programs, the Exchange system would need to assess eligibility not just for subsidies offered through the Exchange but also for the Medicaid and ALL Kids programs.

Outreach, Education, and Enrollment

In addition to coordinated eligibility processes and a "no-wrong-door" approach, consumers will need help assessing their coverage options and completing enrollment. The state will need to undertake a multi-pronged outreach, education, and enrollment effort. Such an effort might include a number of channels, including the Exchange, Medicaid, ALL Kids, other human services programs, the DOI, public schools, community groups, faith-based organizations, private employers, business groups, hospitals, community health centers, physicians, health insurers, producers, paid media, and public service announcements.

In addition to establishing a website, customer service unit, call center, and walk-in centers, the Exchange will need to contract with outside entities—"navigators"—that can assist consumers with eligibility and enrollment. Navigators, pursuant to the ACA, will be responsible for

- conducting public education activities to raise awareness of the availability of qualified health plans through the Exchange;
- distributing information on enrollment and the availability of premium subsidies and cost-sharing reductions;
- facilitating enrollment in qualified health plans;

- referring people to the appropriate agency or agencies if they have questions, complaints, or grievances; and
- providing information in a culturally and linguistically appropriate manner.

Alabama's public assistance programs have already established close ties with a number of community-based organizations that help with outreach and enrollment for Medicaid, ALL Kids, and other programs. These groups may be ideal candidates to become Exchange navigators. Medicaid also trains and certifies "Application Assisters" who help with the initial processing of applications. Alabama's outreach efforts are often cited as national models, and state officials report that more than 93 or 94 percent of children eligible for ALL Kids are enrolled—among the highest CHIP program participation rates in the country. The outreach and enrollment experience of the ALL Kids program offers much to be learned and leveraged by the Exchange.

Furthermore, to reach the hundreds of thousands of Alabamians who will become newly eligible for Medicaid or subsidized coverage through the Exchange, the state will need to expand outreach efforts beyond the traditional groups that currently assist with outreach for ALL Kids and Medicaid. The Exchange, in coordination with Medicaid and ALL Kids, may want to establish a selection process for awarding grants to navigators to assist with outreach, eligibility, and enrollment for all three programs. Leveraging the experience and expertise of various parties—including state agencies, county social service agencies, community-based organizations, and other entities—will be crucial to developing an efficient and effective outreach, education, and enrollment program.

CALL CENTER AND CUSTOMER SERVICE

The Exchange will need to establish a toll-free number and customer service unit to assist people with eligibility, enrollment, and benefits questions, as well as complaints and appeals. The state has a range of choices for how to triage calls and handle inquiries, and a key consideration for setting up the call center and customer service unit will be how closely the Exchange coordinates with Medicaid and ALL Kids, particularly with regard to determining eligibility.

The state currently operates separate call centers for ALL Kids and Medicaid. Eligibility issues are primarily handled in-house, while benefits questions are directed to Blue Cross Blue Shield of Alabama (BCBSAL), which is under contract with the state to administer ALL Kids, and Hewlett-Packard (HP), the state's fiscal agent for Medicaid.

ALL Kids employs 10 customer service workers who respond to approximately 12,000 calls a month. The ALL Kids staff handles eligibility questions and general benefits questions, while directing more specific benefits questions to BCBSAL's customer service unit. Both ALL Kids and BCBSAL employ

Spanish-speaking workers, and they use a language line to handle inquiries from beneficiaries or their parents who speak a language other than English or Spanish.

The Medicaid program relies on state eligibility workers at district offices across Alabama and central office staff to respond to eligibility questions, and on HP, the fiscal agent, to handle benefits questions or complaints. Monthly call center reports for May and June 2011 indicate that HP received more than 45,000 calls each month; however, more than 20 percent of calls received were abandoned before they were answered, an abandonment rate that is appreciably higher than the industry standard of less than 5 percent.

Medicaid recently modified the call center functions performed by HP. The program's fiscal agent is now able to answer basic eligibility questions and make certain changes to the recipient's case file (e.g., updating address and phone number, marital status, etc.), as well as order member identification cards, check benefits and change Patient First doctors for recipients. Also, a member-facing internet portal allows recipients to make certain changes to their case file via the Web without needing to call or visit a district office.

Opportunities for integrating call center and customer service programs may be most appropriate with regard to eligibility issues, particularly if the Medicaid eligibility system is used to determine eligibility for premium subsidies and reduced cost sharing through the Exchange. If Medicaid eligibility staff will be responsible for processing applications for both Medicaid and the Exchange, and potentially for ALL Kids as well, efficiencies might be achieved by having a single call center and customer service unit handle application inquiries, and eligibility complaints and appeals.

In contrast to eligibility, establishing a centralized customer service unit to respond to inquiries from Exchange consumers who have questions about health insurance benefits may be more challenging. Unlike the Medicaid and ALL Kids programs, which have comparable benefits—except for Early Periodic Screening, Diagnosis and Testing (EPSDT) program and long-term care, which are not included under ALL Kids, as well as some minor cost sharing differences—the qualified health plans available through the Exchange will offer consumers a broad range of plan designs.

Although all of the qualified health plans offered through the Exchange will be required to cover essential health benefits (see next section), there will be significant differences in cost sharing (e.g., co-payments, co-insurance, deductibles) for services across the plan levels, and there will be differences across qualified health plans within each level of coverage. To respond to benefits questions about the qualified health plans offered through the Exchange, customer service workers will need to be well-versed in commercial insurance. This will be particularly important given the likelihood that many Exchange purchasers will be newly insured and will have never obtained health insurance directly themselves before using the Exchange.

COVERED BENEFITS

Plans offered through the Exchange must cover essential health benefits (discussed further below), and individual consumers will select from qualified health plans offered in five benefit levels or tiers: platinum, gold, silver, bronze, and catastrophic (i.e., high deductible health plan). While the benefits package (i.e., what is covered) will likely be nearly identical across all of the plan levels, the health plans within each level may have different types and amounts of point-of-service cost sharing (deductibles, co-payments, co-insurance) and different provider networks.

Just as the monthly premiums for enrollees eligible for federal premium subsidies will vary based on annual income (MAGI), cost sharing—the out-of-pocket maximum—will also vary based on MAGI. Table 3 displays the out-of-pocket limits for Exchange plans based on the enrollee's MAGI.

Alabama residents who will become newly eligible for Medicaid as a result of the eligibility expansion will be guaranteed, at a minimum, a "benchmark benefits" package. That package allows states to provide certain groups of Medicaid enrollees with benefits that might differ slightly from the standard Medicaid package (see further discussion below).

Table 3. Out-of-Pocket Limits for Exchange Plans

Income category	Reduction in out-of-pocket limit relative to HSA/HDHP maximum[a]	Out-of-pocket limit (based on 2011 HSA/HDHP maximum for individuals/families)	Actuarial value of silver plan
Up to 150% FPL	Reduced by two-thirds	$1,963/$3,927	94%
150.1–200% FPL	Reduced by two-thirds	$1,963/$3,927	87%
200.1–250% FPL	Reduced by one-half	$2,975/$5,950	73%
250.1–300% FPL	Reduced by one-half	$2,975/$5,950	70%
300.1–400% FPL	Reduced by one-third	$3,986/$7,973	70%
Above 400% FPL	No reduction	$5,950/$11,900	70%

Note: HSA=Health Savings Account; HDHP= high deductible health plan.

[a] Pursuant to the ACA, health plans sold through the Exchange must include an out-of-pocket maximum. The amount of the out-of-pocket maximum will be governed by the limits that apply to HDHPs, whose limits are set annually by the Internal Revenue Service.

Under this approach, the benchmark benefits package may be based on one of three commercial insurance products or a package approved by the Secretary of the Health and Human Services (HHS).

As summarized below, the major federal rules governing benchmark coverage outline requirements for essential health benefits, benchmark plans, and other Medicaid-comparable requirements.

Essential Health Benefits

Benchmark and benchmark-equivalent plans must cover all of the following essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care
- EPSDT.[5]

The Secretary of HHS is responsible for promulgating regulations to further define what constitutes essential health benefits. The exclusion of long-term care (nursing home coverage) may be the most significant difference between a benchmark benefit and traditional Medicaid.

Benchmark Coverage

Coverage must be equal to that provided in one of three benchmarks, equivalent in actuarial value to one of three benchmarks, or a package approved by the Secretary of HHS (a benchmark-equivalent). The three benchmark plans are

- the standard Blue Cross/Blue Shield preferred provider plan offered by the Federal Employees Health Benefits Plan;
- a health plan offered to state employees; or
- a managed care plan with the largest non-Medicaid enrollment in the state.

[5] Health plans available through the Exchange will also be required to cover all of the essential health benefits, with the exception of EPSDT services, which are required to be covered by Medicaid.

The state can choose to provide additional benefits beyond those that are required in a benchmark-equivalent plan, as long as the services are included in the benchmark plan or could be covered under the standard Medicaid benefits package.

Other Requirements

Benchmark and benchmark-equivalent coverage must meet other Medicaid requirements, including coverage for transportation services, family planning services, and care provided by rural health clinics and federally qualified health centers (FQHCs). Also, if such coverage is provided through managed care entities, it must comply with Medicaid managed care requirements. States must obtain public input before filing a proposal with HHS to use benchmark or benchmark-equivalent coverage.

As Alabama develops its benefits package for people who will become newly eligible for Medicaid, as well as the benefits for the qualified health plans offered through the Exchange, the state will need to consider how fully to align the benefits across these programs.

Table 4 compares the major services and benefits of the state's Medicaid plan with the ACA requirements for essential health benefits. Because HHS has yet to issue the final specifications for what the essential health benefits package must include, the information in this table should be viewed as a general guide to the benefits that are likely to be required.

As Table 4 shows, Alabama's Medicaid programs limits coverage for certain core services, including inpatient hospitalizations (limited to 16 days per year), office visits (14 visits per year), and outpatient surgery (three surgical procedures per year). It is very likely that the essential health benefits requirements to be issued by HHS will not allow health plans to limit these types of services. As a result, if Alabama chooses to offer newly eligible Medicaid recipients a benchmark benefit package that does not include these types of coverage limitations, currently eligible Medicaid recipients may have a different (i.e., less generous, in some respects) benefit package than the newly eligible Medicaid recipients. Or, if Alabama chooses to modify the benefits package for currently eligible Medicaid recipients, there will almost certainly be a financial impact to the state.

Table 4. Alabama Medicaid Benefits vs. ACA Requirements

Benefit Description	Alabama Medicaid and ALL Kids Plans		Essential Health Benefits under the PPACA
Plan Year	Current Plan		Likely Essential Benefits as of 1/2011
	Benefit Description	*Mandatory / Optional Benefit*	*Source: IOM*
Annual Deductible for an Individual Annual Deductible for a Family	Not applicable Not applicable		HSA/HDHP Limit HSA/HDHP Limit
Annual Out-of-Pocket Maximum for an Individual Annual Out-of-Pocket Maximum for a Family	Not applicable Not applicable		HSA/HDHP Limit HSA/HDHP Limit
IN-PATIENT HOSPITAL SERVICES			
General Hospital (per admission co-pay for semi-private room and board)	16 inpatient hospital days covered per year in semiprivate room; $50 co-pay per admit	Mandatory	Yes
Physician Services (additional co-pay, if any)	16 days of doctor's care when hospitalized	Mandatory	Yes
Skilled Nursing Facility (maximum days covered per year and co-pay)	Covered in full (prior authorization is required)	Mandatory	TBD
OUTPATIENT HOSPITAL SERVICES			
Emergency Room Visits for Emergency or Accident Care (indicate if co-pay is waived if admitted)	Covered in full	Mandatory	Yes
Out-Patient Surgery (co-pay)	3 outpatient surgical procedures per year, except for emergency procedures; $3 co-pay per procedure	Mandatory	Yes
Diagnostic X-ray and Lab (additional co-pay, if any)	Lab and X-ray when medically necessary	Mandatory	Yes
Physical Therapy \ Occupational Therapy (co-pay and number of covered visits per year)	Not covered for recipients age 21 and older	Optional*	TBD
PHYSICIAN'S OFFICE SERVICES			
Office Visit Primary Care Physician	14 office visits covered per calendar year, including health centers, clinics and non-emergent visits to an emergency room; $1 co-pay per visit	Mandatory	Yes
Office Visit Specialist Physician		Mandatory	Yes
Routine GYN Exam /Adult Routine Physical / Preventive Care	Covered in full	Mandatory	Yes
Routine Vision Exam (co-pay and frequency of covered benefits)	Eye exams and eyeglasses once every 24 months for ages 21 and older; once every 12 months for under 21	Optional*	Yes
MENTAL HEALTH SERVICES (BIOLOGICALLY-BASED)			
Inpatient Admissions in a General or Mental Hospital (co-pay)	Covered in full for recipients under the age of 21; inpatient psych covered for 65 and over; no coverage for adults; $50 co-pay per admit	Mandatory for general hospital; optional for mental hospital	Yes
Outpatient Visits (co-pay)	Covered; treatment provided through community mental health centers; and through DHS and DYR for children served by DHR and DYS; $1 co-pay	Optional* if provided outside of physician's office or outpatient hospital	Yes
OTHER SERVICES			
Durable Medical Equipment (co-pay, if any, and annual maximum)	Covered in full when medically necessary; $0.50 to $3 co-pay	Optional*	TBD
Ambulance (emergency service only)	Covered in full when medically necessary	Mandatory	TBD
PRESCRIPTION DRUGS			
Retail (up to 30 day supply) Generic Brand Name Non-Preferred Brand Name Mail Order (up to 90 day supply) Generic Brand Name Non-Preferred Brand Name	Covered for most medicines order by a physician; prior approval required for some prescriptions; and limits on brand name drugs may apply to some beneficiaries; $0.50 to $3 co-pay	Optional*	Yes

Source: Alabama Medicaid manual and the Alabama State Plan Amendment.

*Some of these services, while optional for Medicaid, may be required as part of EPSDT requirements for children under age 21.

PROVIDER NETWORKS

The expansion of Medicaid and the availability of premium subsidies for health insurance purchased through the Exchange will make coverage available to Alabamians who currently may not be able to afford it. In addition to aligning benefits and services across these programs, Alabama Medicaid, ALL Kids, and the Exchange might also examine whether physicians and hospitals in the provider networks of Exchange qualified health plans are also available through Medicaid and ALL Kids.

Because eligibility for the Exchange can be adjusted throughout the year, some enrollees might be eligible for Medicaid and the Exchange for different parts of the year. This will occur due to changes in family composition (marriage, birth of a child, divorce) and income. One national estimate suggests that as many as 50 percent of enrollees could shift between Medicaid and the Exchange during the year.[6] As noted above, because ALL Kids covers children in families with income up to 300 percent FPL, in some families the parents will be members of a qualified health plan purchased through the Exchange while their children are covered by ALL Kids.

As people move across these three programs or as family members are covered by different programs, a key consideration will be to ensure as much continuity of care as possible in terms of the patient-physician relationship and access to hospitals. In developing criteria to certify qualified health plans, Alabama's Exchange could encourage insurers to include, to the greatest extent possible, physicians and hospitals that also participate in the Medicaid program and ALL Kids' provider networks. In fact, one of the criteria in the ACA pertaining to certification of qualified health plans involves including "essential community providers" such as FQHCs and disproportionate share hospitals, among others.

The state's Medicaid program will need to evaluate its fee-for-service provider network to find out how many physicians and hospitals are also part of the Exchange health plan provider networks. The state may also want to consider strategies to encourage managed care plans to participate in Medicaid. Physicians and hospitals that participate in the networks of plans certified as qualified health plans (QHPs) and accept Medicaid patients can help minimize the potential disruption in care that could occur as people shift between the Exchange and Medicaid.

This will be much less of an issue for the ALL Kids program, in view of its current contract with BCBSAL and the ability of its members to access care from the physicians and hospitals in the BCBSAL network, which includes virtually all providers in Alabama.

[6] "Issues in Health Reform: How Change in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Benjamin D. Sommers and Sara Rosenbaum, *Health Affairs*, February 2011.

HEALTH INSURERS

Another issue that could affect continuity of coverage and the ability of people to navigate the health programs available in 2014 involves the health carriers that will be available through the Exchange and potentially through the state's Medicaid program. As noted above, the 2014 expansion of Medicaid offers an excellent opportunity for Alabama to contract with managed care organizations (MCOs) for its Medicaid program.

Because the ALL Kids program contracts with BCBSAL, families with children covered under ALL Kids may find value in maintaining coverage for all family members under one carrier.

The Exchange will be responsible for certifying QHPs. Much as with the provider networks discussed above, a policy consideration for the Exchange and Medicaid and ALL Kids administrators is to encourage health carriers to serve all three markets. Health reform could increase the number of adults eligible for Medicaid by 513,000.[7] Including adults eligible for but not enrolled in Medicaid and children who will transfer from ALL Kids to Medicaid, total new Medicaid enrollment might reach 706,000—more than doubling current enrollment among children and adults under age 65. The prospect of serving a significantly larger Medicaid population could be a material inducement for policy initiatives to promote contracting with MCOs.

With premium subsidies and reduced cost sharing through the Exchange, as many as 252,000 Alabamians who currently lack coverage could purchase federally subsidized health insurance. This new market opportunity is already prompting a number of the national Medicaid MCOs to consider developing commercial insurance products to offer through Exchanges. Giving people the option to remain with a health carrier as their eligibility shifts between Medicaid and the Exchange could be a worthwhile consideration for improving coordination between these programs.

As noted previously, because ALL Kids eligibility extends to children in families with income at or below 300 percent of FPL, a number of children covered by ALL Kids will have parents covered through the Exchange. Coordinating coverage for these "split" families could be improved by encouraging health plans to serve all of Alabama's publicly subsidized health coverage programs.

[7] D. Chollet, A. Barrett, and T. Bell, "The Uninsured and Underinsured Population in Alabama," Mathematica Policy Research Report for LMI to the Alabama Department of Insurance, Planning for Alabama's Health Benefit Exchange (in draft). This estimate is updated from that reported by Morrisey and Engler (2011) to reflect the demographics of Alabama residents in the 2010 census as well as actual 2010 unemployment, and it is approximately 9 percent higher than the 471,000 adults newly eligible for Medicaid that they reported. See M. Morrisey and S. Engler, "Forecasting New Alabama Medicaid Enrollment as a Result of Health Care Reform," Lister Hill Center for Health Policy, Research and Analysis for Alabama Medicaid, the University of Alabama at Birmingham, April 20, 2011.

KEY ISSUES FOR ALABAMA

Rolling out the Alabama Exchange and expanding Medicaid should give hundreds of thousands of Alabamians new access to affordable health coverage. The following are key issues the state will need to consider as it seeks to establish comprehensive health coverage programs that will work best for its residents.

- How can the state establish a streamlined eligibility determination process that will enable residents to apply for all medical assistance programs through a single application?
- What types of outreach and education will be necessary to reach different groups of people who will become newly eligible for Medicaid and for premium subsidies for commercial insurance through the Exchange?
- What organizations and entities can the Exchange leverage to assist with outreach, education, and enrollment?
- What types of benefits and services should be made available to individuals and families who will become newly eligible for Medicaid as a result of the 2014 expansion?
- How can the benefits in the Exchange plans align with those of Medicaid and ALL Kids to provide for a continuum of coverage as people move between these programs?
- How can the state and the Exchange encourage providers to participate in the Medicaid program and the QHPs offered through the Exchange?
- Should the state begin new initiatives to contract with Medicaid MCOs, given the massive expansion in Medicaid eligibility that will take place in 2014?
- Can the state and the Exchange develop a unified purchasing strategy for Medicaid beneficiaries and QHPs offered through the Exchange?