



# The Health Insurance Exchange, the Medicaid Program, and the Apportionment of Responsibility for Determining Eligibility and Effectuating Enrollment in New Jersey

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## **Executive Summary**

The Affordable Care Act and its implementing regulations embody a “no wrong door” philosophy for determining individuals’ eligibility for, and enrolling them in, federal, state, and local public health insurance programs, including premium subsidies, cost-sharing reductions, Medicaid, the Basic Health Program, if a state chooses to establish one, and the Children’s Health Insurance Program. The Act requires that states build online systems that will enable them to make eligibility determinations in real time, that they use a single, streamlined application for all programs, and that they make full use of data-driven electronic verification of the information applicants provide.

This brief provides an overview of the Act’s provisions regarding eligibility determinations and renewals, with a particular focus on (1) the degree of coordination that will be required between New Jersey’s Division of Medical Assistance and Health Services (DMAHS) and its health insurance Exchange and (2) the options set forth in the Act for apportioning responsibility for the eligibility determination and enrollment functions between DMAHS and a state-based exchange, should the State choose to establish one. The brief then discusses New Jersey eligibility and enrollment law, policy, and practice and sets forth the key decision points facing the state as it strives to create a streamlined and seamless system to support swift and accurate eligibility determinations and enrollment into coverage.



# **The Health Insurance Exchange, the Medicaid Program, and the Apportionment of Responsibility for Determining Eligibility and Effectuating Enrollment in New Jersey**

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## **I. Introduction**

This policy brief was prepared by the Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law for the New Jersey Department of Banking and Insurance. Its purpose is to provide the Department with background information and analysis to support the Department's work implementing the Patient Protection and Affordable Care Act. The brief will review and analyze the provisions of the Affordable Care Act and the implementing regulations that relate to determining individuals' eligibility for and enrolling them in federal, state, and local public health insurance programs, including premium subsidies, cost-sharing reductions, Medicaid, the Basic Health Program, if a state chooses to establish one, and the Children's Health Insurance Program. The brief also evaluates the impact of the Act and regulations on New Jersey law, policy, and practice with a specific focus on the decisions New Jersey will have to make regarding apportioning responsibility for the eligibility determination and enrollment functions between the Division of Medical Assistance and Health Services and the state's health insurance Exchange. Funding for the brief was provided by a grant from the United States Department of Health and Human Services.

## **II. Policy and Legal Context**

The Affordable Care Act sets a high standard for state health insurance Exchanges in discharging their duty to determine individuals' eligibility for and enroll them in the array of government-supported health insurance programs. The Secretary of Health and Human Services has explained that the Department of Health and Human Services interprets the Act "to require the establishment of a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a [qualified health plan (QHP)], advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and [the Children's Health Insurance Program (CHIP)] and receive a determination of eligibility for

any such program.”<sup>1</sup> The system should embody a “no wrong door” philosophy; “[i]ndividuals will not have to apply to multiple programs nor will they be sent from one program to another if they initially apply to a program for which they are not ultimately eligible.”<sup>2</sup> In addition, “the eligibility and enrollment function should be consumer-oriented, minimizing administrative hurdles and unnecessary paperwork for applicants.”<sup>3</sup>

The Secretary’s sharp focus on eligibility and enrollment services is understandable. The Affordable Care Act is projected to newly cover approximately 32 million Americans by 2016, about 16 million through the Exchanges and about 16 million through Medicaid expansion.<sup>4</sup> The newly insured, however, will shift between private, Exchange-based coverage and Medicaid as their income and employment status shifts. There is evidence that within a single year fully half of all low-income adults will lose their Medicaid eligibility and become eligible for coverage through an Exchange or the reverse.<sup>5</sup>

As insureds’ circumstances shift, timely response to their changed eligibility status will be crucial to their uninterrupted insurance coverage. While the current requirements that an individual’s eligibility for coverage on the basis of disability must be determined in not more than 90 days and that eligibility for all other applicants must be determined in not more than 45 days will remain in effect,<sup>6</sup> in the analysis accompanying the final “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010” regulation the Secretary announced that she expects that “the systems and technological capabilities and electronic data matching which are generally available for use by States at reasonable cost” will enable states’ Medicaid agencies to make “real time determinations of eligibility in most cases.”<sup>7</sup> In the analysis accompanying the final “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers” regulation, the Secretary states that

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<sup>1</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,875 (July 15, 2011) [hereinafter “Proposed Exchange Establishment Regulation”].

<sup>2</sup> Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 76 Fed. Reg. 51,148, [12], [74] (August 17, 2011) [hereinafter “Proposed Medicaid Eligibility Regulation”] (“As discussed, most individuals will be evaluated for eligibility in the Exchange, Medicaid, and CHIP using a coordinated set of rules and these programs will work together to ensure that eligible applicants are enrolled in the appropriate program, no matter where their application originates.”).

<sup>3</sup> Proposed Exchange Establishment Regulation, 76 Fed. Reg. at 41,875.

<sup>4</sup> Douglas W. Elmendorf, CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010 18 (Mar. 30, 2011) (statement of the Director of the Congressional Budget Office before the Subcomm. On Health of the H. Comm. on Energy and Commerce), *available at* <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/033011/Elmendorf.pdf>.

<sup>5</sup> Benjamin D. Summers & Sara Rosenbaum, *Issues in Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges*, HEALTH AFF., Feb. 2011, at 228-36.

<sup>6</sup> Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,144, 17169 (Mar. 23, 2012) [hereinafter “Medicaid Eligibility Regulation”].

<sup>7</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,161.

Exchanges are similarly expected to make “the majority of eligibility determinations ... in a very short period of time.”<sup>8</sup>

The Affordable Care Act directs the Secretary of Health and Human Services to “establish a system ... under which residents of each State may apply for enrollment in, and continue participation in, applicable State health subsidy programs.”<sup>9</sup> Within this system, the Act carves out a “central role” for the health insurance Exchanges which will serve as marketplaces for individual and small group health insurance plans.<sup>10</sup>

The Exchanges are responsible for determining whether an individual is eligible to enroll in a QHP and then facilitating his or her choice of plan. The Exchange must (1) accept the individual’s application with his or her QHP selection, (2) notify the plan’s issuer of the individual’s selection, and (3) “[t]ransmit information necessary to enable the QHP issuer to enroll the applicant.”<sup>11</sup> The Act requires the Exchange to provide for the filing of applications “online, in person, by mail, or by telephone.”<sup>12</sup> The Secretary anticipates that many applicants will be able “to complete the eligibility and QHP selection process in a single online session.”<sup>13</sup>

In addition to their private marketplace role, health insurance Exchanges will function as a point of information about and access to the various forms of government health insurance and health insurance subsidies to which individuals will be entitled.<sup>14</sup> The Exchange must inform individuals of the eligibility requirements and determine or facilitate the determination of their eligibility for each of the health subsidy programs.<sup>15</sup>

To this end, each Exchange is required to maintain a website that, among other things, “[m]akes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.”<sup>16</sup> The Exchange website must also be “linked to”<sup>17</sup> and “coordinated with”<sup>18</sup> the Medicaid website. The Secretary states that “[s]tates can and are encouraged to

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<sup>8</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,354 (March 27, 2012) [hereinafter “Exchange Establishment Regulation”] (discussing 45 C.F.R. § 155.310(e) which provides that “[t]he Exchange must determine eligibility promptly and without undue delay.”).

<sup>9</sup> 42 U.S.C. § 18083(a).

<sup>10</sup> Proposed Exchange Establishment Regulation, 76 Fed. Reg. at 41,875.

<sup>11</sup> 45 C.F.R. § 155.400 (a).

<sup>12</sup> 42 U.S.C. § 18083 (b)(1). The regulations elaborate that exchanges must support applications via a call center and an internet web site in addition to in person and by mail. 45 C.F.R. § 155.405 (c)(2).

<sup>13</sup> Proposed Exchange Establishment Regulation, 76 Fed. Reg. at 41,881.

<sup>14</sup> Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, 76 Fed. Reg. 51,202, 51,204 (August 17, 2011) [hereinafter “Proposed Individual Market Eligibility Regulation”] (“[W]e propose that the Exchange will determine eligibility for Exchange participation, as well as for insurance affordability programs.”).

<sup>15</sup> 42 U.S.C. § 18031 (d)(2)(F).

<sup>16</sup> 45 C.F.R. § 155.205(b)(6).

<sup>17</sup> 42 U.S.C. § 1396w-3 (b)(4).

<sup>18</sup> Proposed Exchange Establishment Regulation, 76 Fed. Reg. at 51,167.

operate a single Web site, but are not required to do so as long as the Web sites of the different insurance affordability programs are linked to enable individuals to access the information and range of services required.”<sup>19</sup> The Medicaid website “must promote access to information on all insurance affordability programs, which includes Exchange, Medicaid, CHIP, and the Basic Health Program (BHP) if applicable.”<sup>20</sup> The Medicaid website will also enable individuals to apply for and enroll in Medicaid and CHIP.<sup>21</sup> If the Exchange identifies an individual as being eligible for Medicaid or CHIP, the Medicaid website must be able to enroll him or her “without any further determinations by the State.”<sup>22</sup>

### **A. The Modified Adjusted Gross Income Standard (MAGI)**

Beginning in calendar year 2014, financial eligibility for the premium tax credit, cost-sharing reductions, the BHP, CHIP, and most forms of Medicaid will be determined with reference to the modified adjusted gross income (MAGI) standard, eliminating some of the income and assets tests that have complicated public program enrollment in the past.<sup>23</sup> An individual’s MAGI can be determined from a tax return. There is no income or expense disregard aside from a standard amount equal to five percent of the federal poverty level which is subtracted from an applicant’s household income.<sup>24</sup> Danielle Holahan, who is playing a leadership role implementing health reform in New York, explains that this will eliminate “the need for applicants to report and provide paper verification of expenses as part of the Medicaid eligibility determination process.”<sup>25</sup> There is also no assets or resources test.<sup>26</sup> Using MAGI should allow for real-time eligibility determination for most applicants.<sup>27</sup> To make this possible, the Affordable Care Act requires that individuals be permitted to consent to enroll or reenroll in Medicaid through electronic signature, which will permit verification through electronic

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<sup>19</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,186.

<sup>20</sup> 42 U.S.C. § 1396w-3(b)(4); Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,162.

<sup>21</sup> 42 U.S.C. § 1396w-3(b)(1)(A).

<sup>22</sup> 42 U.S.C. § 1396w-3(b)(1)(B).

<sup>23</sup> Proposed Medicaid Eligibility Regulation, 76 Fed. Reg. at 51,150. An individual’s “modified adjusted gross income” is their “adjusted gross income increased by— (i) any amount excluded from gross income under section 911[relating “Citizens or residents of the United States living abroad.”], and (ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.” “Individuals who meet the eligibility requirements for coverage based on the applicable MAGI standard nonetheless may be excepted from application of MAGI methods for purposes of evaluation under an optional eligibility group which better meets their coverage needs.” 17167 “States must determine eligibility under a basis other than MAGI for an individual described in § 435.911(d), which includes individuals who indicate such potential eligibility on the single streamlined application, alternative application or renewal forms, as well as those who request such a determination.”

<sup>24</sup> *Id.* at 51,190-51,191.

<sup>25</sup> DANIELLE HOLAHAN, COORDINATING MEDICAID AND THE EXCHANGE IN NEW YORK 3 (United Hospital Fund 2011).

<sup>26</sup> Proposed Medicaid Eligibility Regulation, 76 Fed. Reg. at 51,191.

<sup>27</sup> *Id.*

databases.<sup>28</sup> States will not be permitted to require that applicants whose eligibility is based on MAGI appear for in-person interviews.<sup>29</sup>

### ***B. The Single, Streamlined Health Insurance Application***

Moving to the MAGI standard will enable significant streamlining of eligibility determination and enrollment. The Affordable Care Act charges the Secretary with developing “a single, streamlined form that— (i) may be used to apply for all applicable State health subsidy programs within the State[.]”<sup>30</sup> In the regulations, the Secretary echoes the language of the Act, requiring that the Exchanges “use a single streamlined application to determine eligibility and collect information necessary for: (1) Enrollment in a QHP; (2) Advance payments of the premium tax credit; (3) Cost-sharing reductions; and (4) Medicaid, CHIP, or the BHP, where applicable.”<sup>31</sup>

An Exchange may use an alternative application,<sup>32</sup> but if it does the application must be “approved by HHS”<sup>33</sup> and it must “ask[] questions relevant only to the eligibility and administration of insurance affordability programs”<sup>34</sup> and be “no more burdensome on the applicant than” the application HHS develops.<sup>35</sup> That said, in the preamble to the final Medicaid Eligibility Regulation the Secretary states that “[t]he regulations do not prohibit use of multi-benefit applications” and HHS “look[s] forward to working with States interested in developing streamlined multi-benefit applications.”<sup>36</sup>

The preamble to the final Medicaid Eligibility Regulation also provides that all individuals, including those who are potentially eligible for benefits on a basis other than MAGI—because they are blind or disabled, for example, or in need of long-term care services—

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<sup>28</sup> 42 U.S.C. § 1396w-3(b)(1)(A).

<sup>29</sup> 42 C.F.R. § 435.907 (d) (initial determination) & § 435.916 (a)(3)(iv) (redetermination).

<sup>30</sup> 42 U.S.C. § 18083(b).

<sup>31</sup> 45 C.F.R. § 155.405. HHS has proposed the individuals be permitted “to decline an eligibility determination for insurance affordability programs,” explaining that this will “ensure that an individual can bypass the additional steps required for such screening and proceed directly to selecting and enrolling in a QHP.” Proposed Individual Market Eligibility Regulation, 76 Fed. Reg. at 51,209. An applicant cannot, however, choose to be evaluated for eligibility for the premium tax credit and cost-sharing reductions and not Medicaid or vice versa. “[A]n applicant is ineligible for advance payments of the premium tax credit to the extent that he or she is eligible for advance payments of the premium tax credit to the extent that he or she is eligible for other minimum essential coverage, which includes Medicaid and CHIP. This provision means that the Exchange will consider an applicant’s eligibility for Medicaid and CHIP as part of an eligibility determination for advance payments of the premium tax credit.” *Id.*

<sup>32</sup> Legislation authorizing the establishment of an Exchange that was passed by the New Jersey Legislature but vetoed by Governor Christopher J. Christie provided that “[t]he board shall develop and implement a plan of operation for the exchange, which shall include, but not be limited to, the following: ... procedures, criteria, and a standard application form for prospective enrollees seeking to obtain coverage under qualified health benefits plans offered through the exchange.” A.2171, 215<sup>th</sup> Leg., 2012-13 Sess. (N.J. 2012).

<sup>33</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,163.

<sup>34</sup> 45 C.F.R. § 155.405(b).

<sup>35</sup> 42 C.F.R. § 435.907(b)(2).

<sup>36</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,163.

should be able “to begin the application process via the Internet web site, telephone, mail, or in person using the single, streamlined application...”<sup>37</sup> The regulations allow states to use either a combination of the single, streamlined application and supplemental forms or a separate application to collect the information needed to determine eligibility on a basis other than MAGI.<sup>38</sup>

### **C. Verification**

The need to verify the information provided by applicants is a frequent cause of delays in the eligibility determination process. To address this, the Affordable Care Act provides for streamlined verification procedures that rely on electronic data sources where possible.<sup>39</sup> Each state’s Medicaid agency “must develop, and update as modified, and submit to the Secretary upon request, a verification plan describing [the agency’s] verification policies and procedures.”<sup>40</sup> To the extent that the plan is consistent with federal rules, it will set the standard against which states are judged in subsequent payment error rate measurement (PERM) audits. As the Secretary explains, “if a State relies on self-attestation to establish certain facts regarding eligibility consistent with Federal rules, PERM audits also rely on the self-attestations provided.”<sup>41</sup>

The Medicaid Eligibility Regulation provides that “[t]he Secretary will establish an electronic service through which States may verify certain information with, or obtain such information from, Federal agencies and other data sources, including SSA, the Department of Treasury, and the Department of Homeland Security.”<sup>42</sup> Unless they seek and are granted an

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<sup>37</sup> *Id.*

<sup>38</sup> 42 C.F.R. § 435.907(c)(1) & (2). “These forms must be submitted to the Secretary, and will be available for review by the public, but will not have to be approved prior to use.” Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,163-64.

<sup>39</sup> 42 U.S.C. § 300jj-51(b). Specifically, the Act provides that “[t]he standards and protocols for electronic enrollment ... shall allow for the following: (1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation. (2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility. (3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals. (4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations. (5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate. (6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones. (7) Other functionalities necessary to provide eligibles with streamlined enrollment process.”

<sup>40</sup> 42 C.F.R. § 435.945(j).

<sup>41</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,172.

<sup>42</sup> 42 C.F.R. § 435.949(a).

exception,<sup>43</sup> states will be required to go through the service “[t]o the extent that information related to eligibility for Medicaid is available through [it].”<sup>44</sup>

If a state needs information that is not available through the service “but can be obtained through an electronic match directly from another agency or program ... the State must obtain the information from such agency or program.”<sup>45</sup> The Affordable Care Act requires each state to “develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data ... that allows a determination of eligibility for all such programs based on [the] single application.”<sup>46</sup> In addition, unless an exception is sought and granted,<sup>47</sup> all of a state’s health subsidy programs must share information with one another through a “data matching arrangement”<sup>48</sup> and make use of the arrangement to “establish, verify, and update eligibility[.]”<sup>49</sup> Each program is also required to access the information available through the Public Assistance Reporting Information System (PARIS),<sup>50</sup> which includes “Department of Veterans Affairs (VA) compensation and pension payment records and interstate public assistance benefit payments.”<sup>51</sup>

In the absence of an inconsistency between the information an applicant provides and the information obtained through an electronic data match, applicants will not have to produce any additional information or prepare any additional paperwork other than the single streamlined application to receive an eligibility determination.<sup>52</sup> States may not require additional information or documentation unless the information “cannot be obtained electronically or the information obtained electronically is not reasonably compatible ... with information provided by or on behalf of the individual.”<sup>53</sup> The final Medicaid Eligibility

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<sup>43</sup> 42 C.F.R. § 435.945(k).

<sup>44</sup> 42 C.F.R. § 435.949(b).

<sup>45</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,176.

<sup>46</sup> 42 U.S.C. § 18083(c).

<sup>47</sup> 42 U.S.C. § 18083(c)(3)(B).

<sup>48</sup> 42 U.S.C. § 18083(c)(2).

<sup>49</sup> 42 U.S.C. § 18083(c)(3)(A)(i).

<sup>50</sup> 42 C.F.R. § 435.945(d).

<sup>51</sup> U.S. Dep’t of Health & Human Servs., Administration for Children & Families, Public Assistance Reporting Information System (PARIS), <http://www.acf.hhs.gov/programs/paris/about/index.html#history> (last visited July 12, 2012).

<sup>52</sup> 42 U.S.C. § 18082(b) (“Notice. The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.”); 45 C.F.R. § 435.952(b) & (c).

<sup>53</sup> 42 C.F.R. § 435.952(c) (“Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.”). *See also* 45 C.F.R. § 155.300(d) (“For purposes of this subpart, the Exchange must consider information obtained through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange to be reasonably compatible with an applicant’s attestation if the difference or discrepancy does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of

Regulation provides that if the information is incompatible, a state may seek documentation from the individual, but only “to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentations, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage[.]”<sup>54</sup>

The Exchange Establishment Regulation requires that HHS serve as an intermediary, via the electronic service or through other means,<sup>55</sup> for Exchanges seeking to corroborate or verify certain eligibility-related information with federal officials or agencies. Exchanges must submit requests for validation of a social security number to HHS which will pass them on to the Social Security Administration.<sup>56</sup> Requests for verification of citizenship, status as a national, or lawful presence must also be submitted to HHS, which will pass them on to the SSA or to the Department of Homeland Security.<sup>57</sup>

Income and family size information is to be verified by “request[ing] tax return data regarding MAGI and family size from the Secretary of the Treasury by transmitting identifying information specified by HHS to HHS.”<sup>58</sup> Exchanges and state Medicaid agencies are also required to request information related to either “wages, net earnings from self-employment, unearned income and resources” or “eligibility or enrollment” from a list of state and federal agencies set forth at 42 C.F.R. 435.948(a), if they determine that the information would be “useful to verifying the financial eligibility of an individual.”<sup>59</sup> The Secretary “anticipate[s] that the Exchange will leverage State Medicaid and CHIP agencies’ existing relationships with current income sources, but [is] also exploring the potential for supporting connections to sources of current income data through the data services hub.”<sup>60</sup>

To further accelerate the eligibility determination process, states can choose to accept an applicant’s “self-attestation” of all eligibility criteria except for citizenship and immigration status.<sup>61</sup> States are required to accept self-attestation of “pregnancy unless the State has information that is not reasonably compatible with such attestation[.]”<sup>62</sup> Similarly, Exchanges

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cost-sharing reductions.”); 45 C.F.R. § 320(v)(“If a tax filer qualifies for an alternate verification process ... and the applicant’s attestation to projected annual household income ... is no more than ten percent below the annual household income computed [based on tax return data] the Exchange must accept the applicant’s attestation without further verification.”).

<sup>54</sup> 42 C.F.R. § 435.952(c)(2)(ii).

<sup>55</sup> Exchange Establishment Regulation, 77 Fed. Reg. at 18,361.

<sup>56</sup> 42 C.F.R. § 155.315(b).

<sup>57</sup> 42 C.F.R. § 155.315(c).

<sup>58</sup> 42 C.F.R. § 155.320(c)(1)(i)(A).

<sup>59</sup> 42 C.F.R. § 435.948(a).

<sup>60</sup> Exchange Establishment Regulation, 77 Fed. Reg. at 18,367.

<sup>61</sup> 42 C.F.R. § 435.945(a).

<sup>62</sup> 42 C.F.R. § 435.956(e).

must accept self-attestation of household size, unless it is not “reasonably compatible” with other information,<sup>63</sup> and, under certain circumstances, of incarceration.<sup>64</sup> Finally, an individual must be allowed to self-attest to information (with the exception of information about citizenship or immigration status) about which there is an inconsistency that the individual is unable to resolve.<sup>65</sup>

The Exchange Establishment and Medicaid Eligibility Regulations provide for streamlined renewal processes as well. For individuals receiving Medicaid, the agency is required to “make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual’s account or other more current information available to the agency[.]”<sup>66</sup> Nothing will be required of beneficiaries unless available data are not sufficient to continue eligibility, in which case the beneficiary must sign and return a form with the missing or corrected information.<sup>67</sup> Individuals receiving advance payment of the premium tax credit, by contrast, will have to sign and return a “pre-populated” – filled out – form.<sup>68</sup> The Secretary explains that “due to the financial responsibility imposed on an individual accepting an advance payment of the premium tax credit as part of the reconciliation process, we believe it is important to collect a signature from an enrollee as a means of ensuring that he or she accepts this responsibility.”<sup>69</sup>

#### ***D. Exchanges and Eligibility Determinations***

New section 155.302 of 42 C.F.R., which the Secretary has promulgated as an interim final rule, makes clear that states have a number of options with regard to the Exchanges and eligibility determinations. All Exchanges must determine (and redetermine) individuals’ eligibility for QHPs “[d]irectly or through contracting arrangements”<sup>70</sup> and they can, at their option, determine eligibility for Medicaid, CHIP, advance payments of the premium tax credit, and cost-sharing reductions as well. Alternatively, Exchanges can opt out of performing the latter functions.

With regard to Medicaid and CHIP, an Exchange may “conduct an assessment of eligibility for Medicaid and CHIP, rather than an eligibility determination for Medicaid and CHIP[.]”<sup>71</sup> The Exchanges can also opt out of directly determining individuals’ eligibility for

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<sup>63</sup> 45 C.F.R. § 155.320(c)(2)(i)(B).

<sup>64</sup> 45 C.F.R. § 155.315(e).

<sup>65</sup> 45 C.F.R. § 155.315(g).

<sup>66</sup> 42 U.S.C. § 435.916(a)(2).

<sup>67</sup> *Id.*

<sup>68</sup> 45 C.F.R. § 155.335(g).

<sup>69</sup> Exchange Establishment Regulation, 77 Fed. Reg. at 18,377.

<sup>70</sup> 45 C.F.R. § 155.302(a)(1).

<sup>71</sup> 45 C.F.R. § 155.302(b).

advance payments of the premium tax credit and cost-sharing reductions and choose instead to implement determinations made by HHS.<sup>72</sup>

If the Exchange's assessment establishes that an individual is "potentially eligible" for Medicaid or CHIP, the Exchange would be required to "transmit[] all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency or CHIP agency via secure electronic interface, promptly and without undue delay."<sup>73</sup> The Exchange is directed to consider such individuals ineligible for Medicaid and CHIP for purposes of determining their eligibility for advance payments of the premium tax credit and cost-sharing reductions until the Medicaid or CHIP agency notifies the Exchange of its decision.<sup>74</sup> If, on the other hand, the Exchange's assessment is that an individual is not potentially eligible for Medicaid or CHIP, the Exchange must determine his or her eligibility for advance payments of the premium tax credit and cost-sharing reductions and "provide him or her with the opportunity to— (A) Withdraw his or her application for Medicaid and CHIP; or (B) Request a full determination of eligibility for Medicaid and CHIP by the applicable Medicaid and CHIP agencies."<sup>75</sup> Among other things, Exchanges that choose to conduct assessments rather than determinations of eligibility must enter into an agreement with the Medicaid and CHIP agencies that specifies their respective responsibilities.<sup>76</sup>

Exchanges that choose to opt out of directly determining eligibility for either or both Medicaid and CHIP or advance payments of the premium tax credit and cost-sharing reductions must adhere to a set of standards "designed to eliminate duplicative requests for information from applicants and ensure timely eligibility determinations."<sup>77</sup> Specifically, Exchanges must ensure:

- that "eligibility processes are streamlined and coordinated across" agencies;
- that in choosing to opt out they do not increase administrative costs and burdens on applicants, enrollees, beneficiaries, or application filers, or increase delay; and
- that they meet applicable requirements regarding confidentiality, disclosure, maintenance, and use of information.<sup>78</sup>

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<sup>72</sup> 45 C.F.R. § 155.302(c).

<sup>73</sup> 45 C.F.R. § 155.302(b)(3). HHS "will work with Exchanges to establish a reasonable application of the term 'potentially eligible' taking into account an Exchange's assessment procedures." Exchange Establishment Regulation, 77 Fed. Reg. at 18,347.

<sup>74</sup> Exchange Establishment Regulation, 77 Fed. Reg. at 18,347.

<sup>75</sup> 45 C.F.R. § 155.302(b)(4).

<sup>76</sup> 45 C.F.R. § 155.302(b)(6).

<sup>77</sup> Exchange Establishment Regulation, 77 Fed. Reg. at 18,348.

<sup>78</sup> *Id.*

### ***E. State Medicaid and CHIP Agencies and Eligibility and Enrollment***

Regardless of the role played by a state’s Exchange, the Medicaid agency will continue to have eligibility and enrollment responsibilities. First, reflecting the “no wrong door” approach, a Medicaid agency will be required to accept the single, streamlined application via its website or “[t]hrough other commonly available electronic means”, by telephone, by mail, or in person.<sup>79</sup> The regulations also set forth specific requirements for Medicaid agencies when individuals are (1) found eligible for Medicaid by the Exchange or another insurance affordability program, in which case the Medicaid agency must furnish them with Medicaid, or (2) found potentially eligible for Medicaid by the Exchange or another insurance affordability program, in which case the agency must promptly and without undue delay determine their eligibility without “request[ing] information or documentation from the individual already provided to another insurance affordability program and included in the individual’s electronic account or other transmission from the program.”<sup>80</sup> Finally, the Medicaid agency is charged with determining whether individuals who are not eligible for Medicaid based on MAGI are eligible under any other ground.<sup>81</sup>

Medicaid agencies will also have policymaking responsibilities. The Affordable Care Act does not change the requirement that a single state agency administer or supervise the administration of the Medicaid program. While a Medicaid agency can delegate functions, including eligibility determination and enrollment, it cannot cede ultimate authority.

Medicaid agencies must “[c]ertify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.”<sup>82</sup> The regulations also provide that “[t]he single State agency is responsible for ensuring eligibility determinations are made consistent with its policies, and if there is a pattern of incorrect, inconsistent, or delayed determinations for ensuring that corrective actions are promptly instituted.”<sup>83</sup> That said, there is no requirement that agency employees be physically “co-located” with non-employees who are making eligibility determinations, or that agency employees review the determinations of non-employees.<sup>84</sup> There is a requirement that “applicants and beneficiaries [be] made aware of how they can directly contact and obtain information from the single State agency.”<sup>85</sup>

A state’s Medicaid agency must also “assure that eligibility determinations are made consistent with State policies and in the best interests of applicants and beneficiaries, including

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<sup>79</sup> 42 C.F.R. § 435.907 (a) & (b).

<sup>80</sup> 42 C.F.R. § 435.1200(c) & (d).

<sup>81</sup> 42 C.F.R. § 435.911(c)(3).

<sup>82</sup> 42 C.F.R. § 435.1200(b)(2); 45 C.F.R. § 155.305(c).

<sup>83</sup> 45 C.F.R. § 431.10(c)(4).

<sup>84</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,189.

<sup>85</sup> 45 C.F.R. § 431.10(d)(6).

by prohibiting improper incentives and avoiding conflict of interests.”<sup>86</sup> In the Secretary’s summary and analysis, she explains that “arrangements that link the results of eligibility determination dispositions to remuneration” are prohibited.<sup>87</sup> Specifically, “compensation for entities making such determinations may not be linked to a pre-set target for eligibility determinations.”<sup>88</sup>

### ***F. Coordination between the Exchange and the Medicaid Agency***

Very close coordination between the Exchanges and state Medicaid agencies will be necessary to fulfill the aims of the Affordable Care Act with regard to eligibility determinations and enrollment.<sup>89</sup> Coordination requirements apply at renewal, too.<sup>90</sup> The Secretary of Health and Human Services has said “[f]or numerous reasons, including the coordinated enrollment process, we anticipate that States will want to consider different ways to achieve integration across Exchanges, Medicaid agencies and CHIP.”<sup>91</sup> In the preamble to the proposed Medicaid eligibility regulation, the Secretary described “three broad options” for states.<sup>92</sup> First, they can develop a “single integrated entity” to perform the functions of the Exchange and of the Medicaid agency.<sup>93</sup> Second, “one or more of the entities ... could enter into an agreement whereby some or all of the responsibilities of each entity are performed by one or more of the others.”<sup>94</sup> Finally, the entities could remain entirely distinct, in which case they would need to “establish strong connections to ensure the seamless exchange of information and data.”<sup>95</sup>

Language in the preamble to the proposed Medicaid eligibility regulation suggested that, at least when it comes to the eligibility determination function, the Secretary favored integration. The preamble provided that the Secretary:

“expect[s] the use of a shared eligibility service to adjudicate placement for most individuals. The shared eligibility service would coordinate determination and

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<sup>86</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,188 (discussing 42 C.F.R. § 431.10(c)(5) which provides that “[t]he single State agency is responsible for ensuring that eligibility determinations are made in the best interest of applicants and beneficiaries, and specifically ensuring that: (i) There is no conflict of interest by any entity delegated the responsibility to make eligibility determinations or performing eligibility services; and (ii) Improper incentives and/or outcomes are prohibited, monitored, and if found, properly and promptly addressed through corrective actions.”).

<sup>87</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,189.

<sup>88</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,188.

<sup>89</sup> 42 C.F.R. § 435.1200; 45 C.F.R. § 155.345. Section 435.1200 is an interim final rule. The Secretary is “soliciting comments on the provisions in this section to ensure a seamless and coordinated eligibility determination process regardless of the implementation choices exercised by the State.” Medicaid Eligibility Rule, 77 Fed. Reg. at 17,185.

<sup>90</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,184-85.

<sup>91</sup> Proposed Medicaid Eligibility Regulation, 76 Fed. Reg. at 51,169.

<sup>92</sup> Proposed Medicaid Eligibility Regulation, 76 Fed. Reg. at 51,167.

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

renewal requirements for eligibility in each of the insurance affordability programs. It may include processes such as those used for collecting and verifying applicant information, including verification of citizenship and immigration status and certain income information as well as determining and renewing eligibility. Regardless of an applicant's point of entry (directly online at home, with a navigator or community organization/assister, through the mail, or through a consumer assistance office established by the Exchange), this shared eligibility service would be used whenever the single streamlined application ... is initiated or whenever a renewal occurs."<sup>96</sup>

The Secretary went on to make clear that the shared eligibility service can be tasked with all eligibility determinations, even those "based on factors beyond the MAGI-based income standard."<sup>97</sup>

The final regulations preserve states' ability to establish a shared eligibility service. In the summary and analysis that precede the Medicaid eligibility regulation, the Secretary states that "these rules do not prevent States from designing its [*sic*] system in a way that enables one entity to make all eligibility determinations for all insurance affordability programs."<sup>98</sup> The Secretary explains that "State Medicaid and CHIP agencies may make the final Medicaid and CHIP eligibility determination based on the Exchange's initial review; or the State Medicaid and CHIP agencies may accept a final eligibility determination made by an Exchange that uses State eligibility rules and standards."<sup>99</sup> The Secretary "note[s] that we know that several States are considering leveraging a single Exchange/Medicaid/CHIP technology platform in future years to also accommodate non-MAGI applicants, which is permitted under the statute and final rule."<sup>100</sup>

That said, the regulations set a different, less integrated approach as the default. The regulations provide that the Exchange *must* determine an applicant eligible for Medicaid if he or she meets the MAGI-based income standards.<sup>101</sup> Then, "the Exchange must notify the State Medicaid or CHIP agency and transmit all information from the records of the Exchange to the State Medicaid or CHIP agency, promptly and without undue delay, that is necessary for such agency to provide the applicant with coverage."<sup>102</sup> The Medicaid agency must accept the individual's electronic account and furnish Medicaid to the individual promptly and without undue delay.<sup>103</sup> No further action should be required of the individual. The Medicaid agency is

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<sup>96</sup> *Id.*

<sup>97</sup> *Id.*

<sup>98</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,185.

<sup>99</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,184.

<sup>100</sup> Exchange Establishment Regulation, 77 Fed. Reg. at 18,352.

<sup>101</sup> 45 C.F.R. § 155.305(c).

<sup>102</sup> 45 C.F.R. § 155.310(d)(3).

<sup>103</sup> 42 C.F.R. § 435.1200(c); 42 C.F.R. § 435.911(c)(1).

also charged with considering applicants who are eligible based on MAGI “for eligibility on other bases which may be more advantageous to the individual, as appropriate.”<sup>104</sup>

With regard to individuals who are potentially eligible for benefits on a basis other than MAGI, the default approach is for the Exchange to perform what the Secretary calls a “‘screen and refer’ function.”<sup>105</sup> Section 155.345 of 45 C.F.R., which is captioned “Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan”, provides that if an applicant is not eligible for Medicaid based on MAGI, “the Exchange must assess the information provided by the applicant on his or her application to determine whether he or she is potentially eligible for Medicaid based on factors not otherwise considered in this subpart.”<sup>106</sup> If the Exchange determines that an applicant is potentially eligible, or if the individual requests a full determination,<sup>107</sup> “the Exchange must—(1) Transmit all information provided on the application and any information obtained or verified by, [sic] the Exchange to the State Medicaid agency, promptly and without undue delay; and (2) Notify the applicant of such transmittal.”<sup>108</sup>

The final Medicaid Eligibility Regulation specifies that states can delegate MAGI-based eligibility determinations to their Exchanges, regardless of whether their Exchanges are public, governmental, or private, non-governmental, organizations.<sup>109</sup> Similarly, Exchanges can contract with public or private entities to conduct eligibility determinations in MAGI cases. Exchanges that are public organizations can also make eligibility determinations for individuals who are eligible on a basis other than MAGI. Exchanges that are private are limited to “screen[ing] for possible Medicaid eligibility for MAGI-excepted individuals ... and coordinat[ing] the transfer of the application to the Medicaid agency.”<sup>110</sup> Among other requirements, any entity that makes Medicaid eligibility determinations must employ merit system personnel protection principles.<sup>111</sup>

The Affordable Care Act provides that if an applicant applies for Medicaid or CHIP but is found to be ineligible, he or she must be (1) screened for eligibility for enrollment in a QHP, (2) screened for eligibility for premium assistance and reduced cost-sharing, and (3) enrolled, if eligible, in his or her plan of choice without having to submit an additional or separate application.<sup>112</sup> As the Secretary pointed out in the preamble to the proposed Medicaid eligibility regulations, “the Affordable Care Act does not provide express authority for Medicaid

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<sup>104</sup> 42 C.F.R. § 435.911(c)(2).

<sup>105</sup> Exchange Establishment Regulation, 77 Fed. Reg. at 18,379.

<sup>106</sup> 45 C.F.R. § 155.345(b).

<sup>107</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,185.

<sup>108</sup> 45 C.F.R. § 155.345(d).

<sup>109</sup> 42 C.F.R. § 431.10(c)(3).

<sup>110</sup> Medicaid Eligibility Regulation, 77 Fed. Reg. at 17,188.

<sup>111</sup> 42 C.F.R. § 431.10(d)(5).

<sup>112</sup> 42 U.S.C. § 1396w-3(b)(1)(C).

to make eligibility determinations for coverage through the Exchanges[.]”<sup>113</sup> The Act does, however, permit Exchanges to enter into an agreement “under which a State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance[.]” as long as the agency or agencies complies with “such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.”<sup>114</sup> If the Exchange and the Medicaid agency do not enter into such an agreement, the agency will be required to “promptly transfer the electronic account of individuals screened as potentially eligible, via secure electronic interface, to the Exchange, so that such individuals can receive an immediate eligibility determination and, if eligible, be enrolled without delay.”<sup>115</sup>

In addition to charging the exchanges with determining an individuals’ eligibility for public programs, the Affordable Care Act provides that the Exchanges must “enroll such individuals in such program[s].”<sup>116</sup> In the preamble to a proposed regulation, the Secretary suggested that an Exchange could fulfill its duty to enroll individuals by notifying the Medicaid agency of its determination and transmitting the relevant information to the agency.<sup>117</sup> The Medicaid agency would then “provide the individual with his or her choices of available delivery systems (such as a managed care organization, a primary care case management program, or other option) and notify the chosen health plan or delivery system of the individual’s selection.”<sup>118</sup> On the other hand, the Exchange could, with the Medicaid agency’s authorization, take over these functions and “facilitate delivery system and health plan selection, including transmitting enrollment transactions to health plans, if applicable, for individuals determined eligible for Medicaid and CHIP.”<sup>119</sup>

To facilitate the close coordination that the Act requires, the regulations direct the Medicaid agency to enter into written agreements with any agency that determines eligibility on its behalf that, among other things, delineates their respective responsibilities.<sup>120</sup> The regulations also require the Exchange to enter into agreements with the agencies administering Medicaid, CHIP, and, if applicable, the Basic Health Plan.<sup>121</sup> The Secretary expects that these agreements, which must be available to the public upon request, “will establish the

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<sup>113</sup> Proposed Medicaid Eligibility Regulation, 76 Fed. Reg. at 51,168.

<sup>114</sup> 42 U.S.C. § 1396w-3(b)(1)(F). *See also* 42 C.F.R. § 435.1200(e)(3); 45 C.F.R. § 155.110(a)(2).

<sup>115</sup> 42 C.F.R. § 435.912 (e) (“...the agency must, promptly and without undue delay, consistent with timeliness standards established under § 435.912 of this part, determine potential eligibility for, and, as appropriate, transfer via a secure electronic interface the individual’s electronic account to, other insurance affordability programs.”).

<sup>116</sup> 42 U.S.C. §18031(d)(2)(F).

<sup>117</sup> Proposed Individual Market Eligibility Regulation, 76 Fed. Reg. at 51,221.

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> 42 C.F.R. § 431.10(d).

<sup>121</sup> 45 C.F.R. § 155.345(a).

responsibilities across the parties, and [HHS] will work with States to help develop such agreements.”<sup>122</sup>

Coordination beyond federal, state, and local health insurance programs to include other public benefits could be advantageous to beneficiaries. To this end, the Secretary notes that “on August 10, 2011 and January 23, 2012, the Centers for Medicare and Medicaid Services, the Administration for Children and Families (ACF), and the Food and Nutrition Service (FNS) issued joint letters providing guidance on the limited exception to cost allocation guidelines which allows Federally-funded human services programs to benefit from Medicaid, CHIP, and Exchange technology investments.”<sup>123</sup>

### ***G. Agents, Brokers, and Navigators***

The Affordable Care Act requires states to establish a navigator program to, among other things, “distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits ... and cost-sharing reductions” and “facilitate enrollment in qualified health plans.”<sup>124</sup> HHS has indicated that, at states’ option, navigators can be permitted or required to distribute information about, and facilitate enrollment in, Medicaid and CHIP as well. To the extent that navigators undertake such activities, the federal government will shoulder a share of the cost.<sup>125</sup> The Act also authorizes states to allow agents or brokers to enroll “individuals, employers or employees in any QHP in the individual or small group market as soon as the QHP is offered through an Exchange in the State”<sup>126</sup> and to help individuals apply for premium tax credits and cost-sharing reductions.<sup>127</sup>

## **III. New Jersey Laws**

In New Jersey, the single state agency responsible for Medicaid is the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services. DMAHS is also responsible for NJ FamilyCare, New Jersey’s CHIP program. By statute, DMAHS is charged with ensuring “[t]hat all individuals wishing to make application for medical assistance shall have the opportunity to do so” and that “the processing of applications [is] simplified to the end that medical benefits shall be furnished to recipients as soon as possible.”<sup>128</sup>

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<sup>122</sup> Exchange Establishment Regulation, 77 Fed. Reg. at 18,348.

<sup>123</sup> *Id.* at 18,352.

<sup>124</sup> 42 U.S.C. § 18032(i)(3).

<sup>125</sup> Proposed Exchange Establishment Regulation, 76 Fed. Reg. at 41,878.

<sup>126</sup> 42 U.S.C. § 18032(e); 45 C.F.R. §155.220(a)(1).

<sup>127</sup> 45 C.F.R. § 155.220(a)(3).

<sup>128</sup> N.J. STAT. ANN. § 30:4D-15.

DMAHS has delegated responsibility for Medicaid eligibility determinations, enrollment, information verification, and eligibility redeterminations to twenty-one county welfare agencies which are overseen by the Division of Family Development.<sup>129</sup> DMAHS has also contracted with a vendor, ACS, which fields Health Benefits Coordinators (HBCs) to conduct community outreach and serve as “choice counselor[s]” for both Medicaid and NJ FamilyCare.<sup>130</sup> In addition, DMAHS partners with approximately 500 outside agencies, some of which provide referrals and others of which assist individuals with the application for Medicaid and NJ FamilyCare.

The county welfare agencies conduct eligibility determinations for all forms of Medicaid and for NJ FamilyCare for those applicants whose income does not exceed 133% of the federal poverty level. The county welfare agencies refer applicants for NJ FamilyCare with incomes above 133% of the federal poverty level to the HBCs. On redetermination, the county welfare agency can retain responsibility for an NJ FamilyCare case as long as the recipient’s income does not exceed 150% of the federal poverty level. The HBCs conduct eligibility determinations for all forms of NJ FamilyCare and for some forms of Medicaid. The HBCs typically refer applicants with no income to the county welfare agencies, since those applicants are likely eligible for other non-health-related benefits; they also refer individuals who are potentially eligible for Medicaid because they are over 65 years of age, or blind, or disabled.<sup>131</sup>

The county welfare agencies enroll individuals into traditional Medicaid, while the HBCs are responsible for enrollment into Medicaid and NJ FamilyCare managed care plans. Only the HBCs have the ability to assess and collect premiums, which are owed by NJ FamilyCare recipients at higher income levels. In addition to their headquarters in Hamilton, NJ, the HBCs have three satellite offices and are also stationed at many of the county welfare agencies.

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<sup>129</sup> N.J. STAT. ANN. § 30:4D-3 (providing that “[e]ligibility determinations for the medically needy program shall be administered as follows: (i) County welfare agencies and other entities designated by the commissioner are responsible for determining and certifying the eligibility of pregnant women and dependent children. The division shall reimburse county welfare agencies for 100% of the reasonable costs of administration which are not reimbursed by the federal government for the first 12 months of this program's operation. Thereafter, 75% of the administrative costs incurred by county welfare agencies which are not reimbursed by the federal government shall be reimbursed by the division; (ii) The division is responsible for certifying the eligibility of individuals who are 65 years of age and older and individuals who are blind or disabled. The division may enter into contracts with county welfare agencies to determine certain aspects of eligibility. In such instances the division shall provide county welfare agencies with all information the division may have available on the individual.”).

<sup>130</sup> Department of Human Services, in Cooperation with the Department of Health and Senior Services and the Department of Children and Families, State of New Jersey, Section 1115 Demonstration Comprehensive Waiver 25 (Sept. 9, 2011), *available at* <http://www.state.nj.us/humanservices/dmahs/home/waiver.html> [hereinafter “Waiver”].

<sup>131</sup> See OUTREACH, ENROLLMENT AND RETENTION WORKING GROUP IN RESPONSE TO THE NEW JERSEY HEALTH CARE REFORM ACT OF 2008, NJ FAMILYCARE OUTREACH, ENROLLMENT AND RETENTION REPORT 3 (2009) [hereinafter “ENROLLMENT REPORT”] (explaining that “[a]pplications for families earning less than 133 percent of the FPL are routed by the HBC to the county, based on the fact that county offices can assist low-income families/individuals in obtaining additional benefits through programs such as Supplemental Nutrition Assistance (Food Stamps) and Temporary Assistance for Needy Families (TANF).”).

In 2005, New Jersey passed legislation establishing a number of enrollment simplification procedures for both Medicaid<sup>132</sup> and NJ FamilyCare<sup>133</sup> in response to concerns that many technically eligible persons were not enrolled due in part to unnecessary complexities in the enrollment and renewal processes. The simplifications include (1) the use of a streamlined application form, (2) the use of a single recent pay stub to verify income, (3) the provision that if an applicant does not submit income verification the Commissioner must review available Department of the Treasury and Department of Labor and Workforce Development records before issuing a denial, (4) the establishment of an online enrollment and renewal system, (5) the implementation of continuous enrollment, and (6) the adoption of simplified renewal procedures.

New Jersey currently uses a joint application, OneApp, which is available online at [www.njhelps.org](http://www.njhelps.org), a “self-guided online screening tool[.]”<sup>134</sup> Applicants can fill out and submit the OneApp via the NJHelps website with an electronic signature.<sup>135</sup> In addition to Medicaid and NJ FamilyCare, OneApp can be used to apply for General Assistance (WorkFirst NJ), the Supplemental Nutrition Assistance Program (NJ SNAP), and Temporary Assistance to Needy Families (TANF).<sup>136</sup>

As a result of New Jersey’s fragmented information technology infrastructure, processing the OneApp is not yet fully electronic.<sup>137</sup> County employees, NJ FamilyCare Health Benefits Coordinators, and others must currently print the application out in order to process it.<sup>138</sup> In addition, the planned Document Imaging Management System (DIMS) is not yet up and running, so pay stubs and other supporting documents cannot be scanned and uploaded.<sup>139</sup> And, as is noted in New Jersey’s pending application for a comprehensive Medicaid waiver, the state’s current system does not allow DMAHS to track the processing of cases by the county welfare agencies.<sup>140</sup> The waiver application describes plans to correct some of these faults.

New Jersey aims to automate “all or most of the eligibility determination and redetermination process.”<sup>141</sup> To this end, it prepared an Expedited Advance Planning Document

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<sup>132</sup> N.J. STAT. ANN. § 30:4D-3b.

<sup>133</sup> N.J. STAT. ANN. § 30:4J-12.

<sup>134</sup> ENROLLMENT REPORT, *supra* note 131, at 12.

<sup>135</sup> NJHELPS, <http://www.njhelps.com> (last visited Aug. 15, 2012); MARTHA HEBERLEIN, TRICIA BROOKS, JOCELYN GUYER, SAMANTHA ARTIGA, & JESSICA STEPHENS, PERFORMING UNDER PRESSURE: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST-SHARING POLICIES IN MEDICAID AND CHIP, 2011-2012, KAISER COMMISSION ON MEDICAID AND THE UNINSURED 51 (JAN. 2012).

<sup>136</sup> Online Applications, NJHELPS, [http://www.njhelps.com/online\\_apps.html](http://www.njhelps.com/online_apps.html) (last visited Aug. 15, 2012).

<sup>137</sup> ENROLLMENT REPORT, *supra* note 131, at 9.

<sup>138</sup> TRANSITION SUBCOMMITTEE, DEPARTMENTS OF HUMAN SERVICES AND CHILDREN & FAMILIES, FINAL REPORT 7, *available at* <http://www.state.nj.us/governor/news/reports/Human%20Services%20-%20Children%20&%20Families.pdf> [hereinafter “TRANSITION SUBCOMMITTEE REPORT”].

<sup>139</sup> ENROLLMENT REPORT, *supra* note 131, at 12.

<sup>140</sup> Waiver, *supra* note 130, at 28].

<sup>141</sup> *Id.* at 27.

which was approved by the Centers for Medicare & Medicaid Services; the federal government is funding 90 percent of the cost of New Jersey's effort ("up from the regular 50 percent match for administrative functions and systems").<sup>142</sup> Currently, the state is developing the Consolidated Assistance Support System (CASS) which it expects to begin user-testing in 2012 and to go live in some counties in 2013. CASS will allow for fully electronic enrollment into a number of public assistance programs including all of New Jersey's Medicaid programs and NJ FamilyCare. CASS will be fully integrated with DIMS which will "resolve[] many of the major problems of a paper-intensive-system including:

- Lost or misplaced files and documents
- Difficulty sharing information among workers
- Inconvenience for clients who must share the same information multiple times
- High costs of copying, locating and storing information."<sup>143</sup>

CASS is also designed to be the "eligibility rules engine for the Health Care Exchange." It will "process all applications to Medicaid and the Exchange beginning January 1, 2014 and determine program eligibility and handle the expected churning between programs."<sup>144</sup>

New Jersey has already taken steps away from requiring paper documentation, as is expected under the Affordable Care Act. While the Medicaid regulations still provide that eligibility workers "shall verify, either through examination of pay stubs or with the client's employer, the amount of gross earned income[,]"<sup>145</sup> the NJ Family Care statute provides that "[i]f an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's income by reviewing available Department of the Treasury and Department of Labor and Workforce Development records concerning the applicant, and such other records as the commissioner determines appropriate."<sup>146</sup> The state uses data matching with the Social Security Administration to verify citizenship for both Medicaid and NJ FamilyCare. Applicants' immigration status is established using the Systematic Alien Verification for Entitlements (SAVE) Program.<sup>147</sup> Verification of social security benefits can be accomplished through the Automated Benefit Information Exchange (ABIE)/Beneficiary Earnings and Data Exchange (BENDEX) and the

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<sup>142</sup> HEBERLEIN, *supra* note 136, at 16, 17. The "[m]aintenance and operating costs of these systems also may qualify for an ongoing 75 percent federal match." *Id.* at 17.

<sup>143</sup> Waiver, *supra* note 130, at 28-29.

<sup>144</sup> *Id.* at 29.

<sup>145</sup> N.J.A.C. § 10:69-3.4 (b)(1).

<sup>146</sup> N.J. STAT. ANN. § 30:4J-12(d)(2).

<sup>147</sup> N.J.A.C. 10:69-3.9(f). *See also* U.S. Citizenship and Immigration Services, Systematic Alien Verification for Entitlements (SAVE) Program, <http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnnextchannel=1721c2ec0c7c8110VgnVCM1000004718190aRCRD&vgnnextoid=1721c2ec0c7c8110VgnVCM1000004718190aRCRD> (last visited Sept. 18, 2011).

State Data Exchange (SDX).<sup>148</sup> The State Verification and Exchange System (SVES) serves as a back-up.<sup>149</sup> Unfortunately, it has historically been difficult for one state agency to access data obtained by another and county departments of social services have had limited ability to interface with state-level data systems.<sup>150</sup> This is improving, but some counties continue to lag behind others.

New Jersey has presumptive eligibility for children for both Medicaid<sup>151</sup> and NJ FamilyCare<sup>152</sup> “if a preliminary determination by hospital, health center, local health department or licensed health care provider staff indicates that the child meets program eligibility standards and is a member of a household with an income that does not exceed 350% of the poverty level.” Presumptive eligibility allows children to receive care while they await the outcome of the eligibility determination process.<sup>153</sup> Some pregnant women also benefit from presumptive eligibility.<sup>154</sup> As a condition of participation in the state’s Charity Care Program, hospitals are required to refer potentially eligible children and adults to appropriate medical assistance programs and to advise the medical assistance office of the applicants’ possible eligibility.<sup>155</sup> To facilitate this process, there are county social services agency employees stationed in hospitals and federally qualified health centers where they accept and process applications for pregnant women and children.<sup>156</sup> If a newborn with income under 350% of the federal poverty level is uninsured, the hospital where he or she is born is required to apply for Medicaid or NJ FamilyCare on the newborn’s behalf.<sup>157</sup>

New Jersey was one of just four states to pilot Express Lane Eligibility (ELE) for Medicaid and NJ FamilyCare.<sup>158</sup> Nine states have now “adopted the ELE option ... enabling them to enroll or renew children eligible for Medicaid or CHIP by relying on eligibility information from other income-based public programs or the state tax or revenue department.”<sup>159</sup> In addition to the electronic verification efforts described above, New Jersey mails families a simplified, one-page application based on information provided in their state tax return. When a family chooses to fill out the application and return it, the state determines whether the child or children in the

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<sup>148</sup> N.J.A.C. § 10:69-8.2(a).

<sup>149</sup> N.J.A.C. § 10:69-8.2 (b).

<sup>150</sup> ENROLLMENT REPORT, *supra* note 131, at 10.

<sup>151</sup> N.J. STAT. ANN. § 30:4J-12(g)(2).

<sup>152</sup> N.J. STAT. ANN. § 30:4J-12 (g)(1).

<sup>153</sup> HEBERLEIN, *supra* note 136, at 17.

<sup>154</sup> N.J. STAT. ANN. § 30:4D-3.

<sup>155</sup> N.J. STAT. ANN. § 10:52-11.5.

<sup>156</sup> N.J. STAT. ANN. § 30:4D-7a.

<sup>157</sup> Memorandum from Heather Howard, Commissioner, Dep’t of Health & Human Servs. & Jennifer Velez, Commissioner, Dep’t of Human Servs., to New Jersey Hosp. Chief Exec. Officers (Apr. 4, 2008), *available at* [http://njlincs.net/PublicHealthAlertMessages/temp/Charity\\_Care\\_PE\\_4-4-08.100674.pdf](http://njlincs.net/PublicHealthAlertMessages/temp/Charity_Care_PE_4-4-08.100674.pdf).

<sup>158</sup> FAMILIES USA, EXPRESS LANE ELIGIBILITY: EARLY STATE EXPERIENCE AND LESSONS FOR HEALTH REFORM 2 (2011) [hereinafter “FAMILIES USA REPORT”].

<sup>159</sup> HEBERLEIN, *supra* note 136, at 15.

household are eligible for Medicaid or NJ FamilyCare based largely on income information from the Division of Taxation.<sup>160</sup> Also as part of ELE, in 2010 New Jersey piloted a school-based initiative in nine school districts in which children who participate in the National School Lunch Program are automatically enrolled in Medicaid or NJ FamilyCare upon submission of the application.<sup>161</sup>

While New Jersey has made strides,<sup>162</sup> more will be needed to comply with the Affordable Care Act. A review of the regulations governing the Medicaid and NJ FamilyCare programs reveals, for example, that although the state has eliminated the requirement of a “personal face-to-face interview” for those applicants whose eligibility does not depend on their age or the fact that they are blind or disabled, the section of the administrative code governing AFDC-Related Medicaid still provides that “[t]he child (if appropriate), parent, guardian, or caretaker of a presumptively eligible child shall contact the county board of social services during the presumptive eligibility period so that a face-to-face interview can be scheduled.”<sup>163</sup> To give another example, while New Jersey accepts electronic signatures unless a face-to-face interview is required, the administrative code provides that applicants for AFDC-Related Medicaid must prepare an application and affidavit and that “[t]hree signatures under oath are required[.]”<sup>164</sup>

Legislation authorizing the establishment of an Exchange was passed by the New Jersey Legislature in March 2012 and then vetoed by Governor Christopher J. Christie in May 2012.<sup>165</sup> The bill provided as follows with regard to eligibility and enrollment:

“[T]he board [of the exchange] shall: a. provide for the processing of applications, the determination of eligibility for premium tax credits and any cost-sharing reduction and the redetermination of eligibility as necessary due to changes in an individual’s income or circumstances, the enrollment and

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<sup>160</sup> FAMILIES USA REPORT, *supra* note 136, at 10.

<sup>161</sup> FAMILIES USA REPORT, *supra* note 136, at 12-13.

<sup>162</sup> In its latest Medicaid eligibility and enrollment report, the Kaiser Commission on Medicaid and the Uninsured gave New Jersey high marks. *See generally* HEBERLEIN, *supra* note 136. Kaiser highlighted the fact that New Jersey has a joint online application with electronic signature for Medicaid and CHIP and uses the same eligibility system, which it is upgrading, for the two programs and for other public benefits. In addition, there is no asset test, a face-to-face interview is not required, and the state uses a SSA data match to verify citizenship and attempts to administratively verify income. New Jersey also makes use of presumptive eligibility and Express Lane Eligibility and uses out-stationed state eligibility workers for both Medicaid and CHIP. Finally, New Jersey provides for 12-month periods of continuous eligibility. One area where there may be room for improvement in New Jersey is renewal.

<sup>163</sup> *See, e.g.*, N.J. ADMIN. CODE § 10:69-12.7. In addition, the section of the administrative code governing Special Medicaid Programs provides that presumptively eligible pregnant women are required to sit for face-to-face interviews, N.J. ADMIN. CODE § 10:72-6.5, but gives parents a choice of mailing in an application or arranging for a face-to-face interview. N.J. ADMIN. CODE 10:72-7.7.

<sup>164</sup> N.J. ADMIN. CODE § 10:69-2.4.

<sup>165</sup> A2171 "NEW JERSEY HEALTH BENEFIT EXCHANGE ACT[.]" BILLS 2012-2013, <http://www.njleg.state.nj.us/bills/BillView.asp> (last visited Aug. 15, 2012).

disenrollment of enrollees, and the establishment of an enrollee database, and coordinate those activities with Medicaid and NJ FamilyCare, and any other State and local government entities as applicable, in furtherance of which the board shall: (1) adopt policies and procedures, pursuant to a written agreement to be established between the board and the Division of Medical Assistance and Health Services in the Department of Human Services, by which the exchange: provides eligibility determination and redetermination services for, and enrollment in, the exchange, Medicaid, and NJ FamilyCare, as appropriate to the individual's income and circumstances, through the use of a single application form; and ensures the timely processing of applications and enrollment, as appropriate, utilizing consistent methods and standards that, to the maximum extent practicable, are employed by both the exchange and the Division of Medical Assistance and Health Services; (2) arrange, pursuant to the written agreement established between the board and the Division of Medical Assistance and Health Services pursuant to paragraph (1) of this subsection, for the sharing of data with respect to enrollees and recipients of Medicaid and NJ FamilyCare.”<sup>166</sup>

The bill also charges the board with ensuring “continuity of coverage and care when an enrollee transitions between participation in a qualified health benefits plan and participation in Medicaid or NJ FamilyCare, or the reverse...”<sup>167</sup> The board must also “establish uniform billing and payment policies for qualified health benefits plans and coordinate these policies with Medicaid and NJ FamilyCare.”<sup>168</sup>

## IV. Research and Experience

Deborah Bachrach, the former director of Medicaid for the State of New York, along with colleagues, argues that after the Affordable Care Act is fully implemented, the process that “state Exchanges implement for health subsidy eligibility will be applied uniformly to all consumers who wish to determine whether they are eligible for any type of health subsidy program, regardless of their income level.”<sup>169</sup> Danielle Holahan agrees, explaining that “[t]he federal vision is that consumers with income from 0 to 400 percent of the federal poverty level (FPL) will have the same enrollment experience.”<sup>170</sup> In a policy brief written for The

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<sup>166</sup> A.2171, 215<sup>th</sup> Leg., 2012-13 Sess. (N.J. 2012).

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

<sup>169</sup> DEBORAH BACHRACH, PATRICIA BOOZANG & MELINDA DUTTON, MEDICAID'S ROLE IN THE HEALTH BENEFITS EXCHANGE: A ROAD MAP FOR STATES 5 (2011).

<sup>170</sup> HOLAHAN, *supra* note 25, at 3.

Commonwealth Fund, Timothy Stoltzfus Jost points out it will also be central to the Act's success "that the subsidy determination process not stand in the way of unsubsidized individuals" who can choose to purchase insurance outside of the Exchange if purchasing it inside proves too cumbersome.<sup>171</sup>

States vary in whether and how their Medicaid program is or will be coordinated with their health insurance exchange. Sonya Schwartz of the National Academy for State Health Policy reports that in Massachusetts "Medicaid takes center stage in the Exchange's infrastructure," while in Utah "government programs like Medicaid currently have and will continue to have a much more limited role[.]"<sup>172</sup> The Massachusetts Connector "relies on Medicaid to perform eligibility and enrollment functions for the subsidized insurance options"; Virginia also expects that its exchange will partner closely with Medicaid.<sup>173</sup>

Timothy Jost has argued that individuals should be able to apply to the exchange or to Medicaid and that "[e]ither entity must then make certain that the individual is signed up for the appropriate program."<sup>174</sup> He is also in favor of close collaboration at the health plan level, arguing that exchanges should "offer health plans that both participate in Medicaid and CHIP and accept premium tax credits so that people who switch from one to the other, or families that are split between programs can remain with the same plan and use the same providers."<sup>175</sup> Bachrach and her colleagues do not go that far, but they do recommend that Medicaid be integrated into the exchange's "coverage continuum" to facilitate outreach, ease comparison shopping and enable "consumers whose incomes fluctuate to more easily transition among products and plans."<sup>176</sup> NJ for Health Care, a coalition of New Jersey-based consumer organizations, similarly recommends that "Exchange plans ... be fully coordinated and integrated with Medicaid and NJ FamilyCare[]" and that "[p]lans that are available in Medicaid and NJ FamilyCare ... also be available in the Exchange."<sup>177</sup>

Deborah Bachrach has argued that "ongoing enhanced federal matching funds for Medicaid operations are likely to be an important part of Exchange sustainability planning."<sup>178</sup> Bachrach explains that "to the extent that Medicaid functions are consolidated in the Exchange, federal matching dollars will be available to support the operations of the Exchange post-2014, when the ACA mandates that they be self-sustaining."<sup>179</sup> The proposed Medicaid Eligibility Regulation explained "that shared systems and the Medicaid functions they perform are eligible

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<sup>171</sup> TIMOTHY STOLTZFUS JOST, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT, THE COMMONWEALTH FUND 39 (2010).

<sup>172</sup> SONYA SCHWARTZ, CASTING CALL: MEDICAID'S ROLE IN THE EXCHANGE, STATE REFORM (April 12, 2011).

<sup>173</sup> *Id.*

<sup>174</sup> JOST, *supra* note 171, at 48.

<sup>175</sup> *Id.* at 40.

<sup>176</sup> BACHRACH, *supra* note 169, at 1.

<sup>177</sup> NJ FOR HEALTH CARE, PRINCIPLES FOR ESTABLISHING A PRO-CONSUMER NJ HEALTH INSURANCE EXCHANGE 1 (2011).

<sup>178</sup> BACHRACH, *supra* note 169, at 34.

<sup>179</sup> *Id.* at 2.

for enhanced Federal financial participation (FFP) of 90 percent for development (through December 31, 2015) and 75 percent for operations (no time limit) if certain conditions and standards are met.”<sup>180</sup> In its waiver application, New Jersey wrote that it “expect[s] CASS will qualify for 90% federal Medical Assistance percentage (FMAP) for development for the entire cost of the system based upon the Tri-Agency letter of August 10, 2011” and that “[o]perational costs will continue to receive 75% FMAP for Medicaid’s allocated share on an ongoing basis.”<sup>181</sup>

## V. Policy Options

The Affordable Care Act requires states to provide consumers with a seamless eligibility determination and enrollment experience. As described above, the Secretary of Health and Human Services has set forth three broad options for apportioning responsibility between a state’s Exchange and its Medicaid agency: (1) the Exchange could be fully integrated with the Medicaid agency; (2) the Exchange could delegate certain functions to the Medicaid agency or vice versa; and (3) the exchange and the Medicaid agency could remain distinct, with wholly separate responsibilities, but collaborate closely with one another. A federal-state hybrid is also a possibility. HHS has noted that “[s]ome States have expressed a preference for a flexible State partnership model combining State-designed and operated business functions with Federally-designed and operated business functions,” giving as an example of shared business functions eligibility and enrollment.<sup>182</sup> The final Exchange Establishment Regulation specifies that Exchanges can opt out of directly determining individuals’ eligibility for advance payments of the premium tax credit and cost-sharing reductions and choose instead to implement determinations made by HHS.<sup>183</sup>

With the development of the CASS eligibility rules engine, New Jersey will have taken a substantial step toward integration of the eligibility determination function, at least for those individuals who will qualify for assistance on the basis of income as determined by the MAGI standard. The expectation, expressed in both the draft legislation and the comprehensive waiver application, seems to be that both the new health insurance Exchange and the existing county welfare agencies will conduct these more basic eligibility determinations. This comports with the “no wrong door” philosophy. It will also serve the Affordable Care Act’s aim of swift and seamless eligibility determinations. It is sensible for DMAHS to share responsibility for determining eligibility for Medicaid and NJ FamilyCare with the Exchange because the Exchange will need to know if an individual is eligible for those programs in order to determine his or her

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<sup>180</sup> Proposed Medicaid Eligibility Regulation, 76 Fed. Reg. at 51,167.

<sup>181</sup> Waiver, *supra* note 130, at 29.

<sup>182</sup> Proposed Exchange Establishment Regulation, 66 Fed. Reg. at 41,870.

<sup>183</sup> 45 C.F.R. § 155.302(c).

eligibility for premium subsidies and cost-sharing reductions.<sup>184</sup> DMAHS and the Exchange will need to work together to ensure that health-related subsidies are coordinated with other public benefits when accessed through the Exchange, as they are when accessed through the county welfare agencies.<sup>185</sup>

The state must also decide whether the Exchange should be tasked with determining eligibility for individuals who qualify on a basis other than income. The regulations provide that the Exchange may “conduct an assessment of eligibility for Medicaid and CHIP, rather than an eligibility determination for Medicaid and CHIP” and then forward his or her information to the Medicaid agency for a full determination.<sup>186</sup> Adopting this arrangement for individuals who are potentially eligible on a basis other than their income could have the advantage of making the best use of the time and expertise of county welfare agency staff. The more of the formulaic MAGI-related decisions that the Exchange takes on, the more time and resources county welfare agency staff will have to devote to the more fact-sensitive, MAGI-exempt cases.

A health reform working group in Maryland has suggested that as eligibility determinations become more and more automated, case workers “may be able to focus on assisting with more complicated Medicaid eligibility cases, such as long term care and home and community-based waiver eligibility...”<sup>187</sup> In a May 2012 report issued by the Robert Wood Johnson Foundation-funded State Health Access Data Assistance Center, the authors describe the experience of five states – Colorado, Kansas, Minnesota, New York, and Oregon – that received federal grant funding that they used, in part, to modernize or begin the process of modernizing their eligibility and enrollment systems. Officials from the five states “acknowledged that the responsibilities of traditional caseworkers would change as new, highly automated systems are implemented, but at the same time, officials understood that caseworkers would still be needed to manage the most complex eligibility cases.”<sup>188</sup>

Also to be decided is whether the Exchange should be tasked with actually enrolling individuals in Medicaid or NJ FamilyCare.<sup>189</sup> The Exchange would then be responsible for

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<sup>184</sup> Proposed Individual Market Eligibility Regulation, 76 Fed. Reg. at 51,209 (“[A]n applicant is ineligible for advance payments of the premium tax credit to the extent that he or she is eligible for advance payments of the premium tax credit to the extent that he or she is eligible for other minimum essential coverage, which includes Medicaid and CHIP. This provision means that the Exchange will consider an applicant’s eligibility for Medicaid and CHIP as part of an eligibility determination for advance payments of the premium tax credit.”).

<sup>185</sup> CENTER ON BUDGET AND POLICY PRIORITIES, COORDINATING HUMAN SERVICES PROGRAMS WITH HEALTH REFORM IMPLEMENTATION: A TOOLKIT FOR STATE AGENCIES 7 (May 2012). Cf. TRANSITION SUBCOMMITTEE REPORT, *supra* note 138, at 13 (noting that moving the processing of NJ FamilyCare applications from the vendor who currently processes them to the counties would be advantageous because county workers can process food stamp applications as well.).

<sup>186</sup> 45 C.F.R. § 155.302(b).

<sup>187</sup> MARYLAND HEALTH CARE REFORM COORDINATING COUNCIL ENTRY INTO COVERAGE WORKGROUP, WHITE PAPER 7 (Oct. 31, 2010), available at [http://www.statereform.org/sites/default/files/md\\_finalreportentryworkgroup.pdf](http://www.statereform.org/sites/default/files/md_finalreportentryworkgroup.pdf).

<sup>188</sup> BRIGETTE COURTOT & TERESA COUGHLIN, BEST PRACTICES IN SHAP OUTREACH, ELIGIBILITY, AND ENROLLMENT ACTIVITIES 9 (May 2012).

<sup>189</sup> Proposed Individual Market Eligibility Regulation, 76 Fed. Reg. at 51,168.

providing applicants with information about the available Medicaid plans and for transmitting enrollment transactions to the plans. The Secretary has noted that this approach could “reduce administrative costs associated with a two-step process for applicants for applicants who are determined eligible for Medicaid or CHIP, particularly because the Exchange will already have the capacity to allow delivery system selection for individuals determined eligible to enroll in a QHP.”<sup>190</sup> An issue brief by the Robert Wood Johnson Foundation’s Health Policy Connection explains that a single enrollment system would have a number of other benefits, including easier mobility across programs and better ability to ensure continuity of coverage.<sup>191</sup>

Just as New Jersey will have to decide with which duties to task the new Exchange, it will confront a similar set of questions with regard to DMAHS. DMAHS, presumably acting through the county welfare agencies, will have responsibility for processing the single, streamlined application. New Jersey will have to decide whether DMAHS should also have responsibility for (1) determining eligibility for enrollment in a QHP through the Exchange, (2) determining eligibility for premium assistance and reduced cost-sharing, and/or (3) enrolling individuals in QHPs. DMAHS would be supported in these efforts by the Medicaid website, which is required under the Affordable Care Act to include a comparison of the “benefits, premiums, and cost-sharing” under Medicaid with the “benefits, premiums, and cost-sharing” under QHPs offered through the exchange.<sup>192</sup> As discussed above, at a minimum DMAHS will need to screen individuals who are ineligible for Medicaid and NJ FamilyCare to determine whether they could potentially access health insurance coverage through the Exchange and, if the answer is yes, promptly transfer their information to the Exchange.

## Conclusion

New Jersey is in many ways well-positioned to implement the eligibility and enrollment system called for by the Affordable Care Act. There is much still to do, however, and time is of the essence. Convening an entry into coverage workgroup, as other states have, could be a first step. The State Health Access Data Assistance Center report discussed above notes that all five states studied believe that it is important to include experts in eligibility and enrollment, not just in information technology, in the planning process from beginning to end.<sup>193</sup> All five states also recommend including caseworkers with responsibility for determining eligibility and effectuating enrollment under the current system in the planning process<sup>194</sup> noting that “including eligibility caseworkers at the table ... helped to get their buy-in regarding system

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<sup>190</sup> *Id.* at 51,221.

<sup>191</sup> ROBERT WOOD JOHNSON FOUNDATION, SHOULD STATES INTEGRATE HEALTH INSURANCE EXCHANGES AND MEDICAID? 1 (Jan. 2012), available at <http://www.rwjf.org/healthpolicy/coverage/product.jsp?id=73430>.

<sup>192</sup> 42 U.S.C. § 1396w-3(b)(4).

<sup>193</sup> COURTOT & COUGHLIN, *supra* note 188 at 9.

<sup>194</sup> *Id.*

changes, which was particularly important in states with county-administered eligibility determination[.]”<sup>195</sup> Regardless of the specific apportionment of responsibilities, extremely close coordination amongst the exchange, DMAHS, and other programs will be necessary. A coordinated and inclusive planning process will lay the necessary groundwork.

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<sup>195</sup> *Id.*





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