FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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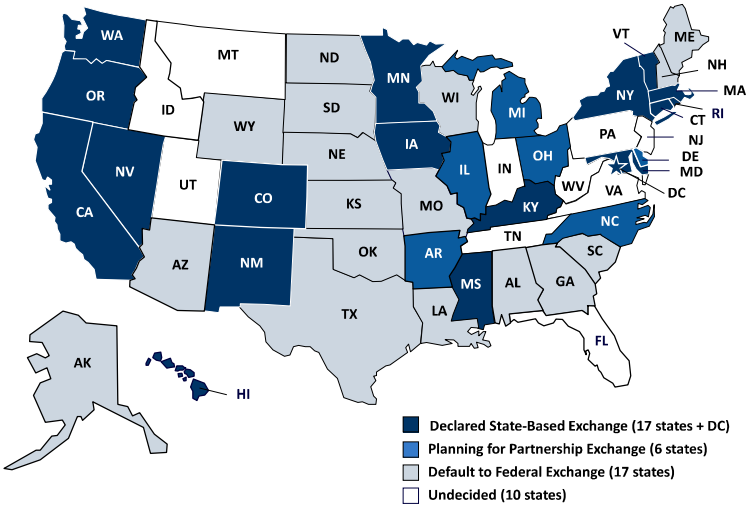
ESTABLISHING HEALTH INSURANCE EXCHANGES: AN OVERVIEW OF STATE EFFORTS

State-based health insurance exchanges, or marketplaces, are a key component of the Affordable Care Act (ACA), and the places where individuals and small businesses will be able to shop for coverage. States have the option of operating their own exchange or partnering with the federal government to run an exchange. States choosing neither option will default to a federally-facilitated exchange. All exchanges, regardless of how they are administered, must be ready to begin enrolling consumers into coverage on October 1, 2013 and must be fully operational on January 1, 2014.

While many states have already announced their intentions, several remain undecided as to which exchange approach they will take. The Department of Health and Human Services (HHS) recently extended the deadlines for states to make their decisions, giving states until December 14, 2012 to decide whether to run a state-based exchange, and until February 15, 2013 to opt for a partnership exchange. Even with the additional time for decision making, states opting for a state-based or partnership exchange will face challenges to making the necessary policy and implementation decisions.

Figure 1

State Decisions For Creating Health Insurance Exchanges



As of November 29, 2012
SOURCE: Data compiled through review of state legislation and other exchange documents by the Kaiser Family Foundation

Exchange Options and Timing

State-Based Exchange

States planning to operate a state-based exchange will perform all exchange-related activities, including contracting with health plans, providing consumer outreach and assistance, and building the necessary information technology (IT) infrastructure to assess eligibility and enroll individuals into coverage. States have the option of using federal services to determine eligibility for premium tax credit and cost-sharing reductions, as well as to operate the risk adjustment and reinsurance programs. To date, 17 states plus the District of Columbia have indicated that they intend to establish a state-based exchange (Figure 1).

States building state-based exchanges are expected to submit a blueprint consisting of a declaration letter signed by the Governor and an application to the federal Department of Health and Human Services (HHS) by December 14, 2012.[1] HHS will review the submitted blueprint application and approve or conditionally approve the state's exchange by January 1, 2013. Conditional approval means that the state's exchange does not meet all requirements by the deadline, but is making progress and is expected to be ready for open enrollment on October 1, 2013.

State-Federal Partnership Exchange

Recognizing the difficulty of building a fully state-based exchange before January 2014, HHS developed a state-federal partnership model as an option for states. The partnership exchange allows 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 Children's Health Insurance Program (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.[2] States opting for a state-federal partnership exchange must submit a blueprint to HHS by February 15, 2013. HHS will issue approvals for partnership exchanges on a rolling basis beginning on March 1, 2013.

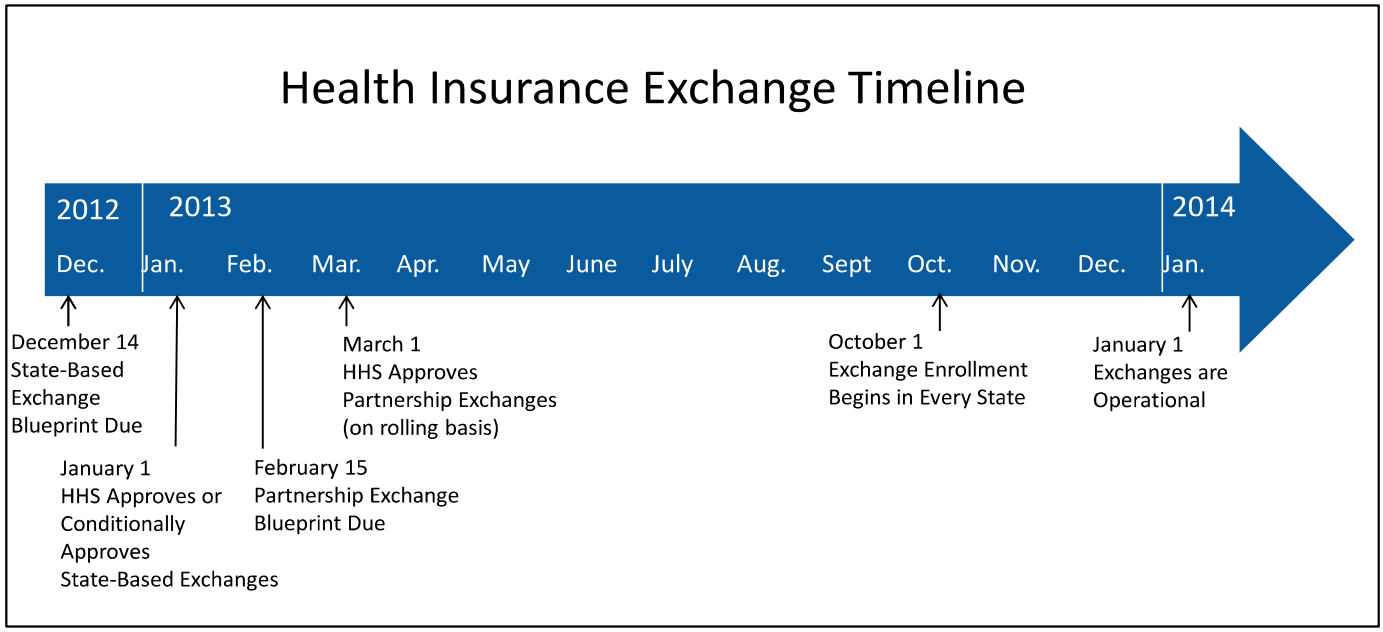
To date, six states are planning to pursue a state-federal partnership exchange: Arkansas, Delaware, Illinois, Michigan, North Carolina, and Ohio. However, Governors in Michigan and Arkansas have indicated their preference for a state-based exchange and continue to work with their legislatures to press for the passage of authorizing legislation. Similarly, Illinois has already signaled that it will move to a state-based exchange in 2015. While only a few states have committed to a partnership to date, this option may become an increasingly viable strategy for the 10 states that remain undecided. States not ready to run their own exchanges in 2014 may transition from a partnership exchange to a fully state-based exchange at a later date when they have the capability, though they must receive approval for their exchange at least 11 months prior to the start of coverage.

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. The federal government will seek to coordinate with state agencies on multiple fronts including, plan certification and oversight functions, consumer assistance and outreach, and on streamlining eligibility determinations for the exchange and Medicaid. 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 or state-based model.

As of the end of November 2012, 17 states had declared they would not create a state-based exchange and will likely to a federally-facilitated exchange. Many of these states had decided early on to default to a federal exchange; however, some had begun laying the foundation for a state-based or partnership exchange before reversing course.

While not much is yet know about how the federal exchanges will operate, Guidance released in May 2012 revealed some initial policy decisions. The guidance indicates that federally-facilitated exchanges will adopt a clearinghouse model and contract with any health plan that meets all certification standards as a Qualified Health Plan (QHP). The federal exchange will determine eligibility for individuals' premium tax credit and cost-sharing reductions. In addition, the federal exchange will establish Navigator programs with a role for agents and brokers to assist consumers in accessing health insurance.[3]



Characteristics of State-Based Exchanges

All but two states pursuing a state-based exchange have established the legal authority for their exchanges. A majority of states have passed legislation authorizing the establishment of a health insurance exchange. The Governors of Kentucky, New York, and Rhode Island established exchanges through executive order, while Mississippi and New Mexico intend to use existing, legislatively-established entities as the basis for an exchange. Exchange authority does not yet exist in Iowa and Minnesota, though the Governors in these states made their intention to establish an exchange known in declaration letters submitted to HHS in November 2012.

Exchanges in these states have begun to take shape. With some notable exceptions, how these exchanges will be structured and governed has been determined (Table 1). Nine states plus the District of Columbia have chosen a quasi-governmental structure for the exchange, four will house the exchange within a state agency, and Hawaii and Mississippi have opted to create their exchanges as non-profit corporations. Iowa and Minnesota have not decided on the structure of the exchange. Most of the exchanges will be governed by an independent Board of Directors, though the number and composition of Board members differs across the states.

Over half of states planning for a state-based exchange have specified the contracting relationship that they will have with QHPs. So far, four states have opted for a clearinghouse model, which requires the exchange to contract with all QHPs that meet specified criteria. Seven states plan to be active purchasers and selectively contract with only certain QHPs. An active purchaser exchange can use selective contracting as a strategy to improve plan quality, to encourage plans to implement strategies to better coordinate health care services, or to negotiate with plans for better pricing. The remaining seven states have yet to decide how the exchange will contract with plans.

While many states that have established or intend to establish state-based health insurance exchanges have already made numerous policy decisions, appointed Boards, and hired staff, significant work still remains for those aiming to be ready by 2014. States moving forward with state-based exchanges are currently tackling issues such as long-term financing options, developing Navigator and consumer assistance programs, and defining the structure of the Small Business Health Options Program (SHOP) exchanges. Most have also undertaken the major task of designing and building the IT infrastructure to support the exchange, particularly the systems for determining eligibility for health coverage programs, including the premium tax credits and cost-sharing subsidies, Medicaid, and CHIP.

Table 1: Characteristics of State-Based Exchanges

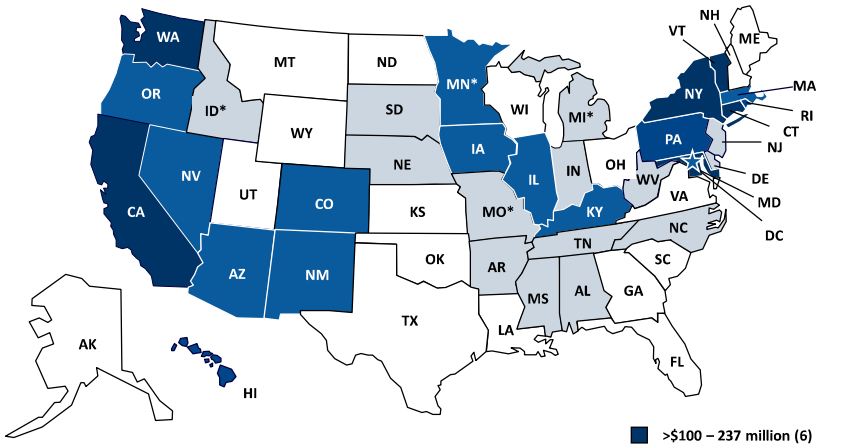
State	Structure of Exchange	Governance	Contracting Relationship with Plans
California	Quasi-governmental	5-member Board	Active purchaser
Colorado	Quasi-governmental	12-member Board	Clearinghouse
Connecticut	Quasi-governmental	14-member Board	Active purchaser
District of Columbia	Quasi-governmental	11-member Board	Active purchaser
Hawaii	Non-profit	15-member Board	Clearinghouse
Iowa	Not yet addressed	Not yet addressed	Not yet addressed
Kentucky	Operated by State	11-member Board	Not yet addressed
Maryland	Quasi-governmental	9-member Board	Clearinghouse (until 2016)
Massachusetts	Quasi-governmental	11-member Board	Active purchaser
Minnesota	Not yet addressed	Not yet addressed	Not yet addressed
Mississippi	Non-profit	9-member Board	Not yet addressed
Nevada	Quasi-governmental	10-member Board	Clearinghouse
New Mexico	Quasi-governmental	10-member Board	Not yet addressed
New York	Operated by State	5 Regional Advisory Committees	Not yet addressed
Oregon	Quasi-governmental	9-member Board	Active purchaser
Rhode Island	Operated by State	13-member Board	Active purchaser
Vermont	Operated by State	5-member Board	Active purchaser
Washington	Quasi-governmental	11-member Board	Clearinghouse

Federal Funding

By November 2012, approximately $2 billion was distributed to states through federal exchange Planning grants, Establishment grants, and Early Innovator grants (Figure 2). All but four states received and accepted some amount of funding to study exchange implementation. Thirty-four states accepted at least one Level One Establishment grant. Six states plus the District of Columbia received Level Two Establishment grants, which fund exchange planning and implementation activities through the first year of operation. Much of the funding is being used to build the IT infrastructure necessary to support exchange functions.

Figure 2

Total Federal Grants for Health Insurance Exchanges



* To date, the state's Legislature has not approved spending some or all of the state's awarded grant money.
Note: Grant totals include Planning, Level One and Two Establishment, and Early Innovator grants.
Data as of November 27, 2012.

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States can apply for and receive additional federal funds through the end of 2014. The federal government encourages states to spend Level One Establishment grants within one year of the date of award and to spend Level Two Establishment grants within three years. However, states may request a no-cost extension for up to five years from the grant award date.[4] As a result, states that decide to establish a state-based exchange or a partnership exchange at a later date may be able to use federal funding for planning, implementation, and/or the first year of operations well after 2014.

Looking Ahead

With open enrollment for all exchanges less than a year away, states moving forward with their state-based exchanges and the federal government are facing an increasingly challenging timetable for implementation. Deadlines to declare a state-based or partnership exchange are fast approaching and many states have yet to submit their formal exchange decisions to HHS. It is likely that some states will adjust their exchange strategies over the next few months as additional federal guidance becomes available and the 2013 legislative session begins. However, the federal government faces increased pressure to operate federal exchanges in a growing number of states. To date, 17 states have decided they will not build a state-based exchange and will likely default to a federal exchange; in addition, HHS will remain responsible for operating most components of the partnership exchanges, which are expected in six states.

For more information on states' health insurance exchange implementation visit, http://healthreform.kff.org/the-states.aspx

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[1] Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services. "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges." Updated November 9, 2012. http://cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf

[2] Presentation by the Center for Consumer Information and Insurance Oversight at the State Exchange Grantee Meeting. "Exchanges: A Proposed New Federal-State Partnership." September 19-20, 2011. http://cciio.cms.gov/resources/files/overview_of_exchange_models_and_options_for_states.pdf

[3] Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services. "General Guidance on Federally-Facilitated Exchanges." May 16, 2012. http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf

[4] Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services. "Exchange Establishment Cooperative Agreement Funding FAQs." http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html

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