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Health Policy Brief

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Health Insurance Exchanges and State Decisions. Exchanges must be ready to begin enrolling people by October 2013. How is each state preparing?

WHAT'S THE ISSUE?

The Affordable Care Act (ACA) established health insurance exchanges—also known as "marketplaces"—in each state as a cornerstone of its health coverage expansion and insurance-market reforms. Exchanges will serve as portals through which individuals and small businesses can compare and purchase private health plans that have been "certified" as meeting federal and state standards. Exchanges will also allow individuals with low-to-moderate incomes to access public coverage programs, such as Medicaid and the Children's Health Insurance Program, or financial assistance to purchase private coverage. Certain small businesses also will be able to access tax credits for employee coverage through exchanges. According to the Congressional Budget Office, an estimated 9 million people will enroll in coverage through individual and small-business exchanges in 2014, increasing to 29 million by 2022.

Under the Affordable Care Act, states may establish and run the exchange in their state, or they may defer responsibility to the federal government. Since the law was enacted, the Department of Health and Human Services (HHS) has created multiple variations of these two options that provide greater flexibility to states to take on responsibility for some, but not all, functions.

By January 1, 2014, all states must have an operational individual and small-business exchange, regardless of whether it is run by the state or the federal government. In practice, exchanges are supposed to be ready by October 1, 2013, the start of the initial open-enrollment period. Although all exchanges will be built off a common framework set by the Affordable Care Act, the design and operation of exchanges is expected to vary substantially among states because of the flexibility states have been given.

WHAT'S THE BACKGROUND?

The attempt to implement exchanges nationwide—along with the Affordable Care Act's broader private insurance-market reforms, Medicaid expansion, and their integration—is unprecedented in our nation's health care system, raising many previously unsolved operational and regulatory questions. Policy experts have noted that previous state or local efforts to establish health insurance exchanges have been stymied by problems such as low enrollment and adverse selection (which is the disproportionate enrollment of sicker, higher-cost individuals, leading to ever-increasing premiums and further discouraging enrollment by lower-cost individuals). To be successful, the Affordable Care Act exchanges must avoid these problems and overcome new challenges, such as the development of first-generation information technology systems that can carry out the law's specifications.

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WHAT'S IN THE LAW?

ORIGINAL ACA OPTIONS: STATE-BASED EXCHANGE OR FEDERALLY FACILITATED EXCHANGE: The Affordable Care Act envisioned that states would either establish a state-based exchange or default to a federally run exchange. In either case, the state or the federal government would take responsibility for implementing core exchange functions: eligibility and enrollment; plan management; consumer assistance, outreach, and education; and financial management. (For more information on core exchange functions, see previous Health Policy Briefs on federally facilitated exchanges, published on January 31, 2013, and on the Small Business Health Options Program [SHOP] exchanges, published on February 9, 2012.)

To ensure that all states would have an operational exchange by January 1, 2014, the law required the secretary of HHS to determine whether a state had taken sufficient action to establish an exchange by January 1, 2013. Any state that did not do so would default to a federally facilitated exchange. To encourage and assist states in setting up their own exchanges, the law included an open appropriation for exchange planning and establishment grants to states (see Exhibit 1 for more key milestones in exchange development).

Initially, 17 states and the District of Columbia gained conditional approval from HHS to run a state-based exchange in 2014, but one of these states, Utah, later obtained approval for a "bifurcated" approach in which the federal government will run the individual exchange, while the state will run its small-business exchange. Thirty-three states opted for some variant of a federally facilitated exchange, as discussed below.

The Affordable Care Act also gave states the option to join with other states to create regional, or multistate, exchanges or to create more than one exchange serving different parts of their state. As of this writing, no state had elected this option. Although as noted in a recent National Academy for State Health Policy study, some states have explored opportunities to share certain exchange functions, such as marketing, information technology, or data collection, in the future.

REGULATORY FLEXIBILITY: ADDITIONAL EXCHANGE ESTABLISHMENT OPTIONS: Since the ACA's enactment, regulations and guidance have moved away from the basic state-federal divide presented in the law and unfurled a continuum of options for dividing responsibility for core exchange functions (see Exhibit 2 for an overview of exchange models). For instance, in a state-based exchange, a state is responsible for all core exchange functions, yet it may use federal services to assist with certain activities, such as determining eligibility for federal financial assistance. On the other hand, in operating federally facilitated exchanges, HHS has stated that it will rely on certain reviews traditionally conducted by states—such as reviews of premium rates and network adequacy—when determining whether to certify health plans for participation.

In addition, the federal government has created distinct variations of state-based and federally facilitated exchanges that offer states even greater flexibility to pick and choose which functions they want to take on. In large part, these variations reflect attempts to respond to states' practical and political needs

EXHIBIT 1

Key Milestones In Health Insurance Exchange Development

Date	Milestone
March 23, 2010	Affordable Care Act enacted
September 1, 2010	Opportunity to apply for exchange planning grants announced
January 20, 2011	Opportunity to apply for exchange establishment grants announced
March 27, 2012	Final rule on exchange establishment published
May 16, 2012	General guidance on federally facilitated exchanges released
November 16, 2012	Initial application and Blueprint submission deadline for state-based and state partnership exchanges
December 14, 2012	Revised application and Blueprint submission deadline for state-based exchanges
January 1, 2013	Approval deadline for state-based exchanges
January 3, 2013	Guidance on state partnership exchanges released
February 15, 2013	Revised application and Blueprint submission deadline for state partnership exchanges
February 20, 2013	Marketplace plan management option announced
March 1, 2013	Approval deadline for state partnership exchanges
May 10, 2013	Bifurcated exchange model announced
June 19, 2013	Proposed rule codifying bifurcated exchange model published
October 1, 2013	Initial exchange open-enrollment period begins
January 1, 2014	Exchange coverage effective
October 15, 2014	Last opportunity for states to apply for exchange establishment grants

SOURCE Authors' analysis.

and to minimize federal duplication of state activities.

• **State partnership exchange.** In proposed regulations issued in July 2011, HHS announced a variant of the federally facilitated exchange known as the state partnership exchange. As later guidance detailed, in a state partnership exchange, the state can elect to conduct certain plan management functions, consumer assistance functions, or both. Plan management functions include recommending health plans for certification to the federally facilitated exchange and conducting health plan oversight and monitoring. Consumer assistance functions include conducting outreach and education and running an "in-person assistance" program, while the federal government runs a "navigator" program, call center, and exchange website.

States interested in pursuing a state partnership exchange were asked to submit a declaration letter and "Blueprint" application by February 15, 2013—two months after applications were due for state-based exchanges. In providing states with the option to enter into a state partnership exchange, HHS was clear in its intent that states could use this model as a "stepping stone" to a state-based exchange in the future. For 2014, 7 of the 33 states with federally facilitated exchanges opted to pursue a state partnership exchange to conduct plan management or consumer assistance functions, or both.

• **Marketplace plan management exchange.** Following the deadlines for states to submit applications to operate a state-based or state partnership exchange, HHS released guidance allowing states to pursue a second variant of the federally facilitated exchange, referred to as the marketplace plan management. Under this option, states can conduct the same plan management functions as a state partnership exchange, while the federal government operates remaining core exchange functions.

HHS required states wishing to pursue this option to submit a letter indicating their interest in doing so and attesting to their capability to perform the same plan management functions as are required for the state partnership exchange, but HHS did not require states to submit a Blueprint application. Although no deadline was given, the Government Accountability Office (GAO) reported that April 1, 2013, was a "natural" deadline for states to choose the marketplace plan management option because insurers interested in participating in exchanges had to submit certain health plan data to either the state or the federal government by that date. For 2014 seven states chose to pursue the marketplace plan management variant of the federal exchange.

• **Bifurcated exchange.** In response to a request from Utah, HHS published a regulation on June 19, 2013, allowing states to pursue a bifurcated approach in which the state runs the small-business exchange, while the federal government runs the individual exchange, noting that "there could be several types of exchanges operating in a state."

In recognition of the limited amount of time before open enrollment begins, only states that have been conditionally approved to operate state-based exchanges can pursue this option for 2014. Any state can submit an application to operate a small business–only exchange for 2015 or later. Utah—the only

EXHIBIT 2

Overview of Exchange Models, June 2013

Exchange model	Exchange activity	Number of states	States
State-based exchange	State operates all core exchange functions; may use federal services for certain exchange functions	14 states and Washington, DC	CA, CO, CT, DC, HI, KY, MD, MA, MN, NV, NY, OR, RI, VT, WA
Supported state-based exchange	State operates most core exchange functions; uses federal information technology infrastructure	2 states	ID, NM
Federally facilitated exchange	Federal government operates all core exchange functions	19 states	AL, AK, AZ, FL, GA, IN, LA, MS, MO, NJ, NC, ND, OK, PA, SC, TN, TX, WI, WY
Variant 1: state partnership exchange	State conducts plan management and/or consumer assistance, outreach, and education functions on behalf of federal government; federal government operates remaining core exchange functions	7 states	AR, DE, IL, IA, MI, NH, WV
Variant 2: marketplace plan management	State conducts plan management on behalf of federal government; federal government operates remaining core exchange functions	7 states	KS, ME, MT, NE, OH, SD, VA
Bifurcated exchange	State operates all core exchange functions for small-business exchanges and conducts plan management on behalf of federal government for individual exchange; federal government operates remaining core exchange functions for individual exchange	1 state	UT

SOURCE Authors' analysis.

state pursuing this option to date—will also conduct plan management for the individual exchange.

• **Supported state-based exchange.** As of this writing, two state-based exchanges—Idaho and New Mexico—have announced that they will initially use the federal information technology infrastructure to support their individual or small-business exchanges, or both, while they develop their own technology platforms. GAO has also reported that the federal government would provide extra assistance to state-based and state partnership exchanges as needed to carry out required activities, but that such states would retain their status as state-based or state partnership exchanges. Although no formal guidance outlining this option has been issued, the two states have used the term *supported state-based exchange* to describe this option.

29 million

Exchange enrollees
According to the Congressional Budget Office, an estimated 29 million people will enroll in coverage through individual and small-business exchanges by 2022.

WHAT'S THE DEBATE?

HOW STATES DECIDED ON EXCHANGE ESTABLISHMENT: The respective roles of the states and federal government in establishing exchanges were a central point of debate during the drafting of the Affordable Care Act. The House health reform bill called for a single federal exchange with a provision allowing states to opt out and run their own exchange, while the Senate bill—which ultimately became law—created an "opt-in" model, deferring states to choose whether to establish an exchange.

As a result, following enactment of the Affordable Care Act, the exchange establishment debate shifted to the states. Despite holding different viewpoints on the merits of the Affordable Care Act itself, every state took one or more steps to analyze options for exchange establishment, including applying for federal exchange planning funding; convening working groups to evaluate options; soliciting public input through surveys, forums, or other mechanisms; or relying on private or public consultants to help them decide on a course of action. The inherently political environment in which states made their decisions, along with compressed time frames for implementation, led some states to change course during the process. Some states initially planned for a state-based exchange but ultimately defaulted to a federally facilitated exchange, or opted for one of its variants.

WHAT'S AT STAKE IN DIFFERENT EXCHANGE MODELS? States considered a range of practical issues when deciding on their level of involvement in creating and running exchanges, including the anticipated level of flexibility they would be given in designing their exchanges; their ability to maintain control over their insurance markets and tailor consumer outreach and assistance to their populations; the ability of the exchange to coordinate with other state agencies and the federal government; and funding and resource constraints.

• **Regulatory flexibility and guidance.** Although proponents of state-based exchanges felt that this option afforded them the greatest level of flexibility to design an exchange tailored to the needs of their consumers, critics argued that the Affordable Care Act included so many constraints that states would not truly have control over their exchanges. In addition, states had to contend with the fact that regulatory guidance was not always available in time to answer critical design questions. Some states felt frustrated that they could not move forward without timely answers, although others felt that this dynamic gave them additional flexibility to design their own solutions.

• **Control over insurance markets.** Depending on the model they have chosen, states, which have traditionally regulated insurance, will have varying levels of control over the health plans offered through the exchange in their state. State-based exchanges have full control over plan management within the exchange, including final responsibility for certifying plans in the exchange.

The federal government will remain responsible for certifying health plans for federally facilitated exchanges, although states conducting plan management activities through the state partnership and marketplace plan management models will recommend health plans for certification. States with a greater degree of involvement in plan management for their exchange may find it easier to conduct consistent oversight of health plans offered inside and outside the exchanges, which can help prevent adverse selection and ensure that consumer protections are evenly applied.

• **Consumer outreach and enrollment.** States operating their own exchanges have full responsibility for running the consumer assistance functions of their exchanges, including establishing a web portal, call center, and navigator program to help people find and

"By January 1, 2014, all states must have an operational individual and small-business exchange."

$2 billion

GAO estimates approximately $2 billion is needed to establish and operate the federally facilitated exchanges in 2014.

enroll in public or private coverage. In federally facilitated exchanges, the federal government will be responsible for conducting these functions. However, states with state-based exchanges and state partnership exchanges also may choose to use federal funds to establish in-person assistance programs to supplement their navigator programs, which cannot be fully funded by exchange establishment grants—thus helping to ensure that there will be enough assisters to help people enroll in coverage.

Consumer assistance will be more limited in states with federally facilitated exchanges, as these states must rely on a limited federal funding stream for grants to navigators and will not have in-person assistance programs to supplement the work. Many states felt that operating a state-based exchange provided the best opportunity to tailor consumer assistance functions to their populations, with state partnership exchanges offering the next-highest degree of control over these programs.

• **Coordination.** The Affordable Care Act requires an unprecedented degree of coordination and integration between state departments of insurance, exchanges, state Medicaid agencies, and the federal government. For example, significant coordination, including the integration of Medicaid and exchange information technology systems, will be necessary to ensure that consumers can seamlessly enroll in either public or private coverage through the exchange. At the same time, consistent oversight of health plans offering coverage inside and outside the exchange will require collaboration between exchanges and state departments of insurance.

States operating their own exchanges may find such collaboration easier to manage within the state, although states with federally facilitated exchanges may experience greater difficulty establishing the necessary integration between state departments of insurance and Medicaid agencies and the federally facilitated exchange, as illustrated in a recent Urban Institute case study of state roles in federally facilitated exchanges. Ultimately, poor coordination between these entities could lead to consumers "falling through the cracks" and not being enrolled into coverage or to inconsistent regulation of insurers inside and outside the exchange, potentially increasing the risk of adverse selection.

• **Funding and resources.** According to the Kaiser Family Foundation and GAO, states to date have been awarded over $3.6 billion in federal funds to plan for and establish exchanges. Although the Affordable Care Act included an open-ended funding stream for exchange establishment grants to the states until December 31, 2014, this funding proved to be a necessary but not sufficient incentive for states to establish state-based or state partnership exchanges.

Some officials raised concerns that exchange operation might become a financial burden on states once federal funding is no longer available, and some states have run into barriers drawing down federal exchange establishment funds because of political opposition. Although according to GAO, 13 states that defaulted to a federally facilitated exchange ultimately turned down or returned all or part of their grant awards.

States that are not running their own exchange in 2014 may still use federal funds for certain exchange activities or to prepare to take on more exchange responsibilities in the future. Meanwhile, the Affordable Care Act provided only limited funding to the federal government for implementation of the federally facilitated exchange and the law's other provisions.

GAO estimates that approximately $2 billion is needed to establish and operate the federally facilitated exchanges in 2014, with only an estimated $450 million provided through exchange user fees. However, whether or not Congress will appropriate additional implementation funds to HHS and other implementing agencies remains a question. Limited federal implementation funding has led to concerns that resources for certain critical activities, such as the navigator program, remain inadequate.

WHAT'S NEXT?

Consumers can get coverage effective as soon as January 1, 2014, with the first open-enrollment period slated to run from October 1, 2013, to March 31, 2014. A recent Commonwealth Fund study demonstrates that states have made substantial progress in designing their exchanges to date; however, certain policy and operational decisions remain to be made.

Although GAO and others have questioned exchanges' ability to be fully operational in

time for open enrollment, particularly given the compressed time frame in which exchanges and supporting infrastructure are being developed, HHS maintains that exchanges will be ready on time. Key milestones to be completed in the months before open enrollment include testing state and federal information technology systems, certifying plans, and training and certifying navigators and in-person assisters.

A number of factors will affect the initial and long-term success of exchanges, including the extent to which consumers are aware of the exchange, receive help determining their eligibility for and enrolling in appropriate health coverage, and find exchange coverage affordable. Other key factors will be SHOP exchanges' ability to add value for small employers, the extent of insurer participation, and the success of state and federal efforts to limit adverse selection.

The substantial flexibility afforded to states throughout the implementation process, along with state-specific factors, such as rates of uninsurance and market dynamics, is likely to lead to variability among states in both exchange design and outcomes, even among states with the same model. It will be critical to watch how differences in state decisions impact insurance markets and, ultimately, consumers' access to adequate, affordable health care.■

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