FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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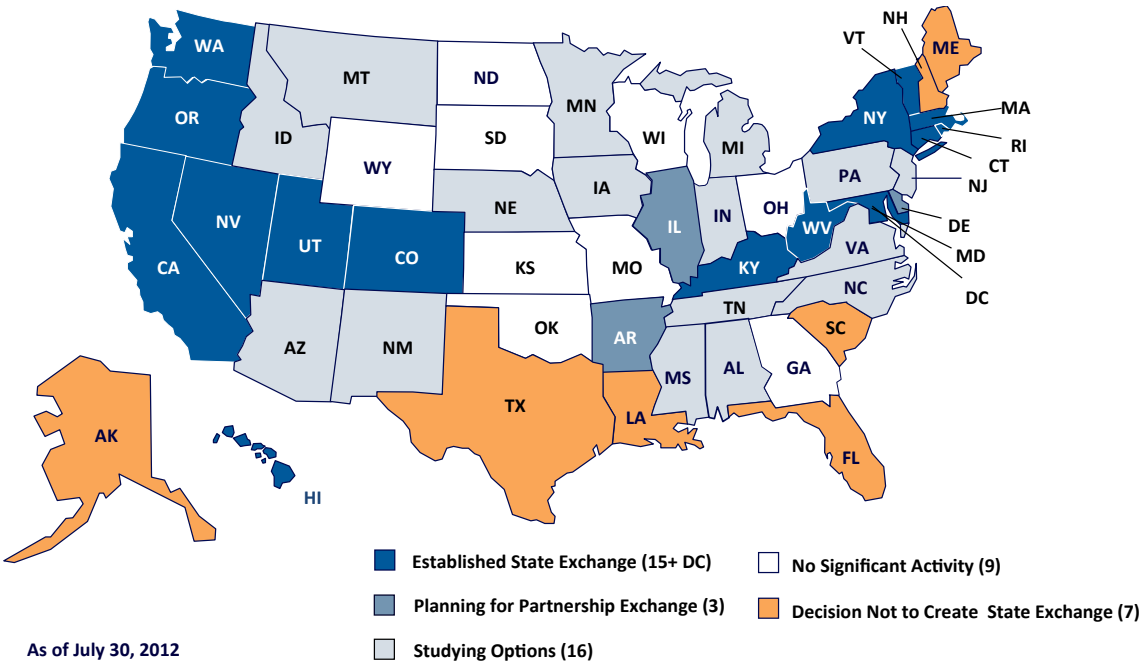
# Establishing Health Insurance Exchanges: An Overview of State Efforts

Following the Supreme Court's decision to uphold the Affordable Care Act (ACA) and preserve the individual mandate, state-based health insurance exchanges remain a key component of the ACA. Exchanges will be the mechanism through which millions of low and moderate-income individuals receive premium and cost-sharing subsidies to make private health coverage more affordable and where employees of small businesses will be able to purchase coverage. States can elect to build a fully state-based exchange, enter into a state-federal partnership exchange, or default into a federally-facilitated exchange. Exchanges are required to be fully operational in every state by January 1, 2014, and their readiness will be evaluated by the federal Department of Health and Human Services (HHS) one year prior to opening. States planning to operate a state-based exchange or a state-federal partnership exchange are required to submit an exchange blueprint consisting of a declaration letter signed by the Governor and an application to HHS by November 16, 2012. Given these fast approaching deadlines and that most states' legislative sessions have come to a close, states face serious challenges to making the necessary policy and implementation decisions.

## State Action Toward Creating Health Insurance Exchanges




To date, 15 states plus the District of Columbia have established state-based exchanges. Of those, three have done so via executive order: Rhode Island, New York, and Kentucky. The majority of states with established exchanges have appointed Boards, hired staff, and solicited subcontractors to begin planning and building exchange infrastructure. These states are also tackling a growing number of policy decisions such as defining their contracting relationship with qualified health plans, the size of their small-business exchange, and their exchange's financing structure.

As of July 30, 2012, three states, Arkansas, Delaware, and Illinois, are planning to pursue a state-federal partnership exchange. A state opting for a partnership exchange can choose to operate plan management functions, consumer assistance functions, or both, leaving the federal government to assume responsibility for all other exchange components in the state. While only a few states have committed to a partnership exchange to date, this option may become an increasingly viable strategy for states that have delayed establishing an exchange. Additionally, states with small populations, such as Montana and Wyoming, are considering the partnership model because it would allow the state to benefit from the economies of scale that arise from sharing costs and resources with the federal government. States that are not ready to run a fully state-based exchange beginning in 2014 may transition from a partnership exchange to a state-based exchange at a later date.

To date, seven states have declared that they will not create a state-based exchange. Louisiana's Governor made the announcement over a year ago. In April 2012, Maine's Governor made clear the state would not pursue a state-based exchange in a letter to HHS. In June 2012, New Hampshire's Governor signed a law prohibiting the state from participating in or enabling a state-based exchange. The Governors of Texas, Florida, South Carolina, and Alaska made their decisions public soon after the Supreme Court's ruling on the ACA. For the most part, these states had not invested in the exchange planning process prior to the announcement.

Another 16 states have not yet committed to a health insurance exchange strategy, but are continuing planning efforts. Some state officials continue to evaluate the policy options related to a state-based exchange in the absence of legislation. For example, in Minnesota, where there are numerous working groups and an exchange task force investigating key decisions, the Governor submitted a letter to HHS in July 2012, declaring the state's intent to continue the planning and development of a state-based exchange. States may consider calling a special legislative session to pass exchange establishment legislation. Other states, such as Alabama and Arizona have considered the use of an executive order or other non-legislative strategies to establish an exchange. Additionally, two states have taken steps to implement a state-based exchange using an existing government entity as an anchor. Specifically, Mississippi is utilizing an existing non-profit high risk pool association created in 1991, while New Mexico began building a state-based exchange using the New Mexico Health Insurance Alliance authorized by the legislature in 1994.

Nine states have not shown significant exchange planning activity. Some of these states made progress in 2011, but ended their exchange planning efforts in the face of increasing political pressure. Planning initiatives in Kansas, Oklahoma, and Wisconsin were halted earlier this year to await the outcomes of the Supreme Court ruling and the November elections. Given the federal timetable for implementation, states with little planning activity to date face an increasing likelihood of defaulting to a federally-facilitated exchange.

## Key Design Areas

As states proceed with establishing their exchanges, they have made a growing number of important decisions, including how their exchanges will be structured, how they will be governed, and how they will contract with qualified health plans (QHPs). Many states have weighed their options on whether to structure their exchange within an existing or new state agency, as an independent public entity, or as a non-profit. While an exchange based within a state agency can leverage established administrative systems and procedures, a quasi-governmental or non-profit exchange may be more insulated from political influence or particular interest groups.[1] All exchanges established with some independence from state government, must have a clearly-defined governing board overseen by the state.[2]

Almost every state with an established exchange has created an independent governing Board responsible for planning and operating the exchange. Board members often represent both stakeholders and subject matter experts in an attempt to balance the political interests and management skills needed to operate an exchange.[3] Only West Virginia and Kentucky have yet to appoint their Board members. Deciding whether to allow

representatives of insurers and brokers to serve on the Board has been a contentious issue in some states. Nearly all states included conflict of interest provisions for Board members in the legislation that establishes the exchanges, though some, like Maryland and California, are more restrictive than others.

Another important consideration for states has been defining the contracting relationship between the exchange and participating QHPs. States can opt to require the exchange to contract with all QHPs which meet specified criteria, commonly referred to as the clearinghouse model. Alternatively, states can require the exchange to be an active purchaser and selectively contract with only certain QHPs, possibly to achieve stated goals around plan choice, quality or value.[4] Typically, states with active purchaser exchanges have prohibited industry representation on their Boards so as to restrict those with financial interests in the exchange from gaining an unfair advantage over competitors.[5]

**TABLE 1: Key Characteristics of Established State Exchanges**

| State | Structure of Exchange | Contracting Type of Exchange | Governance |
|---|---|---|---|
| California | Quasi-governmental | Active purchaser | 5-member Board |
| Colorado | Quasi-governmental | Clearinghouse | 12-member Board |
| Connecticut | Quasi-governmental | Active purchaser | 14-member Board |
| District of Columbia | Quasi-governmental | Active purchaser | 11-member Board |
| Hawaii | Non-profit | Clearinghouse | 15-member Board |
| Kentucky | Operated by State | Not addressed | 11-member Board |
| Maryland | Quasi-governmental | To be decided by the Board | 9-member Board |
| Massachusetts | Quasi-governmental | Active purchaser | 11-member Board |
| Nevada | Quasi-governmental | Not addressed | 10-member Board |
| New York | Operated by State | Not addressed | NA[6] |
| Oregon | Quasi-governmental | Active purchaser | 9-member Board |
| Rhode Island | Operated by State | Active purchaser | 13-member Board |
| Utah | Operated by State | Clearinghouse | NA[7] |
| Vermont | Operated by State | Active purchaser | 5-member Board |
| Washington | Quasi-governmental | Not addressed | 11-member Board |
| West Virginia | Operated by State | Not addressed | 10-member Board |

Over the past year, many states with established exchanges have advanced their planning and decision-making into different policy arenas. As HHS' deadlines near, more states have begun to address issues related to consumer assistance and outreach strategies, information technology systems design, and exchange financing.

### *Consumer Assistance and Outreach*

The ACA and related federal rules require state exchanges to allow consumers to apply for and enroll in coverage online, in person, by phone, fax, or mail. In addition, the exchanges must ensure consumers can acquire linguistically and culturally appropriate assistance and information. To do this, states must provide access to telephone call centers, build a website with information about insurance options and application assistance, and create a Navigator program to improve public awareness and facilitate enrollment. States have flexibility when constructing the Navigator program and can utilize community groups, professional associations, unions, and/or licensed brokers and agents. Multiple states have created stakeholder groups or procured subcontractor assistance to explore Navigator options related to training, certification, and staffing. Recently, Maine, Vermont, and Maryland passed legislation allowing insurance brokers to act as Navigators in their states. In addition, Maryland will create separate Navigator programs for the small-group and individual markets with different licensing and certification procedures.

### *Information Technology (IT)*

The ACA requires states to create a user-friendly interface which allows individuals and small employers to shop for, select, and enroll in a QHP. In addition, the interface must seamlessly determine eligibility for public programs, such as Medicaid or the Children's Health Insurance Program (CHIP), and determine premium tax credits and cost-sharing subsidies for those purchasing insurance through the exchange. To create the necessary IT infrastructure, states must coordinate exchange and Medicaid/CHIP eligibility determination and enrollment functions. In addition to building new IT systems to support exchange functions, many states are also performing significant upgrades to their Medicaid eligibility systems. A few states envision building an integrated eligibility system that will make determinations for the Exchange, CHIP, Medicaid, and potentially other public programs. Many states have already started to solicit subcontractors to upgrade or build the necessary IT infrastructure.

### *Small Business Health Options Program (SHOP) Exchange*

Every state must establish a SHOP exchange to provide insurance options throughout the year for qualified small employers. However, states have flexibility on a number of elements including deciding whether to limit the size of a qualified small-employer to 50 employees before 2016, whether or not the SHOP exchange should include large employers beginning in 2017, and if the individual and SHOP markets should be merged into a combined risk pool. For example, Maryland recently passed legislation specifying that the definition of a small employer would be limited to those with an average of 50 or fewer employees until 2016 and that the small group and individual markets would not be merged. Currently, Vermont is the only state to pass legislation that merges the individual and small group health insurance markets and requires all plans in those markets to be sold through the exchange. Utah's small-business exchange, established prior to federal health reform, currently allows employers with 50 or fewer employees to participate in a defined contribution arrangement.

### *Financing*

Federal grants are available for planning and implementation of the exchange, as well as for the first year of operation. However, states must be able to fully finance the costs of exchange operations beginning on January 1, 2015. States have multiple financing options, which can be used alone or in combination, such as assessing fees on participating health insurance carriers, appropriating state funds to the exchange, and allowing for other public or private funding sources. Nine states are authorized to collect fees from insurance carriers operating in their exchanges. Specifically, Maryland's exchange is authorized to collect fees from plans within the exchange, but not to the extent that the fees create a competitive disadvantage with plans offered outside the exchange. Oregon's legislature set a maximum limit on the charges that the exchange can collect from participating insurers, scaled to the number of enrollees. Since then, Oregon's exchange calculated possible carrier administrative fees for the first two years of operation. One state, Colorado, explicitly prohibits the appropriation of state funds for the exchange, while others have opted to allow for state funding, if necessary. Nearly all exchanges were authorized to apply for public or private grants.

### *Basic Health Program (BHP)*

The BHP is an optional bridge program in the ACA that allows states to use federal funding to offer subsidized health insurance to adults with incomes between 139% and 200% FPL who would otherwise be eligible to purchase subsidized coverage through an Exchange. The BHP has generated interest from states and consumer groups because of its potential to improve affordability and continuity of care for populations just above the Medicaid eligibility threshold. However, there may be significant challenges to implementing a BHP and many states are analyzing the impact that the program would have on their exchange.[8] To date, Massachusetts is the only state to have enacted legislation giving the state authority to create a BHP, though at least 10 other states are considering this option. Tennessee has developed an alternative to the BHP that would allow individuals moving from Medicaid to subsidized coverage in an exchange to remain in lower cost Medicaid managed care plans.[9]

## State-Federal Partnership Exchange

With the deadline to demonstrate an operational exchange less than six months away, even those states intending to build a fully state-based exchange may find it difficult to put all the pieces together in time. Recognizing this challenge, HHS developed a state-federal partnership model as an option for states, which would allow for the combined management of exchange functions and for an easier transition to a fully state-based exchange in the future. States opting for a partnership exchange can choose to operate certain plan management functions, certain consumer assistance functions, or both. In addition, a partnership state can elect to conduct Medicaid and CHIP eligibility determinations or allow the federal government to perform this service. In all partnership states, HHS will perform the remaining exchange functions and ensure the exchange meets ACA standards.[10]

Since the announcement last year to forgo a state-based exchange, Arkansas has moved quickly to define its role in a partnership exchange, focusing on maintaining flexibility and control over insurance plan selection, rating, monitoring and consumer assistance functions including, outreach, education, and a Navigator program. Arkansas has solicited subcontractors' assistance on the development of exchange requirements related to plan management certification and the development of a Navigator program. The state has also created two Advisory Committees which meet bi-monthly, one on consumer assistance and another on plan management.

## Federally Facilitated Exchange

For a state unable or unwilling to establish a state-based or a state-federal partnership exchange, HHS will assume primary responsibility for operating an exchange in that state. Federal guidance released in May 2012 indicates that federally facilitated exchanges will adopt a clearinghouse model — certifying any health plan that meets all certification standards as a QHP — and will establish Navigator programs with a role for agents and brokers to assist consumers in accessing health insurance.[11] While the federal government will retain primary responsibility for operating these exchanges, it will seek to coordinate with states on multiple fronts including, plan certification and oversight functions, consumer assistance and outreach, and on streamlining eligibility determinations. States' involvement with the federal exchange, while not mandatory, will be important for ensuring effective and seamless operation. Over time, this involvement may allow states in a federal exchange to transition into a partnership model.

## Federal Funding

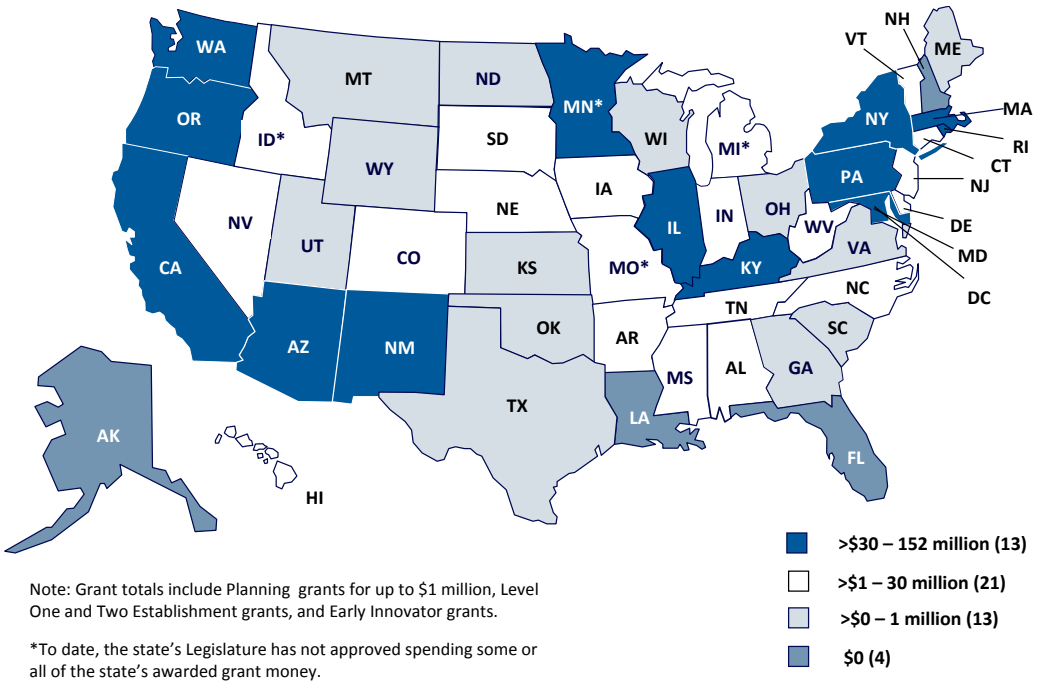
To date, over $1 billion has been distributed to states through federal exchange planning grants, establishment grants, and early innovator grants. All but five states received and accepted some amount of funding to study exchange implementation. Thirty-four states accepted at least one Level One Establishment grant. Two states, Rhode Island and Washington, received a Level Two Establishment grant which funds exchange planning and implementation activities through the first year of operation. So far, states are using most of the awarded grant funding to build the IT infrastructure necessary to support exchange functions. States have the opportunity to apply for and receive additional grant funding through the end of 2014.

For some states that have been awarded Level One Establishment grants, tension over spending has created significant deadlock, in effect, halting exchange planning. Governors in Missouri, Michigan, and Idaho have yet to receive approval from their legislatures to begin spending awarded Level One grants.

## Future Exchange Prospects

Many states have demonstrated a strong commitment towards establishing a state-based or state-federal partnership exchange. To date, at least thirteen states have submitted letters to HHS affirming their commitment to the development of a state-based exchange including, California, Colorado, Connecticut, Hawaii, Kentucky, Massachusetts, Maryland, Minnesota, New York, Oregon, Rhode Island, Vermont, and Washington.[12] A declaration letter signed by the Governor is the first step in completing an exchange blueprint, which also requires an application with information about the state's plans to operate an exchange. Those wanting to create a fully state-based exchange or a state-federal partnership exchange must submit a completed blueprint to HHS by November 16, 2012.

## Total Federal Grants for Health Insurance Exchanges




Note: Grant totals include Planning grants for up to $1 million, Level One and Two Establishment grants, and Early Innovator grants.

*To date, the state's Legislature has not approved spending some or all of the state's awarded grant money.

States also must soon select an Essential Health Benefit benchmark plan which will affect all individual and small-group plans sold in a state, including those offered through the exchange. States can choose to benchmark to one of ten plans operating in the state or default to the largest small-group plan. While many states have begun to explore their options, only a few have made final decisions. In California, legislation selecting the Kaiser small-group HMO plan as the state's benchmark is pending in the legislature and Washington has decided on the largest small-group plan in the state. HHS expects states to select the benchmark plan by the end of September 2012.

The Supreme Court's decision to uphold the ACA has renewed exchange planning activity in some states that had slowed their progress in the early part of 2012. Idaho had largely stopped exchange planning, but the Governor announced in July 2012 the creation of new workgroups to study exchange options. In Michigan, the Governor restarted efforts urging the legislature to finalize exchange establishment legislation that was introduced last year.

However, even though the main legal challenge to the ACA has been resolved, a number of states continue to move cautiously. Several governors have announced they intend to wait until after the November presidential election to implement health reform because of the uncertainty that continues to surround the future of the law. States that have been reticent to prepare for a state-based or state-federal partnership exchange to date face a difficult timetable for implementation. In less than four months states are required to submit an exchange blueprint and by January 1, 2013 their operations will be evaluated by HHS for readiness.

States moving forward to implement an exchange continue to make significant progress some moving rather aggressively to ensure readiness by the time of open enrollment in late 2013. For states interested in running their own exchanges or participating in a state-federal partnership exchange, the next year and a half provide a unique opportunity to plan a health insurance exchange tailored to the needs of their state with the support of federal funding.

For more information on state's health insurance exchange implementation please visit, http://healthreform.kff.org/tags/exchanges.aspx

[1] Van de Water P and Nathan R. Governance Issues for Health Insurance Exchange. Georgetown University Health Policy Institute and the National Academy of Social Insurance. January 2011. www.nasi.org/research/2011/governance-issues-health-insurance-exchanges

[2] Department of Health and Human Services. Notice of Public Rulemaking. 45 CFR 155 and 45 CFR 156. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. July 15, 2011. (CMS-9989-P). www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf

[3] Jost T. Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues. The Commonwealth Fund. September 2010. www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx

[4] Corlette S and Volk J. Active Purchasing for Health Insurance Exchanges: An Analysis of Options. National Academy of Social Insurance. June 2011. www.nasi.org/research/2011/active-purchasing-health-insurance-exchanges-analysis-option

[5] Ibid.

[6] The Executive Order establishing New York s exchange did not create an independent governing Board but did establish regional advisory committees to advise and make recommendations on exchange operations.

[7] Although Utah's exchange doesn t have a formal governing Board, the state has created an Executive Steering Committee to advise exchange staff on operations and transparency issues and a Defined Contribution Risk Adjuster Board to manage risk sharing mechanisms

[8] The Role of the Basic Health Program in the Coverage Continuum: Opportunities, Risks, and Considerations for States. March 2012. Kaiser Family Foundation. www.kff.org/healthreform/upload/8283.pdf

[9] Bridge Option: One Family, One Card Across Time. Tennessee Insurance Exchange Planning Initiative. November 21, 2011. www.tn.gov/nationalhealthreform/forms/onefamily.pdf

[10] Exchanges: A Proposed New Federal-State Partnership. Department of Health and Human Services. PowerPoint presentation State Exchange Grantee Meeting. September 19-20, 2011. http://cciio.cms.gov/resources/files/overview_of_exchange_models_and_options_for_states.pdf

[11] General Guidance on Federally-facilitated Exchanges. CCIIO. May 16, 2012. http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf

[12] Letters to Secretary Sebelius from the Governors on State-Based Exchanges: www.healthcare.gov/law/resources/letters/index.html

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**THE HENRY J. KAISER FAMILY FOUNDATION** **www.kff.org**

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274