Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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STATE CONSIDERATIONS ON ADOPTING HEALTH REFORM'S "BASIC HEALTH" OPTION

Federal Guidance Needed for States to Fully Assess Option

by January Angeles

The Affordable Care Act (ACA) is expected to reduce the number of uninsured people by 34 million by 2021, by providing new options for low- and moderate-income people to obtain affordable, comprehensive health coverage through Medicaid and through tax credit subsidies to help them buy coverage in the new health insurance exchanges.[1] The ACA also allows states to establish "Basic Health" coverage programs for people who have incomes below 200 percent of the poverty line ($22,340 for an individual) and would otherwise be eligible for a tax credit to defray the premium costs of coverage purchased through the exchanges. A state would contract with health plans or provider networks to cover these individuals through a Basic Health plan instead of through subsidized exchange coverage and would receive federal funds to operate the Basic Health program.

Basic Health allows states to offer coverage that could be more affordable and comprehensive than the coverage available through the exchange. That, in turn, could help boost enrollment, retention, and access to care among those eligible for Basic Health.[2] On the other hand, if a state's Basic Health program is not well-designed or not appropriate for the state given its specific circumstances, it could lead to a fragmented system with gaps in coverage and disruptions in care for people who move from one program to another as their incomes rise or fall.

As states develop legislation this year to establish exchanges and plan for implementation of the ACA's coverage expansions and health insurance market reforms, they should consider whether or not to establish a Basic Health program. This paper describes the Basic Health option, the issues

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[1] Starting in 2014, most individuals under age 65 with incomes up to 138 percent of the poverty line ($15,415 for an individual) will be eligible for Medicaid. Individuals and families who do not qualify for Medicaid and have incomes below 400 percent of the poverty line ($44,680 for an individual) can receive tax credits to help them buy private coverage in the exchanges; those with incomes below 250 percent of the poverty line ($27,925 for an individual) will also be eligible for assistance that reduces their deductible and co-payment charges.

[2] Elisabeth Benjamin and Arianne Slage, "Bridging the Gap: Exploring the Basic Health Option for New York," Community Services Society of New York, revised January 2012.

states should consider in determining whether to adopt it, and the issues on which states urgently need federal guidance in order to fully assess the option and whether it is appropriate for them.

Eligibility and Benefits Under Basic Health

In a state with a Basic Health program, residents with incomes between 138 percent and 200 percent of the poverty line who otherwise would have qualified for premium tax credits in the exchange would receive coverage through a health plan or other managed care system contracting with the state's Basic Health program.[3] Legal immigrants with incomes below 138 percent of the poverty line who do not qualify for Medicaid because they have lived in the United States for less than five years also would be eligible for Basic Health. Individuals who are eligible for Basic Health would *not* receive premium tax credits and cost-sharing reductions for plans purchased through a state's exchange.

Under the ACA, Basic Health plan coverage must be at least as affordable and comprehensive as the coverage that individuals would otherwise have received through the exchange: premiums and cost-sharing charges must be no greater than what these individuals would have faced in the exchange, and the plan must cover at least the essential health benefits that all exchange plans are required to cover.[4] The ACA also requires states to establish a competitive process in contracting with Basic Health plans; this would include the negotiation of premiums and cost-sharing levels, as well as the benefits (if any) that the plans would offer in addition to the essential health benefits.

Federal Funding for State Basic Health Programs

To finance their Basic Health programs, states would receive 95 percent of what the federal government would have spent on premium and cost-sharing reductions for Basic Health enrollees if they had instead bought coverage through the exchange. While the federal government has not indicated the specific methodology it will use to calculate the Basic Health funding for states (as discussed below), the ACA requires that Basic Health payments to states take into account factors such as age, income, health status, type of coverage (individual or family), and geographic differences in health care spending for the individuals who enroll in Basic Health.

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[3] The ACA requires states to expand Medicaid eligibility to cover all non-elderly adults with incomes up to 133 percent of the poverty line. In addition, its rules for determining eligibility require states to disregard 5 percent of an applicant's individual or family income, thus making the effective income-eligibility threshold 138 percent of the poverty line.

[4] The ACA states that cost-sharing for Basic Health enrollees must not exceed the cost-sharing required under a "platinum" plan (one with an actuarial value of 90 percent) for people with incomes up to 150 percent of the poverty line or a "gold" plan (one with an actuarial value of 80 percent) for people with incomes between 150 and 200 percent of the poverty line. In the exchange, however, individuals receiving cost-sharing reductions would actually be enrolled in plans with higher actuarial values: 94 percent if their incomes were below 150 percent of the poverty line and 87 percent if their incomes were between 150 and 200 percent of the poverty line. This appears to be a legislative oversight, since the ACA clearly intended to provide the same actuarial values in Basic Health as in exchange coverage. Moreover, it would not make sense to give states payments resulting from the full value of cost-sharing reductions available to Basic Health enrollees but then permit states to provide coverage that is less comprehensive (i.e., to charge higher deductibles and other cost-sharing) than Basic Health enrollees would receive if they were in the exchange. Accordingly, HHS should require state Basic Health programs to, at a minimum, provide the same actuarial values as would be applied to these individuals in the exchanges.

Federal funds provided for Basic Health must be placed in a state trust fund that the state can use only to pay for Basic Health expenditures. If a state can provide exchange-equivalent coverage through Basic Health for *less* than the federal payments it receives, it must use the leftover federal payments to provide *enhanced* Basic Health coverage, such as by covering more services or reducing premiums and/or cost-sharing charges. States may not use federal Basic Health payments to offset costs in other programs such as Medicaid.

Structure of Basic Health Delivery and Eligibility Systems

There are several ways that a state could structure its Basic Health program. It could build upon existing programs such as Medicaid and CHIP and contract with the same managed care plans that currently serve many of its Medicaid and CHIP beneficiaries, principally children and families. In this case, Basic Health would remain a separate program with a separate financing mechanism and risk pool from that of Medicaid and CHIP, but would leverage the state's existing infrastructure for information technology, contracting, rate setting, and other functions. Alternatively, a state could establish new contracts with private insurers to deliver Basic Health coverage or contract with a different network of providers than those that serve Medicaid and CHIP beneficiaries.[5]

Regardless of the approach a state takes, it must establish a competitive process for contracting with managed care organizations or provider networks. Such a process must include provisions to improve health care quality; for example, the ACA requires states to negotiate with plans to include innovative features such as care coordination and care management, incentives for the use of preventive services, and medical homes. Plans also must report on a number of state-established performance measures that focus on health care quality and outcomes.

The ACA requires states to coordinate Basic Health with other state-run health programs, such as Medicaid and CHIP, in order to maximize efficiency and improve the continuity of care. In particular, the ACA's requirement that states establish a "no wrong door" eligibility system that allows individuals to apply for all forms of coverage for which they are eligible in multiple ways specifically applies to Basic Health as well as to Medicaid, CHIP and subsidized exchange coverage. Basic Health must use the same joint application and eligibility determination processes as the ones that a state uses for Medicaid, CHIP, and premium credits and cost-sharing reductions in the exchange. Similarly, Basic Health, like Medicaid and the exchange, must use electronic verification and seamless transfers of income and other eligibility information between programs.

Issues for States to Consider in Assessing the Basic Health Option

A well-designed Basic Health program could help boost enrollment, retention, and access to care by enabling a state to provide seamless, affordable, high-quality coverage for low-income people. Basic Health could allow states to provide coverage that is more affordable and comprehensive than exchange coverage, to cover all family members through the same plan, and to ease the transition between Medicaid and subsidized exchange coverage. Conversely, however, states will need to

[5] Entities eligible to offer standard health plans under a Basic Health program include a licensed health maintenance organization, a licensed health insurance issuer and a network of health care providers established to offer services under the Basic Health program.

examine whether Basic Health could complicate or fragment the ACA's coverage options or have an adverse impact on the viability of the new exchange. They should also examine whether they have the infrastructure in place to effectively contract with managed care organizations or provider networks as the Basic Health option intends.

Providing More Affordable and Comprehensive Coverage

The chief advantage of Basic Health is its potential to significantly reduce health care costs for people with incomes below 200 percent of the poverty line who would be eligible for premium and cost-sharing subsidies through the exchange, and its potential to better coordinate the provision of care to a family that has some members enrolled in Medicaid and CHIP while other members receive other subsidized coverage.

The premium and cost-sharing subsidies for coverage obtained through the exchanges will go a long way toward making care more affordable for millions of low- and moderate income people. Nevertheless, some individuals and families may still have difficulty paying for care. For example, some parents who are eligible for premium subsidies and have children who are covered through CHIP could have to pay both the premium for their child's CHIP coverage and their share of the premium for subsidized exchange coverage.[6] In addition, some benefits that individuals and families may need may not be covered by their exchange plans.

Through Basic Health, a state could negotiate with health plans to provide less costly, more comprehensive coverage than the subsidized coverage that people would get through the exchanges. Currently, states provide comprehensive coverage with low cost-sharing under Medicaid at a lower cost than employer-sponsored or individual-market insurance plans, due in large part to lower provider payments rates and administrative costs. States could leverage the same purchasing power they now have in Medicaid to similarly negotiate more affordable premium costs and greater benefits under Basic Health. (As discussed below, however, states may have to increase provider payment rates above Medicaid levels to ensure adequate provider networks.)

An actuarial analysis examining the potential impact of Basic Health in California shows how Basic Health could reduce beneficiary premiums and cost-sharing. The analysis found that California could lower individual premium contributions to just $10 to $20 per member per month and lower co-insurance for services to only about 2 to 4 percent — and still have $107 per beneficiary per month left from the Basic Health payment after paying health care costs for beneficiaries..[7] Another analysis found that New York could establish a Basic Health program that would not require individuals and families to pay *any* monthly premiums and would impose much lower cost-sharing charges than health plans in the exchange.[8] By comparison, premium contributions for exchange coverage in New York would be between $20 and $128 per month, with higher deductibles and co-insurance.

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[6] Because CHIP qualifies as minimum essential coverage, children eligible for CHIP would not be eligible for subsidized exchange coverage.

[7] Mercer Health & Benefits LLC, "State of California Financial Feasibility of a Basic Health Program Option," May 12, 2011.

[8] Benjamin and Slage.

These analyses found savings at least in part because they assumed the state would pay providers less than the private insurance rates it would be expected to pay in the exchanges. The California analysis modeled the cost of a Basic Health benefit package using Medi-Cal (Medicaid) provider reimbursement rates, which are substantially lower than prevailing rates in the state's private insurance market. The New York analysis assumed provider reimbursement rates that were somewhat higher than what Medicaid pays but lower than the prevailing private insurance rates. Using Medicaid provider payment rates could affect a state's ability to enlist providers to participate in Basic Health plans and may put additional strain on the current network of participating providers in Medicaid. Thus, if a state elects to establish Basic Health, it would need to take steps to ensure that enrollees have adequate access to the providers and services that they need, such as by paying somewhat higher provider rates than in Medicaid.

Minimizing the Impact of "Churn"

Basic Health could help minimize difficulties that could occur when low-income people transition between Medicaid and subsidized exchange coverage. If a state contracts with the same plans that serve its Medicaid and CHIP enrollees to deliver services under Basic Health, low-income residents could keep the same insurers and providers as they move from one program to another; this could result in more stable coverage and fewer coverage gaps and facilitate continuity of care.

Research shows that over the course of a year, many low-income people experience changes in income and other circumstances that could affect their eligibility for Medicaid or premium credits.[9] These shifts in eligibility and coverage could disrupt care, particularly if there is little overlap in the insurers that participate in Medicaid and those that participate in the exchange and if there are significant differences in the benefits that Medicaid and exchange plans cover. In addition, as discussed below, Medicaid and exchange plans may contract with significantly different provider networks, which could force people to change providers as their eligibility status changes. People who move between Medicaid and subsidized exchange coverage have the added burden of learning about any differences in the plans, provider networks, covered benefits, and cost-sharing charges between the two programs.

Basic Health can help bridge this gap if a state contracts with the same plans and provides similar benefits under Basic Health as in Medicaid. Basic Health and Medicaid would still be separate programs that are financed separately, but a state could design its Basic Health program to look like Medicaid. Massachusetts's health reform system offers a model: the state contracts with its Medicaid managed care plans to provide services under Commonwealth Care, a subsidized health insurance program for low- and moderate-income residents who do not have coverage and are not eligible for Medicaid.[10] Thus, the provider networks and benefits under Commonwealth Care are very similar to those in Medicaid. Premiums and cost-sharing in Commonwealth Care are based on an individual's income, but people with incomes below the poverty line do not have to pay premiums and face very low cost-sharing for most services, similar to Medicaid.

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[9] Benjamin Sommers and Sarah Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," *Health Affairs,* February 2011.

[10] Initially, the state only contracted with four Medicaid managed care plans in the state to provide services under Commonwealth Care. It has since opened up contracting to other plans, but only one non-Medicaid plan has joined.

To be sure, Basic Health would not eliminate churn between programs. People enrolled in Basic Health whose income rose above 200 percent of the poverty line would still experience a transition as they move into exchange coverage. With or without Basic Health, a state would need to take steps to smooth the transition to the exchange.[11]

Keeping Families in the Same Plan with the Same Provider Networks

Navigating the health care system already poses challenges for many people. Among other things, individuals have to find a doctor who will accept their insurance, determine what services their insurer covers, and figure out the cost-sharing for particular services. Understanding the intricacies of the health care system is even more difficult for parents whose children have a different insurer than they do. When health reform is implemented, many families will consist of children eligible for Medicaid or CHIP and parents eligible for premium credits, with the children and parents likely covered by different health plans that may use different provider networks.

If a state takes up Basic Health, however, it could provide Medicaid, CHIP, and Basic Health coverage through the same plans and keep families together (at least for families up to 200 percent of the poverty line). Research shows that enrolling parents and children together not only increases participation among eligible families but also improves access to care.[12]

States can establish an exchange that includes insurers who also participate in their Medicaid managed care programs and maintain the same provider networks. Indeed, all states, regardless of whether they take up Basic Health, should strive to do so to ensure better continuity of care. However, Basic Health gives states more flexibility to contract with Medicaid managed care plans, which would enhance their ability to ensure plan continuity with Medicaid. For example, some Medicaid plans are not licensed insurers in a given state, and all plans offered through the exchange must have such licensing. The requirement for licensure, however, would not apply to Basic Health, so states would have more flexibility to contract with Medicaid plans and maintain some continuity.

Coordination with Other Health Care Subsidy Programs

In determining the structure for delivering Basic Health benefits, states will have to consider how to ensure seamless coverage transitions between Medicaid, Basic Health, and subsidized exchange coverage. States that do not effectively coordinate Basic Health with other subsidized health care programs risk ending up with a more fragmented system (by virtue of adding yet another coverage option), with gaps in coverage and disruptions in care for some people who move from one program to another as their incomes change. This, in turn, could result in weaker coverage and a more complex system.

For example, if the managed care plans serving Medicaid and CHIP are completely different from the ones serving Basic Health, parents in a family receiving Medicaid whose income rises to 150 percent of the poverty line would become eligible for Basic Health and would have to switch insurers and most likely providers. Depending on the state's income eligibility level for CHIP, if

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[11] Sara Rosenbaum and Trish Riley, "Building a Relationship Between Medicaid, the Exchange and the Individual Insurance Market," National Academy for Social Insurance, January 2012.

[12] Leighton Ku and Matthew Broaddus, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities, October 20, 2006.

family income increased again to just over 200 percent of the poverty line, the entire family would then be eligible for premium credits in the exchange; if the managed care plans serving Basic Health did not offer products in the exchange, the family likely would have to switch insurers and providers again. For the sake of the beneficiaries, it will be important to avoid such fragmentation.

Overlap in the plans that serve Medicaid, CHIP, Basic Health, and the individual-exchange market could mitigate the impact of changes in eligibility for the various subsidized coverage programs. If at least one insurer offered a Medicaid, CHIP, Basic Health, *and* exchange product, individuals would not necessarily have to switch insurers and providers when they transition from one program to another. (There is a concern, however, that because such plans tend to serve more low-income people who tend to have poorer health, they may experience "adverse selection" if their enrollees end up being in poorer health than those in other exchange plans. Risk adjustment is imperfect and thus may not fully compensate such plans for the higher risk they may experience.)

Regardless, the ACA requires states to have an established infrastructure to support individuals and families as they transition between Medicaid, CHIP, Basic Health, and exchange coverage. In addition to having plan continuity, states must educate beneficiaries about the differences between coverage in these programs, as well as how to navigate the eligibility, enrollment, and transition process.

Impact on Risk Pooling in the Exchange

One area of concern about Basic Health is that it might weaken the exchange's ability to effectively pool risk. If a state provides coverage to individuals with incomes between 138 percent and 200 percent of the poverty line through Basic Health, fewer people will obtain coverage in the exchange, which could make it more difficult to pool risk effectively. If a significant portion of the premium subsidy-eligible population has income below 200 percent of the poverty line and thus obtains coverage through Basic Health rather than the exchange, the exchange might be of insufficient size and less likely to have a stable risk pool.

States will also need to compare the expected health and demographic characteristics of those who would be eligible for Basic Health with the characteristics of those who would remain in the exchange. For example, because people in the lower income ranges receive greater subsidies, low-income individuals who are healthier than average are probably more likely to sign up for Basic Health than the rest of the subsidy-eligible population is likely to sign up for exchange coverage. Thus, if Basic Health enrollees would be younger and healthier than exchange enrollees, on average, creating a separate Basic Health program could lead to higher premiums in the exchange because the exchange would have a sicker pool than it would otherwise have. This, in turn, could discourage participation and make the exchange less viable.

At the same time, however, lower-income people tend to be somewhat less healthy than people with higher incomes, in which case shifting them from the exchange to Basic Health might result in a healthier risk pool for the exchange. It is difficult to predict how Basic Health will affect the risk pool of the exchange, so each state will need to conduct its own analysis of this issue.

State Managed Care Infrastructure

Another area of consideration is the state's experience in delivering Medicaid and CHIP services through managed care. A state that already uses managed care organizations and other provider networks extensively to serve Medicaid beneficiaries could build on this infrastructure for its Basic Health contracts. This could create administrative efficiencies, as the state would not have to set up completely new processes and systems for contracting with and monitoring Basic Health plans. It would likely be difficult to establish a Basic Health program in a state that has little or no managed care and relies heavily on fee-for-service to deliver Medicaid services.

However, it would only make sense to build on a state's current Medicaid managed care infrastructure if it is strong and effective. A strong mechanism for overseeing plans is important to prevent marketing abuses and miscommunication and ensure that care is delivered effectively and efficiently. If a state lacks robust standards for beneficiary access and quality and lacks mechanisms for monitoring plan performance and ensuring that plans comply with the terms of their contracts with Medicaid, its Medicaid managed care program will not serve as a good foundation for Basic Health.

Urgent Need for Federal Guidance on Basic Health

To assess appropriately whether to establish a Basic Health program, states need guidance from the federal government on some key issues. This guidance is particularly urgent considering that states will likely have to consider whether to adopt Basic Health *this year,* as they move forward on legislation to establish exchanges and other health reform implementation issues.

Design of the Basic Health Payment Methodology

The key uncertainty for states deciding whether to take up the Basic Health option is how the federal government will calculate its payments to support the program (and what those payments will be). States understandably want to minimize the risk that the cost of providing benefits under Basic Health may exceed the federal funding they receive. States also want to evaluate the extent to which their residents would benefit from the option. Thus, states need more information on the payment methodology that the federal government will use in order to be able to assess the fiscal impact of Basic Health and what kind of benefits they will be able to offer, as well as to what extent Basic Health might enable them to reduce individuals' premium and cost-sharing obligations.

The ACA directs the Secretary of Health and Human Services (HHS) to determine a payment methodology that takes into account "all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided" to individuals in the exchange, including age, income, geographic differences in costs, health status, and "whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled." (See below for more on this last issue.) Developing such a methodology will be challenging, given that we know little about who will participate in the health insurance affordability programs in 2014, the amount of premium credits and cost-sharing reductions that would go to residents in a state, and the impact of the ACA's health insurance market reforms on premium costs relative to current market conditions.

Nevertheless, credible methods exist or can be developed to reasonably and accurately estimate Basic Health payment amounts in lieu of actual experience with state operation of these programs, and various analyses already conducted on Basic Health can inform the development of the federal methodology. For example, the Urban Institute has produced such estimates for every state, using a microsimulation model and a standard set of assumptions about premium costs that could serve as a guide.[13] In addition, as noted above, consulting and policy organizations in California and New York have attempted to estimate the Basic Health payments that could be available to their states.[14]

One aspect of the payment methodology where there seems to be confusion is whether the payments for a particular enrollee would be subject to reconciliation should that individual's income change during the year. In other words, if a person's income for the year as a whole turned out to be greater than the person's annualized rate of income in the period during which he or she received Basic Health coverage, would the federal government recoup the payments that the state received to cover that individual (since the person would have been entitled to a smaller premium credit if the state had not taken up the Basic Health option)?[15] If year-end reconciliation adjustments that result from changes in income over the year will be made on an individual basis, it would create uncertainty for states regarding the amount of the payments they would receive.

While the ACA states that the payment rate should be determined on a "per enrollee" basis, Congress did not intend that states actually determine whether each enrollee's annual income made him or her ineligible for Basic Health for some months of the year. The relevant ACA provision makes clear that Congress intended the HHS Secretary to develop a "per member per month" payment approach similar to that developed for managed care. The determination of the payment rate would, *in the aggregate,* take into account income volatility, along with age, gender, health status, and other factors. Under this methodology, the per-member-per-month rate would factor in income volatility averaged across enrollees in Basic Health and eliminate the need for reconciliation at the individual participant level once the rate is determined.

States are understandably concerned about the potential to have to "pay back" the federal government. Thus, the guidance should provide clarification on this issue and indicate that such repayment will not be required.

Use of Basic Health Funds for Administration

Another related issue is whether states would be allowed to use Basic Health funding for administrative costs. HHS has said that states may use exchange planning grant dollars to analyze the feasibility of Basic Health but may not use exchange establishment grant dollars to help establish

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[13] Stan Dorn, Matthew Buettgens, and Caitlin Carroll, "Using the Basic Health Program to Make Coverage More Affordable to Low-income Households: A Promising Approach for Many States," The Urban Institute, September 2011.

[14] See Mercer Inc., "State of California, Financial Feasibility of a Basic Health Program," California Health Care Foundation, June 28, 2011; Elisabeth Benjamin and Arianne Slagle, "Bridging the Gap: Exploring the Basic Health Insurance Option for New York," Community Service Society, June 2011.

[15] The reconciliation issue was raised in an analysis of the potential impact of Basic Health in California. Rick Curtis and Ed Neuschler, "Income Volatility Creates Uncertainty About the State Fiscal Impact of a Basic Health Program (BHP) in California," Institute for Health Policy Solutions, September 2, 2011.

the program.[16] More clarification is needed, however, on whether federal funds can be used for ongoing administration once a program is launched. If states cannot get reimbursed for the costs of administering Basic Health, very few will likely take up the option, which will limit the value of the Basic Health provision.

The ACA provides only that states shall deposit all funds for Basic Health in a trust fund and that the "amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals." Clearly, what Congress intended here is that states use the funds for Basic Health, not for other programs. Allowing a modest amount for administrative costs would be fully consistent with this purpose and is likely to be necessary to make Basic Health a viable option for states, as the ACA intends.

HHS could allow states to use Basic Health funding for administrative costs using a method similar to the CHIP methodology, which allows a state to receive matching funds for its administrative costs but limits administrative spending to 10 percent of the state's total CHIP expenditures on health insurance coverage. For Basic Health, a 5 percent cap is likely to be appropriate and is consistent with the level of spending on administrative costs in the Medicaid and CHIP programs.

Conclusion

Basic Health has the potential — if a state designs it well — to provide more comprehensive coverage at lower cost to low-income individuals, allow all members of a family to receive coverage under the same plan even if they qualify for different subsidized coverage programs, and mitigate the impact of transitioning between Medicaid and subsidized exchange coverage because of changes in income and other circumstances. By releasing guidance on Basic Health as soon as possible, the federal government can enable states to determine whether establishing Basic Health is appropriate for them and their residents.

[16] Centers for Medicare & Medicaid Services, "State Exchange Implementation Questions and Answers," November 29, 2011.