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Delaying the Employer Mandate

Small Change in the Short Term, Big Cost in the Long Run

By Carter C. Price and Evan Saltzman

Key Findings

A one-year delay in the implementation of the Affordable Care Act's (ACA's) employer mandate will not have a substantial effect on insurance coverage.

- Only 300,000 fewer people, or 0.2% of the population, will have access to affordable insurance in 2014 because of the delay.
- About 1,000 fewer firms, or 0.02%, will offer coverage in 2014 given the delay.

The employer mandate will affect relatively few firms and employees.

- We estimate that only about 0.4% of firms, employing approximately 1.6% of workers, will pay a penalty for not offering health insurance at all.
- Based on current employer health plan contribution rates, we estimate that 1.1% of firms will pay some penalty for offering unaffordable coverage to a total of less than 1% of the workforce.

The delay in implementation of the employer mandate will lead to less revenue to offset the costs of the ACA.

- We estimate that the one-year delay in enforcement amounts to \$11 billion dollars less in revenue for the federal government—\$7 billion less in penalties that would be assessed on firms that do not offer insurance and \$4 billion less from fines of employers that offer unaffordable care.
- A full repeal of the employer mandate, not merely a one-year delay, would result in the loss of approximately \$149 billion in federal revenue over the next ten years.

In July 2013, the Obama administration announced that it would delay enforcement of the Affordable Care Act's (ACA's) penalty on large employers (those with 50 or more workers) that do not offer affordable health insurance coverage to their employees.¹ Originally slated to take effect on January 1, 2014, the so-called employer mandate will instead take effect at the beginning of 2015. The goals of the mandate are to discourage firms from discontinuing health insurance and to encourage firms that do not currently provide affordable health insurance for some or all of their workers to begin offering coverage. Most Americans currently get their health insurance through their employer, so the employer mandate is intended to provide some stability to the health insurance market as the other parts of the ACA are phased in. Given the complexity of the issues surrounding the implementation of health care reform, we felt an objective, analytically rigorous review of the impact of the one-year delay of the employer mandate would help inform debate on the issue.

Who Will Be Affected?

The employer mandate penalty will only affect firms with 50 or more workers that do not offer affordable health insurance (affordable is defined under the law as an employee needing to contribute less than 9.5 percent of his or her family income towards the single plan premium). Firms that do not offer affordable health insurance will be required to pay \$2,000 for each worker, excluding the first thirty employees, if at least one worker purchases federally-subsidized health insurance through an individual insurance exchange. Firms that do offer health insurance but that do not make that coverage affordable (under the law) for all of their full-time workers will be required to pay the lesser of (1) \$2,000 for each worker excluding the first thirty employees or (2) \$3,000 for each worker who takes advantage of federal subsidies on an individual exchange.

Methodology

Our analysis builds on a 2010 RAND study that examined the effect of the ACA on employers, including a detailed analysis of the employer mandate.² Similar to the 2010 study, we used the RAND COMPARE microsimulation model to assess the impact of the employer mandate. The COMPARE model allows for the fact that firms may choose the kind of insurance they offer, if any, based on the aggregate utility to their workers and accounting for any penalty payments or tax benefits (a full description of the methodology used in the COMPARE model can be found in Eibner et al., 2010). Our present analysis leverages a refined version of COMPARE that incorporates more-recent input data; key model upgrades; and legislative, executive, and judicial adjustments to the ACA. In particular, the current version of COMPARE uses the 2008 Survey of Income and Program Participation (SIPP),³ updating the previous version, which used the 2001 SIPP. We have also modeled the effects of recent changes to the law, such as the 2012 Supreme Court ruling. For example, our analysis assumes that 27 states will choose not to expand Medicaid in response to the Supreme Court ruling, as estimated by the Kaiser Family Foundation.⁴

Table 1: Effect of Employer Mandate on Firms and Workers (2014)

	COMPARE Estimates (2014)	
	Employer Mandate Enforced	Employer Mandate Delayed 1 Year
Firms		
Large firms not offering insurance	23,000	24,000
Large firms with at least 1 employee with an unaffordable offer	65,000	65,000
Percentage that are penalized for not offering insurance	0.38%	0.40%
Percentage that are penalized for having at least 1 employee with an unaffordable offer	1.09%	1.09%
Workforce		
Employed at non-offering large firms	2,300,000	2,600,000
Large-firm employees with an unaffordable offer receiving subsidies	1,200,000	1,200,000
Percentage who work for firms penalized for not offering insurance	1.6%	1.8%
Percentage of large-firm workforce with an unaffordable offer receiving subsidies	0.8%	0.8%

It is important to note that less than 5 percent of firms have more than 50 employees, but more than 70 percent of workers work for firms with more than 50 employees.⁵ Furthermore, more than 95 percent of firms with 50 or more workers already offer health insurance (although not necessarily affordable insurance as defined by the ACA) to their employees.⁶ In other words, most firms will be unaffected by the mandate, and although most people are employed by firms that could be affected, they themselves would not be because their firm offers insurance that is affordable (under the ACA) to them.

Effects on the Rate of Coverage Will Be Small

Using RAND's COMPARE microsimulation model, we looked at the implications of the delay of the employer mandate by one year on firms and workers (see Table 1). We estimate that only about 0.4 percent of firms, employing approximately 1.6 percent of workers, will pay a penalty for not offering health insurance at all. However, some additional large firms will pay penalties because the insurance they offer is not affordable as defined in the ACA—that is, because the premium share paid by some portion of their employees exceeds 9.5 percent of their income (our analysis assumes that these firms will not respond to the penalty by increasing their own contributions to the premium to make them affordable). Based on current employer health plan contribution rates, we estimate that 1.1 percent of firms will pay some penalty for offering unaffordable coverage to a total of less than 1 percent of the workforce—though these numbers are much less certain because firms may take steps such as changing their contribution rates or reducing worker hours to avoid these penalties. (We modeled the decision to offer insurance or not but did not model firms' potential decisions to adjust the insurance contribution rate or to reduce worker hours to avoid penalties.)

Further, we found that a delay in implementing the employer mandate will produce neither a significant change in overall insurance coverage (300,000 fewer people, or 0.2 percent, will have access to insurance from their employer, and nearly all of these will get insurance from another source) nor a substantial drop in employer rates of offering coverage (1,000 fewer firms, or 0.02 percent, will offer coverage given the delay). And because any shifts in the sources of insurance coverage resulting from the employer mandate will be small, the delay will not lead to large increases in the number of people receiving subsidies or Medicaid.

Table 2: Effect of Employer Mandate on Federal Government Revenue (2014–2023)

Year	Employer Mandate Enforced			Employer Mandate Delayed 1 Year		
	Penalties Paid by Non-Offering Firms (billions)	Penalties Paid by Firms with Unaffordable Offers (billions)	Total Revenue (billions)	Penalties Paid by Non-offering Firms (billions)	Penalties Paid by Firms with Unaffordable Offers (billions)	Total Revenue (billions)
2014	\$7.1	\$3.7	\$10.8	\$0.0	\$0.0	\$0.0
2015	\$7.5	\$3.8	\$11.3	\$7.6	\$3.8	\$11.4
2016	\$8.1	\$3.7	\$11.8	\$8.0	\$3.7	\$11.7
2017	\$8.5	\$3.8	\$12.3	\$8.5	\$3.8	\$12.3
2018	\$9.0	\$4.0	\$13.0	\$9.0	\$4.1	\$13.0
2019	\$9.4	\$4.6	\$14.0	\$9.4	\$4.6	\$14.0
2020	\$9.4	\$5.0	\$14.4	\$9.4	\$5.0	\$14.4
2021	\$14.2	\$5.3	\$19.5	\$14.2	\$5.3	\$19.5
2022	\$15.0	\$5.5	\$20.5	\$15.0	\$5.5	\$20.5
2023	\$16.0	\$5.7	\$21.6	\$16.0	\$5.7	\$21.6
Total	\$104.2	\$45.0	\$149.2	\$97.1	\$41.1	\$138.5

NOTE: Totals may not add up due to rounding.

Why are the changes so minimal? The employer mandate only impacts a very small percentage of firms to begin with. Fewer than 5 percent of firms have fifty or more employees; of these firms, more than 95 percent already offer their employees health coverage. Hence, the “stick” of the employer mandate is not necessary to compel most firms with 50 or more employees to offer health coverage. The existing “carrot”—the tax-advantaged treatment of employer-sponsored health insurance—is already a sufficient motivation to incentivize firms to offer health coverage to their employees.

Postponing the Employer Mandate Does Come at a Cost

Does that mean that delaying—or even eliminating—the employer mandate is without a substantive effect? Not quite. In addition to being an inducement for employers to offer affordable health care coverage, the employer mandate is one of the many revenue sources intended to pay for the ACA’s other provisions. As shown in Table 2, we estimate that the one-year delay in enforcement amounts to \$11 billion less in revenue for the federal government—\$7 billion less in penalties that would be assessed on firms that do not offer insurance and \$4 billion less from fines of employers that offer unaffordable care. Note that, were the mandate put into place in 2013 as originally planned, these values could be lower because some firms may

alter their workers’ hours to avoid the penalties associated with the employer mandate, and some firms currently offering unaffordable coverage may adjust the employee contribution rates of their insurance plans to avoid the penalties. In the context of the full cost of the ACA, a one-year drop in revenues of \$11 billion is relatively small (less than 1 percent of the ten-year total for revenue increases and spending reductions that are used to pay for the other components of the law).

We also used the COMPARE model to estimate the cost of a full repeal of the employer mandate, not merely a one-year delay, finding that such an action would result in the loss of approximately \$149 billion in federal revenue over the next ten years. With a one-year delay, the COMPARE model estimates that the federal government would still raise \$138 billion in revenue from the employer mandate between 2015 and 2023; the Congressional Budget Office estimates that the employer mandate will raise a cumulative \$140 billion over the same period, nearly identical to the independently generated results from COMPARE and approximately 10 percent of the ACA’s costs over the next ten years.⁷ So while the employer mandate is not likely to have a large impact on firm behavior or coverage, postponing for a significant length of time or entirely repealing the employer mandate may lead to a loss of revenue that had been intended to offset the costs of expanding coverage under the ACA.

CONCLUSION

In conclusion, postponing the employer mandate for one year won't have a large effect on insurance coverage or firm offer rates. However, a one-year delay in implementation of the mandate will result in a 6-percent reduction (or \$11 billion) in federal inflows from employer penalties. A full repeal of the employer mandate would cause revenue to fall by \$149 billion over the next ten years, providing substantially less money to pay for other components of the law. If there are concerns about the burden the employer mandate is placing on businesses, federal policymakers should assess whether there are other revenue sources to replace it. If the mandate does come into effect in 2015, employers that currently offer insurance coverage will need to ensure that the options they

provide to their workers are affordable for all of their workers to avoid paying penalties under the employer mandate. Some of these firms may also decide to change worker hours to keep the number of full-time equivalent workers below the threshold dictated by the ACA or adopt another avoidance strategy. Firms that don't offer insurance will have to weigh the associated penalties against the costs of offering it. The bottom line is that the delay in the employer mandate for one year will have relatively few consequences, primarily resulting in a relatively small one-year drop in revenue; however, a complete elimination of the mandate will have a large cumulative net cost, potentially removing a nontrivial revenue source that in turn funds the coverage provisions in the ACA.

NOTES

¹ Valerie Jarrett, "We're Listening to Businesses about the Health Care Law," The White House Blog, July 2, 2013. As of July 5, 2013: <http://www.whitehouse.gov/blog/2013/07/02/we-re-listening-businesses-about-health-care-law>

² Christine Eibner, Federico Girosi, Carter C. Price, Amado Cordova, Peter S. Hussey, Alice Beckman, and Elizabeth A. McGlynn, *Establishing State Health Insurance Exchanges: Implications for Health Insurance Enrollment, Spending, and Small Businesses*, Santa Monica, Calif.: RAND Corporation, TR-825-DOL, 2010. As of July 2, 2013: http://www.rand.org/pubs/technical_reports/TR825.html

³ United States Census Bureau, "Survey of Income and Program Participation," webpage, June 6, 2013. As of July 10, 2013: <http://www.census.gov/sipp/>

⁴ Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision," webpage, July 1, 2013. As of July 19, 2013: <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>

⁵ United States Census Bureau, "Statistics of U.S. Businesses," webpage, April 22, 2013. As of July 5, 2013: <http://www.census.gov/econ/susb/>

⁶ Kaiser Family Foundation, "2012 Employer Health Benefits Survey," webpage, September 11, 2012. As of July 5th, 2013: <http://kff.org/private-insurance/report/employer-health-benefits-2012-annual-survey/>

⁷ Congressional Budget Office, "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," May 14, 2013. As of July 5, 2013: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

ABOUT THIS REPORT

Support for this report and for RAND Health's Comprehensive Assessment of Reform Efforts (COMPARE) initiative is provided by RAND's corporate endowment and through contributions from individual donors, corporations, foundations, and other organizations.

The research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.



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ACA Implementation—Monitoring and Tracking

Cross-Cutting Issues:
Moving to High Quality, Adequate Coverage:
State Implementation of New
Essential Health Benefits Requirements

August 2013

Sabrina Corlette, Christine Monahan and Kevin W. Lucia,
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Robert Wood Johnson Foundation



Urban Institute

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally.

INTRODUCTION AND METHODOLOGY

The Patient Protection and Affordable Care Act of 2010 attempts to improve consumers' access to adequate, affordable health insurance coverage through a set of comprehensive market reforms. These include new requirements that insurers guarantee issue policies to all applicants and set premium rates without regard to health status, as well as meet minimum standards for the adequacy of coverage. Beginning January 1, 2014, insurers selling non-grandfathered¹ individual and small-group policies must ensure they include 10 categories of essential health benefits (EHB) and restrict consumers' out-of-pocket costs.

Establishing a meaningful but still affordable EHB standard generated considerable debate at the federal level and in many states.² While benchmark standards have been established for all the states, officials and some health care stakeholders point to continuing implementation challenges, including tight time frames for product development and regulatory review, the need for timely and effective federal/state coordination, potential increased costs for consumers and small business purchasers, and the appropriate balance between a standardized benefit design and the flexibility for insurers to innovate.

This paper focuses on state implementation of the EHB standard. We do not assess state action on other important components of coverage affected by the ACA, such as consumer cost-sharing and network adequacy. To perform

this analysis we reviewed state legislation, regulations, and guidance, and conducted in-depth telephone interviews with health insurance regulators from departments of insurance (DOIs) and insurance industry representatives in five states: Alabama, Colorado, New Mexico, Oregon, and Virginia. See table 1.

Table 1: State Oversight of Plans Inside and Outside the Exchanges

State	Type of Exchange	Oversight for Exchange Plans	Oversight for Plans Outside the Exchange
Alabama	Federally facilitated	Centers for Medicare and Medicaid Services (CMS)	State law: Alabama DOI Federal law: CMS
Colorado	State-based	Colorado DOI*	Colorado DOI
New Mexico	State-based	New Mexico DOI*	New Mexico DOI
Oregon	State-based	Oregon DOI*	Oregon DOI
Virginia	Federally facilitated; state conducting plan management	Virginia DOI and Virginia Department of Health*	Virginia DOI and Virginia Department of Health

**Oversight conducted on behalf of the exchange*

Three of these states (Colorado, New Mexico, and Oregon) are each running their own exchange and the DOIs are

performing reviews for products inside and outside the exchange. One state—Virginia—has a federally run exchange, but its insurance department is conducting the regulatory review for products inside and outside the exchange and performing certain plan management functions with the assistance of the Virginia Department of Health. Alabama, by contrast, has ceded much of its regulatory authority to the federal Centers for Medicare and Medicaid Services (CMS). State regulators note that they lack authority under their state code to enforce federal law, but the DOI has historically reviewed health plans for compliance with pre-ACA federal health insurance laws (such as the Health Insurance Portability and Accountability Act, or HIPAA). In March 2013, Alabama’s governor informed CMS that the state does not intend to enforce any part of federal health care reform, which state officials interpret to include pre-ACA federal law. As a result, CMS is required to directly enforce both the ACA and pre-ACA federal health insurance laws, inside and outside the exchange.

This paper provides an assessment of respondents’ experiences with the development and regulatory review of health insurance products that meet the new EHB standards. Major findings include:

- Technical glitches and tight deadlines posed challenges for insurers and regulators alike, but an “all hands on deck” mentality and commitment to consumers have kept the product development and review process moving forward.
- Officials in all but one state reported that they have had good, if not always timely, communication with CMS regarding plan management and oversight.
- Insurers and regulators in most study states reported that the shift to an EHB standard would cause minimal change or disruption, but one state noted it would result in a significantly expanded set of benefits for individual policyholders.
- Insurers are engaging in minimal substitution of covered benefits in the first year, meaning that plans will closely resemble the benefits, limits, and exclusions prescribed in the benchmark package, with differences primarily reflected in cost-sharing and network design.
- States are adapting to new requirements to review plans for discriminatory benefit designs and coverage of habilitative services.
- One study state is facilitating consumers’ ability to make “apples-to-apples” plan comparisons by standardizing benefit designs inside and outside the exchange.

BACKGROUND

States have traditionally led government efforts to improve the adequacy of benefits covered by private health insurance plans, primarily in the form of benefit mandates.³ Mandates can come in many forms, including requirements to cover certain services, health conditions, or specialty health care providers.

While all states currently have at least some benefit mandates in place,⁴ the individual health insurance market—and, to a lesser extent, the small-group market—have often failed to provide all consumers with adequate health coverage due to gaps or limits in the benefits covered by a plan, as well as high levels of cost-sharing for covered benefits.⁵ For instance, it remains common for individual market plans to not offer coverage for maternity care, mental health and substance abuse services, prescription drugs, and other items and services. When these or other benefits are covered, they are often subject to restrictions on how much or when a health plan will pay.⁶ Even in the small-group market, coverage of certain benefits, such as behavioral health care and pediatric oral and vision services, is often limited.⁷

Affordable Care Act Requirements

To address these gaps and ensure consumers can access a common core set of benefits, the ACA calls for the Secretary of the U.S. Department of Health and Human Services (HHS) to define a set of essential health benefits to be offered by all new fully insured individual and small-group health plans, beginning January 1, 2014. This requirement applies to insurers selling both inside and outside the new health insurance exchanges. The law stipulates that the EHB must include at least the items and services within the following 10 general categories of benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.⁸

To guide the secretary in defining the essential health benefits, the ACA provides that the scope of the benefits

must be equal to that provided under a typical employer plan.⁹ In addition, the secretary is required to ensure that there is an appropriate balance among the 10 categories and take into account the health care needs of diverse segments of the population—including women, children, and persons with disabilities—and is prohibited from making coverage decisions or design benefits in ways that discriminate against individuals on the basis of age, disability, or expected length of life. S/he also must ensure that the items and services within the EHB are not subject to denial to individuals against their wishes on the basis of age or expected length of life, present or predicted disability, degree of medical dependency, or quality of life.¹⁰

Health plans are permitted to provide benefits in excess of the EHB.¹¹ However, such benefits would not be subject to the ACA's prohibition on annual and lifetime limits,¹² nor would they count toward the value of premium tax credits¹³ or be covered by the additional subsidies to reduce cost-sharing for low-income consumers.¹⁴ States may continue to mandate benefits in addition to the EHB as well, but if they do, the law requires that they defray the cost of additional benefits for individuals enrolled in qualified health plans.¹⁵

Federal Rules

Rather than define a uniform, national set of essential health benefits, HHS provided that each state could choose a benchmark plan on which to base their EHB package. In selecting their benchmark, states were allowed to choose among 10 options: the largest health plan by enrollment in any of the three largest small-group insurance products in the state; any of the three largest state employee health benefit plans; any of the three largest plans offered to federal employees; and the largest commercial health maintenance organization (HMO) plan in the state.¹⁶ If a state did not make a benchmark selection, it would default to the largest health plan offered in the largest small-group product in the state.¹⁷

Recognizing that the benchmark options may not include all 10 categories required under the ACA, the secretary ruled that such plans must generally be supplemented through the addition of an entire missing category from any other benchmark plan option.¹⁸ In the case of pediatric oral and vision services, states could choose to supplement their chosen benchmark plans with the benefits provided by a Federal Employee Dental and Vision Insurance Program Plan or a state Children's Health Insurance Program plan.¹⁹ In addition, because

habilitative services are not currently well-defined and may not be explicitly included in many plans, the secretary provided that the state may determine which benefits must be included to meet the habilitative services requirement if the benchmark plan is lacking in this category.²⁰ If a state does not do so, insurers may fill in this category by either covering habilitative services in a similar scope, amount, and duration as rehabilitative services or by determining their own level of coverage and reporting this to HHS.²¹

The secretary also specified that the benchmark plan must not include discriminatory benefit designs²² and must ensure an appropriate balance among categories.²³ However, mechanisms to assess whether a benchmark plan meets these standards and, if not, to bring it into compliance were not provided in rulemaking.

Health plans will be allowed to deviate from the benchmark package so long as they provide benefits that are "substantially equal" to the benchmark in terms of covered benefits and limits.²⁴ Unless prohibited by a state, a health insurer may substitute one benefit for another within a category so long as it submits certified evidence that the benefits are "actuarially equivalent."²⁵ With respect to prescription drug benefits, a health plan must cover at least the greater of one drug in every category and class in the United States Pharmacopeia or the number of prescription drugs in each category and class as the benchmark plan.²⁶ Health insurers covering the EHB are also prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation,²⁷ and plans will not be considered to provide the essential health benefits if its benefit design, or the implementation of its benefit designs, discriminates on the grounds described in the law.²⁸

Implementation

Twenty-four states and the District of Columbia submitted formal benchmark plan selections to HHS; all but five selected one of the small-group benchmark plan options. By not selecting a benchmark plan, the remaining 26 states defaulted to the largest small-group plan by enrollment in the state. Some states, such as California, took action to define habilitative services and prohibit or discourage benefit substitution.²⁹

In the spring of 2013, states began reviewing rates and forms for the 2014 plan year. While standards and practices vary, states typically require health insurers to submit policy forms to demonstrate that their plans are

in compliance with state laws and regulations. In some cases, states permit insurers to “file and use” their rates and policy forms. In other words, insurers are allowed to use their premium rates and plan designs without state review, as long as the information is on file with the DOI. Other states require regulators to review and approve rates and forms before they can be used.³⁰ State reviews can often take 60 to 90 days or more.³¹

Implementation of the ACA’s 2014 market reforms and new health insurance exchanges in every state presents many new challenges for insurers and regulators alike. First, both are facing more compressed time frames than normal. A number of federal regulations affecting the terms and pricing of insurance products—including rules on the EHB, cost-sharing requirements, and rating practices—were not finalized until late February,³² just two months before insurers were typically required to submit their rates and policy forms to participate in health insurance exchanges. In states operating state-based exchanges or conducting plan management functions on behalf of the federal government, regulators must finish their reviews of exchange plans by July 31st so plan information can be integrated accurately into state and federal IT systems ahead of open enrollment.³³ States may choose to review plans intended to be sold solely off of exchanges on the same or a different timeline.

Second, both insurers and regulators in most states must adjust to the new and unprecedented role of the federal government in plan review and oversight. The degree of federal involvement will vary based on two factors: the state’s role in exchange implementation and the state’s willingness and ability to enforce ACA market reforms.

In the 14 states conducting plan management on behalf of the federally run exchange,³⁴ the state is responsible

for reviewing plan rates, covered benefits, and cost-sharing requirements and making recommendations that plans meet exchange certification standards to HHS.³⁵ HHS will review state recommendations and make final certification decisions, work with insurers to upload and verify exchange information for display, and enter into agreements with insurers to complete the certification process. Insurers will be expected to use the federal data system, the Health Insurance Oversight System (HIOS), to request a plan identification number and a state data submission system, typically the System for Electronic Rate and Form Filing (SERFF).

In other states with federally run exchanges, the state will continue to conduct its traditional rate and form review process while the federal government will review plan information for certification. HHS anticipates integrating any information made available by the state in its reviews; however, insurers will need to go through both processes independently, including submitting plan data through both HIOS and SERFF.³⁶ In addition, some states have also informed the federal government that they will not or cannot enforce the ACA’s 2014 market reforms. In these states, all insurers, regardless of whether they want to participate in the exchange, are required to submit policy forms to the federal government to review for compliance with federal law in addition to following their state’s rate and form review processes.³⁷

In states operating state-based exchanges,³⁸ there will be less need for coordination between state and federal officials during the plan review and approval process. However, even in these states, insurers will need to work directly with the federal government in other regards, as HHS will be operating some or all of the premium risk stabilization programs (risk adjustment, reinsurance, and risk corridors) depending on the state.³⁹

FINDINGS

Technical Glitches and Tight Deadlines for Product Filing and Review

Insurers in the five study states were faced with tight deadlines for the submission of their products—both exchange and non-exchange—to state regulators for review. See table 2. The federal government’s final EHB regulation was not published until February of 2013, and additional, critical details for insurers developing

exchange plans were not released until early April.⁴⁰ Even after this guidance was published, insurers and state regulators alike reported that CMS continued to issue evolving instructions that in some instances completely reversed their prior understanding of the agency’s policy. As a result insurers had only a few weeks to file their plans for review in a very fluid regulatory environment. As one insurance company representative put it, “One of the bigger [challenges] was speed—trying to complete and file our products in time.”

As a result insurers had only a few weeks to file their plans for review in a very fluid regulatory environment.

The rush and technical glitches required “workarounds” and caused mistakes. During the filing process, HIOS, and to a lesser extent, SERFF, suffered from technical problems. “The HIOS system—it seems like it was kind of propped up. I know people were working hard, but there wasn’t much time to test it,” observed one insurance company representative. Another labeled the process “frustrating and challenging” due to the technical problems.

Table 2: State Filing Deadlines for Policy Forms*

State	Filing Deadline for Exchange Plans	Filing Deadline for Plans Outside the Exchange
Alabama	May 3, 2013	State deadline: 60 days prior to offering for sale Federal deadline: 60 days prior to offering for sale**
Colorado	April 1, 2013 to June 30, 2013	April 1, 2013 to June 30, 2013
New Mexico	April 30, 2013 (extended due to technical problems)	August 15, 2013
Oregon	April 30, 2013	April 30, 2013
Virginia	May 3, 2013	May 3, 2013 (if insurer also filed to sell plans on the exchange)

*Sources: State Department of Insurance websites and interviews with state officials.

**CCIIO, *Form Filing Instructions and HIOS Training Webinar Memo*, April 1, 2013. Available from <http://www.cms.gov/CCIIO/Resources/Training-Resources/Downloads/issuer-form-filing-instructions-04012013.pdf>.

As the filing deadline approached, DOI staff and insurance companies took an “all hands on deck” approach to make sure filings were submitted properly and on time. “In some cases we held hands [with the insurers] until the wee hours in the morning to work through the [technical problems],” one recalled. And although the filing deadline had passed at the time of our interviews, DOI staff were continuing to collect information from insurers who had needed “workarounds” to get their submissions in on time. “Because this came down to the wire, there wasn’t time to do this thoughtfully or carefully,” observed one regulator. Another has found numerous problems with insurers’

filings. “With the tight time frames, [the insurers] were just hastily putting [filings] together—a lot of things were missed in the rush to get them in.”

The filing of thousands of new, ACA-compliant plans has also generated concerns about the capacity of DOIs (and for the federally facilitated exchanges, of CMS) to complete their reviews in a timely way, so that plans can be available in time for open enrollment in the new health insurance exchanges. “The [essential health benefits] have added a whole new level of form review and it’s a lot more than we have had to look at [in the past],” observed one DOI official. “We’ve done some cross-training [of staff] but we’re...stretched very thin.”

Other DOIs have engaged in triage. New Mexico’s DOI, for example, required insurers to submit exchange plans by April 30, 2013, but asked insurers offering products outside the exchange to hold off submitting their filings until August 15, 2013. Although this approach may allow the New Mexico DOI to better manage the volume of filings, other respondents noted that the different filing deadlines for plans offered inside and outside the exchange could potentially lead to “gaming, adverse selection, and other anti-competitive problems.” The New Mexico review team has also prioritized individual market filings over those for the Small Business Health Options Program (SHOP), in the hopes they can get their exchange contractor to accept the SHOP filings later in the process. Regulators in another state suggested that the deadlines established by CMS for the review of QHPs would have to shift. “At some point this immovable deadline has got to move or some concession has to be made...maybe to stagger things by priority.”

In spite of concerns about DOI capacity and looming deadlines, DOI officials expressed confidence that they would maintain a rigorous review process. “We are more interested in...the policyholders,” asserted one DOI official. “We need to make sure the contracts are clear and accurate, or they will be of no benefit to the policyholder.” This commitment to consumers and willingness on the part of insurers and regulators alike to find solutions to technical and operational challenges has kept the product development and review process moving forward in all the study states.

With One Exception, States are Working with CMS to Conduct EHB Reviews

Among our study states, all but one DOI reported that they have had good communication with CMS regarding

plan management and oversight. However, some complained that CMS was not always timely in answering technical questions or helping DOIs interpret federal rules. State DOIs reported that they would sometimes need to get out in front of CMS on an issue, or fill in gaps in federal guidance and hope that CMS would not later put out guidance contradicting the state's interpretation.

Among our study states, only Alabama reported a lack of communication with federal regulators, which they attributed primarily to staff turnover at CMS (Alabama's project officer at CMS has reportedly changed "at least six times"). The federal government is not only conducting plan management for the federally facilitated exchange in Alabama, it is also directly enforcing the ACA's market rules inside and outside the exchange.⁴¹ However, the state is far from abdicating its role as an insurance market regulator and will continue to review health plans for compliance with health insurance protections under state law. Officials noted that they would continue to require all companies to file the necessary forms with the state, for both exchange and non-exchange products. What this actually means for insurers and consumers is still a bit of a mystery, especially if the state were to approve a filing that CMS did not approve. State regulators noted that there is no clear mechanism or process for informing CMS of state decisions or requests to amend insurance company filings. As recently as June, Alabama insurance company representatives were uncertain how the review process would work. "We're still trying to figure it out," they said.

Other insurance industry representatives working directly with CMS to develop and file plans have expressed some concerns about their interactions. Some have observed that federal officials lack sufficient experience and understanding of state markets and industry dynamics. Further, they complain about the deluge of new guidance from CMS—hundreds of "frequently asked questions" have been posted, requiring insurers to revise and retool their product filings, up to and even after the filing deadlines. Insurers also found that the CMS help desk did not have sufficient capacity to answer questions in a timely way. "They'd take a question and then take a few days [to get back to us]," noted one insurance company representative. "They seemed to really struggle to handle the volume."

New Benefit Requirements have a Smaller Impact in States with Many Pre-ACA Benefit Mandates

Among our study states, those that had key benefit mandates in place prior to the enactment of the ACA, such as Colorado and New Mexico, indicated that the shift to an EHB standard would cause minimal change or disruption. For example, Colorado regulators asserted that because the state has mandated coverage of a number of key benefits over the last several years, the most recent being a maternity benefit for individual health plans, the shift to an EHB standard is "not a big issue" in the state. Similarly, New Mexico state regulators highlighted that they have historically been a "heavily mandated" state, resulting in very little difference between individual market and small-group market policies. Oregon regulators noted that some of their insurers already provide robust coverage, so shifting to the EHB standard would not be a "big lift." And even though other insurers will need to make "major changes" to comply with the EHB standard, regulators did not anticipate that it will be a major driver of premium increases.

Most insurance industry respondents suggested that they made minimal changes to their products to meet the ACA's new EHB standards, even if they were not the issuer of the state's selected "benchmark" plan. For example, an insurer in Colorado found that the benefits covered in their products were not very different from those in the state's benchmark, offered by Kaiser Foundation Health Plan: "Our plan and the Kaiser plan were extremely close so we didn't make many modifications." And a New Mexico insurer concluded that the EHB requirements were a "non-issue" in the state because their benefits had already been rich. Among insurers who did offer the selected benchmark plan, the changes were even less dramatic, requiring

In spite of initial concerns from some observers that the adoption of a new benefit standard would result in dramatic changes to insurance policies—and commensurate increases in cost—regulators in most study states reported that it did not result in a major market change.

only the addition of pediatric vision and dental and a few other small adjustments. “It wasn’t a drastic change for us,” one observed.

In Virginia, by contrast, individual market policyholders will have access to a significantly expanded set of benefits. Maternity care has not traditionally been covered in their individual market, and, according to regulators, some insurers also offered policies that did not cover prescription drugs. Because the new EHB standard requires individual market plans to cover these benefit categories, individual policyholders are likely to gain access to more a broader range of benefits.

For most insurers, substitution represented an actuarial and administrative headache that they calculated not worth the trouble.

Overall, in spite of initial concerns from some observers that the adoption of a new benefit standard would result in dramatic changes to insurance policies—and commensurate increases in cost—regulators in most study states reported that it did not result in a major market change. In the one state suggesting a greater impact, regulators noted the significant expansion of benefits for individual policyholders.

For 2014, Insurers are Engaging in Minimal Substitution of Covered Benefits

While all of our study states are allowing insurers to substitute benefits within the statutorily prescribed benefit categories, some have actively discouraged the practice. For example, Virginia’s DOI advised insurers that “actuarially equivalent substitutions...are permitted,” but they are warned that “such substitutions may result in significant delays in the review of their form and rate filings.”⁴² Oregon enacted a law requiring insurers to offer standardized bronze and silver plans in order to facilitate consumers’ ability to make “apples to apples” comparisons among plans and prohibiting benefit substitution in those plans.⁴³ Perhaps as a result, state officials in the study states consistently reported that insurers are not filing plans that substitute benefits. “I’ve only seen one minor benefit substitution [relating to nursing home coverage] so far,” one regulator noted.

Consistent with these findings, our insurance company respondents reported that they were not substituting benefits in their plans, at least not for 2014. For most, substitution represented an actuarial and administrative headache that they calculated not worth the trouble. “As an actuary,” one health plan representative noted, “it’s hard to guess what [CMS] means by ‘actuarially equivalent.’ There’s a lot of room to argue [about what it means].” Such arguments with regulators would cost time and resources—costs that insurers can ill afford. Other insurers observed that the federal regulations had effectively “shut down” any attempts to design a plan to attract or repel certain populations. “When we finally saw [federal] regulations, it became clear that plan design would be simple and straightforward and not a matter for agonizing over,” said one insurance company official.

As a result, some insurers predicted that competition will occur primarily around product pricing, and not around benefit design: “From the beginning we assumed that the plan designs that we would offer and that our competitors would offer would be very similar.... The angst is around pricing.”

To the extent insurers do engage in substitution, several of our DOI respondents indicated they will independently review the assertions of actuarial equivalence. As one DOI reviewer put it, “I will view [the filing] for whether the substitution is reasonable and ... is explained well. Otherwise we might ask for more information.”

Given insurer trepidation about moving forward with significant substitution, plans will closely resemble the benefits, limits, and exclusions prescribed in the benchmark package in the first year, with differences primarily reflected in cost-sharing and network design. However, substitution remains an issue to monitor. While some insurers declined to engage in much substitution this year because of concerns about oversight, tight deadlines, and administrative costs, it is possible that over time they will find it an attractive way to differentiate themselves as the initial burdens of ACA implementation dissipate.

Confusion Over the Lack of a Clear Review Standard for Discrimination in Benefit Design

Both insurers and regulators indicated they have little experience assessing whether a plan’s benefit design discriminates against less healthy people, and the lack of a clearly defined standard for what constitutes

discrimination has made the review process challenging. “There is no standard for identifying discriminatory benefit design yet,” noted one regulator. However, some DOIs intend to use a software tool developed by CMS, which is designed to identify certain outliers in a plan’s benefit design and flag them for more in-depth review. Regulators suggested that this tool will be critical. “We don’t know how we would do [the review] without it,” asserted one state regulator.

In that vein, Colorado has published guidance for insurers on discriminatory benefit design, informing them that the DOI will “compare benefit designs for outliers,” and assess limits and restrictions in plans, including visit limits and prior authorization requirements associated with specific benefits. The guidance further provides specific benefits that will get a close examination, such as in-patient hospital stays, inpatient mental/behavioral health stays, and prescription drugs.⁴⁴ Similarly, Virginia and Oregon regulators indicated that, while they have traditionally conducted comprehensive benefit reviews, the new non-discrimination requirements mean they’ll need to take a closer look.

Table 3: State Benchmark Plans and Supplemented Categories*

State	Benchmark	Supplemented Categories	Does Benchmark Include Habilitative Services?
Alabama	Blue Cross Blue Shield of Alabama 320 Plan	Pediatric Oral Pediatric Vision	Yes
Colorado	Kaiser Foundation Health Plan of Colorado Ded/HMO 1200	Pediatric Oral	No
New Mexico	Lovelace Insurance Company Classic PPO	Pediatric Oral Pediatric Vision	Yes
Oregon	PacificSource Health Plans Preferred CoDeduct Value 3000 35 70	Pediatric Oral Pediatric Vision	No
Virginia	Anthem Health Plans of VA PPO	Pediatric Oral Pediatric Vision	Yes

*Source: CMS, *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*. Available from <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#Alabama>.

Insurers expressed little concern over the new non-discrimination standard, generally presuming that their own benefit designs were not discriminatory. “It’s not been a big concern for us,” one insurer noted. Others joked that they were not smart enough to design discriminatory benefit designs. “Cleverer people may have figured it out,” one said, “but I’d be surprised if I saw anything that was fundamentally discriminatory.”

To date, none of our study states have notified an insurer of a discriminatory benefit design among their plan filings. However, it is unclear at this time whether the lack of reported enforcement actions stems from widespread insurer compliance or instead from regulators’ lack of a clear definition or standard with which to assess benefit designs. As plans are marketed and sold, it will be important for regulators to monitor the experience of policyholders, particularly those with significant health care needs, in obtaining necessary care at a reasonable cost.

Supplementing Benefits: Some States Defined Habilitative Services for Insurers

None of the state benchmark plans cover all 10 of the statutorily required benefit categories. See table 3.

All but one state had to add both the pediatric dental and vision benefits. The coverage of habilitative services was more ambiguous. This ambiguity is consistent with HHS’ findings nationally. In their review of habilitative coverage in employer-sponsored health plans, they identified no generally accepted definition of habilitative services among health plans, and found considerable variation in the breadth and depth of coverage.⁴⁵

In our study states, both insurers and regulators told us that while benchmark policy documents indicated habilitative services were not covered, in actual practice, some insurers paid habilitative claims. For example, CMS’ summary of Virginia’s benchmark plan (based on information provided by the insurer) indicated that habilitative services were included. See table 3. But state regulators told us that their own analysis of the benchmark plan suggested habilitative services were not covered.

Given the ambiguity, three of our study states—Virginia, Colorado, and Oregon—provided insurers with a published definition of habilitative services that must be included in contracts to comply with the EHB

requirement. For example, Colorado’s guidance defines habilitative services as

“...services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado’s EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.”⁴⁶

But even with this guidance, at least one insurance industry respondent felt that the definition of habilitative services was “left ambiguous.” However, some of our insurer respondents indicated they would just “copy what we have on the physical therapy side” to comply with the requirement to cover habilitative services.

New Mexico did not provide published guidance on habilitative benefits, but will conduct plan reviews to assess compliance with the ACA’s requirement to include coverage of habilitative benefits within the EHB package. By contrast, Alabama allows insurers to define habilitative services and will defer to CMS to review whether insurers are in compliance.

Habilitative services are included within the EHB because Congress concluded they were a critical component of any comprehensive benefit package. However, our findings indicate that what constitutes habilitative services, as well as the appropriate amount, duration, and scope of coverage for these services, remains poorly defined. Some states have attempted to guide insurers on these questions to encourage a minimum standard of coverage; others are letting insurers decide. As policyholders begin using their new benefits, it will be important for state officials to monitor their access to care in order to determine the extent to which their coverage meets their needs.

Oregon Moves Forward to Standardize Benefit Design Inside and Outside the Exchange

In order to facilitate consumers’ ability to make “apples-to-apples” comparisons among health plans, Oregon’s legislature enacted a law in 2011 requiring insurers to market standardized benefit designs at the bronze and silver levels of coverage.⁴⁷ This requirement applies to individual and small-group policies inside and outside the state exchange, and the Oregon exchange, Cover Oregon, additionally requires participating insurers to offer a standardized gold plan.⁴⁸ However, while the exchange limits insurers to only two additional non-standardized plans at each coverage level, insurers are not limited in the number of non-standardized plans they can offer outside the exchange.

The Oregon DOI was charged with designing the standardized plans. Regulators reported that they attempted to match what was currently popular in the market. At least one insurance company respondent indicated support for standardized plans, suggesting it would benefit consumers to easily compare plans across key dimensions such as price, quality, and network. Oregon respondents indicated that insurers are complying with the standardization rules.

Oregon is one of six states—including California, Connecticut, Massachusetts, New York, and Vermont—requiring insurers to offer standardized plans on the exchange. Other states, such as the District of Columbia, are considering doing so in the future.⁴⁹ Oregon’s experiences with standardization and the impact on consumer decision-making and plan choice will undoubtedly be closely watched by state and federal policy-makers.

CONCLUSION

Developing health plans that comply with the ACA's 2014 market rules has been no small lift for insurers in our study states, and the review and approval process has stretched the capacity of state DOIs. However, in spite of technical glitches, most companies were able to meet federal and state filing deadlines and insurance departments have implemented practical approaches to manage the significant expansion.

At the same time, in a majority of our study states, consumers are unlikely to see dramatic changes in the scope of their covered benefits, in part because states had pre-ACA benefit mandates in place. However, there

remain long-term questions about the extent to which individual and small-group policies will conform to the state's benchmark benefit package. In this first year, while benefit substitution was allowed in all of our study states, insurers and regulators alike reported minimal activity in this area. And one state, Oregon, is requiring insurers to market a set of plans that have not only a standardized offering of benefits, but standardized cost-sharing as well. In addition, new ACA requirements, such as the prohibition against a discriminatory benefit design and coverage of habilitative services, present new compliance and review challenges for insurers and regulators alike.

ENDNOTES

1. A “grandfathered” plan is one that was in existence as of the date the ACA was enacted (March 23, 2010) and to which there have not been substantial changes in benefits or cost-sharing. Many of the ACA’s market reforms, including the guaranteed issue, rating, and EHB standards, do not apply to grandfathered plans.
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12. ACA § 1001, adding new § 2711(b) to the Public Health Service Act.
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16. 45 CFR §156.100(a).
17. 45 CFR §156.100(c).
18. 45 CFR §156.110(b)(1).
19. 45 CFR §156.110(b)(2).
20. 45 CFR §156.110(f).
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22. 45 CFR §156.110(d).
23. 45 CFR §156.110(e).
24. 45 CFR §156.115(a)(1).
25. 45 CFR §156.115(b).
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About the Authors and Acknowledgements

This study was funded by the Robert Wood Johnson Foundation. Sabrina Corlette is a research professor, Christine Monahan is a senior health policy analyst and Kevin Lucia is a research professor at the Georgetown University Health Policy Institute’s Center on Health Insurance Reforms (CHIR). The authors are grateful to Linda Blumberg and John Holahan for their thoughtful comments and feedback. We also thank the state officials and insurance company executives who generously shared with us their time and insights.

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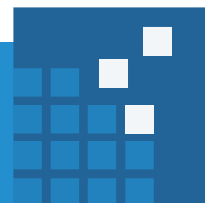
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ISSUE BRIEF



August 2013

Quantifying Tax Credits for People Now Buying Insurance on Their Own

A number of states have recently released information on what premiums will be in the individual insurance market in 2014 when significant changes in that market take effect due to the Affordable Care Act (ACA). In some cases, states have provided estimates of how those premiums compare to what people buying their own insurance are paying today.

However, these premiums are in effect “sticker prices” that many people will not pay because they will be eligible for federal tax credits under the ACA to offset the cost of insurance. In this data note, we explain how the tax credits will work and estimate how much premium assistance people now buying their own insurance will be eligible for in 2014.

WHY PREMIUMS IN THE INDIVIDUAL MARKET WILL CHANGE

There are a number of [reasons](#) why individual market premiums will change, both overall and for any given individual now buying coverage:

- » Prohibiting discrimination against people with pre-existing health conditions will tend to raise premiums as higher-cost individuals who have previously been excluded from the market buy coverage. This may be offset by an influx of younger and healthier people, due to the ACA’s individual mandate and premium subsidies for low- and middle-income people buying insurance in new health insurance marketplaces (also known as exchanges).
- » Eliminating premium surcharges based on health status and limiting premium variation due to age will tend to lower premiums for people who are older and sicker and raise premiums for people who are younger and healthier. Also, eliminating gender-based rating will generally result in higher premiums for younger men and lower premiums for younger women.
- » Establishing a minimum level of coverage will generally raise premiums for people who are buying skimpier coverage today, though it will also lower their out-of-pocket costs on average when they use services.
- » Creating a \$10 billion reinsurance pool to reimburse insurers for high-cost enrollees in the individual market in 2014 will tend to lower premiums.

Premiums will be higher in 2014 for some current individual market purchasers and lower for others, and on average will likely be higher in most states.

HOW PREMIUM TAX CREDITS WORK

Premium subsidies (in the form of federal tax credits) will be available for people buying their own insurance in new marketplaces and who have incomes from 100% up to 400% of the poverty level (about \$26,000 to \$94,000 per year for a family of four in 2014). Those with access to affordable employer-provided insurance or Medicaid are ineligible for tax credits.

The amount of the tax credit is based on a benchmark premium, which is the cost of the second-lowest-cost silver plan in the area where a person lives. The tax credit equals that benchmark premium minus what the individual is expected to pay based on their family income, which is calculated on a sliding scale from 2% to 9.5% of income.

Here is how the calculation might work for a 40-year-old individual making \$30,000 a year:

Estimated benchmark premium for a 40-year old = \$3,857 per year (which will vary from area to area)

Person is responsible for paying 8.37% of their income = \$2,512

Tax credit = \$1,345

The tax credit can be used in any plan offered in the health insurance marketplace, so the person would end up paying less than \$2,512 to enroll in the lowest cost silver plan or a lower cost bronze plan, and more to enroll in a higher cost plan. A [calculator](#) from the Kaiser Family Foundation provides subsidy estimates for families of varying characteristics.

ESTIMATING TAX CREDITS FOR PEOPLE CURRENTLY BUYING IN THE INDIVIDUAL MARKET

While premium tax credits will provide substantial subsidies to people now buying individual insurance, it can be difficult to characterize the level of subsidies because they vary so much based on personal characteristics (e.g., age, income, family size, and place of residence). To provide a sense of how much assistance these subsidies will provide, we quantified how much of a tax credit on average current individual market enrollees will be eligible for. We look at people who are currently purchasing their own insurance and are anticipated to continue to do so in 2014 because they do not have access to employer coverage and are not eligible for Medicaid (including expanded Medicaid eligibility in states that have adopted the ACA expansion) or the Child Health Insurance Program.

Our analysis – which is described more fully in the methodology appendix – is based on premium estimates from the Congressional Budget Office (CBO) and the characteristics of current individual market enrollees in the federal government's Survey of Income and Program Participation. While our premium estimate is based on CBO's projection and actual premiums will vary from area to area, the premium values we are using are consistent with those that have been released to date in several states.

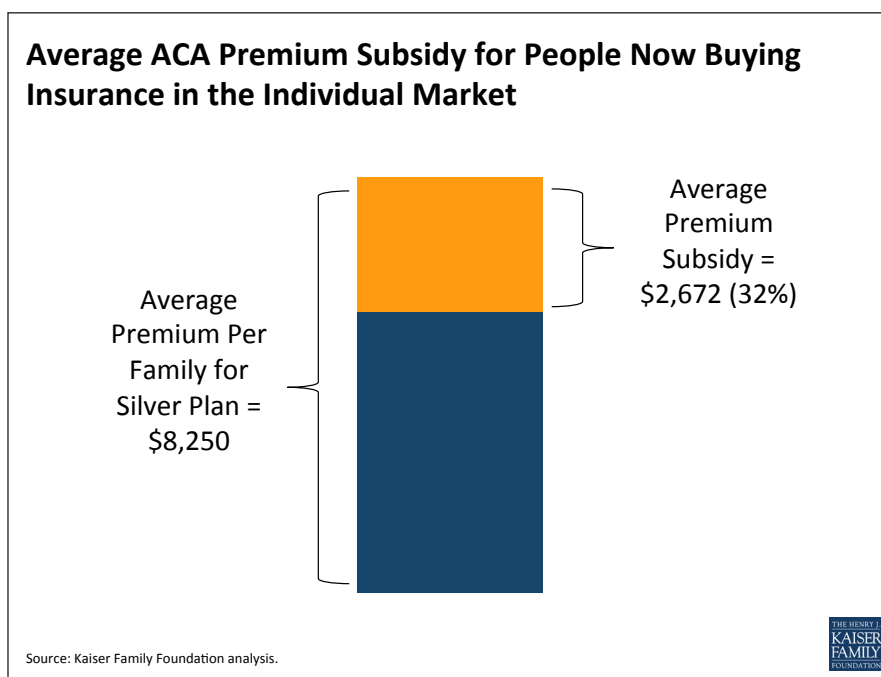
Using CBO's estimate of an average premium for the second-lowest-cost silver plan in 2016, we estimate that the national average benchmark premium for a 40-year-old in 2014 would be \$3,857 per year (or \$321 per month). Benchmark premiums at other ages are based on uniform age factors that have been established in regulations issued by the Department of Health and Human Services.

We estimate that current individual market purchasers will face an average premium per family for the second-lowest-cost silver plan of \$8,250 in 2014. This is an average premium across families of all sizes. Most current individual market enrollees are in families of one person (55%) or two people (29%). (Note that for the purposes of tax credit eligibility under the ACA, families are defined as including people who are claimed as dependents on an income tax return. Our estimates reflect that definition to the extent possible with data available.)

About half (48%) of people now buying their own insurance would be eligible for a tax credit that would offset their premium. This does not include over one million adults buying individual insurance today who will be eligible for Medicaid starting in 2014 (i.e., they have family income up to 138% of the poverty level and are living in states that have decided to expand Medicaid under the ACA).

Tax credits have the potential to cover a substantial portion of the premiums paid by current individual market enrollees:

- » Across all current individual market purchasers anticipated to continue buying coverage, the average tax credit their families would be eligible for would be \$2,672. Assuming all eligible current enrollees applied for a tax credit, the subsidy would reduce the premium for the second-lowest-cost silver plan by an average of 32% across all people now buying insurance in the individual market.
- » Among the approximately half of current enrollees who will be eligible for tax credits, the average subsidy would be \$5,548 per family, which would reduce their premium for the second-lowest-cost silver premium by an average of 66%.
- » Tax credits would subsidize a higher share of the premium for individuals choosing to enroll in lower cost plans. For example, enrolling in a bronze plan from the same insurer offering the benchmark silver plan would mean an average subsidy across all current individual market enrollees of about 38% of the premium and an average subsidy among only those eligible for tax credits of 77%.



This data note was prepared by Larry Levitt, Gary Claxton, and Anthony Damico.

METHODOLOGY APPENDIX

We estimated the availability and size of health insurance premium subsidies for people enrolled in non-group coverage using data from the 2008 Survey of Income and Program Participation (SIPP), Wave 6 (interview period April to July, 2010).

Individuals were grouped into families based on a series of decision rules designed to approximate what is referred to as “health insurance unit (HIU)” or “tax filing unit,” which is the basis for determining eligibility for premium tax credits under the ACA.

The analysis is based on the universe of people currently purchasing non-group insurance (also referred to as individual insurance) and anticipated to continue to do so. Based on ACA rules regarding eligibility for premium tax credits in health insurance marketplaces (also known as exchanges), certain groups of current non-group purchasers were assumed to obtain alternative coverage:

- » All individuals belonging to a health insurance unit where any member received health insurance through work or an offer of employer-sponsored insurance. All members of a family were assumed to have access to employer-sponsored insurance if one member of the family was offered coverage. People with access to affordable employer coverage are ineligible for exchange-based premium tax credits.
- » Adults with incomes up to 138% of the poverty level and living in a state that has [decided](#) to expand Medicaid under the ACA (as of July 1, 2013). People eligible for Medicaid are ineligible for tax credits in exchanges. In states that choose not to expand, adults with incomes below 100% of the poverty level are included in the analysis but are ineligible for premium tax credits.
- » Children (up to age 18 and full-time students up to age 20) with family incomes that would qualify them for Medicaid of the Child Health Insurance Program (CHIP) based on [current eligibility levels](#).
- » All individuals currently receiving Medicare or Medicaid as well as purchasing non-group coverage, who would be ineligible for premium tax credits and presumed not to purchase exchange-based coverage starting in 2014.

There are a small number of uninsured people (under 200,000 nationwide) living in families where another person is currently buying non-group coverage, and they are assumed to remain uninsured for the purposes of this analysis. If they purchased coverage, average tax credits would be higher than are reported here.

Health insurance units were assigned a premium based on age and family composition, assuming all current non-group purchasers (excluding those described above) continue to buy coverage. Premiums are based on our estimates for 2014 using the latest projection from the Congressional Budget Office (CBO) of the national average premium for the second-lowest-cost silver plan in 2016. Some states have begun to report approved premiums for 2014, and these early reports suggest CBO’s estimates are reliable.

Since tax credits are determined at the family level, all premium and subsidy figures are reported for adult purchasers based on the aggregate amounts for their entire health insurance units.



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This publication (#8469) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.



Federally Run Insurance Exchanges Likely To See Lower Premiums

Friday, July 26, 2013

Some health policy analysts are predicting that 2014 premium rates for individual-market health plans offered through federally run exchanges under the Affordable Care Act could be lower than expected, similar to those announced in some state-operated exchanges, *Modern Healthcare* reports (Block, *Modern Healthcare*, 7/25).

Last week, Obama touted a new HHS report that found the lowest cost plan in the individual market among 10 surveyed states and the District of Columbia would be about \$320 per month, or 18% lower than previous HHS and Congressional Budget Office estimates

However, the HHS report did not include data for plans in the 34 federally run exchanges, according to a group of seven Republican House and Senate committee leaders. The lawmakers sent a letter to HHS Secretary Kathleen Sebelius this week asking her to release premium rate data from insurers applying to participate in those exchanges. They cited a separate report indicating that premium rate data for plans in the 34 exchanges would not be publicly released until September (*California Healthline*, 7/19).

According to *Modern Healthcare*, states with federally run exchanges have until July 31 to submit premium rate data for HHS approval. HHS is required to notify insurers by Sept. 4 of their application status, according to Caroline Pearson, vice president of the health reform practice at Avalere Health.

Although those premium data have yet to be released, Pearson said she believes the 34 states will follow the "pattern of (rates) looking a little bit lower than expected." She suggested that competition among insurers and consumers' ability to compare prices will drive down rates.

Meanwhile, Rachel Dolan -- a health reform policy specialist at the National Academy for State Health Policy -- said the expected declines in premium rates will vary by state, in part because some states already have insurance market reforms in place and the number of insurers participating in the exchanges will differ between states (*Modern Healthcare*, 7/25).

THE IMPACT OF THE AFFORDABLE CARE ACT ON ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS IN CALIFORNIA

SMALL BUSINESSES

In 2013, the Asian & Pacific Islander American Health Forum (APIAHF) did a study on Asian American, Native Hawaiian, and Pacific Islander small business owners and employees throughout California. We were interested in identifying barriers they faced in getting health insurance, finding out what they knew about the Affordable Care Act (ACA), and if they thought its provisions would help them access health care services.

Why is the ACA important to small business owners?

- Many small business employers do not provide health insurance to their employees. (single most important reason why immigrants lack health insurance coverage)

What to know about small business owners and employees...

- High cost** was the most common barrier (for employers and employees) to obtaining health insurance.
- Employers and employees have heard about the ACA, but **know very little** about its provisions, incentives, or where to get more information.
- Both employers and employees felt that the **income requirements** to qualify for Medi-Cal (\$15,000 for an individual, \$32,000 for a family of four) are **too low** and should be raised to allow more people to be covered.

“Any kind of coverage is better than none”

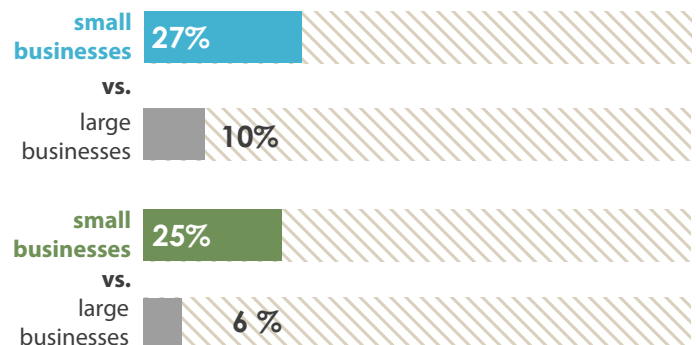
– Hmong Employee

“I’m all for it, because everyone should have health insurance”

– Pacific Islander Employer & Employee



uninsurance rates are **significantly higher** for AAs and NHPIs in small businesses...



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Unique findings from employers and employees in small businesses...

Employers

Some employers are **covered by their spouse's plan** or have another job (in addition to owning their business) so they can have insurance.

Many employers are **confused** about whether they are **required to provide insurance** under the ACA, and what the penalties are if they don't.

Employers felt online resources would **NOT** be helpful (due to language, complexity of information, and computer literacy).

Most employers felt that tax credits would **NOT** help them because they would not offset the cost of providing health insurance to their employees.



Employees

Most small business employees had **health insurance through Medi-Cal** (California Medicaid) or were **uninsured**; most small business owners reported having private insurance.

Employees expressed **concerns** that the new ACA rules for businesses may drive business owners to **pay employees less** or reduce their number of employees.

Employees felt that online resources **WOULD** be helpful.

Even with the new ACA subsidies, employees felt that health insurance will still be **too expensive**. Expanding Medi-Cal would be better.

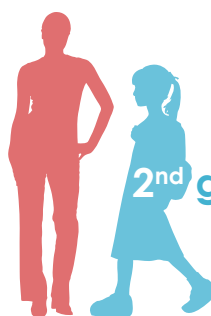
Note: No employer (small or large business) is required to provide insurance to employees until the year **2015**.

Trusted information sources vary by age...



- ethnic media
- ethnic language resources
- community-based organizations

1st generation



2nd generation

- online resources

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NEWS RELEASE

Embargoed for release:
12:01 a.m. ET,
Thursday, July 11, 2013

For further information, contact:

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NEW REPORT: MANY STATE HEALTH INSURANCE MARKETPLACES WILL EXCEED REQUIREMENTS FOR QUALITY REPORTING AND CHOICE FOR SMALL-BUSINESS EMPLOYEES

State Exchanges Using Innovative Tactics to Create Competitive Markets and Give Consumers an Array of Plan Choices

New York, NY, July 11, 2013—Many state-run health insurance marketplaces are poised, by 2014, to exceed federal quality-reporting requirements, offer small-business employees a choice of health plans that won't be available in states with federally run marketplaces until 2015, and promote a seamless "one-stop shop" for consumers to enroll in coverage, according to a new Commonwealth Fund report. In addition, many state-run exchanges, now referred to as marketplaces by the Department of Health and Human Services, will employ innovative strategies to provide consumers with a range of distinct plan choices exceeding the Affordable Care Act's minimum requirements.

The report, *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges*, looks at the 17 states that, along with the District of Columbia, have elected to run their own health insurance marketplaces. The marketplaces will begin to enroll consumers on October 1, 2013, for coverage beginning January 1, 2014. They are a key element of the Affordable Care Act, designed to remedy the major shortcomings of the current individual and small-business health insurance markets: high premiums, lack of health plan choice, inadequate health insurance coverage, and a complex purchasing process that leaves consumers in the dark about key features of the plans they are buying.

"The report shows that many states are testing innovations with their marketplaces aimed at improving the ability of individuals to buy health plans on their own and small businesses to offer coverage to their employees," said Sara Collins, Ph.D., vice president for affordable health insurance at The Commonwealth Fund. "Combined with new insurance market protections in the law, these approaches will encourage insurers to compete on value and better position consumers and small businesses to make informed choices."

The report's authors, Sarah Dash, Kevin Lucia, Katie Keith, and Christine Monahan of Georgetown University's Health Policy Institute, look at how the marketplaces are developing in

five key areas: structure and sustainability, fostering a competitive marketplace, providing meaningful consumer choice, improving options for small employers, and maximizing enrollment.

The researchers found that several states are using innovative tactics to improve consumers' experiences in the marketplaces, often going beyond the law's minimum requirements:

- **Reporting quality data:** Nine states—California, Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New York, Oregon, and Rhode Island—plan to display data on quality in their marketplaces in 2014. This is a full two years before the federal government requires such data to be displayed.
- **Promoting choice of plans:** Small-business employees in state-run marketplaces will have more choices sooner than required. Nearly every state-run Small Business Health Option (SHOP) marketplace will provide firms the ability to offer their employees a choice of more than one plan, starting in 2014. The federal government does not require this level of choice until 2015. In addition, eight states—Hawaii, Minnesota, Nevada, New York, Oregon, Rhode Island, Utah, and Vermont—will let employers offer workers the choice of any plan in the SHOP marketplace.
- **Promoting insurer participation:** Eight states—Colorado, Connecticut, Maryland, Massachusetts, New Mexico, New York, Oregon, and Vermont—and the District of Columbia have adopted formal rules to require or incentivize insurers to participate in the marketplaces. For example, Colorado, New Mexico, New York, and Oregon have established “waiting periods” prohibiting insurers from entering the marketplace for up to two years if they don't participate in 2014.
- **Reducing adverse selection:** Many states have taken steps beyond the Affordable Care Act requirements to encourage a balance of healthy and sicker people to enroll in the marketplaces, so that participating plans do not end up insuring mostly unhealthy people with high medical costs. California, for example, requires insurers that participate in the marketplace to offer the same coverage to consumers outside the marketplace. In Oregon and Washington, insurers will not be able to sell catastrophic coverage—an option available only to young adults and individuals otherwise unable to afford coverage—outside of the marketplace. It is hoped that this will encourage young, healthy enrollees to buy insurance.
- **Balancing choice with ease of comparing plans:** Insurance carriers may sell health plans at five different “metal tiers” of coverage in the insurance exchanges: bronze, silver, gold, platinum, and a catastrophic plan for young adults and people who cannot find an affordable health plan. While the law requires insurers to offer health plans at a minimum at the silver and gold levels, eight states—California, Connecticut, Kentucky,

Massachusetts, Maryland, New York, Oregon, and Vermont—and the District of Columbia, require insurers to sell plans at additional coverage levels.

But to ensure that consumers have a manageable number of choices, eight states limit the number of plans each insurer can sell at each metal tier in the marketplace. For example, in Nevada, insurers will only be allowed to offer up to five plans at each coverage level. In Kentucky, they will be able to offer up to four.

To further simplify consumer choice, six states—California, Connecticut, Massachusetts, New York, Oregon, and Vermont—require insurers to offer some standardized plans in the exchange, with additional specifications for plan benefits and cost-sharing.

- **Streamlining eligibility and enrollment systems:** Fourteen states—California, Colorado, Connecticut, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont, and Washington—and the District of Columbia used federal funds to adopt a one-stop-shop computer system that will be able to determine what kind of coverage potential enrollees are eligible for, whether marketplace coverage, Medicaid, or the Children’s Health Insurance Program.
- **Improving enrollment assistance:** In addition to allowing agents and brokers to sell coverage through the exchange, all states are expected to establish programs to educate consumers and help them sign up for health coverage through the exchanges. These programs include either “navigators” or “in-person assisters.” Thirteen states and the District of Columbia will have both in-person assistors and navigators; the remaining states either plan to operate only a navigator program or are still finalizing their approach.

The report highlights the need for a continued focus on the financial soundness of the marketplaces, which must be self-sustaining by 2015. Currently, seven states and the District of Columbia have yet to finalize their approach to long-term revenue. Ten state marketplaces—California, Colorado, Connecticut, Idaho, Maryland, Minnesota, Nevada, Oregon, Vermont, and Utah—have plans in place to ensure there are long-term, sustainable revenue sources. Of these states, six—California, Colorado, Idaho, Minnesota, Nevada, and Oregon—will fund their marketplaces by assessing insurers that offer coverage in the marketplace while Connecticut will assess all insurers in the individual and small-group markets regardless of whether they participate in the marketplace. Maryland, Vermont, and Utah will use existing state funds or revenue sources.

The authors conclude that the design of the state marketplaces will likely affect how well they function, how many people enroll, and how much the offered plans cost. It will be crucial, they say, that states pay attention to the real-world outcomes of their policy decisions and make adjustments as needed. In addition, the experience of these states will inform future exchange implementation efforts, at both the federal and state levels. “States have made remarkable progress to date and capitalized on the flexibility of the Affordable Care Act. We hope that an

understanding of their design decisions will be valuable for policymakers as additional states consider how to transition to a state-based exchange in the future,” Dash said.

“The level of innovation many states have displayed in creating their health insurance marketplaces is an encouraging sign that states are working to ensure that consumers will be able to get affordable, comprehensive coverage in their state exchange,” said Commonwealth Fund president David Blumenthal, M.D. “It will be critical for states to monitor their success and amend their design as needed to ensure consumers have the best possible experience.”

METHODOLOGY

The report findings are based on ongoing monitoring of exchange decisions in 17 states and the District of Columbia between March 23, 2010, and May 31, 2013. The report does not include a review of state actions or decisions in the 33 states that defaulted to a federally facilitated exchange. The findings reflect analysis of state laws, regulations, subregulatory guidance, press releases, declaration letters, blueprint submissions, board and meeting minutes, media reports, other public information related to exchange development, and interviews with state regulators. The resulting assessments of state action were confirmed by state officials.

The data presented are limited to state decisions for the initial year of operation of the exchange. Because states may reevaluate these decisions in response to changes in their marketplace or the experience of other states, these data should not be construed as representing a final or long-term decision, with many states reporting that design decisions will be reconsidered as needed.

The Commonwealth Fund is a private foundation supporting independent research on health policy reform and a high performance health system.

Harnessing Technology to Streamline Enrollment: Experience from Eight Maximizing Enrollment Grantee States

A Maximizing Enrollment Report

By

Alice M. Weiss

Katie Baudouin

National Academy for State Health Policy

July 2013

*A product of the
Maximizing Enrollment Program*

Maximizing Enrollment is a national program of the Robert Wood Johnson Foundation with technical assistance and direction provided by the National Academy for State Health Policy.

About Maximizing Enrollment

The *Maximizing Enrollment* program has worked intensively with eight states to help them more effectively use data to improve performance in enrolling and retaining eligible individuals. This report presents key lessons learned from grantee states' work on strategies to make enrollment more simple, efficient, and accessible. Strategies were adopted in four areas: application and renewal simplifications, customer interfaces, system functioning, and workflow management. These strategies go beyond what federal law requires, and will be useful as states move forward with ACA implementation.

About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. A non-profit and nonpartisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues. Our funders include both public and private organizations that contract for our services. For more information, visit www.nashp.org.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measureable and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter [www.rwjf.org/twitter](https://twitter.com/rwjf) or Facebook [www.rwjf.org/facebook](https://www.facebook.com/rwjf).

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Acknowledgements

The authors wish to thank the Maximizing Enrollment state team members from Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin whose work and reflections informed this report, and who offered valuable insights in the review process. We would also like to specifically acknowledge Andrew Snyder, Catherine Hess, Alan Weil, and Maureen Hensley-Quinn at the National Academy for State Health Policy (NASHP), and Mara Youdelman and Vikki Wachino for their editorial review. We also thank Nicole Dunifon, Program Assistant at NASHP, for her excellent research and technical support that was invaluable to the paper. Finally, we thank Andrew Hyman and Lori Grubstein at the Robert Wood Johnson Foundation for their continued guidance of the Maximizing Enrollment national program and whose vision and commitment to the program have ensured that we have findings to share.

July 2013

Dear Reader,

In 2009, eight states—Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin—received million-dollar grants from the Robert Wood Johnson Foundation's Maximizing Enrollment program to improve enrollment and retention of children in Medicaid and the Children's Health Insurance Program, and to promote best practices in enrollment simplification that could offer new models for the nation. With the enactment of the Affordable Care Act in 2010, the Foundation expanded the goal of the program to encompass state eligibility and enrollment strategies to prepare for newly eligible individuals in 2014.

The grantee states participated in a diagnostic assessment to identify areas of strength, challenges and opportunities; created improvement plans; received technical assistance; and participated in a peer-learning network. Four years later, Maximizing Enrollment grantee states have implemented new strategies and pioneered innovations to streamline and simplify eligibility, enrollment and retention. They used grant funds to revamp cumbersome, paper-driven enrollment processes, modernize systems, change business processes, and procure new tools.

In this series of final reports, the National Academy for State Health Policy—the national program office for Maximizing Enrollment—will explore the results of grantee states' efforts to:

- Harness technology to make enrollment more simple, efficient, and accessible;
- Simplify and streamline processes to reduce unnecessary paperwork and relieve burden on both applicants and eligibility workers; and
- Manage programmatic change by setting a consistent, data-driven vision for coverage among the state agencies and local entities that share responsibility for health and human services programs.

Please visit www.maxenroll.org to download the reports in this series. Throughout 2013, we will also hold virtual and in-person meetings where you can learn more about our states' work to transform their enrollment systems and policies. We hope you will join us.

Sincerely,



Catherine Hess
Co-Director
Maximizing Enrollment



Alice Weiss
Co-Director
Maximizing Enrollment

Our sincere thanks to the Robert Wood Johnson Foundation for its support, to our partners and technical assistance faculty, and especially to the state teams who participated in the Maximizing Enrollment program.

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Executive Summary

Since 2009, the eight states (Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin) participating in the Robert Wood Johnson Foundation's Maximizing Enrollment program have worked to streamline eligibility and enrollment systems for children and those eligible for coverage in 2014. Although the participating states began their work before the enactment of the Patient Protection and Affordable Care Act (ACA), several of their technology-based solutions have paved the way for new simplifications that the ACA requires of all states. Maximizing Enrollment states are more likely than other states to have adopted technology-based simplifications and have piloted inventive strategies that go beyond what federal law requires that are worthy of consideration as states move forward with ACA implementation.

This paper shares findings and lessons learned from Maximizing Enrollment state grantees' experiences using technology to streamline enrollment. Strategies were adopted in four areas: 1) application and renewal simplifications; 2) customer interfaces; 3) system functioning; and 4) workflow management.

All grantee states used technology to simplify the application and renewal process to increase worker efficiency and to manage an increasing caseload with diminishing resources. Six out of eight Maximizing Enrollment states allow consumers to fill out and submit electronic applications for Medicaid or CHIP health coverage online.¹ Five (Alabama, Louisiana, Utah, Virginia, and Wisconsin) implemented online renewal of benefits for Medicaid and/or CHIP,² and five (Alabama, Illinois, Louisiana, Virginia and Wisconsin) have implemented telephonic applications and renewals for Medicaid and/or CHIP program. Maximizing Enrollment grantees' other innovative application and renewal strategies include:

- *Online Submissions of Verifications* in order to reduce rates of incomplete applications.³
- *Automatic Data Population into Eligibility System* to reduce data-entry time for eligibility workers and reduce errors that could lead to administrative denials or delays for the state.
- *Bar Coding* application materials to more easily match documents to the electronic case record.
- *Translation and Toggling From English to Foreign Language Versions* of online applications.
- *Horizontal Integration with Human Services Programs* through online applications that allow beneficiaries to apply for multiple health and human service programs.
- *Telephonic Signatures* that allow workers to create a brief recording of the application transaction.
- *Automated Voice Response* systems that allow families to renew by phone, helping to save money (postage, paper and staff time) and improve families' access to renewals.

States preparing to implement new technologies will want to consider operational issues, including consumer preference in usage, reducing redundancies among assistive technologies, using data to monitor and improve performance, and ensuring new technologies are accessible to limited English proficient, disabled and other populations with special needs.

Technological enhancements improved states' ability to communicate with consumers about their application, renewal, or case status. Common strategies employed by grantees included expanding application access, providing updated information in a timely manner, answering questions in a consumer-friendly way, and allowing applicants and enrollees to more easily check their benefit status and update their personal information. Key strategies included:

- *Online Accounts* to foster two-way communication between the Medicaid or CHIP agency and the client, allow clients to keep their accounts updated, and reduce call center volume. Utah's myCase system is a model for third party access and electronic notices that may be interesting to other states.
- *Self-Service Kiosks* to expand access to and provide assistance with the online application, particularly in rural areas where in-person assistance is unavailable or Internet connectivity is unreliable. Special planning may be required to make kiosks accessible to individuals with low literacy, limited English proficiency, or physical disabilities.
- *Online Chat* between applicants and eligibility staff through instant messages while completing an online application. Online chat allows staff to serve multiple applicants at once. Utah's online chat usage increased quickly after implementation, from 6.3 percent of in-bound contacts in 2010 to 14.4 percent in 2012.

Maximizing Enrollment grantee states used technology to improve eligibility system operations, streamline eligibility verification and determination processes. Grantee states developed and implemented strategies to rely less on paper-based verifications and case files. Increasing electronic access to case information will help states respond to the increase in application volume with ACA implementation in 2014. Influential system changes adopted by grantees included:

- *Electronic Verification* will be required of all states in 2014, with states expected to rely primarily on federal and state electronic data sources for eligibility documentation. Utah's eFind system takes electronic verification a step further by collecting all verification information into one location. The \$2 million system saved the state \$2.1 million in its first year of operation and is projected to save the same or more in subsequent years.⁴
- *Electronic Document Management (EDM)* systems that accept and manage all eligibility documentation electronically. EDM allows states to collect and process verification documents centrally, speed up collection, and better manage how work is assigned. Alabama's CHIP Document Imaging and Workflow Management System has reduced the average processing time for all CHIP applications from six days to just one day.⁵
- *Electronic Case Records (ECR)* to track and record all case-related information and transactions in an electronic file that is secure, storable and shareable among workers. ECR implementation eliminates paper case files, fosters better accuracy and timeliness, and allows more flexible workloads, remote workforces, improved oversight, and better customer service.
- *Express Lane Eligibility (ELE)* allows states to use income determinations from programs like SNAP to facilitate Medicaid or CHIP enrollment.⁶ ELE has been implemented by four Maximizing Enrollment states for children, and Alabama and Massachusetts are pioneering adult ELE programs that may reduce their enrollment burden in 2014.

States revamping their eligibility systems and processes changed how they managed their workflow, including redesigning business processes, restructuring jobs, and introducing new management tools and incentives. States needed to allow themselves the freedom to invent new, different and more modern ways of doing business rather than simply incorporating old, outdated, and unnecessary processes into an electronic environment. Change strategies included:

- *Business Process Redesign* to adapt to the shift from a paper-based to an electronic environment. Utah developed a "throughput operating strategy" that focused on "feeding the control point" – the eligibility worker – to maximize the worker's capacity to move cases to

complete decisions. Using these new tools, Utah was able to eliminate the backlog of cases, manage an increasing workload of cases with fewer staff, and bring the timeframes for outstanding tasks from 108 days to 10-15 days.

- *Rethinking Workforce Structures and Roles* in light of new technologies. New York began moving from a county-based to a centralized enrollment system by centralizing renewal case processing and offering a telephone renewal option, which is now available in 31 counties. Utah transitioned from a region-based to a state-based operational approach and restructured worker roles to better fit the technologically-enabled eligibility system. As a result, Utah has been able to manage an increasing caseload with fewer workers, error rates have dropped, and processing costs have dropped from \$45 to \$35 per case.⁷ Louisiana adopted a local empowerment model that, along with a shift to task-based work, helped Louisiana reduce denials of children eligible for coverage at renewal, from 22 percent in 2001 to less than 1 percent in 2011.
- *Management Tools and Incentives* to manage workers in a paper-free environment. Louisiana transitioned 42 percent of its Medicaid eligibility workforce to remote status, saving money in office costs and improving worker productivity and retention. Utah is piloting a “pay for performance” initiative that has grown from 45 to 400 workers due to increased demand for voluntary participation among workers. Workers participating report improved morale and appreciation for the bonuses.⁸

Lessons for Other States: Maximizing Enrollment grantee states have learned important lessons from their experiences on the leading edge of technological improvements, including:

- **Let Policy Drive the Technology.** Participating states reported their greatest successes when technology became a lever to accomplish a larger goal, rather than an end in itself.
- **Technology Does Not Eliminate the Need for “Human Touch.”** Grantees that worked to simplify and automate the enrollment process learned that in many cases there is no replacement for the value of direct human contact.
- **Training In-House IT Staff Can Pay Significant Dividends.** While many states rely on technology support from vendors, a few of the Maximizing Enrollment states were able to reap significant rewards when they trained their own IT and policy staff on the new technologies being implemented.
- **New Technologies Require New Approaches and Processes.** Many grantee states reported that technology changed their business operations substantially.
- **Involve Local Staff in the Change Process.** Grantee states can attest to the value of involving local staff in planning and implementing change.
- **Plan for Security Protections.** Two of the grantee states experienced security breaches during the program. While both states thought their security was adequate before the breach, both regretted not having clearer protocols for sensitive information or a plan for post-breach management.
- **Leadership and Vision Are Essential.** Grantees clearly benefited from the strong leadership and vision articulated by leaders to support using new technology. As one official in Utah observed, “nothing implements itself.”
- **Change Takes Time.** While new technologies may be implemented on a speedy timeframe, grantee state experience demonstrates that real change in terms of worker culture and agency impact happens more slowly.

Future Directions: States may want to consider additional strategies for the future, including: embracing new technologies, including data profiling to support outreach efforts; making mobile applications accessible, translating application materials, and preparing for new application technologies; creating streamlined plan selection capacities and improving interfaces among state systems; and ensuring truly seamless transfers. Federal officials and states will need to work together in collaboration to promote continuous improvement of system in achieving the goal of maximizing enrollment of those eligible for coverage.

The following report shares the successes and challenges grantee states experienced with adoption of technology in each of these four areas. States considering technological improvements will benefit from the lessons Maximizing Enrollment states learned throughout the process.

¹ All of the six states that provide consumer-facing online applications except one (Illinois) accept electronic signatures. Two more states (Massachusetts and New York) allow electronic submission of applications through application assisters.

² Three of the five states that have implemented online renewal (Alabama, Utah and Virginia) implemented or improved access during the grant period. An additional grantee state (New York) developed an online renewal tool during the grant period. This tool is used by their centralized Enrollment Center to process renewals in 31 counties.

³ Rebecca Mendoza, “Getting in the Act? The State of State Implementation of Health Care Reform: Virginia’s Experiences Using Technology to Streamline Enrollment”, slide 16.

⁴ State of Utah, eFind one-page information sheet. Uploaded to StateRefor(u)m, June 21, 2012. <http://www.statereforum.org>.

⁵ Alabama Department of Public Health, data received from state Maximizing Enrollment team, Bureau of Children’s Health Insurance, Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll Grantees, April 5, 2013.

⁶ Maureen Hensley-Quinn, Mary Henderson, and Kimm Mooney, *State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future*, (Washington, DC: State Health Reform Assistance Network, 2012).

⁷ For more information on Utah’s approach to Workforce Culture Change, see Nicole Dunifon, *IT Innovations One Piece of the Puzzle: A Look at Utah’s Workforce Culture Change*, (Washington, DC: Maximizing Enrollment, Forthcoming.

⁸ Id.

Introduction

“One of the most important decisions we made early on was that we were going to let the policy drive the technology, not the other way around.”

– Diane Batts, Louisiana Medicaid Deputy Director

In 2009, eight states received grants from the Robert Wood Johnson Foundation as part of the Maximizing Enrollment program to increase enrollment and retention of eligible children into Medicaid and the Children’s Health Insurance Program (CHIP) and to establish and promote best practices in streamlining eligibility and enrollment systems, policies and procedures to share with other states. With the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, the Foundation expanded the goal of the program to encompass state strategies to modernize eligibility, enrollment, and retention policies to prepare for newly eligible individuals in 2014. After four years of work in the program, these Maximizing Enrollment program states have made important strides forward in their efforts to streamline and simplify eligibility and enrollment, with many states pioneering new approaches in their use of technology to promote simpler, more efficient, and more accessible enrollment. In this paper, the term “technology” means the use of alternative media (electronic, Internet supported, and other devices making use of new technological tools) to support simplified eligibility and enrollment procedures.

The states participating in Maximizing Enrollment initiated their work before the enactment of the ACA and many of their strategies have paved the way for the ACA’s approach to using technology to simplify the enrollment process. Although many of the Maximizing Enrollment states’ strategies are now required under the ACA, Maximizing Enrollment states are also piloting inventive strategies that go beyond what federal law requires and are worthy of consideration as states move forward with ACA implementation.

A guiding mantra for many Maximizing Enrollment states was one aptly expressed by Louisiana’s Deputy Medicaid Director Diane Batts as “let the policy drive the technology.” Many of the Maximizing Enrollment states saw their greatest successes in technological advancements when they let their policy needs drive and inspire their technology solutions. In this way, technology improvements are often not a goal in their own right, but technology has been instead viewed as a means to achieve another valued end. With the enactment of the ACA and the magnitude of change required in how eligibility and enrollment systems function, the Centers for Medicare and Medicaid Services (CMS) indicated that “[s]ystem transformations will be needed in most [s]tates to accomplish these changes.”¹ Given states’ new imperative for system redesign with policy changes as a driver, the strategies and lessons learned by Maximizing Enrollment states may offer useful insights to other states as they work to transform their eligibility and enrollment systems for 2014 and beyond.

Technology-enabled strategies observed among the Maximizing Enrollment grantee states are grouped into four main areas: 1) application and renewal simplifications; 2) customer interfaces; 3) system functioning; and 4) workflow management. This paper will discuss advancements and innovations in technology from the experience of the Maximizing Enrollment grantee states – Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia and Wisconsin – in each of these four areas of state eligibility and enrollment simplification work. In the Appendix, there is a chart that maps each state’s adoption of the strategies discussed. This paper includes all of the technology strategies that these states have adopted, including those adopted outside of the Maximizing Enrollment work, to demonstrate these states’ approach to technology and their accomplishments, as part of Maximizing Enrollment and outside the program.

Background

In 2009, the Maximizing Enrollment grantee states participated in a “Diagnostic Assessment” to help each understand its strengths, challenges and opportunities in its effort to simplify enrollment for children. This diagnostic assessment gathered data from the grantee states on their eligibility and enrollment policies and procedures including the creation of a process map for enrollment and renewal and key informant interviews during a site visit. Each state received an individual assessment and these findings were summarized in a final report. The value of states adopting technologies to support streamlined enrollment was a key theme that emerged from the assessment.

The diagnostic assessment revealed that most Maximizing Enrollment states were facing major barriers to implementing system modernizations, including the age and poor condition of existing legacy eligibility systems, the absence of funding for IT system improvements, eligibility system resources that were managed by separate agencies that often did not share the same priorities as the Medicaid or CHIP program, and the lack of skilled IT staff or vendor contracts to support implementation.² The report recommended states “invest in system improvements identified as having a high productivity payoff.”³ The report also identified technology as an essential component in improving states’ capacity to identify problems, monitor performance and collect eligibility and enrollment data. Finally, the report cautioned states that technological advancements, while promising, could never replace the need for “human touch” in the enrollment process, especially given the low literacy rates, language needs and complex lives of many applicant populations.

Several Maximizing Enrollment states had made important progress prior to the grant program. Two states, Louisiana and Wisconsin, had already implemented a number of strategies, including using electronic case records to manage their programs and online applications. Wisconsin was also using an online screening tool to help applicants decide if they should apply for health and other human service programs and customer-facing electronic accounts. Utah’s Department of Workforce Services was just launching what would become a statewide initiative to modernize all human services eligibility determination processes, including the overhaul of the state’s eligibility infrastructure that would allow electronic links to other programs and systems to verify eligibility. While all but one state were providing online applications and five out of eight states were providing online renewals, many of the states still required applicants to print out, sign, and mail in the final page of an application, and most states had only applied these simplifications to their child populations.⁴

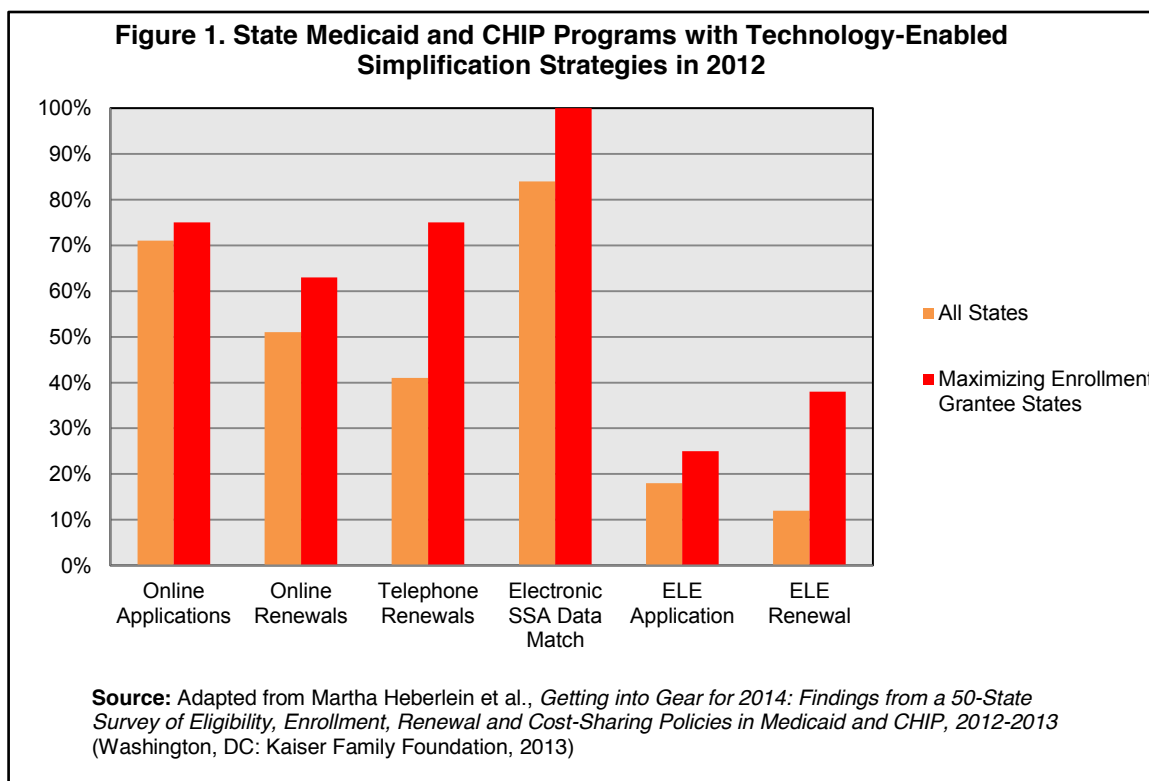
The ACA requires states to develop and implement new coordinated, consumer-friendly and technology-enabled strategies for enrolling individuals into public and publicly subsidized health coverage.⁵ State enrollment and information technology systems for Medicaid that were outdated and paper-based are to be reinvented as an “enrollment superhighway” that will provide a streamlined, integrated enrollment process for all health coverage programs, including Medicaid, CHIP, Basic Health Programs and premium tax credits and cost-sharing reductions provided for qualified health plans purchased through a health insurance exchange.⁶ System redesigns that fulfill the ACA’s eligibility and enrollment policy imperatives are a critical component to ensure successful enrollment of eligible individuals and, ultimately, access to care. Recognizing states’ need for additional resources to modernize their eligibility systems to comply with these new requirements, CMS provided guidance allowing states to apply for enhanced federal funding to support the development, implementation and maintenance of new IT systems.⁷

Key ACA provisions that all states must have in place by 2014 to promote simplified enrollment that rely on technological improvements include:

- Developing an Internet website portal for applications, benefit and other program information;
- Allowing submission of applications and renewals online and by phone;

- Using electronic verifications to document eligibility to the greatest extent possible, including real time data exchange with federal and state data sources (if the state determines that the information in those sources is available and “useful”);
- Providing an electronic notice option to consumers that allows applicants and enrollees to elect to receive coverage status or other program information electronically through a secure individual account; Securely exchanging electronic data with health insurance exchanges and other insurance affordability programs, as needed to determine eligibility;
- Providing the capacity to request appeals online or by phone; and
- Upgrading eligibility system functionality to comply with these new requirements and the Secretary’s standards for electronic enrollment.⁸

State adoption of technologies supporting simplified enrollment also accelerated significantly during the four years of the Maximizing Enrollment program, most likely in part due to the federal policy changes under the Children’s Health Insurance Program Reauthorization Act (CHIPRA) and the ACA. As the chart in Figure 1 below demonstrates, state adoption of a number of technology-enabled simplifications has increased dramatically for state Medicaid programs in just the past three years. As a result of the availability of new enhanced federal matching funds, nearly all states (92 percent) are pursuing a major upgrade of their Medicaid eligibility systems, intended to completely modernize how Medicaid eligibility determinations are made.⁹ Maximizing Enrollment grantee states are leading the field in adoption of each of these new technologies and have a valuable story to tell about their experience with implementation.



While it is clear that the work of the Maximizing Enrollment states on streamlining enrollment was part of a broader movement among states to adopt technology-enabled solutions, the grantees' work warrants examination, both as an example of the broader trend and because of the signal innovations the grantees adopted during this period. Maximizing Enrollment grantees have pioneered new strategies, in many cases paving the way for other states, for new federal policies under the ACA, and for the future.

Key Areas of State Work

Application and Renewal Technologies

All of the Maximizing Enrollment grantee states have leveraged technology to simplify the application and renewal process, although in different ways. A primary goal among all states has been to increase worker efficiency and capacity to manage an increasing caseload with diminishing resources. Providing an electronic application and renewal process that allows applicants or beneficiaries to enter their own personal information saves state workers time and can also lead to fewer omissions, transcription errors, and fewer incomplete applications submitted.¹⁰ Online and telephonic processes eliminate the need for individuals to be physically present at local eligibility offices, making applications and renewals more accessible to those eligible for coverage.¹¹ Online applications and renewals can also lead to faster processing of eligibility decisions, especially in states using an automated rules engine (logic-based system that can automate eligibility decision-making) that can provide a near-immediate review of the eligibility case record.

Given that all states must implement online and telephonic applications and renewals by 2014 under the ACA, there is much that states can learn from Maximizing Enrollment grantees' implementation experience, both in terms of operational implications and new strategies to consider.

Online Application and Renewal: Six out of eight Maximizing Enrollment states allow consumers to fill out and submit electronic applications for Medicaid or CHIP health coverage online.¹² While most Maximizing Enrollment states had online applications operational before the program launched in 2009, many made improvements to their online applications during the grant period, either as part of or outside the Maximizing Enrollment grant work. Only five of the eight Maximizing Enrollment grantees (Alabama, Louisiana, Utah, Virginia, and Wisconsin) implemented online renewal of benefits for Medicaid and/or CHIP.¹³ Three of the five states either implemented or improved online renewal during the grant period. The chart in the Appendix provides more detail on state activity in these and other areas.

Virginia's Online Renewal Process

Virginia's online renewal process for CHIP is already compliant with the ACA standards requiring maximum use of existing data and ensuring that beneficiaries don't need to sign a form to renew benefits.

The Online Renewal Process

- Virginia sends out a mailing 85 days before the renewal date providing a CHIP identification number and PIN code that will enable access to a pre-populated renewal form.
- The enrollee is then able to make updates on the screen or verify that all information is correct and must attest to income or provide updated information.
- Pay stubs can be uploaded online if needed to verify income.
- No signature is required to renew if there are no new applicants on the case.
- The renewal can be electronically submitted and processed.

Maximizing Enrollment grantees have implemented a number of inventive strategies that go beyond what the ACA will require of states in 2014 and may be worth additional consideration by states. These strategies include:

- *Online Submissions of Verifications:* Virginia (CHIP) and Wisconsin allow consumers to submit verification documents electronically. Virginia's CHIP program has reported that allowing applicants and beneficiaries to submit verifications electronically has contributed to increased complete application submissions and a lower denial rate for children due to incomplete applications.¹⁴
- *Automatic Data Population into Eligibility System:* During the Maximizing Enrollment grant period, Louisiana, Utah and Virginia (CHIP) updated their eligibility system functionalities so that eligibility data entered into the online application would automatically populate an electronic case record in the state's eligibility system. This small but important and technologically complex improvement meant a significant time savings for eligibility workers, who no longer have to enter in new data by hand, and for the state in reducing typographic errors that could lead to administrative denials or delays.
- *Bar Coding:* Utah and Virginia's CHIP program use bar codes on application materials to help the state more easily match application documents to the electronic case record. This is especially valuable in cases where documentation is outstanding and submitted later and can speed the process of ensuring that submitted verifications are married with the pending application in a way the system can recognize and enable additional decisions on the case to be triggered through an automated system.

- *Translation and Toggling From English to Foreign Language Versions:* States are required to ensure that application and enrollment materials are accessible to limited English proficient populations under the ACA. While final standards for state translation of application materials are still forthcoming, CMS has reported they plan to provide a Spanish language version of the application and will provide an outreach and enrollment guide in at least seven languages that will provide written translation of application questions from the online model application, which can be a resource for states using the model application.¹⁵ States that wish to use an alternate application format or that wish to have a foreign-language version may want to consider options for translating their application. A number of Maximizing Enrollment states have invested resources into translating their applications into foreign languages. Alabama built the system functionality to allow online applicants to toggle back and forth between English and a foreign language, enabling the user to translate some of the application as needed to confirm understanding of terms, but implementation has been delayed due to imminent changes to the online application under the ACA's streamlined model application requirements.
- *Horizontal Integration with Human Services Programs:* The U.S. Departments of Health and Human Services (HHS) and Agriculture have issued tri-agency guidance that supports state efforts to integrate benefits and recent ACA guidance gives states the option of using an alternative integrated application to allow low-income applicants to apply for multiple health and human service programs so long as they also provide access to a health-only application upon request.¹⁶ Illinois, Utah, and Wisconsin have online applications that allow beneficiaries to apply for multiple health and human service programs and Wisconsin allows individuals to use an electronic screening tool to determine whether they might be eligible for multiple health and human service programs.

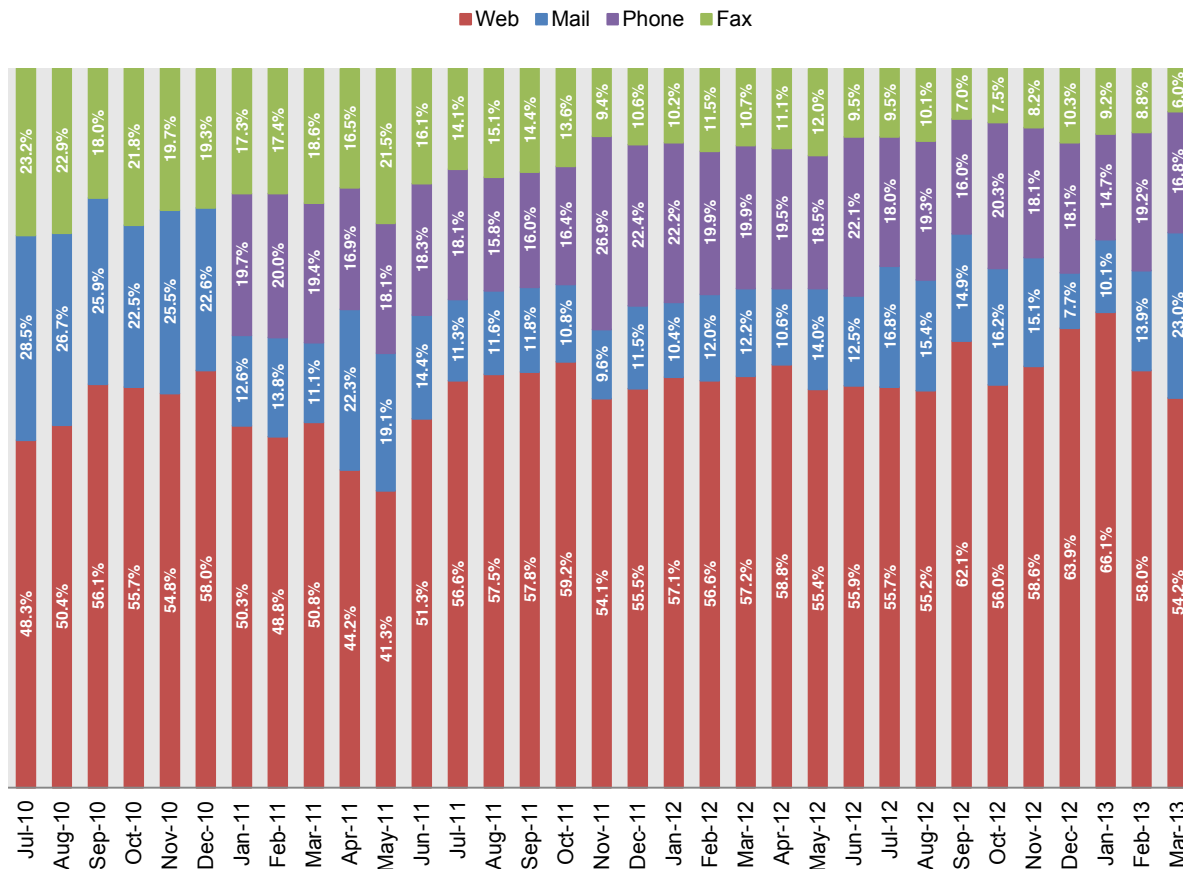
Telephonic Application and Renewal: An increasing number of states across the country now allow applicants to either apply for or renew benefits over the telephone, through conversation with a call center worker or through automated-voice response technology. Five out of eight Maximizing Enrollment states (Alabama, Illinois, Louisiana, Virginia and Wisconsin) have implemented some form of telephonic applications and renewals for Medicaid and/or CHIP programs.¹⁷ Completing applications and renewals over the phone allows workers to ask questions and get immediate answers and complete the process, which can lessen the rate of denials due to incomplete applications or renewals. Some states utilize this option only for renewals, as a signature is not required. For consumers in states that have adopted telephonic signatures, telephonic applications can speed enrollment because the date that the application is “signed” over the phone is considered the application date.

As early adopters of telephonic application and renewal technologies, Maximizing Enrollment states have piloted strategies that other states may want to consider, including:

- *Telephonic Signature:* Although states will have to accept applications and renewals by phone in 2014, the ACA doesn't require the use of a telephonic signature to document attestation by the applicant. Virginia's CHIP Central Processing Unit and Wisconsin have adopted systems for telephonic signatures that allow workers to create a brief recording of the application transaction. First, the worker repeats key information shared by the applicant, including a confirmation of household status. Then, the worker reads the applicant her rights and responsibilities and lists any documents needed to complete the application. Finally, the applicant attests to the information. The recording then becomes an electronic file that is attached to the case record for documentation. Wisconsin's experience has been that the entire telephonic signature process takes about five minutes. By contrast, Alabama's CHIP program, ALL Kids, creates a system-generated form summarizing the renewal information received over the phone that is mailed to the enrollee for review and signature. A mail-in process may take longer, since the final step requires return of the form, and there is a risk that the form may not be returned.¹⁸
- *Automated Voice Response:* Louisiana adopted automated voice response for Medicaid and CHIP renewals in July of 2004. This phone renewal option allows families to renew whenever they communicate with the state, providing them with a "rolling" or "off cycle" renewal that updates their enrollment for a year following the most recent renewal contact. Individuals can use this option any time they call the LaCHIP hotline, which serves Medicaid and CHIP and is available any day of the week at any hour of the day. All renewal letters also include this information. Under this process, an applicant has the option to renew by using the automated system, and the renewal information is then electronically routed to her local eligibility office. This type of system promotes efficiency for states and was cited by Louisiana as helping to save money (postage, paper and staff time) and improve accessibility of the program's renewal process for families.

As states prepare to adopt technologies to allow for online and telephonic applications and renewals, there are operational issues Maximizing Enrollment states have experienced that warrant consideration. First, a key issue for states has been the extent to which consumers are ready to embrace and use technology, which has varied among states. For example, Virginia adopted telephonic signatures for applications in January of 2011 and that same month received 20 percent of its new applications by phone (See Figure 2). Virginia's experience with Internet usage also shows that consistently roughly half of applications and a third of renewals are being submitted online. By contrast, Alabama implemented telephonic renewals for CHIP enrollees and has seen very low consumer use of this option, with only 163 enrollees attempting to renew telephonically (139 successfully) since the strategy became available in March 2011.¹⁹ Former Alabama Medicaid and CHIP enrollees interviewed about enrollment preferences in focus groups reported that they preferred online or paper applications over telephone renewal.

Figure 2: New Applications by Received Method July 2010 - March 2013

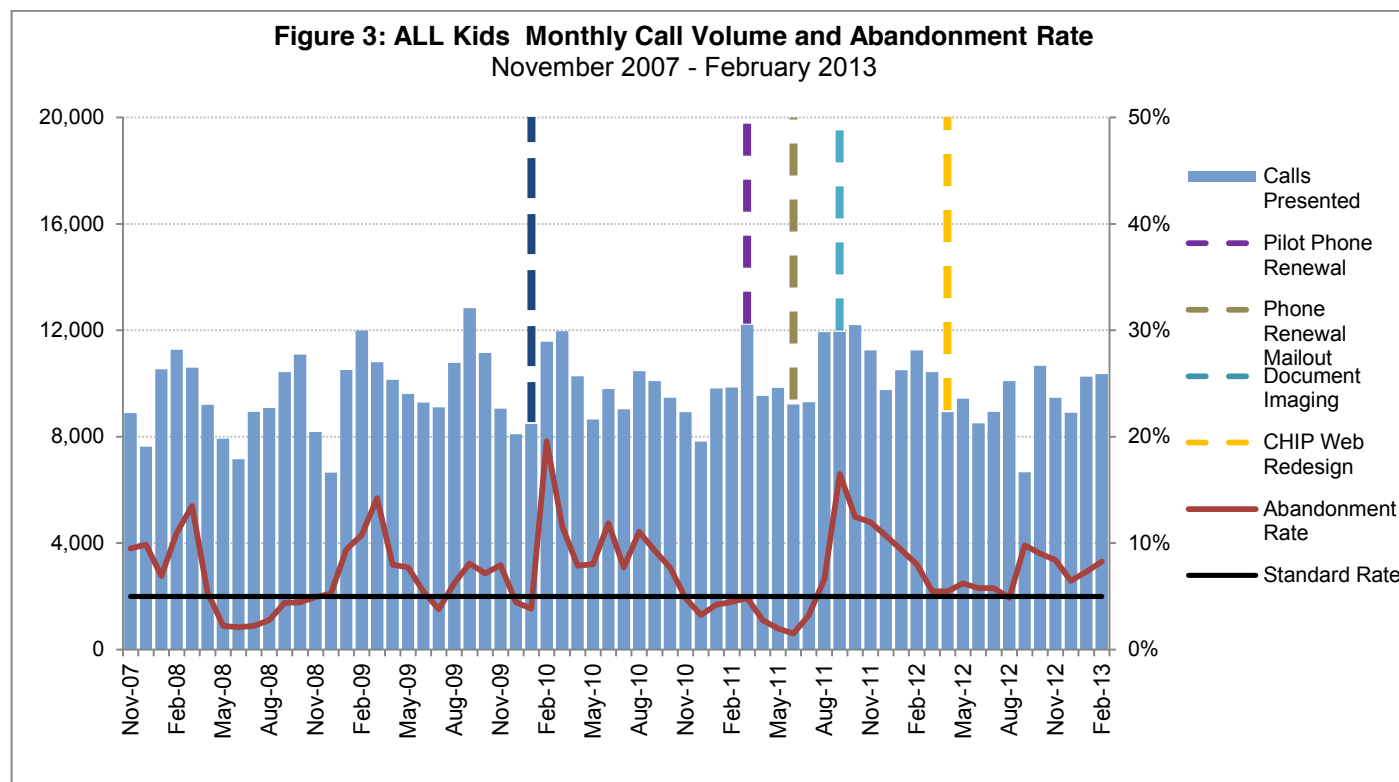


Source: Data received from Virginia's Maximizing Enrollment Team and collected from Virginia's Central Processing Unit. CPU Application and Renewals by Method. Kate Honsberger, email to Maureen Hensley-Quinn, April 17, 2013.

States have also developed new strategies to drive traffic to and deliver assistance for online and telephonic options. Utah has used eChat technology (discussed in greater detail in Consumer Interfaces, below) to answer questions during the application process or about a pending, open, or denied case. Louisiana crafted mailings to remind consumers about renewal and prompt them to use new telephone renewal options. Alabama, Utah, Louisiana have used focus group research to learn from consumers' challenges in the enrollment process and applied what they learned to adjust strategies for enrollment options.

Maximizing Enrollment grantees have also leveraged data to monitor and improve the effectiveness of these technologies in practice. Virginia has tracked the impact of telephonic enrollment on its vendor call center performance, including the increase in duration of the calls and total agent hours used to deliver this service. From this data, Virginia was able to determine that including a telephonic signature increased the average call time for all calls initially from a little more than four minutes to six minutes per call.²⁰

Alabama's ALL Kids (CHIP) program collects and tracks monthly call center volume and abandonment rates and overlays key policy changes to measure impact of the change on volume and call wait times/abandonment by consumers. (See Figure 3 below) In order to make the most of online and phone applications, states will want to capture and track data on bottlenecks that impede consumers' use of these technologies.



Source: Alabama Department of Public Health, data received from Maximizing Enrollment team, Bureau of Children's Health Insurance, *Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll Grantees*, April 5, 2013.

A final issue that states implementing new online and telephonic application and renewal technologies must keep in sight is being mindful in their implementation that they are not undermining access to traditional paper-based and in-person applications and that their processes are responsive to the diverse needs of the applicant population, including factors like language, disability, behavioral health, and Internet connectivity access. Access to all modalities is not only mandated by the ACA, but will be essential to ensuring access for the significant percentage of the population for whom other application and renewal options are not viable. States' investments in new technologies must support a full spectrum of accessible, functional application and renewal approaches.

Consumer Interfaces

Over the course of the grant, all grantee states made progress in their use of technology to interact more effectively with consumers. Common strategies employed by grantees included expanding application access, providing updated information in a timely manner, answering questions in a consumer-friendly way, and allowing applicants and enrollees more access to their benefit status and making it easier for them to update their personal information. These strategies helped improve staff productivity and consumers' access to information. Early implementation of these strategies means grantee states in some cases are already compliant with some new ACA requirements aimed at increasing consumer access to information. Under the ACA, all states will be required to:

- *Provide application, renewal, appeal and benefit information accessible to consumers electronically, by phone, in person and by mail;*
- *Receive and verify eligibility information electronically;*
- *Create secure electronic portals for submitting applications for coverage and Internet websites;*
- *Create an electronic notices option; and*
- *Provide consumer assistance for Medicaid, CHIP and exchange coverage.*²¹

Online Accounts: Online accounts can foster two-way communication between the Medicaid or CHIP agency and the client, allow Medicaid and CHIP clients to keep up with their accounts at their convenience, and reduce calls to a call center. By the end of the grant period, seven of eight Maximizing Enrollment grantee states (all but New York) provided access to online accounts, which reflects similar adoption of this technology across the country. The robustness of online accounts varies widely across states that have implemented them. Most online accounts allow applicants to complete an application, or to start one and then return to it later, still others also allow users to view the status of their account and report changes to demographic information. The more robust the online account, the more benefit the state will see in terms of reduced contacts and increased administrative savings.

Massachusetts' web portal, called the Virtual Gateway, allows families to apply for multiple programs, including Medicaid and CHIP, through registered community-based assistors called Virtual Gateway providers. My Account Page (MAP) was created to allow registered Virtual Gateway providers to access basic account information and report changes in contact or demographic information for clients. In 2010, with the support of the Maximizing Enrollment project, Massachusetts started allowing direct access to MAP by enrollees who are heads of household. Heads of household can set up a Virtual Gateway account with only their name, date of birth, an email address, and a four-digit PIN of their choosing. Once that account is active, they can use that unique username and password to manage certain aspects of their account using MAP. They can view case status, health insurance information, eligibility notices, and outstanding items needed for eligibility determination. Through MAP, users can also view the current status of documents submitted to the agency and submit changes to certain basic information.²² The state has found that online access to account information and encourages retention by reducing procedural closures.

Utah's myCase, an online account system implemented in November 2010, demonstrates the great potential of online accounts. The functionality of the myCase system goes far beyond most states' online account systems in place in 2013. MyCase's major functionalities include:

- Displaying basic case information
- Allowing customers to report changes online
- Allowing customers to submit applications and renewals online
- Allowing customers to view electronic notices online
- Integration with eREP, Utah's rules-based eligibility system, allowing for greater automation in eligibility determinations and notices²³

Electronic communication and data sharing come with an element of risk and the stringent security measures put in place by the Health Information Portability and Accountability Act (HIPAA) may not always be enough to protect health, financial, and other sensitive information. Utah experienced a data breach in 2012 and, as a result, an unauthorized third party accessed 780,000 myCase users' data – including 280,000 social security numbers. The state identified the cause as a default password that hadn't been changed in the department responsible for all IT systems, including myCase. In response, the state immediately alerted the media as well as affected individuals that the information had been compromised. They used myCase to share information quickly but also held community meetings, sent out paper notices, and opened a hotline for concerned citizens to call for more information. To protect their users from fraud, the state provided credit monitoring services for those whose social security numbers were involved in the breach. The state learned that you cannot assume things are always working as they should; that interagency agreements should have good deliverables and that all parties should know what is expected of them.

Grantee states have implemented additional strategies worth considering as states contemplate whether to create customer-facing online accounts:

- *Third-Party Access:* Some states have allowed individuals who have the applicant or enrollee's permission, including application assisters, family members, and other designated representatives, to log into a Medicaid or CHIP online account on the applicant or enrollee's behalf. In addition to increased convenience for many, third-party access is essential for those who need assistance applying for and managing their health insurance, particularly those with mental or physical impairments. Massachusetts and Utah have implemented this strategy. In Massachusetts, third party access is limited to Virtual Gateway providers through the My Account Page. In Utah, clients using myCase can designate an authorized representative to access their account information. Clients can manage how much access to their case the representative is allowed and can limit the access to a certain time period. All authorized representatives must agree to terms and conditions to gain access to account information.²⁴ Third party access can improve retention by allowing someone else to keep up with timelines and documentation requirements, particularly those with mental or physical impairments. Under the ACA, states will be required to accept applications submitted by authorized representatives on behalf of an applicant, so building in third party access capacity may be something all states will want to consider.²⁵

- *Electronic Notices:* MyCase gives customers the option to receive notices through the mail, to also have them sent to their account, or to go completely “paperless” and have notices only shared through the online account. Users must sign into their myCase account to actually view the notice, protecting sensitive information from others. Since Utah implemented e-notices in 2011, they have become a standard feature of eligibility in Utah. Under the Utah protocol, consumers can opt into receiving notices electronically and can choose to receive information either through email or text communication that new notices are available for review or that an interview is needed. All notices regarding hearings are sent through the mail. In 2012, 63 percent of households enrolled in Medicaid or CHIP were using myCase and, of these 39 percent had opted for eNotices. Between implementation in 2011 and 2012, Utah sent 101,000 eNotices, 26,000 text eAlerts and 551,000 email eAlerts, representing 40 percent of all notices sent. The state estimates annualized savings from reducing paper notices sent out to be \$522,408.²⁶ Providing electronic access to notices was not in line with CMS’s existing regulations in 2010. The state and federal agencies agreed to limit Utah’s initial implementation to a pilot and CMS outlined operational parameters.²⁷ Today, the national requirements for electronic noticing are based on Utah’s pilot process.

Kiosks: In an effort to bring online applications to populations with limited Internet access, several states have developed and deployed self-service kiosks. Two grantee states, Louisiana and Alabama, have implemented kiosks to expand access to and, in the case of Alabama, provide assistance with the online application. Kiosks can be effective in rural areas where access to in-person assistance through an eligibility office or community-based application assister is inconvenient, or where Internet connectivity is sparse or unreliable. Kiosks can also extend capacity to receive applications in understaffed local offices. While kiosks can go a long way to remove the barrier of access to hardware or Internet connectivity, additional barriers often remain. States must consider how to address the needs of individuals with low literacy or limited English proficiency or those with physical disabilities when implementing technology that might otherwise be inaccessible to certain populations. In some cases, these considerations are part of the kiosk design process by ensuring physical access or access for limited English proficient or visually impaired applicants and, as in Alabama’s case, providing translation assistance to Spanish-speaking users. A person’s ability to complete an application successfully using a kiosk ultimately depends on how user-friendly the online application is. Alabama collects data on applicants’ experience with the online application and found that 89 percent of applicants did not require assistance.²⁸

Louisiana’s kiosks consist of dedicated computer terminals in Medicaid eligibility offices available for use by all clients. As part of their Maximizing Enrollment grant, the state has investigated custom kiosks and appropriate partnerships for placement but, to date, has not been able to secure funding for the hardware needed for implementation.

The Alabama Department of Public Health expanded access to the joint Medicaid/CHIP online application through kiosks in 2008. Additionally, many of the kiosks employ a system, called Audio Visual Application Assistor (AVAA), which provides assistance to individuals with low literacy or limited English proficiency. Kiosks are located in some county health departments and Federally Qualified Health Centers. The kiosks allow applicants to submit verification documents through access to a fax machine and scanner and have a printer for the applicants’ convenience. Applications are submitted to the agency through a web service in the same manner as online applications submitted from a personal computer, a function supported by the state’s Maximizing Enrollment grant.

While some states have had positive experiences with implementing kiosks at both state and local levels, a comprehensive study of experience with kiosks conducted by Consumers’ Union identified

challenges and issues to consider in using kiosks to meet the needs of newly eligible populations under the ACA that may offer useful insights for states considering kiosk implementation. One challenge identified was that some states did not fully integrate kiosks into the state's eligibility systems so that the data provided into a kiosk application had to be manually entered into the state system. Another set of challenges related to barriers to use among the applicant population, including limited computer literacy, low literacy, limited English proficiency, and physical and mental health disabilities. A final issue identified was the need for privacy while entering personal health and income data into a kiosk application, which was incompatible with the open access environment offered by some states. To address these challenges, the report recommended that states design their kiosks stations to automatically populate application data into the state eligibility system, provide a robust consumer assistance model that includes assistance at kiosk stations including through interpreters, and ensure privacy by outfitting kiosks with privacy screens or locating them in private locations.

Online Chat: Medicaid and CHIP agencies are beginning to embrace online chat as they develop and improve their online applications; this consumer assistance technology is already a popular method of customer service in the private sector.²⁹ Chatting gives applicants an alternate option to ask questions while completing an online application. The technology benefits eligibility staff as well, allowing them to provide assistance to multiple applicants simultaneously. Utah and Louisiana are the only Maximizing Enrollment grantee states using this technology.

Utah implemented eChat in 2010 using the state's existing technology platform. EChat allows consumers to communicate through instant messaging with eChat communications staff regarding the application process or a pending, approved or denied case. The system also allows application assisters to chat with an eligibility specialist while assisting an applicant with their application.³⁰ EChat usage by consumers has grown over time. In March 2012, eChat communications represented 14.4 percent of in-bound contacts – up from 6.3 percent in August 2010. To hire staff with appropriate skills for the new technology, the Utah Department of Workforce Services (DWS) recruited interested and experienced staff and supervisors from the call center and conducted interviews for eChat applicants online to assess workers' capacity to communicate clearly and succinctly in a text-based environment. Utah piloted eChat before the statewide launch.

Utah learned lessons that might be helpful to other states considering eChat technology. The first is that customers looking for help will seek it out using all means available – even simultaneously. When Utah launched eChat, they allowed consumers to use it for any question relating to their application for benefits. The state immediately noticed that customers on hold with the telephone call center were also awaiting a response via chat. The state realized it needed to make a change, since eChat was effectively increasing their work burden instead of reducing it. Utah also learned that chat is not a one-size-fits-all solution, that some problems require verbal assistance. Utah addressed both issues by routing eligibility questions to the call center and technical questions about the online application to the chat.³¹ In this way, Utah is preventing consumers from “double dipping” for assistance and also ensuring that more complex eligibility issues are handled more effectively through interactive verbal communication.

Louisiana began using chat technology in December 2012. The state reports that five to seven staff working on the telephone hotline are also trained to answer questions via online chat, though only three are active on the chat at any given time, depending on demand. Online chat staff were selected based on their ability to type quickly and communicate effectively through text. Staff can address only one chat at a time and also answer phone calls. Any member of the public can ask a question using chat, which is accessible from any page of the online application or from the public Medicaid website. The chat function serves a general customer service purpose, with inquiries typically ranging from questions about applications, to case status, to complicated inquiries about the Medicaid program itself. The wait times for this program, albeit a new one, are significantly shorter than wait times for the hotline – wait times on chat are roughly four minutes, compared to an average of 20 minutes for the hotline.

System Improvements

Maximizing Enrollment grantee states employed technology to improve eligibility system operations and streamline eligibility verification and determination processes. A common driver among states spurring system improvements was the need to lessen burdens on eligibility staff in processing applications. Throughout the grant period, grantee states developed and implemented strategies to rely less on paper-based verifications and case files. Reducing or eliminating time spent completing verifications and increasing electronic access to case information will help states respond to the increase in applications they will receive with implementation of the ACA in 2014.

Electronic Verification: All eight Maximizing Enrollment grantee states use an electronic interface to verify at least one eligibility criterion: citizenship and identity. Additional electronic verifications are listed below.

State	Citizenship/ identity (SSA)	Income	Third Party Liability	Other Government income or benefits
Alabama	✓			
Illinois	✓	✓	✓	✓
Louisiana	✓	✓	✓	✓
Massachusetts	✓	✓		✓
New York	✓			
Utah	✓	✓	✓	✓
Virginia	✓	✓		
Wisconsin	✓	✓	✓	✓

Electronic verification is a key component of the ACA's "real time" approach to the enrollment process. Beginning in 2014 states will be required to rely primarily on electronic verification for eligibility decisions with paper available as a backup or secondary source, through the Federal Data Services Hub and state data sources, where available. While some states use electronic data sources to confirm information submitted on an application, others have begun automatically importing available information into the eligibility system, and not asking the applicant for the information at all.

Utah's eFind system takes electronic verification a step further by collecting all verification information into one location. The system is searchable and allows workers to note which data point they've used while processing a case. The \$2 million system paid for itself in its first year of operation, saving the state \$2.1 million in the first year and projected to save the same or more in subsequent years.³² Louisiana is in the development phase of a similar system, called the Consolidated Verification Summary (CVS), which is being supported by Maximizing Enrollment grant funds and is modeled after Utah's eFind system

Electronic Document Management (EDM): States with EDM accept and manage all eligibility documentation electronically. In most states, this also entails using a centralized system that stores and allows access to documents for any workers in the system. These documents may be submitted in person or by mail, scanned into the system using a kiosk or home computer, or inputted from another source. In some states, applicants may submit documentation by using the camera function on their smartphone. In many cases, EDM allows states to collect and process verification documents centrally and make them accessible to all workers, enabling the state to improve the speed of receiving documents, the capacity of staff to use documents to work a case, and ultimately to manage how work is assigned based on need. Six of the eight grantee states have adopted EDM (Alabama, Louisiana, Massachusetts, Utah, Virginia, and Wisconsin), with two of these states (Alabama and Massachusetts) implementing EDM with Maximizing Enrollment support.

Massachusetts has found great success in implementing EDM. Begun through pilots in selected enrollment centers in 2009, the state rolled out full implementation of EDM in all enrollment centers in 2011. The state quickly felt the impact of the technology on retention and customer service. With immediate access to documents, eligibility staff are able to answer customers' questions immediately, often resolving outstanding issues for applications that are awaiting final determination. This first-time resolution of issues, along with implementation of other operational efficiencies, has both reduced the volume of calls to the call center and call wait times.

Alabama's CHIP agency implemented a Document Imaging and Workflow Management System, which scans all incoming applications and documents into a centralized system managed in an electronic workflow, in September 2011. In addition to making applications and accompanying documents centrally available, this system has greatly increased the agency's ability to monitor the quantity and type of incoming applications, track the process of an application through the system, and assign work. State data documenting the impact of this system demonstrates it has greatly improved efficiency of the eligibility determination process, reducing the average processing time for all CHIP applications from six days to just one day.³³

This movement away from paper-based documents reduces the need for physical space for document storage and increases access to eligibility documentation beyond the caseworker processing the case. Implementation of this technology is not without challenges. States will need hardware, including digital scanners or multi-function printers, and the staff to complete the work of digitizing existing documents, which has required dedicated funds that have been hard for states to find given budget pressures in recent years. The availability of more generous federal matching funds to support upgrading eligibility systems and 75 percent enhanced federal Medicaid match for systems-related eligibility work may address some of these issues for states that implement changes before 2015. In addition, the availability of emerging technologies that allow applicants to upload photographs of scanned documents may also create another, lower cost means for applicants and states to share and store electronic documentation.

Electronic Case Records (ECR): ECR enables states to eliminate paper case records completely and instead track and record all case-related information and transactions in an electronic file that is secure, storable and shareable among eligibility workers. Essentially a virtual filing cabinet, ECR systems store images of application forms and verification documentation, notices and requests for information sent to clients, metadata on the members of the case, and records of calls or other activity related to the case. Half of the grantee states (Louisiana, Utah, Virginia CHIP, and Wisconsin) implemented this technology, all either before or outside of Maximizing Enrollment.

An early adopter of ECR, Louisiana has used ECR since 2004. Paper documents submitted to the Medicaid agency, either by mail or in person, are scanned into the ECR within 24 hours and then shredded. The information is accessible across the state and searchable by social security number or name. Universal access to the ECR allows greater flexibility with case processing. A case can be begun by one eligibility worker and finished by another in a different part of the state. This is particularly helpful in the aftermath of hurricanes when it is not uncommon to have an entire eligibility office closed for an extended period of time. The ECR is also accessible remotely, which has allowed Louisiana to have a robust telework program (discussed in greater detail in Workflow Process below).

Implementation of ECR fosters better accuracy and timeliness of determinations, more flexible workloads, and better customer service. With all case information accessible to customers online, inquiries can be resolved quickly, application processing can proceed without eligibility staff involvement, and supervisors can conduct quality control.

Express Lane Eligibility (ELE): Included as an option for states under CHIPRA for enrolling children into Medicaid or CHIP, ELE is a technology-reliant strategy that has shown promise in increasing enrollment and retention in recent years.³⁴ ELE has been implemented by four Maximizing Enrollment states (Alabama, New York, Massachusetts and Louisiana), all with Maximizing Enrollment support. Fundamentally, ELE allows states to borrow the determinations made by other needs-based programs to determine eligibility for children in Medicaid or CHIP. Louisiana and Alabama implemented the policy for applications and renewals in Medicaid. Massachusetts only uses the policy for Medicaid and CHIP renewals. New York uses it during the transition between Medicaid and CHIP at renewal.

Two grantee states' adoption of ELE may have significant implications for managing the increased workload associated with the Medicaid expansion in 2014. CMS has approved federal waivers for both Alabama and Massachusetts to use ELE as a strategy for enrolling adults.³⁵ Alabama uses the policy to identify and enroll Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF)-eligible women into their Medicaid Family Planning Program. Massachusetts uses ELE to renew coverage for parents and children receiving subsidized health benefits.³⁶ States with currently low adult eligibility levels that choose to expand eligibility to 138 percent FPL as envisioned by the ACA, will likely experience an immediate and significant increase in enrollment. To the extent enrollment or renewal can be automated, states may significantly reduce the administrative burden of the expansion. In May 2013, CMS released guidance approving several temporary strategies states can use to streamline enrollment of Modified Adjusted Gross Income (MAGI)-eligible adult groups, including one that allows states to use SNAP income data to enroll non-elderly non-disabled persons into Medicaid without completing a separate Modified Adjusted Gross Income calculation and determination.³⁷ Either the ELE waiver or the temporary income determination option offer opportunities for states to use existing data from existing SNAP enrollment to support Medicaid enrollment in 2014 and beyond.

Workflow Management

The implementation of new technologies has prompted most Maximizing Enrollment grantees to rethink how the work of making eligibility and enrollment determinations is done. As a result, a few grantee states have redesigned business processes, changed job structures, and introduced new management tools and incentives to better fit their programs' new goals. While these changes are not always well documented or publicized, they can allow states and their workers to reap the greatest benefits from new technologies, including cost savings, greater worker efficiency, improved staff morale, faster benefit decisions, and a leaner business operation. Wisconsin's former Medicaid Deputy Director and Maximizing Enrollment project lead James Jones once said the challenge for states in implementing new technology was to "not pave over cow paths." States needed to allow themselves the freedom to invent new, different and more modern ways of doing business rather than simply incorporating old, outdated, and unnecessary processes into an electronic environment. Maximizing Enrollment grantees have employed a number of innovative strategies to rethink their work practices and structures to keep pace with technology.

Business Processes to Manage Work: Maximizing Enrollment states with the greatest change in their use of technology before and during the grant period also experienced some of the greatest shifts in how they approached their work processes. When Utah implemented its new eRep eligibility system in 2009, the state faced multiple challenges: more work coming in, significant changes in how work was being done, new leadership for the state's eligibility agency, the Department of Workforce Services (DWS), and a sizeable backlog of cases. Leaders quickly realized their first priority was to figure out how to streamline the workflow process for staff and use new technologies to lessen staff burden. With support from the governor and partner agencies like the Department of Health, DWS worked to define their management tools and developed a "throughput operating strategy" that would focus on "feeding the control point" – the eligibility worker – to maximize the worker's capacity to move cases to complete decisions. The state developed tools, like the "full kit" approach that informs eligibility workers when cases assigned to them have all the information and documentation needed for a decision, and used eChat and electronic notices to help consumers quickly resolve issues and respond with information when needed. Using these and other tools that enhanced eRep, Utah was able to eliminate the backlog of cases, manage an increasing workload of cases with fewer staff, and bring the timeframes for outstanding tasks down to 10-15 days from a previous maximum of 108 days.

Virginia's CHIP agency has also made major changes to business processes as the state has assimilated new technologies. Virginia also found the movement to online and phone processes required them to move from case management (where one worker "owns" a case and works it exclusively) to a "production work" mindset (where multiple workers can work a case, performing case tasks as needed to help get the case to a final decision when it is ready to work). Responding to the new challenge of not being able to see and directly monitor the paper case files to determine workflow needs, Virginia adopted a "Paperless Workflow" system to manage their work.

As noted above, Alabama's CHIP agency has also adopted a document imaging and workflow management system, that helps them monitor applications coming in and assign work out to staff based on need and work burden. Before implementing this system Alabama used paper-based applications and had only informal, manual tracking systems in place to monitor application processing. With the new system, Alabama's CHIP program increased its ability to monitor the number of applications being submitted, track their progress, and assign and manage work associated with incoming cases. As a result of implementing this new system, Alabama's CHIP program is processing its applications faster and is better able to manage work to equalize work burdens among staff. Alabama CHIP reports that the new system enabled the state to reduce the number of days to process a Medicaid application from six to only one day and to reduce renewal processing from six days to two days (see Figure 5, below). Alabama has also developed quality

control measures and metrics to ensure that processing time is reported accurately and can be monitored. One key issue for the state has been ensuring that additional staff is trained to assist with scanning documents in case of vacancies or increased application volume so that the state can keep its processing time low.³⁸

Figure 5: Alabama CHIP Average Processing Times Pre- and Post- Document Imaging and Workflow Management System

Average Processing Time (Days From Rcvd/Scan Date)	New apps	Medicaid	Renewals	All App Types
Post- Implementation of New CHIP E/E System (Jan 2010 – Aug 2011*)	6	6	6	6
Post-Implementation of Document Imaging/Workflow Management System (Jan 2012* – Feb 2013)	1	1	2	1

***Note:** The Document Imaging and Workflow System, while initially implemented in September 2011, was not fully implemented until January 2012; therefore processing time was excluded from these calculations from September through December 2012.

Source: Alabama Department of Public Health, data received from Maximizing Enrollment team, Bureau of Children's Health Insurance, *Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll Grantees*, April 5, 2013.

Workforce Structures and Roles: A number of Maximizing Enrollment grantees opted to rethink existing agency structures and worker roles and responsibilities in light of new technologies coming on line to support eligibility and enrollment work. New York has been gradually moving from a local, county-based approach to enrollment toward greater centralization of functions. New York began by centralizing the processing of renewals and offering a telephone renewal option in twelve counties. Telephone renewals are an option in 31 counties today. The state is centralizing the processing of applications for Insurance Affordability Programs (Medicaid, CHIP, and federal premium tax credits and cost-sharing reductions) beginning in October 2013. As part of this transition, the state has already hired a number of county eligibility workers into the state system to do this work and plans to transition many of the eligibility functions from county to state control over the next five years.

Utah also reorganized how eligibility work is done in the state. In anticipation of implementation of their eRep system in 2009, Utah transitioned from a region-based system to a state-based operational approach. After forming in-house work teams, the agency's leaders set a new organizational vision and goals. Their primary goals were to reduce costs, improve operations to be more competitive with private sector models and use technology to "virtually centralize" staff in county offices and work-at-home employees to better distribute work, provide access to comparable work tools and standardize consumers' experience of the program. Within six months, the eligibility agency reorganized into a state-based operational structure with four eligibility service centers, 36 offices, and 166 telecommuters. All staff are linked by a central phone line with interactive voice recognition software and all eligibility workers receive and process cases through eRep.

As part of this transition, Utah also completely restructured worker roles to better fit the needs of a technologically-enabled eligibility agency. The newly developed work teams realized that they needed to recreate positions to better match the types of work and different roles needed given the increase reliance on online casework. Agency leaders then required all agency employees including managers to reapply for the new positions and worked to match individuals with new positions based on skills and interests. While this process was described by Utah officials as "painful," only one of the state's hundreds of merit-based employees filed a grievance and no one was laid off, although some workers were reassigned. The staff was organized into teams (for Family, Aged, Blind and Disabled, CHIP, refugees, Long Term Care and waiver populations) to ensure that work would flow to the right staff for

casework needs. Even though caseloads have grown, fewer workers manage the entire caseload, error rates have dropped, and the cost to process each case has dropped from \$45 to \$35 per case.³⁹

Louisiana has aggressively used telephone renewal as a tool to maximize renewals of eligible children in part by engaging their workforce and moving from a passive to proactive approach. As part of their reform efforts in the Covering Kids and Families program, Louisiana decided to engage their workers in identifying work flow barriers and recommending solutions that could be tested on a small scale, measured, and then expanded to more sites. This local empowerment and “plan, do, study, act” model, along with a shift from case-based to task-based approach, has helped Louisiana develop new strategies in its approach to renewal and has accomplished a significant reduction in denials of children eligible for coverage at renewal, from 22 percent in 2001 to less than one percent in 2011.

Management Tools and Incentives: Maximizing Enrollment grantees have used a number of inventive tools and incentives to manage workers in a paper-free environment. In Louisiana, the state created new ways to distribute cases on a monthly basis electronically and created new metrics to allow workers and managers to monitor and incent completion of work. Louisiana also uses a remote workforce, enabled in part due to the adoption of the ECR. Louisiana managers are able to monitor worker performance of case-based tasks at quarter-hour increments to ensure work is getting done, even when work is off site. Louisiana has a formal work from home policy that outlines worker rights and responsibilities. As a result of formalizing their policy, Louisiana has been able to transition 42 percent of its Medicaid eligibility workforce to remote status. This transition has saved the state money as the state has been able to close local offices, reduce its spending for office space and equipment, and improve worker productivity and retention. The state also reports improved worker morale due to the flexibility that remote work offers.

Utah has been piloting a “pay for performance” initiative on a voluntary basis to incent worker performance under an electronic work model. The state recognized that under the old system, workers have a disincentive to work harder since the reward for doing more work was just a greater workload. The agency leaders received permission to create a new model that would reward high performance with additional pay. To do this, the agency didn’t fill eight vacant positions and used the extra funds to create an incentive fund. Agency managers created performance metrics with case processing expectations for workers on a monthly basis, based on average number of cases processed. Workers that participate in the pilot can earn financial bonuses for every pay period in which their work exceeds the performance standards, up to \$8,000 in extra bonuses per year. Although the pilot started with only 45 staff, it now includes 400 workers due to increased demand for voluntary participation among workers. Workers participating have reported improved morale and appreciation for the bonuses.⁴⁰

Lessons for Other States

Maximizing Enrollment grantee states have learned important lessons from their experiences on the leading edge of technological improvements that may offer value to other states as they enter this field more fully in preparation for implementation of the ACA’s technology requirements. Key themes either reported or drawn from these states’ experience are noted below.

Let Policy Drive the Technology

Many of the grantee states that experienced major, successful technological improvements said that their work had been driven by a policy goal to improve operational functioning. Louisiana Maximizing Enrollment project lead and Medicaid Deputy Director Diane Batts reported that they first developed their vision for transforming renewals through tools, including Express Lane Eligibility, then worked

with their IT experts to accomplish the vision. In past experiences, she reported, eligibility policy staff often felt like their capacity for change was constrained by what the IT experts said could be accomplished. In their work, Batts said, policy was going to “drive the technology” instead. In this way, technology became a lever to accomplish Louisiana’s larger goal of improving retention of eligible children, rather than an end in itself. Other participating states, including Wisconsin, Massachusetts, Utah and Virginia, also reported a similar approach with successful outcomes. Given the rapid pace of reforms to implement the ACA, many states may feel pressure to pursue more off-the-shelf technological solutions, but the Maximizing Enrollment state experience underscores the value of making sure the technology is suited or adapted to meet states’ goals.

Technology Does Not Eliminate the Need for “Human Touch”

Grantees that worked to simplify and automate the enrollment process learned that in many cases there is no replacement for the value of direct human contact. While Utah has seen increased productivity and streamlined processes and operations, its performance in enrolling and retaining children, while improved over the grant period, remains low compared to other states. One concern some state officials raised was that driving too much enrollment traffic online and removing direct human contact could be undermining their enrollment successes. While Utah does provide support through call centers and online chat, it does not provide as much direct in-person consumer assistance through application assisters as some of the other grantee states do.

Training In-House IT Staff Can Pay Significant Dividends

While many states tend to rely on outside technology support from vendors, a few of the Maximizing Enrollment states found they were able to reap significant rewards when they included and trained their own IT and policy staff on the new technologies being implemented. Utah had this experience when the state implemented its eRep system. When the state wanted to customize an IT solution to support using eRep, the state staff ended up helping to design and create support tools and interfaces for eligibility worker use. Utah also reported that their trained staff now review all proposed IT projects and can reject any that does not fit with Utah’s vision and technology operations. In this way, the state has been able to maintain a unified technological approach that doesn’t rely on too many complex structures and vendors for ongoing maintenance.

New Technologies Require New Approaches and Processes

Many grantee states reported having a realization, either before or after implementation of a new technology, that business operations needed to change substantially to take their new environment into account. Rebecca Mendoza, Virginia’s CHIP and Maternal and Child Health Director and Maximizing Enrollment project lead, articulated the challenge of managing what had previously been a paper-based eligibility production in an electronic environment, asking if the paper is “out of sight,” are worker’s caseloads “out of mind”? Louisiana experienced the same challenge and, due in part to its innovations in managing work electronically, was able to transition to a remote workforce model that allows 42 percent of its workforce to work off site, which has saved the state in office space and equipment costs and improved worker retention and morale.

Involve Local Staff in the Change Process

Grantee states can attest to the value of involving local staff in the process of planning for and implementing change. Louisiana found that involving local staff offices prompted creativity, improved morale and resulted in greater ownership and understanding among all staff about the reasons for change. Virginia has also worked to include local offices as they look to implement ACA-driven changes to ensure workers on the front lines understand change drivers and expectations as they evolve. Utah also shared that “change challenges morale.” States implementing major technological improvements will want to anticipate morale challenges with approaches that will improve direct communication with front-line workers and ensure that workers understand their new roles and contribution towards new technology so that workers don’t end up feeling like it is them feel like the workforce itself is outdated.

Plan for Security Protections

Two of the grantee states experienced security breaches during the grant period. While both states had thought that their security protections were adequate before the breach, both regretted the absence of clearer protocols to protect sensitive information and not having a plan for post-breach management. The ACA requires states to implement more stringent security protections and to ensure that electronic data transfers are secure. States may also want to invest time in planning how to manage securing information in case of a breach and a solid communications plan for the public.

Leadership and Vision Are Essential

Grantees clearly benefited from strong leadership and vision articulated by their leaders to support implementation of new technology. As one state official in Utah observed, “nothing implements itself.” New technology is complex and requires dozens of policy decisions to be implemented successfully. Having clear goals and principles to guide the change will ensure that the implementing team can stay on track. Strong leaders who can shepherd the team and support definitive and timely decision-making are essential to success. Having a clear governance structure to support decision-making and work, including incentives for cooperation among agencies that will need to work together to implement change, is also positive. One grantee also stressed the value of asking for what is needed to support new technology – whether from federal or state leaders. Utah cited their example of asking CMS for permission to implement electronic notices, which will now be required for all states under the recent proposed ACA eligibility guidance.

Change Takes Time

While new technologies may be implemented on a speedy timeframe, grantee state experience demonstrates that the process of real change in terms of worker culture and agency impact happens more slowly. Utah reported that it implemented the organizational restructuring needed to bring eRep online in six months, but it took about three years for the agency to truly assimilate the changes and normalize its work. Many of our grantees also reported finding that their technology solutions needed adjustments with implementation and talked about the value of listening to customers and frontline workers to understand better when and which adaptations are needed.

Future Directions

As states consider new opportunities to use technology to support more seamless and efficient eligibility, enrollment and retention practices in coming years, there are a number of additional strategies they may want to consider:

- **Outreach:** States will have new challenges and opportunities to confront as they work to identify and enroll the newly eligible into coverage programs and new technologies can aid their work. Groups like Enroll America are already planning to use publicly available consumer database information paired with sophisticated data mining algorithms to help them identify adults who are likely to be uninsured. States may want to adopt these technologies and use what they learn to engage in micro-targeting of likely uninsured through person- or area-targeted outreach or targeted media buys in certain parts of the state. States like Virginia are already using social media like Facebook and YouTube to drum up interest among teens in coverage programs like Medicaid and CHIP. Other states will likely want to explore social media as a way to reach and engage the public, especially millennials, in new coverage options.
- **Applications:** States are already considering developing special smart phone applications, including functions that allow individuals to apply for coverage and upload documentation with their phone. Ensuring that applications are accessible via smart phones is critically important, especially for racial and ethnic minority populations that are more likely to access the Internet using smart phones and other hand-held devices. According to research published in 2010 by the Pew Internet & American Life Project, nearly two-thirds of African-Americans (64 percent) and Latinos (63 percent) are wireless Internet users, and minority Americans are significantly more likely to own a cell phone than their white counterparts (87 percent of blacks and Hispanics own a cell phone compared with 80 percent of whites).⁴¹ States will also want to be thinking about new ways to make application materials and assistance accessible in other languages and for individuals with disabilities. Secretary Sebelius announced in June of 2013 that the federally facilitated marketplace national call center will communicate in more than 150 languages, and CMS has separately disclosed that the electronic model application all states will be available in English and Spanish with an online companion tool in another seven languages. Federal assistance with qualified, expert translation of the application and culturally competent translation for all forms of assistance will be needed to ensure that limited English proficient applicants have equal access to the application process and, ultimately, coverage.
- **Enrollment:** For many states, selection of a health plan has not historically been well-connected to the eligibility determination process. Given the seamless approach to enrollment into coverage that states are planning to adopt, technologies that allow for automated plan selection based on applicant preference or default enrollment is a next frontier in state enrollment work.
- **Renewals and Transfers:** Once states have invested human capital into enrolling individuals into coverage, they will want to protect their investment to ensure that renewals or transfers of coverage due to a change in eligibility are as seamless as possible. To that end, it will be vitally important for states to invest in new system interfaces and new technological tools that make the process of renewing or transferring as easy as possible, both for consumers and for

workers. Another area of work for states and federal agencies is ensuring the complete interoperability and capacity to exchange information, not only between states and the federally facilitated marketplace or the federal data hub, but also across state eligibility systems, so that individuals who move across state lines can be enrolled quickly.

Federal and state policymakers can also take action to ensure that investments in technology improve enrollment and promote efficiencies. First and foremost, states and federal officials will want to convene together to learn from their early experiences, share and document best practices, and promote adoption of successful strategies. Given the diversity of state progress and approaches, providing opportunities for peer-learning will improve efficiencies by ensuring that states don't need to recreate the technological wheel. CMS is already doing this through learning collaboratives and a shared cloud-based space for posting electronic artifacts, but increased direct engagement of all states at learning conferences and webinars will be needed in the coming years to maximize opportunities for success by states and federal agencies.

States and federal agencies can also benefit from a more focused approach to learning about the end user experience of the eligibility and enrollment process. While many Maximizing Enrollment states have used focus groups to support this end, it will be critical for states and federal agencies to invest resources into data collection and evaluation to learn as much as possible about how well the process is working for the end user. California's recent series of evaluations on the Health-E-App program is a great example of the value of data collection and its impact for policymakers. In that evaluation, California has already learned that online applications can draw in more affluent and Internet-savvy consumers without much additional outreach but that other applicants, including lower-income applicants, previously uninsured applicants, and those that predominantly speak Spanish, have been less likely to apply online without additional outreach. In order to be able to monitor and learn about user experience, states first have to have metrics in place to measure utilization and performance. Foundations and research organizations can also inform the dialogue by undertaking projects to shed light on the impact of technology for end users. The topic of performance measurement metrics will be addressed more fully in a forthcoming Maximizing Enrollment paper addressing state strategies to manage policy and system changes.

Importantly, many state and federal agency investments in system change and new technologies primarily target eligibility of non-disabled, non-elderly individuals. As a result, there is a real risk that elderly and disabled applicants will be left with an antiquated, paper-laden process. States and federal officials may want to leverage new technologies and strategies to streamline eligibility and enrollment processes for elderly and disabled individuals, to ensure that Medicaid's modernization is program-wide.

Conclusion

As states prepare for the ACA-driven technology changes in how they conduct eligibility and enrollment operations in their health coverage programs, they can gain new insights from Maximizing Enrollment grantee states' experiences, innovations and lessons learned. These lessons represent a leading edge of what will likely be a new era of technology-based eligibility and enrollment strategies that will be widely tested across the nation with the implementation of the ACA in the coming decade.

While 2014 will be a year of significant change for states, experience with Maximizing Enrollment states demonstrates that this will be the beginning, not the end, of the learning curve. As states continue with their work, they should continue to invest in and reap the rewards from peer state learning and look for new opportunities to learn and grow as they forge a new vision for the future of eligibility and enrollment systems.

Notes

¹ Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, Final Rule, 76 Fed Reg 21950 (U.S. Department of HHS, April 19 2011, Preamble) at 21951. CMS further noted that “these systems transformations should be undertaken in full partnership with Exchanges in order to meet coverage goals, minimize duplication, ensure effective reuse of infrastructure and applications, produce seamless enrollment for consumers, and ensure accuracy of program placements.”

² It is worth noting that these barriers to system modernization have been very common among all states and are not unique to Maximizing Enrollment states.

³ Jennifer Edwards et al, Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States, (Washington, DC: National Academy for State Health Policy and The Robert Wood Johnson Foundation, 2010), 3.

⁴ Jennifer Edwards et al, Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States, 37-38.

⁵ Beth Morrow and Julia Paradise, Explaining Health Reform: Eligibility and Enrollment Processes For Medicaid, CHIP, and Subsidies in the Exchanges (Washington, DC: Kaiser Family Foundation, 2010).

⁶ Alice Weiss and Laura Grossmann, Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today (Washington, DC: National Academy for State Health Policy, 2011).

⁷ Patient Protection and Affordable Care Act: Health Insurance Premium Tax Credit, Final Rule 77 Fed. Reg. 30377, May 23, 2012 (to be codified at 42 CFR § 433); United States, memorandum from Health and Human Services, Centers for Medicare & Medicaid Services, Medicaid/CHIP Affordable Care Act Implementation: Answers to Frequently Asked Questions Availability of Enhanced Funding for IT Systems (90/10), Nov. 19, 2012. <http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/Eligibility-and-Enrollment-Systems-FAQs.pdf>

⁸ Alice Weiss, Abby Arons and Julien Nagarajan, States’ Medicaid ACA Checklist for 2014, (Washington, DC: State Health Reform Assistance Network, 2013).

⁹ 47 States have either submitted or received approval of an advanced planning document to implement a major Medicaid eligibility system overhaul and most states (82%) had already begun work at the time the survey was completed in January of 2013. Martha Heberlein et al., Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013 (Washington, DC: Kaiser Family Foundation, 2013), 13.

¹⁰ Virginia halved its percentage of new applications denied due to an incomplete application submission, from 18% of all new applications received in June of 2010 to only 8% in July of 2011. In July of 2010, Virginia implemented e-signatures and online submission of documentation to support enrollment. While it is unclear whether there is a causal relationship between the policy and the impact on denials, it seems likely that some of the decline in denials may be due to the increased accessibility of online application completion through the use of these new technologies. Rebecca Mendoza. PowerPoint Presentation. “Getting in the Act? The State of State Implementation of Health Care Reform: Virginia’s Experiences Using Technology to Streamline Enrollment.” Uploaded to StateReform, October 11, 2011. <http://www.statereform.org>.

¹¹ Oklahoma’s experience with online enrollment demonstrates that consumers will use this increased accessibility where the opportunity exists – in calendar year 2011, a quarter of all online applicants filed their applications during evening and weekend hours. Alice M. Weiss, “Hard Work Streamlining Enrollment Systems Pays Dividends to the Sooner State,” Health Affairs 32, no. 1 (Jan 2013): 8.

¹² All of the six states that provide consumer-facing online applications except one (Illinois) accept electronic signatures. Two more states (Massachusetts and New York) allow electronic submission of applications through application assisters.

¹³ Three of the five states that have implemented online renewal (Alabama, Utah and Virginia) implemented or improved access during the grant period. An additional grantee state (New York) developed an online renewal tool during the grant period. This tool is used by their centralized Enrollment Center to process renewals in 31 counties.

¹⁴ Rebecca Mendoza, “Getting in the Act? The State of State Implementation of Health Care Reform: Virginia’s Experiences Using Technology to Streamline Enrollment”, slide 16.

¹⁵ Asian & Pacific Islander American Health Forum, letter from Centers for Medicare & Medicaid Services, Department of Health & Human Services, April 22, 2013. http://www.healthlaw.org/images/stories/CMS_LEP_letter-05052013214435.pdf

¹⁶ United States, Tri-Agency Letter from The Department of Health and Human Services and The Department of Agriculture, Cost Allocation of Information Technology Systems, Jan 23, 2012; Patient Protection and Affordable Care Act: Medicaid Program: Eligibility Changes Under the Affordable Care Act, Final Rule 77 Fed. Reg. 17144, March 23, 2012 (to be codified at 42 CFR § 431, 435, and 457).

¹⁷ A number of states’ use of telephonic applications and renewals are limited and not as expansive as what will be required under the ACA in 2014. Illinois’ telephonic application requires applicants to sign and submit a signature page and both applications and renewals require paper documentation of any eligibility issue that cannot be verified electronically. Louisiana applicants must follow up with a written signature until the new application is ready for signature. New York is piloting telephonic renewal through a centralized enrollment center, and now exists in 31 counties. Utah provides assistance in completing online applications over the phone but requires a signature to be submitted and does not use a telephonic signature process. Virginia’s telephonic applications are only accepted through calls to their Central Processing Unit, not through local departments of social services.

¹⁸ Alabama reported that 163 enrollees attempted to renew by phone from March 2011 until May 2013 as part of a pilot program soliciting 500 enrollees to renew coverage. Of these 163 enrollees, 60 percent (97 enrollees) successfully renewed, 15 percent (25 enrollees) were income eligible for Medicaid and referred for enrollment, about 10 percent (17 enrollees) did not successfully renew because they were ineligible or hadn't paid their premium, and 15 percent (24 enrollees) failed to complete the process. Alabama Department of Public Health, data received from state Maximizing Enrollment team, Bureau of Children's Health Insurance, Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll Grantees, April 5, 2013.

¹⁹ Ibid. Note that Alabama has not advertised the availability of telephonic renewal beyond the pilot group.

²⁰ Impact of Telephonic Signature on CPU Call Center, Submission from Virginia. Kate Honsberger, email to Maureen Hensley-Quinn, April 2, 2013.

²¹ Katie Baudouin, Christina Miller, Rachel Dolan, Designing Consumer Assistance Programs: Resources from the Field, (Washington, DC: State Health Reform Assistance Network, 2013); Alice Weiss, Abby Arons and Julien Nagarajan, States' Medicaid ACA Checklist for 2014.

²² Massachusetts Executive Office of Health and Human Services. "Viewing Health Assistance Benefit Information." Retrieved April 11, 2013. <http://www.mass.gov/eohhs/consumer/basic-needs/vg/map/viewing-health-assistance-benefit-information.html>.

²³ State of Utah. MyCase one-pager information sheet. Uploaded to StateRefor(u)m, June 21, 2012. <http://www.statereforum.org>.

²⁴ Utah Department of Workforce Services, "3rd Party Provider Services." Retrieved June 6, 2013. <http://jobs.utah.gov/occ/occ2/forproviders/mycase3party.pdf>

²⁵ Under federal guidance, states must ensure applicants have the ability to designate an individual or organization to act as an authorized representative, either at the time of application or at any point thereafter. CMS intends to include the ability to designate an authorized representative on the single streamlined application but states may include this on alternative applications as well. Court orders, powers of attorney, and other legal documentation can also be used to designate a representative. Both the applicant and the representative must have the ability to terminate the relationship as they wish and all representatives must adhere to confidentiality and data security standards. U.S. Department of Health and Human Services, Federal Register 78, no. 14 (January 22, 2013).

²⁶ Tricia Cox. PowerPoint Presentation. "eNotices & eAlerts." Presented at the State-to-State Exchange, Maximizing Enrollment, Salt Lake City, May 17, 2012.

²⁷ State of Utah, CMS Letter of Approval for eNotice Pilot. Uploaded to StateRefor(u)m, June 25, 2012. https://www.statereforum.org/sites/default/files/cms_enotice_waiver_1.pdf

²⁸ Julie Silas and Christina Tetreault, Addressing Barriers to Online Applications: Can Public Enrollment Stations Increase Access to Health Coverage?, (San Francisco, CA: Consumer Union, 2011).

²⁹ Tricia Brooks and Jessica Kendall, Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP and the Exchanges, (Washington, DC: Maximizing Enrollment, 2012). Several states are planning to build chat functionality into their new eligibility systems. Additionally, at least three states, Arizona, California, and New Mexico have included it in their Exchange plans.

³⁰ Greg Paras. PowerPoint Presentation. "Online Chat Overview." Presented at the State-to-State Exchange, Maximizing Enrollment, Salt Lake City, May 17, 2012.

³¹ Tricia Brooks and Jessica Kendall, Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP and the Exchanges.

³² State of Utah, eFind one-page information sheet. Uploaded to StateRefor(u)m, June 21, 2012. <http://www.statereforum.org>.

³³ Alabama Department of Public Health, Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll,

³⁴ Maureen Hensley-Quinn, Mary Henderson, and Kimm Mooney, State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future, (Washington, DC: State Health Reform Assistance Network, 2012).

³⁵ Though in recent years CMS has been supportive of waivers to use ELE for adults, recent comments from the agency indicate that that support is softening.

³⁶ Maureen Hensley-Quinn, Mary Henderson, and Kimm Mooney, State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future.

³⁷ Center for Medicare and Medicaid Services, State Health Official Letter: SHO#13-003, Facilitating Medicaid and CHIP Enrollment and Renewal in 2014, May 17, 2013. <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>

³⁸ Alabama Department of Public Health, Response from Alabama CHIP Regarding NASHP Inquiry on Technology Experience for MaxEnroll, 4-5.

³⁹ For more information on Utah's approach to Workforce Culture Change, see Nicole Dunifon, IT Innovations One Piece of the Puzzle: A Look at Utah's Workforce Culture Change, (Washington, DC: Maximizing Enrollment, Forthcoming).

⁴⁰ Ibid.

⁴¹ Aaron Smith, Mobile Access 2010 (Washington, DC: Pew Internet & American Life Project, 2010).

Appendix: Maximizing Enrollment Grantee State Adoption of Enrollment and Eligibility Technologies

Topic	AL	IL	LA	MA	NY	UT	VA	WI
Application/Renewal Technologies								
Online application/ e-signature	✓	✓	✓+			✓	✓	✓
Online renewal	✓		✓		+	✓	✓+(C)	✓
Telephonic application/renewal	✓	✓	✓		✓(M) ¹	✓	✓+ ²	✓
Customer Interfaces								
E-notices/texts						✓+	✓+	
Customer-facing accounts (including benefit status, report changes, viewing notices)	✓+(M)			✓		✓+	✓	✓
System Improvements								
Electronic verification	✓(C)	✓	✓	✓	✓	✓+	✓(C)	✓
Electronic case records			✓			✓	✓(C)	✓
Express lane eligibility	✓(M) ³		✓+(M) ⁴	✓+ ⁵	✓(M) ⁶			
Electronic Document Management	✓(C)		✓	✓+		✓	✓(C)	✓
Workforce Management								
Paperless workflow			✓+				✓(C)	✓
Centralizing processes/ rethinking work in light of technology			✓	✓	+	✓	✓(C)	

(Unless specified otherwise, this chart assumes these improvements apply to children, parents, and caretaker relatives)

- ✓ - Implemented before or outside Maximizing Enrollment support
- ✓+ - Implemented with Maximizing Enrollment support
- + - In progress
- (M) - Implemented in Medicaid only
- (C) = Implemented in CHIP only

¹ Only implemented in Medicaid and for certain counties.

² Virginia does telephonic renewals for both CHIP and Medicaid, but telephonic applications are used for CHIP only and telephonic signature only for applications submitted through CHIP Central Processing Unit, not to local offices.

³ Alabama's ELE policy covers enrolling and renewing SNAP children and SNAP and TANF-eligible women eligible into the Family Planning program

⁴ Louisiana's ELE policy covers enrolling SNAP-eligible children into Medicaid.

⁵ Massachusetts has implemented ELE for children and parents with incomes up to 150 percent FPL.

⁶ New York's ELE policy covers transitioning Medicaid- and CHIP-eligible children into either program when income changes.



IMPLEMENTING THE AFFORDABLE CARE ACT:

KEY DESIGN DECISIONS FOR STATE-BASED EXCHANGES

Sarah Dash, Kevin W. Lucia, Katie Keith, and
Christine Monahan
Georgetown University

JULY 2013

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

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IMPLEMENTING THE AFFORDABLE CARE ACT: KEY DESIGN DECISIONS FOR STATE-BASED EXCHANGES

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JULY 2013

Abstract: The Affordable Care Act requires the establishment of new health insurance marketplaces—known as exchanges—in every state by October 1, 2013. This report examines key design decisions made by the 17 states and the District of Columbia that chose to establish a state-based exchange. The analysis finds that states made significant progress in structuring their exchanges, with states varying in their design decisions. Many states expect to exceed some federal requirements—to collect and display quality data, for instance—for 2014. These findings suggest that states capitalized on the flexibility provided by the Affordable Care Act to tailor their exchanges to their unique needs and made decisions with an eye towards outcomes, such as enrollment, consumer experience, and sustainability. These findings also suggest that states' initial decisions will inform future exchange implementation and that states will adjust their decisions while continuing to adopt innovative approaches to accomplish policy goals.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and [register to receive email alerts](#). Commonwealth Fund pub. 1696.

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ACKNOWLEDGMENTS

The authors thank the state exchange and insurance department officials who participated in this study by reviewing our findings, sharing their insights, and contributing thoughtful comments. We are also grateful for the thorough review and incisive comments by Tim Jost, Sara Rosenbaum, Sonya Schwartz, Jennifer Tolbert, and Dave Chandra.

Editorial support was provided by Deborah Lorber.

EXECUTIVE SUMMARY

The Affordable Care Act requires the establishment of new health insurance marketplaces—known as individual exchanges and Small Business Health Options (SHOP) exchanges—in each state. States must make complex decisions about how to design their exchanges in ways that reflect the unique needs of their consumers and insurance market. This report examines key structural, operational, and policy decisions made by 17 states and the District of Columbia that chose to establish a state-based exchange for 2014.

States Structured Exchanges to Reflect Needs and Capabilities

Ten states and the District of Columbia established a quasi-governmental entity to govern the exchange, with the others choosing private nonprofits or state agencies to house the exchange. Most exchanges can write rules to govern their operations. Seven states and the District of Columbia remain undecided on their long-term revenue source; most of the remaining states will assess insurers that offer coverage in the exchanges. State officials reported that decisions in these areas often reflected compressed timelines, political realities, and the state's long-term vision for the exchange.

States Adopted Formal and Informal Mechanisms to Foster a Competitive Marketplace

More than half of states selectively contracted with insurers or managed plan offerings. Ten states and the District of Columbia adopted formal requirements regarding exchange participation or alignment of coverage options inside and outside the exchange. These mechanisms include establishing a single marketplace, prohibiting insurers from entering the exchange if the insurer did not participate in 2014, and requiring insurers to offer the same coverage inside and outside the exchange. States also negotiated informally with insurers to encourage participation and aligned exchange standards with existing market standards to maintain a level playing field. State officials adopted these

approaches to spur competition and limit adverse selection within and against the exchange.

States Limited or Standardized Plans and Emphasized Quality in Consumer Choice

Nine states limited the number of plans per insurer or required insurers to offer some standardized plans in the exchange. Of the remaining states, only two and the District of Columbia adopted a meaningful difference standard of review to ensure that plans are substantially distinct from other plans offered in the same market by the same insurer. State officials reported that these limits were designed to give consumers a manageable number of choices while also retaining flexibility for insurers. Despite federal delays in quality requirements until 2016, nine states plan to display quality data on the exchange in 2014 and 10 states intend to develop quality rating systems ahead of federal guidance. State officials expect quality improvement and innovation to be an ongoing priority for exchanges.

States Designed SHOP Exchanges to Minimize Market Disruption and Improve Choice

Every state defined “small employer” as 50 or fewer full-time employees; only three chose to merge the individual and small-group markets. Despite a delay in federal requirements, nearly all SHOP exchanges are expected to offer “employee choice” options that give employees a choice of more than one plan, and eight states provided maximum flexibility by allowing employers to give employees the choice of any plan on the SHOP exchange. State officials emphasized the importance of employee choice models for ensuring that the SHOP exchange is attractive to small employers and sought to balance the goal of meaningful employee choice with concerns about adverse selection.

States Promoted Consumer Assistance via Navigators, In-Person Assistants, and Producers

Thirteen states and the District of Columbia established both a navigator and in-person assistance

program while two states will operate only a navigator program for 2014. An additional two states have not yet finalized their approach and continue to consider whether their exchanges will operate navigator and/or in-person assistance programs for 2014. To initially fund navigator programs, nine exchanges planned to use state funds or private grants until exchange funds become available. Every exchange allowed producers—otherwise known as or agents and brokers—to help consumers enroll through the exchange. While some exchanges planned to set and pay commissions, most allowed insurers to set producer compensation. State officials reported that navigators, in-person assisters, and producers will be critical to exchange success in 2014.

Looking Forward

While states with federally facilitated exchanges can influence the way some exchange functions are performed, states operating their own exchanges had significant flexibility in designing their exchanges to meet state needs. Overall, states made significant progress in structuring and operationalizing their exchanges, and made design decisions with an eye toward minimizing market disruption, promoting exchange viability, and providing value for consumers.

States also built on—and, in some areas, exceeded—minimum federal requirements to accomplish policy objectives. With much at stake in 2014, these design decisions are expected to affect critical outcomes, such as enrollment, cost, consumer experience, and sustainability. While states made significant progress, many will continue to adjust their design decisions in response to implementation successes and challenges. Continued monitoring and evaluation of exchange design decisions will be critical to inform future exchange implementation.

IMPLEMENTING THE AFFORDABLE CARE ACT: KEY DESIGN DECISIONS FOR STATE-BASED EXCHANGES

INTRODUCTION

The Affordable Care Act introduces significant reforms designed to improve the accessibility, adequacy, and affordability of private health insurance. Among these, the law requires the establishment of new marketplaces—known as individual exchanges and Small Business Health Options (SHOP) exchanges—in each state.¹

Exchanges are intended to address the current barriers to affordable and adequate health coverage in the individual and small-group markets: high premiums, limited competition, and limited transparency about coverage options.² To remedy these flaws, individual exchanges are expected to provide a seamless, one-stop experience for individuals to: apply for federal premium tax credits and cost-sharing subsidies; compare the cost, quality, and value of private health insurance; and ultimately purchase private coverage or enroll in public coverage.³ Similarly, SHOP exchanges are designed to aggregate the purchasing power of small businesses, enable employers and employees to compare

a wider range of coverage choices, and reduce administrative costs.⁴

Under the Affordable Care Act, states can choose to establish a state-based exchange or default to a federally facilitated exchange.⁵ To date, 17 states and the District of Columbia chose to establish a state-based exchange, while 33 states defaulted to exchanges run by the federal government with varying degrees of state participation.⁶ Throughout this report, we refer to Idaho, New Mexico, and Utah as having state-based exchanges. However, during the initial implementation year, Idaho and New Mexico will use the federal exchange platform to perform some core functions, such as eligibility and enrollment, as they build their own systems, while Utah will operate a state-based SHOP exchange and have the federal government operate the individual exchange.⁷

Each exchange must perform critical tasks in four core functional areas: plan management, financial management, eligibility and enrollment, and consumer

EXHIBIT 1. KEY DESIGN DECISIONS FOR STATE-BASED EXCHANGES

Categories	Key design decisions
Structuring a sustainable exchange	Governance Rulemaking authority Eligibility and enrollment functions Financing
Fostering a competitive marketplace	Plan selection approach Plan participation requirements Waiting periods to encourage plan participation Alignment of standards inside and outside the exchange Required coverage levels
Promoting meaningful consumer choices	Limits on the number of plans inside the exchange Standardization of plans Meaningful difference standards Quality reporting requirements
Improving options for small employers	Small employer definition Merging the individual and small-group markets Employer/employee choice models Minimum participation and contribution requirements
Maximizing enrollment	Navigator and in-person assistance programs Producer participation requirements Affordability initiatives

assistance and outreach.⁸ To better understand the impact of these areas on the availability, affordability, and adequacy of private health insurance, we categorized the most critical exchange design decisions into five domains (Exhibit 1). Although terms are defined in the text, we also include a glossary that defines key terms as they are used in this report ([Appendix A](#)).

FINDINGS

States Structured Exchanges to Reflect Needs and Capabilities

States have significant flexibility in designing their exchanges, including in critical operational areas such as governance, eligibility and enrollment functions, and long-term financing. State decisions in these areas often reflected compressed timelines, political realities, and each state's long-term vision for the exchange.

Most States Established a Quasi-Governmental Entity

Governance can have a significant impact on an exchange's ability to make binding decisions, receive and spend resources, and coordinate with other agencies.⁹ In 10 states and the District of Columbia, the exchange will be operated by a quasi-governmental entity, which is typically an independent public agency with a governing board or, as in Colorado and New Mexico, a public nonprofit (Exhibit 2). In contrast, the exchanges in Kentucky, New York, Rhode Island, Utah, and Vermont sit within state agencies and do not have governing boards with decision-making authority; many of these exchanges instead consult with advisory boards. Most but not all exchanges can write regulations to govern their operations. However, even those exchanges with rulemaking authority have had to wait for their state's legislature to develop or approve some design decisions, such as the exchange's long-term financing mechanisms.

States Capitalized on Federal Funds to Adopt Streamlined Eligibility and Enrollment Systems

To help exchanges serve as “one-stop shops” for consumers, federal funding is available to states to upgrade and streamline exchange and Medicaid eligibility and

enrollment systems to meet minimum federal specifications.¹⁰ All but three states—Idaho, New Mexico, and Utah—are developing IT systems that house and execute the eligibility determination rules for exchange coverage, federal premium tax credits and cost-sharing subsidies, Medicaid, and the Children's Health Insurance program (CHIP) in 2014 (Exhibit 2).¹¹

To meet federal specifications, states must develop a “single rules engine” to calculate an individual's modified adjusted gross income (MAGI). After conducting this calculation, the state has flexibility in how it proceeds with eligibility determinations. While some states are relying on communication between

EXHIBIT 2. STATE STRUCTURAL AND OPERATIONAL DECISIONS, AS OF MAY 31, 2013*

State	Type of entity	Rulemaking authority	State IT system will conduct eligibility determinations for exchange, Medicaid, and CHIP
FFE	N/A	N/A	No ^{1,2}
CA	Quasi-governmental	Yes	Yes
CO	Quasi-governmental	No	Yes ¹
CT	Quasi-governmental	Yes	Yes
DC	Quasi-governmental	Yes	Yes
HI	Private nonprofit	Yes	Yes
ID	Quasi-governmental	No	No ^{1,2}
KY	Existing state agency	Yes	Yes
MD	Quasi-governmental	Yes	Yes ¹
MA	Quasi-governmental	Yes	Yes
MN	Quasi-governmental	Yes	Yes
NV	New state agency	Yes	Yes
NM	Quasi-governmental	No	No ^{1,2}
NY	Existing state agency	Yes	Yes ¹
OR	Quasi-governmental	Yes	Yes ¹
RI	Existing state agency	Yes	Yes
UT	Existing state agency	No	No ^{1,2}
VT	Existing state agency	Yes	Yes
WA	Quasi-governmental	No	Yes ¹

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.

FFE = federally facilitated exchange.

¹ The exchange plans to rely on the federal system to make the final eligibility determination for exemptions from the individual mandate.

² The exchange plans to rely on the federal system to make the final eligibility determination for the payment of premium tax credits and cost-sharing subsidies through the exchange.

the exchange and other state eligibility engines—such as the databases that determine if individuals are eligible for programs like Medicaid and CHIP—to make such determinations, many states are building a single, consolidated system to determine eligibility for exchange coverage, Medicaid, or CHIP. Most of these single, streamlined systems will make final determinations of eligibility for Medicaid or CHIP.¹² In contrast, the exchange system in California expects to assess a consumer’s eligibility for Medicaid or CHIP but then transmit this information to a separate agency for a final determination.¹³

Exchange officials in many states hope to incorporate eligibility determinations for other programs, such as the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program) in the future. State officials reported that a streamlined system will be critical to maximizing administrative efficiencies and consumer experience.

Many States Undecided on Long-Term Revenue Sources for the Exchange

Despite significant federal funding for states to establish exchanges, the Affordable Care Act requires exchanges to be self-sustaining by 2015.¹⁴ Seven states and the District of Columbia, however, have not finalized their long-term revenue strategies (Exhibit 3). Of these eight, some are awaiting legislative action while others are considering how and whether to use existing funding mechanisms. State officials continue to consider the added cost to consumers of any new fees and the need to maintain similar costs inside and outside the exchange.

Six states—California, Colorado, Idaho, Minnesota, Nevada, and Oregon—will assess only those insurers that offer coverage in the exchange while Connecticut will assess all insurers in the individual and small-group markets regardless of whether they participate in the exchange. Others will use financing mechanisms that predate the exchange: Maryland, for example, will reallocate a portion of an existing premium tax.¹⁵ Some states plan to use multiple revenue mechanisms. Colorado, for example, will initially rely

EXHIBIT 3. LONG-TERM EXCHANGE FINANCING MECHANISMS, AS OF MAY 31, 2013*

Long-term revenue source to support the exchange	States
Assessment on insurers offering coverage in the individual and small-group markets	CA, CO, CT ¹ , ID, MN, NV, OR
Preexisting state assessment or premium tax	MD, VT, UT ²
Undecided on long-term revenue source	DC, HI, KY, MA ³ , NY, NM, RI, WA

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.

¹ In Connecticut, the exchange will be funded through an assessment that applies to all insurers in the individual and small-group markets, both inside and outside the exchange.

² In Utah, the federal government will collect an assessment on insurers for the individual exchange. The SHOP exchange will be funded through state appropriations and a monthly charge to employees enrolled through the exchange.

³ In Massachusetts, the exchange has historically been funded through state appropriations and by charging an administrative fee on insurers that participate in the exchange; however, future long-term financing mechanisms remain undecided.

on multiple sources of funding, including high-risk pool funds and an unclaimed property tax fund; Nevada plans to generate additional revenue by allowing organizations that meet certain requirements to advertise on the exchange’s website.¹⁶

States Adopted Formal and Informal Mechanisms to Foster a Competitive Marketplace

States had flexibility in adopting strategies to encourage insurers to offer plans in the exchange and foster a competitive marketplace to bring better value to consumers. More than half of states selectively contracted with insurers or managed plan offerings. Few states required insurers to participate in the exchange, although most adopted formal requirements to provide incentives for participation or to align their markets. States also noted the importance of informal negotiation with insurers to ensure exchange participation and promote a level playing field.

More Than Half of States Selectively Contracted or Managed Plan Choices

States have significant flexibility in designing their certification criteria for the exchange and can be selective about the plans they allow to be offered on the

EXHIBIT 4. STATE APPROACHES TO SELECTION OF EXCHANGE PLANS, AS OF MAY 31, 2013*

Plan selection approach	Definition	States
Selective contractor	Contracts only with insurers that advance exchange goals and may manage plan choices through limits on the number or type of plans that an insurer can offer.	CA, MA, RI, VT
Market organizer	Manages plan choices through limits on the number or type of plans that an insurer can offer but does not selectively contract with insurers.	CT, KY, MD, NV, NY, OR
Clearinghouse	Allows all plans meeting minimum criteria to participate on the exchange; does not selectively contract with insurers or manage plan choices.	CO, DC, HI, ID, MN, NM, UT, WA

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years. The federally facilitated exchange will operate as a clearinghouse in 2014.

exchange. State exchanges can operate as a “clearinghouse”—that is, the state would certify all plans that meet minimum criteria to participate in the exchange. Alternatively, a state can act as a “selective contractor” and choose to contract only with insurers that advance overarching exchange goals.¹⁷ Even if an exchange does not selectively contract with insurers, it can act as a “market organizer” and adopt additional requirements to manage plan choices by limiting the number or types of plans that an insurer can offer.

Four states—California, Massachusetts, Rhode Island, and Vermont—chose to operate their exchanges as selective contractors, while six chose to operate as market organizers (Exhibit 4). In California, for example, the exchange evaluated plans based on factors such as affordability, access to quality care, and efforts to reduce health disparities.¹⁸ The remaining seven states and the District of Columbia will operate as clearinghouses, but some states may transition to different models after 2014. For example, Maryland and Minnesota have the authority to adopt a selective contractor model in future years.¹⁹

States Adopted Formal Requirements to Promote Insurer Participation and Align Their Markets

Ten states and the District of Columbia adopted formal requirements regarding exchange participation or market alignment (Exhibit 5). State officials adopted these requirements to facilitate robust competition among insurers and to limit adverse selection within and against the exchange.

Three states and the District of Columbia formally required insurers to offer coverage in the exchange and adopted varied approaches in doing so. Maryland, for example, was the only state to explicitly require certain insurers to participate in the exchange, while Massachusetts requires insurers to apply to offer coverage in response to a solicitation and then selects plans to be offered on the exchange.²⁰ The District of Columbia and Vermont required all individual and small-group coverage to be sold through a single marketplace.²¹

Five states sought to provide incentives for plans to enter and remain in the exchange by establishing “waiting periods” for entry if an insurer failed to participate in 2014 or voluntarily withdraws from the exchange. For example, New York will not allow insurers that did not offer coverage on the exchange in 2014 to participate until 2016 unless doing so is determined to be in the best interest of consumers.²² California—while not imposing formal waiting periods—planned to limit opportunities for insurers not participating in 2014 to enter the exchange in 2015, with the exception of Medicaid plans.²³

Five states sought to reduce adverse selection—the disproportionate enrollment of individuals likely to incur high medical costs—by requiring insurers to offer similar coverage inside and outside the exchange. California, for example, required all coverage offered inside the exchange to also be offered outside the exchange.²⁴ Some states also prohibited or required the sale of certain plans outside the exchange, even if an

insurer is not participating in the exchange. For example, Oregon and Washington prohibited insurers from offering catastrophic coverage—which is less comprehensive coverage than bronze coverage and is only available to young adults and individuals otherwise unable to afford coverage—outside the exchange.²⁵ By limiting catastrophic coverage to the exchange, these states hope to encourage the enrollment of young adults and limit adverse selection against the exchange. Washington similarly prohibited insurers from offering only bronze coverage outside the exchange; instead, insurers that offer bronze coverage must also offer silver and gold coverage.²⁶

States also established requirements for insurers to offer a range of coverage levels within the exchange. While the Affordable Care Act requires insurers that participate in the exchange to offer at least silver and gold plans,²⁷ eight states and the District of Columbia required insurers to offer plans at additional coverage

levels (Exhibit 6). States reported doing so to ensure that coverage was available at most metal tiers and to limit adverse selection within the exchange.

States Adopted Informal Mechanisms to Promote Insurer Participation in the Exchange

Officials also reported using informal mechanisms to foster insurer participation and promote market alignment. Many states noted the importance of maximizing exchange participation by minimizing the requirements on insurers. Some states negotiated with insurers directly to balance the need for meaningful protections with the importance of participation.

Other mechanisms to promote participation included aligning exchange standards with the state's existing insurance laws or coordinating with the state's insurance department. Such strategies help ensure that insurers in the exchange did not face dramatically different requirements than insurers outside the exchange.

EXHIBIT 5. FORMAL EFFORTS TO PROMOTE PARTICIPATION AND MARKET ALIGNMENT, AS OF MAY 31, 2013*

Type of decision	Description	State
Requiring insurers to participate in the exchange	State required certain insurers that offer coverage in the individual or small-group markets to participate in the exchange or submit a bid to participate in the exchange.	MA ¹ , MD ²
	State established a single marketplace where all individual and small-group coverage must be sold through the exchange.	DC ³ , VT
Encouraging insurers to participate in the exchange	State prohibited an insurer from entering the exchange for up to two years if the insurer did not participate in 2014.	CO, NM, NY, OR
	State prohibited an insurer from re-entering the exchange for two years if the insurer voluntarily ceases to participate in the exchange.	CO, CT
Aligning coverage options inside and outside the exchange	State required exchange insurers to also offer certain coverage outside the exchange.	CA ⁴ , MA ⁵ , MD ⁶
	State required exchange insurers that offer certain plans outside the exchange to also offer the same or similar coverage inside the exchange.	MD ⁶ , MN ⁷ , NY ⁸

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.

¹ In Massachusetts, the exchange requires insurers that cover 5,000 or more lives to respond annually to a solicitation for fully insured product proposals. It then selects plans from these solicitations to be sold in the exchange.

² In Maryland, insurers that offer individual or small-group coverage must also offer coverage in the exchange, with exemptions for insurers that do not meet a specified revenue threshold or those that offer only student health plans.

³ In the District of Columbia, the exchange board approved a strategy that would establish a single marketplace for all individual coverage in 2014 with a transition period for some small-group coverage through 2015.

⁴ In California, insurers that participate in the exchange and sell any plans outside of the exchange must offer all exchange plans outside the exchange.

⁵ In Massachusetts, all plans offered in the exchange must also be offered outside the exchange, except for subsidized "wrap" plans, which are available outside the exchange but without the subsidy.

⁶ In Maryland, insurers that offer coverage inside and outside the exchange must also offer a silver and gold plan outside the exchange, and insurers that offer catastrophic plans outside the exchange must also offer a catastrophic plan in the exchange.

⁷ In Minnesota, insurers that participate in the exchange that offer coverage outside the exchange must offer plans at the same metal tier and for each service area inside the exchange as are offered outside the exchange.

⁸ In New York, insurers that participate in the exchange that offer out-of-network products outside the exchange must also offer an out-of-network product inside the exchange for the same county and market.

EXHIBIT 6. MINIMUM COVERAGE LEVEL REQUIREMENTS IN THE EXCHANGE, AS OF MAY 31, 2013*

Number of minimum levels required	Description	State
5	Insurers in the exchange must propose or offer all five coverage levels: catastrophic, bronze, silver, gold, and platinum coverage.	CA, MA ¹ , NY ²
4	Insurers in the exchange must offer at least bronze, silver, gold, and platinum coverage.	VT
3	Insurers in the exchange must offer at least bronze, silver, and gold coverage.	CT, DC, MD, OR
3	Insurers in the exchange must offer at least catastrophic, silver, and gold coverage.	KY

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years. The Affordable Care Act requires insurers that participate in the exchange to offer at least silver and gold coverage. Note that Hawaii has additional requirements with respect to the Prepaid Health Care Act.

¹ In Massachusetts, insurers may request, and subsequently exercise, the option to withdraw their proposed catastrophic plan should the exchange receive a sufficient number of qualifying catastrophic plans per service area from insurers wishing to make such plans available.

² In New York, if the Department of Health determines there is adequate catastrophic coverage in a particular county, the exchange may allow insurers in the same county the option of not offering the required catastrophic plan.

For example, many exchanges deferred to existing state standards on network adequacy—standards used to ensure that plans include a sufficient number and type of health care providers—and relied on their insurance department to review insurance rates. However, a few exchanges expect to negotiate rates directly with insurers or augment the department’s review by, for example, conducting an additional review of rates.²⁸

States Limited or Standardized Plans and Emphasized Quality in Consumer Choice

States also took steps to allow consumers to make meaningful comparisons between plans by limiting the number of plans that each insurer can offer in the exchange, standardizing some of the plans offered, and ensuring that the differences between plans are meaningful. States also implemented quality requirements even though not required to do so until 2016.

Nine States Chose to Limit or Standardize Plans

Consistent with research that shows that consumers have difficulty identifying important distinctions among health insurance plans when faced with many similar choices,²⁹ states sought to balance the need for sufficient choice with the risk of overwhelming consumers. To do so, states limited the number of plans that each insurer can offer in the exchange, standardized the plans offered, or adopted a standard to ensure that

differences between plans are meaningful. Eight states limited the number of plans that each insurer can offer (Exhibit 7). Five of these states, as well as California, also required insurers to offer some standardized plans in the exchange. Of the remaining eight states and the District of Columbia—which neither limited the number of plans nor required standardized plans—only Colorado, the District of Columbia, and Utah adopted a “meaningful difference” standard to ensure that the plans offered on the exchange by the same insurer have substantive distinctions between benefit design features, such as cost-sharing levels and benefit limits.

Eight states—Connecticut, Kentucky, Maryland, Massachusetts, Nevada, New York, Oregon, and Vermont—limited the number of plans that each insurer can offer or propose on each metal tier. For example, Nevada limited insurers to five plans in each metal tier per service area while Kentucky opted for no more than four plans per metal tier.³⁰ State officials reported that limiting the number of plans gives consumers a manageable number of choices while retaining flexibility for insurers. Other states reported “soft limits” by encouraging insurers to offer fewer plans.

Six states—California, Connecticut, Massachusetts, New York, Oregon, and Vermont—required insurers to offer standardized plans in the exchange. Plan standardization typically takes the form of requiring similar benefits and cost-sharing across

EXHIBIT 7. STATE DECISIONS TO LIMIT OR STANDARDIZE PLANS AND PROMOTE QUALITY, AS OF MAY 31, 2013*

State	Limited the number of plans per insurer	Required some standardized plans	Adopted a meaningful difference standard	Required display of quality data
FFE	—	—	X	X ¹
CA	—	X	X	X
CO	—	—	X ²	X
CT	X	X	X	X
DC	—	—	X	—
HI	—	—	—	—
ID	—	—	—	—
KY	X	—	—	—
MD	X	—	—	X
MA	X	X	X	X
MN	—	—	—	X
NV	X	—	X	TBD
NM	—	—	—	— ³
NY	X	X	—	X
OR	X	X	—	X
RI	—	—	—	X
UT	—	—	X	— ⁴
VT	X	X	X	— ⁴
WA	—	—	—	— ³

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.

FFE = federally facilitated exchange.

¹ Prior to 2016, federally facilitated exchanges will only display existing Consumer Assessments of Healthcare Providers and Systems indicators. States may also request the exchange to display a link to existing state quality data.

² In Colorado, the Department of Insurance will apply a meaningful difference standard to individual and small-group plans offered both on and off the exchange.

³ New Mexico and Washington will not publicly report quality information during the initial open enrollment period; however, they expect to begin collecting this information from health insurers in 2014.

⁴ In Utah and Vermont, the exchange will include a link to existing quality reports but will not incorporate or otherwise display this information into the exchange for 2014.

or within each metal tier.³¹ For 2014, the number of standardized plan designs ranges from three plans in Oregon to 17 in California.³² While insurers may also offer nonstandardized plans in these states, all states except California explicitly limited the number of nonstandardized plans per insurer.³³ Other states may require some standardized plans in the future; the District of Columbia intends to do so for 2015.³⁴

To prevent insurers from offering an overwhelming number of similar plans and to give consumers meaningful distinctions between plans, seven states and the District of Columbia adopted a “meaningful difference” standard (Exhibit 7). For example, in evaluating plans to ensure a meaningful difference, Connecticut plans to consider factors such as

differences in the amount of out-of-pocket costs that consumers face for medical and pharmacy services.³⁵ Ten states did not adopt such a standard. Of these 10 states, six did not adopt any of the three tools (i.e., limiting the number of plans insurers may offer in the exchange, requiring some standardized plans, or adopting a meaningful difference standard), in part because state officials were concerned that doing so would negatively impact insurers’ participation in the exchanges.

Many States Proceeded with Quality Requirements Ahead of Federal Guidance

To provide consumers with comparable information on health plan quality and value, the Affordable Care Act requires exchanges to collect and display quality

ratings and data, among other measures.³⁶ This requirement does not go into effect until 2016;³⁷ however, many states planned to display quality measures for 2014 (Exhibit 7). State officials reported that quality improvement and innovation will be an ongoing priority for exchanges.

Nine states—California, Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New York, Oregon, and Rhode Island—plan to display quality data on their exchanges in 2014. Most plan to display national quality measures while some states are developing their own metrics or incorporating existing state-specific measures. New York’s exchange, for example, will leverage the state’s existing quality reporting system, which includes national and state-specific measures, while Rhode Island’s exchange is developing unique metrics to help plans identify ways to improve health outcomes.³⁸

The Affordable Care Act also directs federal regulators to develop a rating system to summarize and display a plan’s quality metrics to encourage consumers to select high-quality plans.³⁹ While this rating system is being developed for display in 2016, 10 states—California, Connecticut, Maryland, Minnesota, New York, Oregon, Rhode Island, Utah, Vermont, and Washington—are developing state-specific quality rating systems ahead of federal guidance. Many states are also taking a proactive approach to the law’s requirements for insurers to implement a quality improvement strategy to achieve outcomes such as reducing hospital readmissions. Most states are requiring insurers to submit a written narrative of their quality improvement strategy or meet state-specific quality improvement standards.

States Designed SHOP Exchanges to Minimize Market Disruption and Improve Choice

Given significant flexibility in designing the SHOP exchange, states adopted standards that reflect existing market requirements, but varied on the “employee choice” options through which employees may choose a plan. State officials reported that these decisions were

largely the result of efforts to minimize market disruption, maximize economies of scale, and improve coverage choices and value for small businesses.

States Largely Structured SHOP Exchanges to Reflect Existing Market Standards

Most states declined to make major deviations from existing market standards when defining “small employer,” deciding whether to merge the individual and small-group markets, and adopting participation and contribution requirements in the SHOP exchange. Although the Affordable Care Act defines small employer as an employer with 100 employees or fewer, states may limit this definition to 50 employees or fewer for plan years beginning before January 1, 2016.⁴⁰ As of May 31, 2013, every state except Hawaii defined small employer as having 50 or fewer full-time employees until 2016; since then, Hawaii enacted legislation to define “small employer” as 50 or fewer employees.⁴¹ Only two states—Massachusetts and Vermont—and the District of Columbia chose to merge the individual and small-group markets.⁴² While not required, many states also established or maintained existing minimum participation and contribution requirements, which specify the percentage of employees that must purchase coverage and the employer’s contribution toward an employee’s coverage.

States Exceeded Federal Requirements to Make Employee Choice Available to Small Employers

To provide small employers with a wider range of coverage options than is typically available in today’s market, the Affordable Care Act requires SHOP exchanges to enable employers to choose a metal tier of coverage (such as bronze or silver) and allow employees to select any plan from that tier.⁴³ While this requirement was delayed until 2015,⁴⁴ nearly every state-based exchange is expected to offer at least one employee choice option in 2014, with most allowing multiple types of employee choice models (Exhibit 8). Eight states—Hawaii, Minnesota, Nevada, New York, Oregon, Rhode Island, Utah, and Vermont—provided maximum flexibility by

allowing employers to give employees the choice of any plan on the SHOP exchange.

In 2014, all states except Washington will allow employers who opt to provide their employees with one of the “employee choice” models to select a reference plan on which to base employer contributions.⁴⁵ For example, in its Employee Choice option, Massachusetts allows employers to select a reference plan from one of the metal tiers.⁴⁶ Using the reference plan as a guide as to how much the employer will contribute toward each employee’s coverage, employees then choose among

plans on the same metal tier and pay the difference between the price of the plan they selected and the price they would have paid for the reference plan.⁴⁷

In making design decisions, state officials emphasized the importance of employee choice in ensuring the SHOP exchange is attractive to small employers and sought to balance the goal of meaningful employee choice with concerns about adverse selection. States also cited challenges in operationalizing the SHOP exchanges, such as ensuring robust insurer participation and developing an IT system that enabled officials to offer maximum choice to employers

EXHIBIT 8. SHOP EMPLOYEE CHOICE SELECTION MODELS, AS OF MAY 31, 2013*

State	Single plan	Employee choice plan selection models ¹			
		One tier, multiple insurers	Multiple tiers, one insurer	Multiple tiers, multiple insurers	All tiers, all insurers
FFE	X	—	—	—	—
CA	—	X	—	—	—
CO	X	X	X	X ²	—
CT	X	X	X	—	—
DC	X	X	X	—	—
HI	—	X	—	X ³	X ³
ID	X	—	—	—	—
KY	X	X	—	X ⁴	—
MD ⁵	—	X	X	—	—
MA	X	X ⁶	X ⁶	—	—
MN	X	X	X	X	X
NV	X	X	X	X	X
NM	TBD	TBD	TBD	TBD	TBD
NY	X	X	X	X	X
OR	X	X	X	X ²	X ⁷
RI	X	—	—	—	X
UT	—	X	—	—	X
VT	—	X	—	—	X
WA ⁸	X	X	—	—	—

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.

FFE = federally facilitated exchange.

¹ Employee choice models include: 1) allowing employers to choose a single metal tier and employees select plans from different insurers; 2) allowing employers to choose a single insurer and employees select plans at different metal tiers; 3) allowing employers to select multiple insurers and employees select plans from multiple insurers at different metal tiers; or 4) allowing employees to select any plan on the SHOP exchange.

² In Colorado and Oregon, employees are limited to choosing plans on the SHOP exchange on metal tiers that are adjacent to the reference plan chosen by the employer (i.e., if the employer selects a silver plan, employees can only choose a plan from among bronze, silver, and gold options).

³ In Hawaii, the two models are only available for employers not subject to the requirements of the Prepaid Health Care Act.

⁴ In Kentucky, employers are limited to choosing plans on the SHOP exchange on metal tiers that are contiguous (i.e., the employer may not select only the bronze and gold levels for employees).

⁵ In Maryland, the SHOP exchange will not open until January 1, 2014.

⁶ In Massachusetts, the employee choice models may not be available by January 1, 2014, but are expected to be available in 2014.

⁷ In Oregon, this model is available only if the employer selects a gold or platinum plan as its reference plan.

⁸ In Washington, the SHOP exchange will operate as a pilot program in 2014 with only one insurer.

and employees. Because of these and other challenges, Maryland and Washington, for example, delayed or scaled back their SHOP operations for 2014.⁴⁸

States Promoted Consumer Assistance via Navigators, In-Person Assistants, and Producers

With millions of Americans expected to enroll in coverage through the individual and SHOP exchanges, consumer outreach and assistance will be critical to achieving expanded access to coverage. The Affordable Care Act requires every exchange to establish a navigator program, and states can use federal exchange funding for planning and training navigators, but not for compensating navigators.⁴⁹ To supplement the navigator program in early years, state-based exchanges can also use federal funds to establish an in-person assistance program.⁵⁰ In most states, both programs are expected to conduct public outreach and education, distribute fair and impartial information regarding enrollment in coverage through the exchange, and provide information in a culturally and linguistically appropriate manner, among other duties.

Exchanges placed few requirements on agents and brokers (known as “producers”) to promote producer participation. State officials expect navigators, in-person assistants, and producers to be critical to the exchanges’ success in 2014. In addition, some states will promote exchange participation through state-based initiatives that supplement federal financial assistance available through the exchanges.

Thirteen States and the District of Columbia Established Both Navigator and In-Person Assistance Programs in 2014

In addition to the District of Columbia, 13 states—all study states except Idaho, Kentucky, Massachusetts, and Utah—established an in-person assistance program in addition to the federally required navigator program in 2014 (Exhibit 9). In Massachusetts and Utah, the exchanges will operate only a navigator program in 2014 (and Utah’s state-run navigator program will function only in the SHOP exchange).⁵¹ As of this

writing, Idaho and Kentucky had not yet finalized their approach to consumer assistance programs and continue to consider whether their exchanges will operate navigator and/or in-person assistance programs in 2014.

State officials reported that limitations on the use of federal funds for navigator programs were challenging. Because of this limitation, some states expect to operate limited navigator programs for 2014 but will transition to a more robust program in the future. Other states identified state-based funding sources to fill this gap. Six states—Maryland, Massachusetts, Minnesota, Nevada, Oregon, and Vermont—initially planned to use state funds for their navigator programs while Colorado, Connecticut, and Hawaii looked to private grants until exchange revenue becomes available.

Despite the different funding streams for navigator and in-person assistance programs, state officials viewed the programs as components of a unified consumer assistance effort with largely consistent training requirements and functions. In most states operating both programs, the primary distinction between the navigator and in-person assistance programs is the funding source (with federal exchange funding for in-person assistance programs and state-based funding for navigator programs). Officials also reported that the programs are likely to be administered jointly and have common training requirements, with the main differences based on the ways that navigators and in-person assistants will be compensated and whether the exchange limits the duties of in-person assistants to, for example, outreach and education only.

States Expect Producers to Play a Significant Role in Exchange Success

Every exchange allowed producers to assist consumers in enrolling in an insurance plan through the exchange, and state officials hoped to encourage producers’ participation on the exchange by adopting few additional restrictions or requirements on producers. Exchanges in nine states elected to set or pay producers’ commissions or set rules guiding the relationship between insurers and producers. This relationship is known as an “appointment” and allows producers to sell an insurer’s

EXHIBIT 9. STATE DECISIONS ON CONSUMER ASSISTANCE, AS OF MAY 31, 2013*

State	Navigator and in-person assistance programs			Producer rules		
	Navigator program	In-person assistance program	Planned training hours	Exchange pays commissions	Appointment or affiliation rules	Planned training hours
FFE	X	—	<i>Up to 30 hours¹</i>	—	—	<i>TBD¹</i>
CA	X	X	16–24 hours	X ²	X ²	TBD
CO	X	X	43 hours	—	X ³	20 hours
CT	X	X	30 hours	—	X	16 hours
DC	X	X	30 hours	—	—	TBD
HI	X	X	60 hours	X	—	TBD
ID	TBD	TBD	TBD	—	—	TBD
KY	TBD	X	23 hours	—	X	8–10 hours
MD	X	X	120 hours	—	—	4–6 hours
MA	X	—	30 hours	X	X	—
MN	X	X	Variable	—	—	Variable
NV	X	X	20 hours	—	—	20 hours
NM	X	X	TBD	—	TBD	TBD
NY	X	X	40 hours	—	—	TBD
OR	X	X	Variable	—	X ⁴	8.5–9 hours
RI	X	X	TBD	— ⁵	X ⁵	TBD
UT ⁶	X	—	TBD	—	X	2 hours
VT	X	X	24 hours	—	—	24 hours
WA	X	X	25–35 hours	—	—	8 hours

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.

FFE = federally facilitated exchange.

¹ States may adopt additional training or certification requirements for navigators, in-person assisters, and producers.

² In California, standards apply only to the SHOP exchange, which is licensed as a business entity.

³ In Colorado, appointment requirements apply unless an insurer does not use producers.

⁴ In Oregon, the exchange is licensed as a business entity and producers affiliate with the exchange in lieu of being appointed by insurers.

⁵ In Rhode Island, while insurers set and pay commissions, the exchange will pay an additional per-person payment for enrolling small businesses in the SHOP exchange. Producer appointment standards apply only to the SHOP exchange.

⁶ In Utah, these standards apply only to the SHOP exchange, which will operate only a limited navigator program. Producer appointment standards apply only to the SHOP exchange, which will require a minimum of two hours of training. (The federal government may require additional producer training for the individual exchange.)

plans and be compensated by that insurer (Exhibit 9). States typically imposed fewer training requirements on producers than on navigators or in-person assisters.

The vast majority of states will defer to existing state rules on producer compensation. California, Hawaii, and Massachusetts are the only states in which SHOP exchanges will set and pay agent and broker commissions directly. The SHOP exchange in Rhode Island will provide a per-person payment to producers that enroll small employers.⁵²

To ensure that consumers have access to coverage offered by all insurers in the exchange, states can

require insurers to appoint all participating producers or require producers to be appointed by all participating insurers. Only four exchanges—Colorado, Connecticut, Rhode Island, and Utah—adopted such rules. Kentucky required producers to be appointed by at least two insurers participating in the exchange. Massachusetts expects producers to be appointed by more than one exchange insurer as well, but had not yet specified a minimum number. California’s SHOP exchange and Oregon’s individual and SHOP exchanges are expected to operate as licensed business entities, which will

allow the exchange itself to appoint or affiliate with producers.⁵³

States Opt to Improve Affordability and Access to Coverage to Further Maximize Participation

To enhance the affordability of coverage for low-income consumers purchasing coverage through the exchange, some states pursued state-funded initiatives to supplement federal subsidies. Massachusetts and Vermont, for example, will use state funds to further subsidize premiums for individuals with incomes up to 300 percent of the federal poverty level, while New York will fully subsidize premiums for parents with incomes up to 150 percent of the federal poverty level and who are currently covered by the state's Medicaid program but who will transition to exchange coverage in 2014.

POLICY IMPLICATIONS

The Affordable Care Act established a national framework for reform while retaining significant flexibility for states and providing resources to implement its provisions. While states with federally facilitated exchanges can influence the way some functions are performed, states operating their own exchanges had significant flexibility to design their exchanges in ways that reflect the unique needs of their consumers and insurance markets.

Given the rapid time frame for exchange implementation, states made design decisions with an eye toward minimizing market disruption and promoting exchange viability. To this end, states were selective when making major changes. For example, most states declined to merge their individual and small-group markets. Yet, states also built on—and, in some areas, exceeded—minimum federal requirements to accomplish policy objectives such as offering employee choice, establishing consumer assistance programs, and implementing long-standing policy goals such as modernizing IT infrastructure.

While states made significant progress, most state exchange officials would have liked to achieve additional objectives for 2014. However, the lack of timely federal guidance, the complexity of building a

new IT system, and political realities hindered the range of policy decisions that states were able to consider. With most federal requirements now finalized and the first generation of exchange IT systems in place, state officials thought that states that opt to transition to a state-based exchange in the future would be able to look to and choose components from existing exchanges that best meet their needs.

The opportunity to understand the lessons learned in these states will be critical for additional states that transition to state-based exchanges in 2015 and for those with already existing state-based exchanges. Indeed, most states expect to adjust their design decisions as implementation unfolds to accomplish additional policy goals, such as adding new features to enhance consumer experience and advancing quality and delivery system reform.

The design of state-based exchanges—along with other important decisions such as whether to expand Medicaid and how to enforce the Affordable Care Act's market reforms—could affect key outcomes, such as enrollment, cost, consumer experience, and sustainability. As we enter the first year of exchange operations, continued monitoring of exchange design decisions will be critical to help a range of stakeholders, including state and federal officials, Congress, and researchers, assess the impact of these policy decisions on real-world outcomes.

METHODOLOGY

This report examines critical structural, operational, and policy decisions made by 17 states (California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington) and the District of Columbia that chose to establish state-based exchanges. This report does not include a review of state action or decisions in the 33 states that defaulted to a federally facilitated exchange.

Throughout this report, we refer to Idaho, New Mexico, and Utah as state-based exchanges. However, Idaho and New Mexico will leverage federal

infrastructure as they build their own systems, with Idaho leveraging this infrastructure for both its individual and SHOP exchanges and New Mexico doing so only for its individual exchange. Utah will only operate the SHOP exchange and the federal government will operate its individual exchange.

Our findings are based on ongoing monitoring of exchange decisions between March 23, 2010, and May 31, 2013, and reflect our analysis of state laws, regulations, subregulatory guidance, press releases, declaration letters, blueprint submissions, board and meeting minutes, media reports, other public information related

to exchange development, and interviews with state regulators. The resulting assessments of state action were confirmed by state officials.

The data presented here are limited to state decisions for the initial operation of the exchange through 2014. Because states may reevaluate these decisions in response to changes in their marketplace or the experience of other states, these data should not be construed as representing a final or long-term decision, with many states reporting that design decisions will be reconsidered as needed.

APPENDIX A. GLOSSARY

Catastrophic coverage: Health coverage that is less comprehensive than bronze coverage and is only available to individuals under the age of 30 or individuals who have received an exemption from the individual mandate on the basis of affordability or hardship.

Clearinghouse: An exchange that allows all plans meeting minimum criteria to participate on the exchange and does not selectively contract with insurers or manage plan choices through limits on the number or type of plans that an insurer can offer.

Employee choice: Plan selection models in the SHOP exchange that give employees more than one choice of health plan. Employee choice models may allow employees to choose among multiple plans on one or multiple metal tiers; among multiple plans or tiers offered by one insurer; among any plan on the SHOP exchange; or among a combination of those options. If multiple employee choice models are available, an employer may select one or more models to use for their employees.

Federally facilitated exchange: A type of exchange model, also known as a federally facilitated marketplace, where the federal government operates all core exchange functions and retains ultimate authority over operation of the exchange. No state action is required for states with a federally facilitated exchange, but states can choose to conduct certain exchange operations.

In-person assistance program: An optional, federally funded program that an exchange can set up before its navigator program is fully functional. In-person assisters may perform the same functions as navigators, including providing assistance with eligibility and enrollment in exchange coverage and public programs as well as conducting consumer outreach and education. Consumers may also access exchange call centers where assistance may be administered in person, online, or via telephone.

Market organizer: An exchange that manages plan choices through limits on the number or type of plans that an insurer can offer, but does not selectively contract with insurers.

Meaningful difference standard: A review standard used by insurance regulators or exchange officials to ensure that a plan's benefit design, such as cost-sharing levels and benefit limits, is substantially distinct from other plans offered in the same market by the same insurer.

Metal tier (bronze, silver, gold, platinum): A designation of the level of financial protection a plan offers based on the expected share of health care costs a plan covers for a typical enrollee. Bronze plans cover the lowest share of health care costs (60%) while platinum plans cover the highest share of health care costs (90%).

Minimum participation and contribution requirements: Standards that specify the minimum percentage of employees (and, in some cases, dependents) that must purchase coverage and the employer's minimum contribution toward an employee's coverage in order for the group to enroll in exchange coverage.

Navigator program: A program that an exchange must establish to provide assistance with eligibility and enrollment in exchange and public coverage as well as to conduct consumer outreach and education. Unlike the in-person assistance program, operation of the navigator program may not be funded through federal grants. Consumers may also access exchange call centers where assistance may be administered in person, online, or via telephone.

Network adequacy standards: Standards used to ensure that health plans include a sufficient number and type of health care providers. These standards can vary significantly by state.

Producer: A person or entity licensed by a state as an insurance agent or broker. Producers typically have an affiliation with an insurer, known as an “appointment,” to sell that insurer’s plans and be compensated by the insurer.

Quasi-governmental entity: A form of exchange governance in which the exchange is not set up within an existing state agency, as a new a state agency under the executive branch, or as a private, nonprofit entity. In this instance, the exchange is set up as an independent public entity governed by a board of directors and is often exempt from some, but not all, state administrative rules and procedures.

Selective contractor: An exchange that certifies and contracts only with insurers that advance exchange goals. The state exchange may manage plan choices through limits on the number or type of plans that an insurer can offer.

Single rules engine: A software system that houses and executes all the rules to calculate an individual’s modified adjusted gross income (MAGI), on which eligibility determinations for exchange subsidies, Medicaid, and the Children’s Health Insurance Program are based.

Standardized plan: A plan that complies with benefit and cost-sharing standards established by an exchange or state to limit variation among plans within and across coverage levels and to facilitate consumer selection of plans.

NOTES

- ¹ Pub. L. 111-148, 124 Stat. 782 (2010) § 1321 (codified at 42 U.S.C. § 18041 (2012)).
- ² S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act* (New York: The Commonwealth Fund, April 2013); and T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).
- ³ Jost, *Health Insurance Exchanges*, 2010.
- ⁴ S. R. Collins, K. Davis, J. L. Nicholson, and K. Stremikis, *Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Sept. 2010).
- ⁵ Pub. L. 111-148, 124 Stat. 782 § 1321(c) (codified at 42 U.S.C. § 18041); 45 C.F.R. §§ 155.100 et seq.
- ⁶ S. Dash, C. Monahan, and K. Lucia, *Implementing the Affordable Care Act: State Decisions About Health Insurance Exchange Establishment* (Washington, D.C.: Georgetown University Health Policy Institute, April 2013).
- ⁷ C. L. Otter, "Implementing State Insurance Exchange Requires Moving Quickly, Creatively," Press Release, May 23, 2013, gov.idaho.gov/media-center/press/pr2013/5%20May/pr_28.html; B. Massey, "New Mexico Changing Its Plans for Health Exchange," *Las Cruces Sun-News*, May 20, 2013, www.lcsun-news.com/las_cruces-news/ci_23284657/nm-changing-its-plans-health-exchange; and Avenue H, "Utah's Solution for State-Based Health Exchange Moves Forward," Press Release, May 10, 2013, www.avenueh.com/news/item/68-utah-s-solution-for-state-based-health-exchange-moves-forward.
- ⁸ Dash, Monahan, and Lucia, *Implementing the Affordable Care Act*, 2013.
- ⁹ P. N. Van de Water and R. P. Nathan, *Governance Issues for Health Insurance Exchanges*, Health Policy Brief No. 1 (Washington, D.C.: National Academy of Social Insurance, Jan. 2011), <http://www.nasi.org/research/2011/governance-issues-health-insurance-exchanges>; and M. Tutty and J. Himmelstein, *Establishing the Technology Infrastructure for Health Insurance Exchanges Under the Affordable Care Act: Initial Observations from the "Early Innovator" and Advanced Implementation States* (Washington, D.C.: National Academy of Social Insurance, Sept. 2012), <http://www.nasi.org/research/2012/establishing-technology-infrastructure-health-insurance-exch>.
- ¹⁰ Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1311, 1411, 1412, 1413 (codified at 42 U.S.C. §§ 13031, 18081, 18082, 18083 (2012)). The U.S. Department of Health and Human Services made funding available for the development of upgraded IT systems through exchange establishment funding and Medicaid matching funds.
- ¹¹ As noted above, Idaho and New Mexico will use the federal IT system in 2014 as they prepare their own state systems, while Utah will defer to operation of its individual exchange to the federal government.
- ¹² States can choose between allowing the exchange system to make an assessment or a final determination of Medicaid and CHIP eligibility. This decision applies only to so-called "MAGI Medicaid" populations which are eligible for Medicaid on the basis of modified adjusted gross income (MAGI). With the exception of Kentucky and Massachusetts, exchange systems are not expected to conduct eligibility determinations for non-MAGI Medicaid populations (e.g., low-income seniors, people with disabilities, etc.) in 2014. The exchange system in Massachusetts is expected to make an eligibility determination for MAGI Medicaid populations and non-MAGI Medicaid populations with the exception of those that require long-term care.
- ¹³ Personal correspondence with exchange officials, Covered California (May 15, 2013) (on file with authors).
- ¹⁴ Pub. L. 111-148, 124 Stat. 782 (2010) § 1311 (codified at 42 U.S.C. § 13031 (2012)); 45 C.F.R. § 155.160.
- ¹⁵ 2013 Md. H.B. 228.

- ¹⁶ 2013 Colo. H.B. 1245; 2013 Colo. H.B. 1115; Colorado Health Benefit Exchange, *Application for a Cooperative Agreement to Support Establishment of a State Health Insurance Exchange (Level 2)* (Denver, Colo.: Colorado Health Benefit Exchange, May 2013), http://www.connectforhealthco.com/?wpfb_dl=660; and Silver State Health Insurance Exchange, *Advisory Committee Recommendations Approved by the Board* (Carson City, Nev.: Silver State Health Insurance Exchange, May 10, 2013), http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/About/Board_Approved_Recommendations_5.10.13.pdf.
- ¹⁷ This concept has been referred to elsewhere as “active purchasing.” However, because this term suggests that the state is procuring health plans using state or exchange dollars—which is strictly not the case—we instead adopt the term “selective contracting.” This term applies to exchanges that contract only with insurers that advance exchange goals.
- ¹⁸ Covered California, *Health Insurance Companies and Plan Rates for 2014: Making the Individual Market in California Affordable* (Sacramento, Calif.: Covered California, May 23, 2013), http://coveredca.com/news/PDFs/CC_Health_Plans_Booklet.pdf.
- ¹⁹ In Maryland, the exchange has the authority to employ selective contracting strategies beginning in 2016, while Minnesota’s exchange has the authority to do so beginning in 2015. Md. Ins. Code § 31-110(e); 2013 Minn. H.B. 5.
- ²⁰ Md. Ins. Code §§ 15-1204.1, 15-1303(b); Mass. Code 176J, § 3; personal correspondence with exchange officials, Massachusetts Health Insurance Connector (May 15, 2013) (on file with authors).
- ²¹ In the District of Columbia, the exchange board approved a strategy that would establish a single marketplace for all individual coverage in 2014 with a transition period for some small-group coverage through 2015.
- ²² New York State Department of Health, Office of the New York Health Benefit Exchange, *Invitation for Health Insurer and Dental Plan Participation in the New York Health Benefit Exchange* (Albany, N.Y.: New York State Department of Health, Jan. 2013), <http://www.healthbenefitexchange.ny.gov/invitation>.
- ²³ Personal correspondence with exchange officials, Covered California (June 10, 2013) (on file with authors).
- ²⁴ Calif. Code § 100503(f); Calif. Health & Safety Code § 1366.6; Calif. Ins. Code § 10112.3
- ²⁵ O.R.S. § 743.826; and Washington Health Benefit Exchange, *Guidance for Participation in the Washington Health Benefit Exchange* (Olympia, Wash.: Washington Health Benefit Exchange, Feb. 2013), http://wabhexchange.org/wp-content/uploads/HBE_Guidance_for_Participation1.pdf.
- ²⁶ R.C.W.A. § 48.43.700.
- ²⁷ Pub. L. 111-148, 124 Stat. 782 (2010) § 1301 (codified at 42 U.S.C. § 18021 (2012)); 45 C.F.R. § 156.200(c).
- ²⁸ In the District of Columbia, for example, the exchange will use actuarial support to review rates in addition to the review conducted by the insurance department. D.C. Health Benefit Exchange Authority, *Carrier Reference Manual v.4* (Washington, D.C.: Health Benefit Exchange Authority, May 2013); and personal correspondence with exchange official, District of Columbia Health Benefit Exchange Authority (May 10, 2013, May 15, 2013) (on file with authors).
- ²⁹ L. Quincy and J. Silas, *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making* (Washington, D.C.: Consumers Union, Nov. 2012), <http://consumersunion.org/research/report-the-evidence-is-clear-too-many-health-insurance-choices-can-impair-not-help-consumer-decision-making/>.
- ³⁰ Kentucky Health Benefit Exchange, *Board Meeting Minutes* (Lexington, Ky.: Kentucky Health Benefit Exchange, Feb. 2013); and Silver State Health Insurance Exchange, *Advisory Committee Recommendations Approved by the Board*.
- ³¹ S. Corlette, D. Downs, C. H. Monahan et al., “State Insurance Exchanges Face Challenges in Offering Standardized Choices Alongside Innovative Value-Based Insurance,” *Health Affairs*, Feb. 2013 32(2)418–26.

- ³² Covered California, *Standard Benefit Plan Designs—Final: Summary of Benefits and Coverage* (Sacramento, Calif.: Covered California, March 2013), http://www.healthexchange.ca.gov/BoardMeetings/Documents/March21_2013/Regulations%28Chart%29-QHP_Standard_Plan_Design.pdf; and Oregon Insurance Division, *Exhibit to OAR 836-100-0200 (SB 91 Standard Plan Designs)* (Durham, Ore.: Cover Oregon), http://insurance.oregon.gov/rules/prop_admin_rules.html#metal-plans.
- ³³ As a selective contractor, the exchange in California may choose to limit the number of plans during its plan certification process.
- ³⁴ D.C. Health Benefit Exchange Authority, *Resolution of the Executive Board: To Establish Further Essential Health Benefit Standards and to Establish Additional Qualified Health Plan (QHP) Certification Standards to Promote Benefit Standardization in the District of Columbia Health Benefit Exchange* (Washington, D.C.: D.C. Health Benefit Exchange Authority, March 2013), http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/Resolution-EHBandPlanOfferingStandardsmk_o.pdf.
- ³⁵ Access Health Connecticut, *Amendment to: Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges* (Hartford, Conn.: Connecticut Health Insurance Exchange, Dec. 2013).
- ³⁶ Pub. L. 111-148, 124 Stat. 782 (2010) § 1311 (codified at 42 U.S.C. § 13031 (2012)); and Department of Health and Human Services, “Request for Information Regarding Health Care Quality for Exchanges,” *Federal Register*, 77(228):70786 (Washington, D.C.: U.S. Department of Health and Human Services, Nov. 2012).
- ³⁷ U.S. Department of Health and Human Services, Center on Consumer Information and Insurance Oversight, *Letter to Issuers on Federally-Facilitated and State Partnership Exchanges* (Washington, D.C.: U.S. Department of Health and Human Services, April 2013).
- ³⁸ Personal correspondence with exchange official, New York Health Benefit Exchange (May 15, 2013) (on file with authors); personal correspondence with exchange official, Rhode Island Health Benefit Exchange (May 14, 2013) (on file with authors).
- ³⁹ Pub. L. 111-148, 124 Stat. 782 (2010) § 10329.
- ⁴⁰ Pub. L. 111-148, 124 Stat. 782 (2010) § 1304(b)(2)-(3).
- ⁴¹ 2013 Ha. H.B. 848 was signed into law on June 25, 2013, and becomes effective as of July 1, 2013.
- ⁴² In the District of Columbia, the exchange adopted a modified merged market where the individual and small-group markets remain separate for some requirements (e.g., federal reporting standards) but not others (e.g., rating and single risk pool requirements).
- ⁴³ 45 C.F.R. § 155.705(b)(2).
- ⁴⁴ U.S. Department of Health and Human Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program,” *Federal Register*, March 11, 2013 78(47):15553, 15557, www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04952.pdf.
- ⁴⁵ Employers offering their employees a single plan will, by definition, base their contributions toward employee coverage on that plan.
- ⁴⁶ Commonwealth Health Insurance Connector Authority, (Feb. 15, 2013).
- ⁴⁷ *Ibid.*
- ⁴⁸ Maryland Health Connection, *Maryland Health Benefit Exchange Board of Trustees Meeting Minutes* (Baltimore, Md.: Maryland Health Connection, March 29, 2013), marylandhbe.com/wp-content/uploads/2013/03/MHBE_Board_Minutes_032913.pdf; and Washington Health Benefit Exchange Board, *Small Business Health Options Program (SHOP) Implementation—2014* (Olympia, Wash.: Washington HealthPlanFinder, May 8, 2013).
- ⁴⁹ 45 C.F.R. § 155.210. States may use exchange operating funds to compensate navigators once these funds become available.
- ⁵⁰ U.S. Department of Health and Human Services, *Cooperative Agreement to Support Establishment of the Affordable Care Act’s Health Insurance Exchanges* (Washington, D.C.: Department of Health and Human Services, June 29, 2012), <https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=15353>.

- ⁵¹ In Utah, federal regulators will establish and operate the navigator program for the individual exchange.
- ⁵² Mass. Code 176Q, § 11, as amended by 2011 Mass. H.B. 4144, § 48; personal correspondence with exchange officials, Rhode Island Health Benefit Exchange (May 14, 2013) (on file with authors).
- ⁵³ Covered California, *Qualified Health Plan Contract for 2014* (Sacramento, Calif.: Covered California, May 6, 2013), <http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%207,%202013/QHP%20Model%20Contract%20Clean.pdf>; and Oregon Health Insurance Exchange, *Level 2 Establishment Grant Narrative* (Durham, Ore.: Oregon Health Insurance Exchange, Nov. 2012).

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June 2013

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges

GAO Highlights

Highlights of [GAO-13-601](#), a report to congressional requesters

Why GAO Did This Study

The Patient Protection and Affordable Care Act required the establishment in all states of exchanges—marketplaces where eligible individuals can compare and select health insurance plans. CMS must oversee the establishment of exchanges, including approving states to operate one or establishing and operating one itself in states that will not do so. CMS will approve states to assist it in carrying out certain FFE functions. CMS will also operate an electronic data hub to provide eligibility information to the exchanges and state agencies. Enrollment begins on October 1, 2013, with coverage effective January 1, 2014. GAO was asked to examine CMS's role and preparedness to establish FFEs and the data hub. In this report, GAO describes (1) the federal government's role in establishing FFEs for operation in 2014 and state participation in that effort; and (2) the status of federal and state actions taken and planned for FFEs and the data hub.

GAO reviewed regulations and guidance issued by CMS and documents indicating the activities that the federal government and states are expected to carry out for these exchanges. GAO also reviewed planning documents CMS used to track the implementation of federal and state activities, including documents describing the development and implementation of the data hub. GAO also interviewed CMS officials responsible for establishment of the exchanges. GAO relied largely on documentation provided by CMS—including information CMS developed based on its contacts with the states—regarding the status of the exchanges and did not interview or collect information directly from states.

View [GAO-13-601](#). For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

June 2013

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) will operate a health insurance exchange in the 34 states that will not operate a state-based exchange for 2014. Of these 34 federally facilitated exchanges (FFE), 15 are in states expected to assist CMS in carrying out certain FFE functions. However, the activities that CMS plans to carry out in these 15 exchanges, as well as in the state-based exchanges, have evolved and may continue to change. For example, CMS approved states' exchange arrangements on the condition that they ultimately complete activities necessary for exchange implementation. CMS indicated that it would carry out more exchange functions if any state did not adequately progress towards implementation of all required activities.

CMS completed many activities necessary to establish FFEs by October 1, 2013, although many remain to be completed and some were behind schedule. CMS issued numerous regulations and guidance and took steps to establish processes and data systems necessary to operate the exchanges. The activities remaining cross the core exchange functional areas of eligibility and enrollment, plan management, and consumer assistance. To support consumer-eligibility determinations, for example, CMS is developing a data hub that will provide electronic, near real-time access to federal data, as well as provide access to state and third party data sources needed to verify consumer-eligibility information. While CMS has met project schedules, several critical tasks, such as final testing with federal and state partners, remain to be completed. For plan management, CMS must review and certify the qualified health plans (QHP) that will be offered in the FFEs. Though the system used to submit applications for QHP certification was operational during the anticipated time frame, several key tasks regarding plan management, including certification of QHPs and inclusion of QHP information on the exchange websites, remain to be completed. In the case of consumer assistance, for example, funding awards for Navigators—a key consumer assistance program—have been delayed by about 2 months, which has delayed training and other activities. CMS is also depending on the states to implement specific FFE exchange functions, and CMS data show that many state activities remained to be completed and some were behind schedule.

Much progress has been made, but much remains to be accomplished within a relatively short amount of time. CMS's timelines provide a roadmap to completion; however, factors such as the still-evolving scope of CMS's required activities in each state and the many activities yet to be performed—some close to the start of enrollment—suggest a potential for challenges going forward. And while the missed interim deadlines may not affect implementation, additional missed deadlines closer to the start of enrollment could do so. CMS recently completed risk assessments and plans for mitigating risks associated with the data hub, and is also working on strategies to address state preparedness contingencies. Whether these efforts will assure the timely and smooth implementation of the exchanges by October 2013 cannot yet be determined.

In commenting on a draft of this report, the Department of Health and Human Services emphasized the progress it has made in establishing exchanges, and expressed its confidence that exchanges will be open and functioning in every state by October 1, 2013.

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Abbreviations

BSD	Business Service Definitions
CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
data hub	federal data services hub
DHS	Department of Homeland Security
DOD	Department of Defense
FFE	federally facilitated exchange
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
OPM	Office of Personnel Management
PPACA	Patient Protection and Affordable Care Act
QHP	qualified health plan
SHOP	Small Business Health Options Program
SLA	Service Level Agreements
SSA	Social Security Administration
VHA	Veterans Health Administration

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June 19, 2013

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Darrell Issa
Chairman
Committee on Oversight and Government Reform
House of Representatives

The Patient Protection and Affordable Care Act (PPACA) requires the establishment in all states¹ of health insurance exchanges—marketplaces where eligible individuals can compare and select among insurance plans offered by participating private issuers of health coverage.² The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing the establishment of these exchanges. Enrollment in the exchanges is to begin on October 1, 2013, and the exchanges are to become operational and offer health coverage starting on January 1, 2014. The Congressional

¹In this report, the term "state" includes the District of Columbia.

²Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 119, 173, 186 (Mar. 23, 2010) (hereafter, "PPACA"), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-52, 124 Stat. 1029 (Mar. 30, 2010) (hereafter, "HCERA"). In this report, references to PPACA include any amendments made by HCERA.

PPACA also requires the creation of similar exchanges, called Small Business Health Options Program (SHOP) exchanges, where small employers can shop for and purchase health coverage for their employees. We are separately reporting on the implementation of SHOP exchanges. See GAO, Patient Protection and Affordable Care Act: Status of Federal and State Efforts to Establish Health Insurance Exchanges for Small Businesses, [GAO-13-614](#) (Washington, D.C.: June 19, 2013).

Budget Office estimated that about 7 million individuals will enroll in exchanges by 2014, increasing to about 24 million by 2022.³

The exchanges are intended to provide a seamless, single point of access for individuals to enroll into private health plans, apply for income-based financial subsidies established under the law, and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid or the State Children's Health Insurance Program (CHIP).⁴ In order to enroll in health insurance coverage offered through an exchange, individuals must complete an application and meet certain eligibility requirements defined by PPACA; for example, they must be U.S. citizens or legal immigrants. To support exchanges' efforts to determine applicants' eligibility to enroll, CMS is building a tool called the federal data services hub (data hub). According to CMS officials, the data hub is to provide one electronic connection to federal sources for near real-time access to data, as well as provide access to state and other data sources needed to verify consumer exchange application information.⁵

PPACA directed states to establish state-based exchanges by January 1, 2014.⁶ In states electing not to establish and operate such an exchange, PPACA requires the federal government to establish and operate an exchange in the state, referred to as a federally facilitated exchange (FFE).⁷ As a result, the federal government's role with respect to an exchange for any given state—in particular, whether it will establish an exchange or oversee a state-based exchange in the state—is dependent

³Congressional Budget Office, *Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline* (Washington, D.C.: May 14, 2013).

⁴Medicaid is a joint federal-state program that finances health care coverage for certain low-income individuals. CHIP is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirements for Medicaid.

⁵Near real-time refers to a system capability to deliver data in response to transactions one at a time, as they occur.

⁶PPACA, § 1311(b)(1), 124 Stat. at 173. We recently reported on the preparatory actions of selected state-based exchanges. See GAO, *Health Insurance: Seven States' Actions to Establish Exchanges Under the Patient Protection and Affordable Care Act*, [GAO-13-486](#) (Washington, D.C.: Apr. 30, 2013).

⁷PPACA, § 1321(c), 124 Stat. at 186.

on state decisions. As directed by PPACA, FFEs must carry out the same functions as exchanges established and operated by a state. The federal government bears responsibility for establishing and operating FFEs; however, in establishing the framework within which an FFE in a particular state will be established and operated, CMS has provided states the option to assist with certain FFE operations. CMS refers to FFEs in these states as partnership exchanges. States seeking to operate a state-based exchange were required to submit an application to CMS containing attestations regarding when the state would complete specific required activities CMS deemed essential to operating an exchange. States electing not to establish a state-based exchange, but seeking to participate in a partnership exchange were required to complete an abbreviated version of that application tailored to the particular activities that the state would assist the FFE to carry out. On the basis of this documentation, CMS conditionally approved states to establish a state-based exchange or to participate in a partnership exchange on the basis that they complete the required activities by certain dates, among other steps necessary for the operation of an exchange. States electing not to establish a state-based exchange or participate in a partnership exchange were not required to submit an application to CMS.

As the required start of health plan enrollment draws near, an important question is whether CMS will have FFEs ready to begin accepting applications by October 1, 2013, and fully operational by January 1, 2014. You asked us to examine the federal government's role and preparedness to establish FFEs and the data hub, and the sources and amounts of funding used by the federal government to carry out preparatory activities. In this report, we describe

1. the federal government's role in establishing FFEs for operation in 2014 and state participation in that effort,
2. the status of federal and state actions taken and planned for FFEs and the data hub, and
3. CMS spending to support establishment of FFEs and the data hub.

To describe the federal government's role in establishing FFEs for operation in 2014 and state participation in that effort, we reviewed regulations and guidance issued by CMS in preparation for establishing the FFEs. We examined documentation from CMS indicating the activities that the federal government and states are expected to carry out for these exchanges. We also interviewed CMS officials to clarify these documents

and obtain updated information on the evolving decisions related to federal and state activities in specific areas.

To describe the status of federal and state actions taken and planned for FFEs and the data hub, we examined planning documents used by CMS to track the implementation of key activities to be conducted by the federal government to establish FFEs and the data hub. In particular, we reviewed a February 22, 2013, timeline used by CMS to track the activities that remained to be completed before the implementation of the exchanges. In addition, we developed a data collection instrument for CMS to complete about its key activities underway or planned for establishing the FFEs. The instrument asked CMS to provide information on the percent of each activity that it had completed, the expected or actual completion date, and a description of key activities completed and remaining to be completed. For those FFEs where states chose to participate in a partnership exchange, we examined the activities they agreed to perform as a requirement of their conditional approval from CMS. We examined those activities and targeted completion dates that were reported in the conditional approval letters issued from December 2012 through March 2013. CMS later provided us with an update on the status of certain of these activities as of April 24, 2013. We also interviewed CMS officials to understand CMS's plans for establishing FFEs and, in early May, obtained updated information on the status of key federal activities. We discussed with CMS other activities generally related to exchanges that the agency may have to perform if states planning to operate a state-based exchange or participate in a partnership exchange decide not to or are unable to perform as planned. To provide an overview of the status of CMS's development and implementation of the data hub, we reviewed project management documentation, such as plans, schedules, and technical documentation describing the data hub's functionality. We also assessed project management documents that described the extent to which CMS had completed steps towards implementing the data hub, such as evidence of test results and project milestone reviews. When examining the actions taken by the federal government and states, we relied largely on information and documents provided to us by CMS regarding the status of the exchanges—including information CMS developed based on its contacts and information exchanges with states—and did not interview or collect information directly from states.

To describe CMS spending to support establishment of FFEs and the data hub, we requested data from CMS on the sources of funding for activities conducted for the purpose of establishing the FFEs and the data

hub, including activities carried out by contractors, and the total amount of such funding obligated or expected to be obligated through fiscal year 2013. We received data from CMS on obligations for contracts and interagency agreements from fiscal year 2010 through March 31, 2013, to assist in the development and operation of the FFEs and the data hub and carry out certain other exchange-related activities.⁸ CMS provided the total amounts obligated, the appropriations account to which the obligations were charged, a brief description of the projects, and the contractors or other recipients of funds. CMS officials said the data do not include CMS staff salaries and other administrative expenses, which are not tracked specifically for the FFEs and the data hub. In addition, the data do not include obligations for grants CMS awarded to states to assist in the establishment of FFEs. We performed data reliability checks, such as checking the data for obvious errors and examining the actions taken by CMS to ensure its reliability. We determined that these data were sufficiently reliable for the purpose of this report.

We conducted this performance audit from February 2013 through June 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Exchanges are intended to allow eligible individuals to obtain health insurance, and all exchanges, whether state-based or established and operated by the federal government, will be required to perform certain functions. The federal government's role with respect to an exchange for any given state is dependent on the decisions of that state.

Overview of Exchanges

PPACA required that exchanges be established in each state to allow consumers to compare health insurance options available in that state and enroll in coverage. Once exchanges are established, individual consumers will be able to access the exchange through a website, toll-

⁸CMS indicated that certain of these obligations supported activities, such as state oversight, financial management, and risk adjustment model development, in which CMS would have engaged in even if all states planned to operate their own exchange in 2014.

free call centers, or in person. The exchanges will present qualified health plans (QHP) approved by the exchange and offered in the state by the participating issuers of coverage.⁹ The benefits, cost-sharing features, and premiums of each QHP are to be presented in a manner that facilitates comparison shopping of plans by individuals. Once individuals wish to select a QHP, they will complete an application—through the exchange website, over the phone, in person, or by mailing a paper form—that collects the information necessary to determine their eligibility to enroll in a QHP.¹⁰ On the basis of the application, the exchange will determine individuals' eligibility for enrollment in a QHP, and also determine their eligibility for income-based financial subsidies—advance payment of premium tax credits and cost-sharing subsidies¹¹—to help pay for that coverage. Also at the time of the application, the exchange will determine individuals' eligibility for Medicaid and CHIP. After an individual has been determined to be eligible for enrollment in a QHP, the individual will be able to use tools on the exchange website to compare plans and make a selection. For individuals applying for enrollment in a QHP and for income-based financial subsidies, eligibility determinations and enrollment should generally occur on a near real-time basis, to be accomplished through the electronic transfer of eligibility information between the exchange and federal and state agencies, and through the electronic transfer of enrollment data between the exchange and QHP issuers. Assistance with the enrollment process will be provided to individuals either through the website, an established telephone call center, or in person.

To undertake these functions, all exchanges, including those established and operated by the federal government, will be required to perform

⁹The QHPs offered through the exchanges are required to meet certain benefit design, consumer protection, and other standards.

¹⁰To be eligible to enroll in a QHP through an exchange, an individual must be a U.S. citizen or a legal immigrant who is not incarcerated and must reside in the state in which the exchange operates.

¹¹Premium tax credits and cost-sharing subsidies were authorized by PPACA to help certain individuals and families with incomes between 100 percent and 400 percent of the federal poverty level pay for exchange coverage. To qualify for these income-based financial subsidies, individuals must also meet the criteria for eligibility for enrollment in a QHP and not be eligible for other health insurance coverage that meets certain standards. PPACA, § 1401(a), 124 Stat. at 213; 26 C.F.R. § 1.36(B)-2(a)(1).

certain activities, many of which fall within the core functions of eligibility and enrollment, plan management, and consumer assistance.

- **Eligibility and enrollment:** All exchanges will be required to determine an individual's eligibility for QHP enrollment, income-based financial subsidies, and enrollment in Medicaid and CHIP.¹² Exchanges will be required to enroll eligible individuals into the selected QHP or transmit information for individuals eligible for Medicaid or CHIP to the appropriate state agency to facilitate enrollment in those programs. The exchange is to use a single, streamlined enrollment eligibility system to collect information from an application and verify that information. CMS is building the data hub to support these efforts. The data hub is intended to provide data needed by the exchanges' enrollment eligibility systems to determine each applicant's eligibility. Specifically, the data hub will provide one electronic connection and near real-time access to the common federal data, as well as provide access to state and third party data sources needed to verify consumer application information. For example, the data hub is to verify an applicant's Social Security number with the Social Security Administration (SSA), and to access the data from the Internal Revenue Service (IRS) and the Department of Homeland Security (DHS) that are needed to assess the applicant's income, citizenship, and immigration status. The data hub is also expected to access information from the Veterans Health Administration (VHA), Department of Defense (DOD), Office of Personnel Management (OPM), and Peace Corps to enable exchanges to determine if an applicant is eligible for insurance coverage from other federal programs that would make them ineligible for income-based financial subsidies. In states in which an FFE will operate, the hub is also expected to access information from state Medicaid and CHIP agencies to identify whether FFE applicants are already enrolled in those programs.

¹²Rather than make an official eligibility determination for Medicaid and CHIP, an exchange may transmit the information to the appropriate state agency for a final eligibility determination and, if applicable, enrollment into Medicaid or CHIP. Exchanges are also required to redetermine the eligibility of an enrollee in a QHP on an annual basis. For example, the exchange is to reexamine information about income and family size for enrollees who apply for insurance affordability programs, such as Medicaid, CHIP, and income-based financial subsidies.

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- **Plan management:** Exchanges will be required to develop and implement processes and standards to certify health plans for inclusion as QHPs and recertify or decertify them, as needed.¹³ As part of these processes, the exchange must develop an application for issuers of health coverage that seek to offer a QHP. The exchange must review a particular plan's data to ensure it meets certification standards for inclusion in the exchange as a QHP. The exchange must also conduct ongoing oversight and monitoring to ensure that the plans comply with all applicable regulations.
 - **Consumer assistance:** All exchanges will be required to provide a call center, website, and in-person assistance to support consumers in filing an application, obtaining an eligibility determination, comparing coverage options, and enrolling in a QHP.¹⁴ Other consumer assistance function activities that exchanges must conduct are outreach and education to raise awareness of and promote enrollment in QHPs and income-based financial subsidies. One such form of consumer assistance required by PPACA is the establishment of Navigators—entities, such as community and consumer-focused nonprofit groups, to which exchanges award grants to provide fair and impartial public education regarding QHPs, facilitate selection of QHPs, and refer consumers as appropriate for further assistance.¹⁵

Federal and State Roles in Exchanges

The role of the federal government with respect to an exchange for a state is dependent on whether that state seeks to operate a state-based exchange. States can choose to establish exchanges as directed by PPACA and seek approval from CMS to do so. States electing to establish and operate a state-based exchange in 2014 were required to

¹³An exchange may initially certify a plan as a QHP if the plan meets the required minimum criteria and if the exchange determines that it is in the best interest of qualified individuals to have such a plan available. The annual recertification process, at a minimum, must include a review of the general certification criteria and must be completed on or before September 15 of the applicable calendar year. The exchange must also have the ability to decertify a plan at any time if the exchange determines that the QHP no longer meets the certification requirements.

¹⁴In general, exchanges are required to provide in-person assistance only for the purpose of assisting individuals to complete an application. However, exchanges operating as part of a partnership exchange will be required to offer more robust in-person assistance programs.

¹⁵PPACA, §1311(i), 124 Stat. at 180.

submit to CMS, by December 14, 2012, a declaration of intent and the “Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchange.” Through this Blueprint, the state attests to how its exchange meets, or will meet, all legal and operational requirements associated with a state-based exchange. For example, the state must demonstrate that it will establish the necessary legal authority and governance, oversight, financial-management processes, and the core exchange functions of eligibility and enrollment, plan management, and consumer assistance.¹⁶ Although a state assumes responsibility for the exchange when it elects to operate a state-based exchange, it can choose to rely on the federal government for certain exchange-related activities, including determining individuals’ eligibility for income-based financial subsidies and activities related to reinsurance and risk adjustment.¹⁷ In addition, CMS will make financial subsidy payments to issuers on behalf of enrollees in all exchanges.

Under PPACA, if a state did not elect to establish a state-based exchange or is not approved by CMS to operate its own exchange, then CMS is required to establish and operate an FFE in that state. Although the federal government retains responsibility to establish and operate each FFE, CMS has identified possible ways that states may assist it in the day-to-day operation of these exchanges:

- CMS indicated that a state can choose to participate in an FFE through a partnership exchange by assisting CMS with the plan

¹⁶For each activity in the Blueprint, the state must attest to either the completion of the activity or its expected completion and provide a timeline and work plan. Depending on the activity, the state may also be required to provide supporting documentation.

¹⁷The regulations implementing PPACA allow state-based exchanges meeting certain requirements to rely on HHS’s determinations of eligibility for income-based subsidies. PPACA and implementing regulations provide for states, regardless of whether they are establishing an exchange, to create a transitional reinsurance program for 2014 through 2016 to help stabilize premiums for coverage in the individual market. HHS will establish a reinsurance program for any state that fails to establish this program. PPACA and implementing regulations also provide that, beginning with the 2014 benefit year, states electing to operate a state-based exchange may establish a permanent risk adjustment program for all nongrandfathered plans in the individual and small-group markets both inside and outside of the exchanges. HHS will establish this risk adjustment program for any state that will have an FFE, including a partnership exchange, or for states operating a state-based exchange but that do not elect to administer the risk adjustment program. These risk-spreading mechanisms are designed to mitigate the potential effect of adverse selection and provide stability for health insurance issuers in the individual and small-group markets.

management function, consumer assistance function, or both. According to CMS, the overall goal of a partnership exchange is to enable the FFE to benefit from efficiencies to the extent states have regulatory authority and capability to assist with these functions, help tailor the FFE to that state, and provide a seamless experience for consumers. The agency also noted that a partnership exchange can serve as a path for states toward future implementation of a state-based exchange.¹⁸ Although the states would assist in carrying out the plan management function, consumer assistance function, or both on a day-to-day basis, CMS would retain responsibility for these and all other FFE functions. For example, for plan management, states would recommend QHPs for certification, and CMS would decide whether to approve the states' recommendations and, if so, implement them. In the case of consumer assistance, states would manage an in-person assistance program and Navigators and may choose to conduct outreach and education activities. However, CMS would be responsible for awarding Navigator grants and training Navigators, and would operate the exchange's call center and website. By February 15, 2013, states seeking to participate in a partnership exchange had to submit a declaration letter and Blueprint to CMS regarding expected completion dates for key activities related to their participation.

- CMS indicated in guidance issued on February 20, 2013, that an FFE state choosing not to submit a Blueprint application for a partnership exchange by the February 15, 2013, deadline could still choose to assist it in carrying out the plan management function on a day-to-day basis.¹⁹ CMS officials said that, operationally, the plan management functions performed by these states will be no different than the functions performed by partnership exchange states. Instead of a Blueprint application, states interested in participating in this alternative type of arrangement had to submit letters attesting that the

¹⁸Through regulation, CMS has outlined a process for states, regardless of whether they participate in a partnership exchange, to seek approval to establish a state-based exchange after 2014. See 45 C.F.R. § 155-106.

¹⁹For the purposes of this report, we only refer to partnership states as those that have been conditionally approved to participate in partnership exchanges.

state would perform all plan management activities in the Blueprint application.²⁰

- Even in states in which CMS will operate an FFE without a state's assistance, CMS plans to rely on states for certain information. For example, it expects to rely on state licensure of health plans as one element of its certification of a QHP.²¹

After a state submits an application to operate a state-based exchange or participate in a partnership exchange, CMS may approve or conditionally approve the state for that status. Conditional approval indicates that the state had not yet completed all steps necessary to carry out its responsibilities in a state-based exchange or partnership exchange, but its exchange is expected to be ready to accept enrollment on October 1, 2013. To measure progress towards completing these steps, CMS officials indicated that the agency created a set of typical dates for when specific activities would need to be completed in order for the exchanges to be ready for the initial enrollment period. The agency then adapted those dates for each state establishing a state-based exchange or participating in a partnership exchange. The agency officials said that if the state indicated in its Blueprint that it planned to complete an activity earlier than CMS's typical targeted completion date, CMS accepted the state's earlier date. If the state proposed a date that was later than CMS's typical targeted completion date, the state had to explain the difference and CMS determined whether that date would allow the exchange to be ready for the initial enrollment period. The agency indicated that a state's conditional approval continues as long as it conducts the activities by the target dates agreed to with the individual state and demonstrates its ability to perform all required exchange activities.

²⁰CMS officials said that they considered whether to offer FFE states this type of arrangement for other functions. However, they noted that there are differences between plan management and consumer assistance that made the plan management function a better candidate for such an arrangement. In particular, they said that many elements of the plan management function are similar to those activities that states traditionally engage in as part of their role as an insurance regulator. Therefore, according to these officials, these states would not have to take many additional steps or incur large financial obligations to assist with an FFE's plan management function. They said that, in contrast, consumer assistance is more resource-intensive for the state.

²¹CMS indicated that it is coordinating with FFE states to ensure that CMS oversight efforts do not duplicate state efforts.

CMS's role in operating an exchange in a particular state may change for future years if states reassess and alter the roles they play in establishing and operating exchanges. For example, a state may be approved to participate in a partnership exchange in 2014 and then apply, and receive approval, to run a state-based exchange in 2015. Although the federal government would retain some oversight over the state-based exchange, the responsibility for operating the exchange would shift from the federal government to the state.

Funding for FFEs and the Data Hub

HHS indicated that it has drawn from several different appropriations to fund CMS activities to establish and operate FFEs and the data hub. These include the Health Insurance Reform Implementation Fund,²² HHS's General Departmental Management Account, and CMS's Program Management Account.²³ HHS also indicated that it plans to use funds from the Prevention and Public Health Fund and the agency's Nonrecurring Expenses Fund to pay for certain exchange activities in 2013.²⁴ Specifically, the agency plans to use these funds for activities that will assist with eligibility determinations and activities to make people

²²Congress established the \$1 billion Health Insurance Reform Implementation Fund for administrative expenses associated with carrying out PPACA. HCERA, § 1005, 124 Stat. at 1036.

²³The HHS General Departmental Management Account supports those activities associated with the Secretary's roles as chief policy officer and general manager of HHS in administering and overseeing the organization, programs, and activities of HHS. The CMS Program Management Account supports the agency's administration of programs under its management.

²⁴PPACA established the Prevention and Public Health Fund to fund programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventative Benefits, and immunization programs. PPACA, § 4002, 124 Stat. at 541. See GAO, *Prevention and Public Health Fund: Activities Funded in Fiscal Years 2010 and 2011*, [GAO-12-788](#) (Washington, D.C.: Sept. 13, 2012).

HHS's Nonrecurring Expenses Fund is a no-year account that captures expired unobligated balances from discretionary accounts prior to cancellation. HHS may use the fund for nonrecurring expenses such as facilities infrastructure, information technology infrastructure, or other department-wide secretarial priorities. Amounts in the fund may be obligated only after the Committees on Appropriations of the House of Representatives and the Senate are notified of the planned use of funds. Pub. L. No. 110-161, § 223, 121 Stat. 1844, 2188 (Dec. 26, 2007).

aware of insurance options and enrollment assistance available to them.²⁵ For fiscal year 2014, CMS has estimated that it will need almost \$2 billion to establish and operate the FFEs. Specifically, the President's fiscal year 2014 budget requests \$1.5 billion in appropriations for CMS's Program Management Account for the implementation and operation of the exchanges. In addition to this amount, it estimated that \$450 million in user fees will be collected from issuers of health coverage participating in the exchanges in fiscal year 2014 and credited to the Program Management Account.²⁶ According to the agency, these funds will be used for activities related to operation of the exchanges, including eligibility and enrollment, consumer outreach, plan oversight, SHOP and employer support, information-technology systems, and financial management.

In addition to these sources of funding, the agency also awarded grants with funds appropriated under section 1311 of PPACA to states in which an FFE will operate for activities related to the FFE. These include the plan management and consumer assistance activities that certain states will undertake on behalf of the FFE, as well as the development of state data systems to coordinate with the FFE.²⁷

²⁵This report does not discuss spending by other agencies to support the exchanges. For example, HHS announced on May 9, 2013, that the Health Resources and Services Administration would award approximately \$150 million to community health centers to provide in-person assistance to enroll uninsured individuals into health insurance coverage through an exchange, Medicaid, or CHIP. In addition, in June 2012, we reported that IRS planned to spend \$881 million through fiscal year 2013 to help implement the exchanges and other PPACA provisions, of which \$521 million was to come from HHS's Health Insurance Reform Implementation Fund. See GAO, *Patient Protection and Affordable Care Act: IRS Managing Implementation Risks, but Its Approach Could be Refined*, [GAO-12-690](#) (Washington, D.C.: June 13, 2012).

²⁶CMS indicated that it will collect user fees from issuers participating in FFE and partnership exchanges beginning in January 2014 to support exchange operations. PPACA requires that exchanges be self-sustaining by 2015, and allows exchanges to charge assessments, collect user fees, or to otherwise generate funding to support ongoing operations. PPACA, § 1311(d)(5), 124 Stat. at 177-78.

²⁷Section 1311 appropriates an amount necessary to enable HHS to make awards to states for activities related to establishing exchanges. For more information on the amounts awarded to each state and their use, see GAO, *Patient Protection and Affordable Care Act: HHS's Process for Awarding and Overseeing Exchange and Rate Review Grants to States*, [GAO-13-543](#) (Washington, D.C.: May 31, 2013).

CMS Expects to Operate an Exchange in Most States, but Planned CMS and State Exchange Activities Continue to Evolve

CMS expects to operate an FFE in 34 states in 2014. States are expected to assist with certain day-to-day functions in 15 of these FFEs. However, the precise activities that CMS and the states will perform have not been finalized and may continue to evolve.

CMS Expects to Operate FFEs, including Partnership Exchanges, in 34 States in 2014

For 2014, CMS will operate the exchange in 34 states, although it expects that states will assist in carrying out certain activities in almost half of those exchanges. As of May 2013, 17 states were conditionally approved by CMS to establish state-based exchanges. CMS granted conditional approval to these states in letters issued from December 2012 to January 2013. CMS is required to operate an FFE in the remaining 34 states. While CMS will retain full authority over each of these 34 FFEs, it plans to allow 15 of the states to assist it in carrying out certain exchange functions. Specifically, as of May 2013, CMS granted 7 FFE states conditional approval to participate in a partnership exchange. CMS issued these conditional approval letters from December 2012 to March 2013. Of the 7 partnership exchange states, 6 (Arkansas, Delaware, Illinois, Michigan, New Hampshire, and West Virginia) indicated that they planned to assist with both the plan management and consumer assistance functions of the exchange and 1 (Iowa) indicated that it would only assist with the plan management function. In an alternate arrangement, CMS plans to allow the other 8 of these 15 FFE states (Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, Utah, and Virginia) to assist with the plan management function.²⁸ In the remaining 19 FFE states, CMS plans to operate all functions of an FFE without states' assistance for plan year 2014. (See fig. 1 for a map of exchange arrangements for 2014.)

²⁸CMS conditionally approved Utah to operate a state-based exchange in January 2013. However, on May 10, 2013, CMS indicated that, in response to Utah's request to operate only its SHOP as a state-based exchange and to have CMS operate its individual exchange, the agency would issue a proposed rule that, if finalized, would permit Utah to adopt this approach. On June 14, 2013, CMS released this proposed rule, which will be published in the Federal Register on June 19, 2013.

Legend:

- State-based exchange
- Federally facilitated exchange (FFE)
- FFE partnership exchange
- FFE alternate arrangement with state plan management assistance

^aIowa planned to assist with the plan management function, and not the consumer assistance function.

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Some states also informed CMS of whether or not they chose to carry out certain other activities related to the exchanges.²⁹ First, CMS officials said that all states with an FFE are to notify CMS whether or not their relevant state agencies will determine the Medicaid/CHIP eligibility for individuals who submit applications to the FFE or if the states will delegate this function to the FFE.³⁰ As of May 2, 2013, CMS officials indicated that none of the 34 FFE states had notified CMS as to whether they would conduct Medicaid/CHIP eligibility determinations rather than delegate this responsibility to CMS. CMS officials indicated that states do not have a deadline for notifying CMS of their decisions on this area, but would have to do so before initial enrollment on October 1, 2013. Second, states notified CMS as to whether they would operate a transitional reinsurance program.³¹ CMS indicated that for plan year 2014, two state-based exchange states—Connecticut and Maryland—notified CMS that they would each operate a transitional reinsurance program, leaving CMS to operate programs in the remaining 49 states.

²⁹Although not specifically related to exchange operation, states are also informing CMS whether they are enforcing, or plan to enforce, new health insurance market reforms enacted under PPACA. Some of these reforms, including a provision prohibiting lifetime limits on the dollar value of benefits provided under a group or individual health plan, are already in effect; others, including a provision prohibiting issuers of group and individual health coverage from denying coverage or charging higher premiums because of preexisting conditions, do not take effect until 2014. These provisions apply whether a plan is offered on an exchange or outside of an exchange. States were asked to notify CMS whether they would enforce PPACA's health insurance market reforms. As required under a 1999 rule implementing the Health Insurance Portability and Accountability Act of 1996, CMS is required to enforce these and other health insurance market regulations under the Public Health Service Act in states that do not have authority to enforce them or otherwise fail to enforce them. CMS indicated that, as of April 8, 2013, 11 states notified CMS that they do not have the authority to enforce or are not otherwise enforcing PPACA insurance market provisions, leaving CMS to assume an enforcement role. CMS officials indicated that there is no deadline for this notification, but a notification is required of all states.

³⁰Even in those states in which the relevant state agencies will retain responsibility for determining QHP applicant eligibility for Medicaid and CHIP, the exchanges must have the capacity to screen QHP applicants for potential Medicaid and CHIP eligibility.

³¹PPACA and implementing regulations provide for states, regardless of whether they are establishing an exchange, to create a transitional reinsurance program for 2014 through 2016 to help stabilize premiums for coverage in the individual market. HHS will establish a reinsurance program for any state that fails to establish this program.

Planned CMS and State Activities to Establish Exchanges Have Evolved Recently and May Continue to Change

The activities that CMS and the states each plan to carry out to establish the exchanges have evolved recently. CMS was required to certify or conditionally approve any 2014 state-based exchanges by January 1, 2013.³² CMS extended application deadlines leading up to that date to provide states with additional time to determine whether they would operate a state-based exchange. On November 9, 2012, CMS indicated that in response to state requests for additional time, it would extend the deadline for submission of the Blueprint application for states that wished to operate state-based exchanges in 2014 by a month to December 14, 2012. The agency noted that this extension would provide states with additional time for technical support in completing the application. At the same time, the agency extended the application deadline for states interested in participating in a partnership exchange by about 3 months to February 15, 2013. In addition, the option for FFE states to participate in an alternative arrangement to provide plan management assistance to the FFE was made available to states by CMS in late February. CMS did not provide states with an explicit deadline for them to indicate their intent to participate in this arrangement, but CMS officials said April 1, 2013, was a natural deadline because issuers of health coverage had to know by then to which entity—CMS or the state—to submit health plan data for QHP certification.

The specific activities CMS will undertake in each of the state-based and partnership exchanges may continue to change if states do not make adequate progress toward completion of their required activities. When CMS granted conditional approval to states, it was contingent on states meeting several conditions, such as obtaining authority to undertake exchange activities and completing several required activities by specified target dates. For example, in April 2013, CMS officials indicated that Michigan—a state that had been conditionally approved by CMS in March to participate in a partnership exchange—had not been able to obtain passage of legislation allowing the state to use federal grant funds to pay for exchange activities, which had been a requirement of its conditional approval. As of May 2, 2013, CMS officials expected that Michigan would remain a partnership exchange state, but indicated that Michigan may not

³²There was no statutory deadline for approvals of partnership exchanges, as such exchanges were not specifically identified in PPACA.

be able to conduct consumer assistance without funding authority.³³ They noted, however, that a final decision about Michigan's responsibilities had not been determined. In addition, on May 10, 2013, CMS indicated that it intended to allow Utah's exchange, which was conditionally approved as a state-based exchange in January 2013, to now be an FFE.³⁴ Officials indicated that final approval for state-based and partnership exchanges will not be granted until the states have succeeded in completing required activities, and that some of these exchanges may still be under conditional approval when enrollment begins on October 1, 2013.

Agency officials indicated that they are working with each state to develop mitigation strategies to ensure that all applicable exchange functions are operating in each state on October 1, 2013. CMS officials said that they are assessing the readiness of each state as interim deadlines approach. For example, issuers began submitting applications to exchanges for QHP certification on April 1, 2013. Therefore, CMS officials said that they began assessing state readiness for this activity in March 2013. They also indicated that CMS is doing this kind of assessment for each state as deadlines approach for other functions—such as eligibility and enrollment, and consumer assistance. If a state is not ready to carry out a specific responsibility, CMS officials said the agency will support them in this area. As of May 2, 2013, CMS had not granted final approval to any state to operate a state-based exchange or participate in a partnership exchange. If any state conditionally approved to operate a state-based exchange or to participate in a partnership exchange does not adequately progress towards implementation of all required activities, CMS has indicated that it would carry out more exchange functions in that state. CMS officials indicated that exchanges receiving this assistance would retain their status as a state-based or partnership exchange.

³³CMS officials noted that it is generally more resource intensive for states to implement consumer assistance activities than plan management activities, because, unlike plan management activities which are similar to traditional state insurance functions, consumer assistance is not a function in which states were previously engaged.

³⁴CMS indicated that Utah still intended to operate its SHOP exchange as a state-based exchange and that the agency would issue a proposed rule that, if finalized, would permit this arrangement. On June 14, 2013, CMS released this proposed rule, which will be published in the Federal Register on June 19, 2013.

CMS Completed Many Activities to Establish FFEs and the Data Hub by the Beginning of Open Enrollment, Although Completion of Some Activities Was Behind Schedule

CMS has completed many activities necessary to establish FFEs and the data hub. The agency established targeted completion dates for the many activities that remain to be completed by the beginning of initial enrollment on October 1, 2013, and certain activities were behind schedule.

CMS Issued Numerous Regulations and Guidance Necessary to Establish FFEs, and Made Progress in Each of the Core Exchange Functions and in Developing the Data Hub

CMS issued numerous regulations and guidance that it has said are necessary to set a framework within which the federal government, states, issuers of health coverage, and others can participate in the exchanges. For example, in March 2012, the agency issued a final rule regarding implementation of exchanges under PPACA, and in February 2013, it issued a final rule setting forth minimum standards that all health insurance issuers, including QHPs seeking certification on a state-based exchange or FFE, have to meet.³⁵ The March 2012 rule, among other things, sets forth the minimum federal standards that state-based exchanges and FFEs must meet and outlines the process a state must follow to transition between types of exchanges. The February 2013 rule specifies benefit design standards that QHPs must meet to obtain certification.³⁶ That rule also established a timeline for QHPs to be accredited in FFEs. CMS also issued a proposed rule related to the Navigator program on April 5, 2013.³⁷ This rule proposes conflict of interest, training, and certification standards that will apply to Navigators in FFEs.³⁸ CMS officials expected to issue this final rule prior to initial enrollment. CMS officials indicated that before initial enrollment begins in October 2013, they would propose an additional rule that would set forth exchange oversight and records retention requirements, among other

³⁵77 Fed. Reg. 18,310 (Mar. 27, 2012); 78 Fed. Reg. 12,834 (Feb. 25, 2013).

³⁶These standards also apply to health plans offered outside an exchange.

³⁷78 Fed. Reg. 20,581 (Apr. 5, 2013).

³⁸These conflict of interest, training, and certification standards also will apply to other in-person assistance personnel whose activities are funded with federal exchange grants.

things. On June 14, 2013, CMS released this proposed rule, which will be published in the Federal Register on June 19, 2013.

CMS also issued guidance specifically related to the establishment of FFEs and partnership exchanges to assist states seeking to participate in a partnership exchange and issuers seeking to offer QHPs in an FFE, including a partnership exchange. For example, the agency issued general guidance on FFEs and partnership exchanges in May 2012 and January 2013, respectively. On April 5, 2013, the agency issued guidance to issuers of health coverage seeking to offer QHPs through FFEs or partnership exchanges.

In addition to establishing the basic exchange framework for state-based exchanges and FFEs, including partnership exchanges, CMS also completed activities needed to establish the core FFE functions—eligibility and enrollment, including the data hub; plan management; and consumer assistance. (See table 1.)

Table 1: Examples of Activities Completed by CMS to Establish Federally Facilitated Exchanges (FFE), Including Partnership Exchanges

Core exchange function	Activities
Eligibility and enrollment	<ul style="list-style-type: none">• In late January 2013, CMS released a draft of the online and paper applications that consumers will use to apply for health care coverage in the exchanges. Following a public comment period, the agency issued the final application on April 30, 2013, as planned.• CMS indicated that, since May 2012, it has consulted with, received feedback from, and provided training to issuers of health coverage on the eligibility and enrollment process standards for the exchanges.• According to agency officials, CMS has completed many of the activities required to support eligibility and enrollment data verification through the development and implementation of the data hub. These activities include, among other things, establishing connections with and access to data from federal and state systems, and testing of certain functionalities internal to CMS.
Plan management	<ul style="list-style-type: none">• CMS indicated that it completed development of the information- technology systems necessary for it to carry out the plan management function, such as to collect plan data and certify qualified health plans (QHP).• CMS contracted with a vendor to help the agency certify QHPs that will be offered in FFEs, including partnership exchanges.^a Officials said that the contractor will review plan data, perform quality-assurance checks, and help CMS determine whether issuers applying for QHP certification are in full compliance with Patient Protection and Affordable Care Act (PPACA) requirements.

Core exchange function	Activities
Consumer assistance	<ul style="list-style-type: none"> In 2010, CMS awarded Consumer Assistance Program grants to 36 states and 4 territories,^b including 23 states with FFEs, in 2010. Although the grants were not for activities specific to the exchanges, CMS has indicated that grantees must collect data on consumer inquiries and complaints to help the agency identify problems in the private insurance marketplace (both inside and outside the FFEs) and strengthen enforcement. Starting in 2014, programs must also help resolve problems with premium credits for exchange coverage and receive referrals from Navigators for QHP enrollees who have concerns about their coverage. CMS awarded a contract to a private vendor on February 28, 2013, for the development of training and quality-assurance metrics for the call center that will assist consumers who use the exchanges. CMS provided information to consumers about health care insurance and the operation of FFEs through its website, healthcare.gov.

Source: CMS.

Notes: Some of these activities also support the establishment of state-based exchanges. For example, Consumer Assistance Program grants were awarded to 13 states with state-based exchanges.

^aIn FFEs where the state will assist with the plan management function, the state will review plan data and make recommendations for certification to CMS.

^bPPACA appropriated \$30 million to the Secretary of Health and Human Services for the award of federal grants to states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsmen programs. PPACA, § 1002, 124 Stat. at 138. Consumer Assistance Program grants are to be used to assist consumers with filing health coverage complaints and appeals, assist consumers with enrollment into health coverage, and educate consumers on their rights and responsibilities with respect to such coverage. According to CMS, as of June 2013, there were Consumer Assistance Programs operating in 22 states and 1 territory.

CMS Established Timelines for Completing the Many Activities That Remain, Although Some Activities Were Behind Schedule

CMS established timelines to track its completion of the remaining activities necessary to establish FFEs. CMS has many key activities remaining to be completed across the core exchange functions—eligibility and enrollment, including development and implementation of the data hub; program management; and consumer assistance. In addition, the agency established targeted completion dates for the required activities that states must perform in order for CMS to establish partnership exchanges in those states. However, the completion of certain activities was behind schedule.

Eligibility and Enrollment

CMS expects to complete development and testing of the information technology systems necessary for FFEs to determine eligibility for enrollment into a QHP and to enroll individuals by October 1, 2013, when enrollment is scheduled to begin for the 2014 plan year. As of April 2013, CMS indicated that it still needed to complete some steps to enable FFEs to be ready to test development of key eligibility and enrollment functions, including calculation of advance payments of the premium tax credits and cost-sharing subsidies, verification of consumer income, and verification of citizenship or lawful presence. CMS indicated that these steps will be

completed in July 2013. For one activity—the capacity to process applications and updates from applications and enrollees through all channels, including in-person, online, mail, and phone—CMS estimated that the system will be ready by October 1, 2013. CMS officials said that redeterminations of consumer eligibility for coverage will not occur until the middle of 2014.

Effective use of the FFEs' eligibility and enrollment systems is dependent upon CMS's ability to provide the data needed to carry out eligibility determination and enrollment activities through the implementation of the data hub. According to program officials, CMS established milestones for completing the development of required data hub functionality by July 2013, and for full implementation and operational readiness by September 2013. Project schedules reflect the agency's plans to provide users access to the hub for near real-time data verification services by October 1, 2013.

Agency officials stated that ongoing development and testing activities are expected to be completed to meet the October 1, 2013, milestone. Additionally, CMS has begun to establish technical, security, and data sharing agreements with federal partner agencies and states, as required by department-level system development processes. These include

- Business Service Definitions (BSDs), which describe the activities, data elements, message formats, and other technical requirements that must be met to develop, test, and implement capabilities for electronically sharing the data needed to provide various services, such as income and Social Security number verification.
- Computer Matching Agreements, which establish approval for data exchanges between various agencies' systems and define any personally identifiable information the connecting entity may access through its connection to the data hub; and
- Data Use Agreements, which establish the legal and program authority that governs the conditions, safeguards, and procedures under which federal or state agencies agree to use data.

For example, CMS officials stated that they established Data Use Agreements with OPM and the Peace Corps in April 2013 and completed

BSDs by mid-June.³⁹ Additionally, these officials plan to obtain final approval of Computer Matching Agreements with IRS, SSA, DHS, VHA, and DOD by July 2013.⁴⁰

CMS began conducting both internal and external testing for the data hub in October 2012, as planned. The internal testing includes software development and integration tests of the agency's systems, and the external testing begun in October included secured communication and functionality testing between CMS and IRS. These testing activities were scheduled to be completed in May 2013. CMS has also begun to test capabilities to establish connection and exchange data with other federal agencies and the state agencies that provide information needed to determine applicants' eligibility to enroll in a QHP or for income-based financial subsidies, such as advance premium tax credits and cost-sharing assistance, Medicaid, or CHIP. For example, CMS officials stated that testing with 11 states began on March 20, 2013, and with five more states in April. They also stated that, although originally scheduled to begin in April, testing with SSA, DHS, VHA and Peace Corps started early in May 2013 and that testing with OPM and DOD was scheduled to begin in July 2013. Additionally, CMS recently completed risk assessments and plans for mitigating identified risks that, if materialized, could negatively affect the successful development and implementation of the data hub.

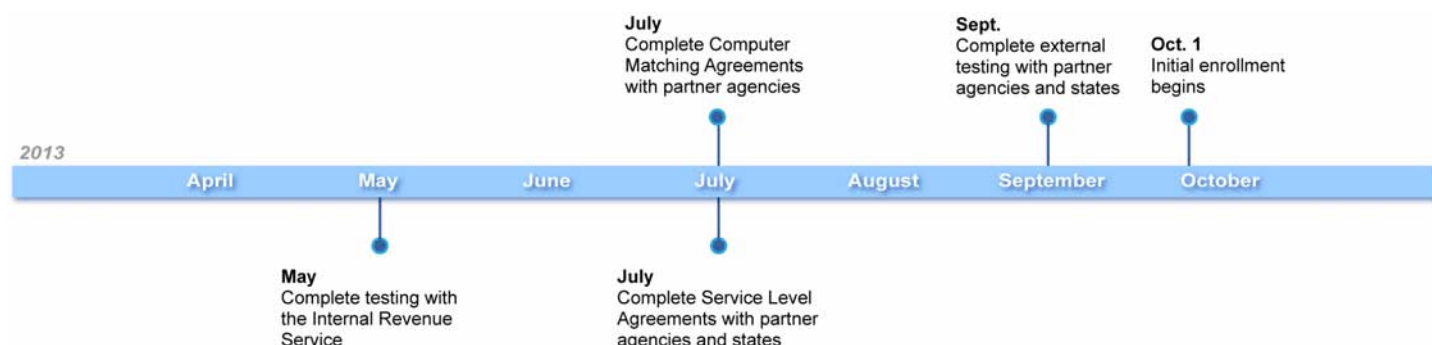
While CMS stated that the agency has thus far met project schedules and milestones for establishing agreements and developing the data hub, several critical tasks remain to be completed before the October 1, 2013, implementation milestone. (See fig. 2). According to CMS officials and the testing timeline:

³⁹According to CMS, the agency is required to establish Data Use Agreements only with OPM and the Peace Corps because these two entities provide batch files of data for processing data hub queries, which CMS stores in the data hub environment.

⁴⁰According to CMS, Computer Matching Agreements are required for data exchanges between CMS and IRS, SSA, DHS, VHA, and DOD because information is transmitted from the data hub and matched against the other agencies' records for use by the exchanges or Medicaid or CHIP agencies for use in eligibility determinations. The results of these matches are stored by the entity making the eligibility determination, but are not stored in the data hub environment.

- Service Level Agreements (SLA) between CMS and the states, which define characteristics of the system once it is operational, such as transaction response time and days and hours of availability, are planned to be completed in July 2013;
- SLAs between CMS and its federal partner agencies that provide verification data are expected to be completed in July 2013; and
- Completion of external testing with all federal partner agencies and all states is to be completed by the beginning of September 2013.

Figure 2: Timeline for CMS Data Hub Activities to Be Completed Prior to Initial Enrollment, as of May 2013



Source: CMS.

Plan Management

The activities that remain for CMS to implement the plan management function primarily relate to the review and certification of the QHPs that will be offered in the FFEs. CMS has set time frames that it anticipates will allow it to certify and upload QHP information to the exchange website in time for initial enrollment. CMS indicated that its system for issuers of health coverage to submit applications for QHP certification was available by April 1, 2013, and issuers were to submit their applications by May 3, 2013.⁴¹ Once received, CMS, with the assistance of its contractor, expects to evaluate and certify health plans as QHPs by July 31, 2013. CMS will then allow issuers to preview and approve QHP information that will be presented on the exchange website by August 26,

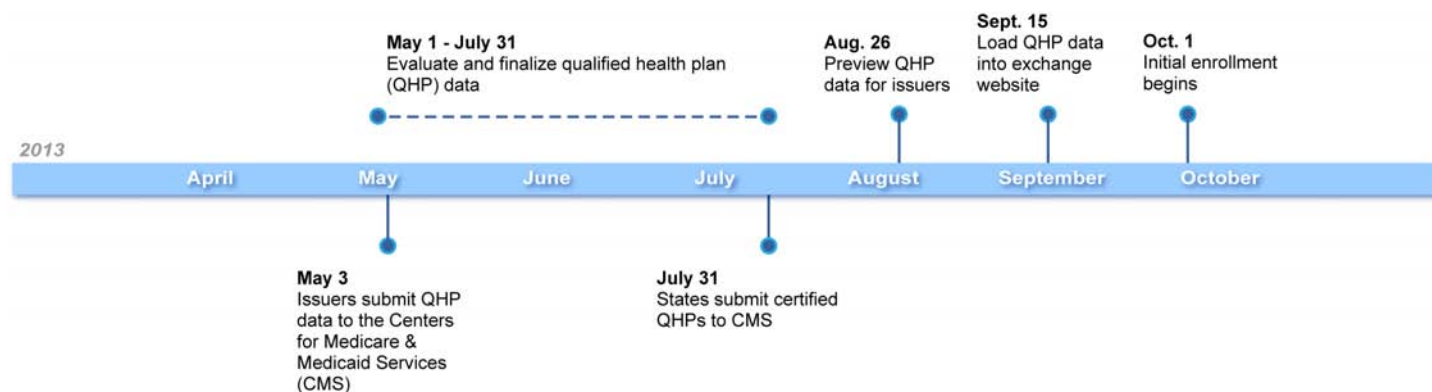
⁴¹The deadline was originally April 30, 2013. CMS officials indicated that, on April 30, 2013, it pushed back the deadline for issuers to submit their applications to May 3, 2013.

2013. CMS then expects to finalize the QHP information and load it into the exchange website by September 15, 2013.

For those 15 FFEs for which states will assist with the plan management function, CMS will rely on the states to ensure the exchanges are ready by October 2013. In contrast to other FFE states in which CMS manages all aspects of the QHP application and certification process, these 15 states were to evaluate health issuer plan applications to offer a QHP in the exchange and submit recommendations to CMS regarding the plans to be certified as QHPs. CMS indicated that the states are expected to submit their recommendations by July 31, 2013, which is also when CMS expects to complete its evaluation of QHPs for the other FFE states.⁴² (See fig. 3.)

⁴²Seven of the 15 states submitted an application to CMS and were approved to assist with QHP certification and other plan management functions on the condition that they complete certain required activities by targeted completion dates. In contrast, an additional 7 states were not required to submit an application and CMS officials indicated that the agency has no formal monitoring relationship with the states. Instead, CMS conducted a 1-day review of these states in February and March to determine the states' operational plans and capacity to assist with the plan management functions. The last state, Utah, was originally conditionally approved to operate a state-based exchange. On May 10, 2013, CMS indicated that it intended to allow the exchange to instead operate as an FFE and the state attested that it would be able to assist with all aspects of the plan management function.

Figure 3: Timeline for Plan Management Activities to Be Completed by CMS and States for Federally Facilitated Exchanges (FFE) Prior to Initial Enrollment, as of May 2013



Source: CMS.

Note: The July 31, 2013, deadline for states to submit QHP certification recommendations to CMS applies to the 15 FFEs in which states agreed to assist with the plan management function. For the remaining 19 FFE states, issuers were to submit their QHP data to CMS by May 3, 2013.

Consumer Assistance

CMS has yet to complete many activities related to consumer assistance and outreach, and some initial steps were behind schedule. Specifically, several steps necessary for the implementation of the Navigator program in FFEs have been delayed by about 2 months. CMS had planned to issue the funding announcement for the Navigator program in February 2013 and have two rounds of awards, in June and September 2013. However, the announcement was delayed until April 9, 2013, and CMS officials indicated that there would be one round of awards, with an anticipated award date of August 15, 2013. CMS did not indicate the number of awards it expected to make, but noted that it expects that at least two types of applicants will receive awards in each of the 34 FFE states,⁴³ and at least one will be a community or consumer-focused nonprofit organization. CMS officials indicated that, despite these delays,

⁴³CMS indicated that it would award up to \$54 million to organizations and individuals in the 34 FFE states. It indicated that funds available for award would be allocated among states based on their numbers of uninsured, but at least \$600,000 would be available for award in each state. Texas was allocated the largest share of funding for award, \$8.2 million. CMS gave applicants until June 7, 2013, to submit their applications. Federal regulations require exchanges to award Navigator grants to at least two types of entities, including a community and consumer-focused nonprofit organization. 45 C.F.R. § 155.210(c)(2).

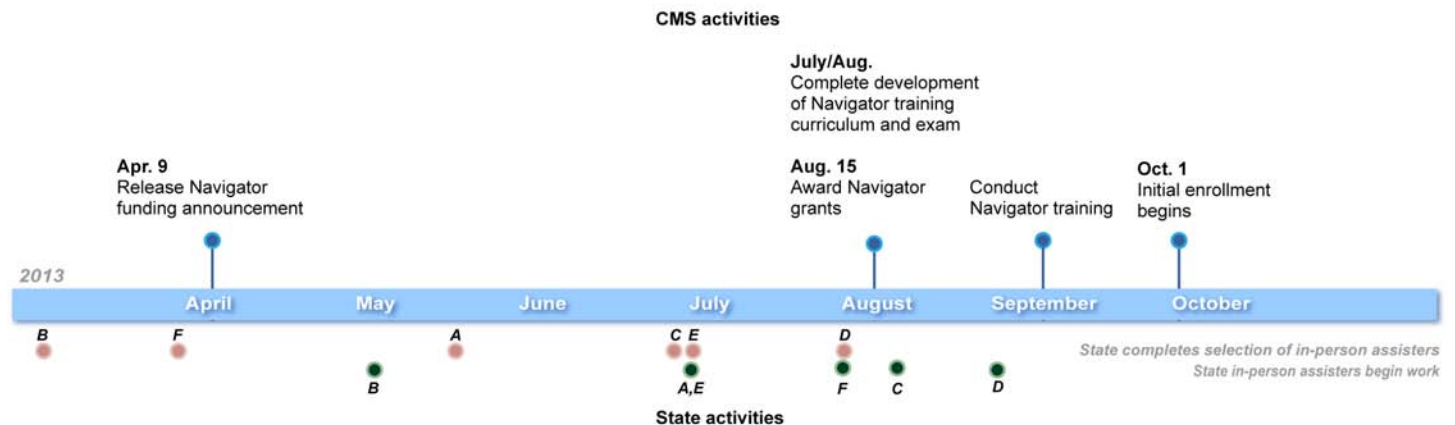
they planned to have Navigator programs operating in each FFE state by October 1, 2013.

Before any federally funded in-person assisters, including Navigators, can begin their activities, they will have to be trained and certified. For example, these individuals are required to complete an HHS-approved training program and receive a passing score on all HHS-approved certification exams before they are able to assist with enrollment activities.⁴⁴ CMS officials said that the required training for Navigators will be web-based, and it is under development. According to CMS, the Navigator training will be based on the training content that is being developed for agents and brokers in the FFEs and partnership exchanges, which CMS indicates is near completion. In addition, CMS is developing similar web-based training for the state partnership exchange in-person assistance programs. While CMS had planned to begin Navigator training in July 2013, under its current plan, the agency will not have awarded Navigator grants by this date. CMS indicated that it plans to complete development of the training curriculum and certification exam in July or August 2013. CMS officials expected that the training would begin in the summer of 2013, following completion of the curriculum and exam.

Each of the six partnership exchange states that CMS conditionally approved to assist with certain consumer assistance responsibilities plans to establish other in-person assistance programs that will operate in addition to Navigator programs in these states. The dates by which the states planned to release applications and select in-person assisters varied. (See fig. 4.) For example, according to the conditional approval letters, one partnership exchange state planned to select in-person assisters by March 1, 2013, to begin work by May 15, 2013, while another planned to make that selection by August 1, 2013, to begin work by September 1, 2013. Five of the states' required activities indicated that they planned to add state-specific modules to the required federal training for Navigators and in-person assisters.

⁴⁴CMS officials indicated that the agency is considering allowing Navigators to assist with outreach activities prior to completing their training. They expected this issue to be addressed in the final Navigator rule.

Figure 4: Timeline for Navigator and In-Person Consumer Assistance Activities to Be Completed by CMS and States Prior to Initial Enrollment, as of May 2013



Source: CMS.

Note: Under the state implementation activities, each letter denotes a different partnership exchange state. Six of the seven partnership exchange states indicated that they planned to assist with the consumer assistance function. The dates listed were identified in the conditional approval letters that CMS sent to the partnership exchange states between December 2012 and March 2013.

As of April 24, 2013, CMS indicated that these six partnership exchange states had made progress, but the completion of some activities was behind schedule.⁴⁵ For example, three states that had planned to release the applications to select in-person assisters by April 2013 had done so. While the deadline for most states to select in-person assisters had not passed as of April 24, 2013, there were delays for two states. One state that planned to select in-person assisters by March 15, 2013 delayed that deadline to May 30, 2013, while the other delayed it to June 15. CMS indicated that these delays are not expected to affect the implementation of these programs. However, the state now planning to complete selection by May 30, 2013, had originally planned to begin training assisters in March and begin work May 15, 2013. The second state had planned that in-person assisters would begin work August 1, 2013.

⁴⁵Michigan was conditionally approved by CMS to assist with the plan management and consumer assistance functions. However, CMS officials indicated that the state had not been able to obtain the legislative authority it needed to use federal grant funds to pay for exchange activities. Therefore, CMS officials indicated that Michigan may not be able to assist with the consumer assistance function. As of May 2, 2013, however, the state had not made a final determination about this responsibility.

CMS and states with partnership exchanges have also begun, and established time frames for, undertaking other outreach and consumer assistance activities that are necessary to implement FFEs. CMS recommended that in-person outreach activities begin in the summer of 2013 to educate consumers in advance of the open enrollment period. Examples of key activities that remain to be completed include the federal call center, healthcare.gov website, media outreach, and the consumer complaint tracking system for the FFEs. While states with partnership exchanges will utilize the federal call center and website, they have established plans for undertaking other outreach and consumer assistance activities. (See table 2.)

Table 2: Other CMS and State Consumer Assistance and Outreach Activities to be Completed Prior to Initial Enrollment in the Federally Facilitated Exchanges (FFE), as of May 2013

Activity	Implementation plans for CMS and partnership exchange states	
Call center	CMS	CMS awarded the contract for operation of the call center on April 15, 2013, with the call center to begin operations by June 2013.
	States	Partnership exchange states will use the federal call center.
Healthcare.gov website	CMS	CMS planned to relaunch the healthcare.gov website in June 2013 to provide a greater focus on exchange enrollment. For example, the updated website will include checklists to help consumers prepare for enrollment in October.
	States	Partnership exchange states will use the federal website.
Media outreach	CMS	CMS planned to award a contract for English-language media outreach targeting FFEs in April 2013, and planned to award a contract for Spanish-language outreach by June 2013. By August or September, the agency also planned to translate educational materials into 25 languages.
	States	Four partnership exchange states planned to begin their media and marketing campaigns by June or July 2013, and one planned to begin its campaign in December 2013.
Consumer complaint tracking system	CMS	CMS plans that the system used by the FFE in states not assisting with consumer assistance activities will be available by the October 2013 initial enrollment date.
	States	Six partnership states identified various dates between February and October 2013 for their systems to become operational. As of April 24, 2013, CMS indicated that the February 2013 targeted completion date for one state had been revised to June 15, 2013.

Source: CMS.

Notes: CMS conditionally approved six partnership exchange states to assist with certain consumer assistance responsibilities.

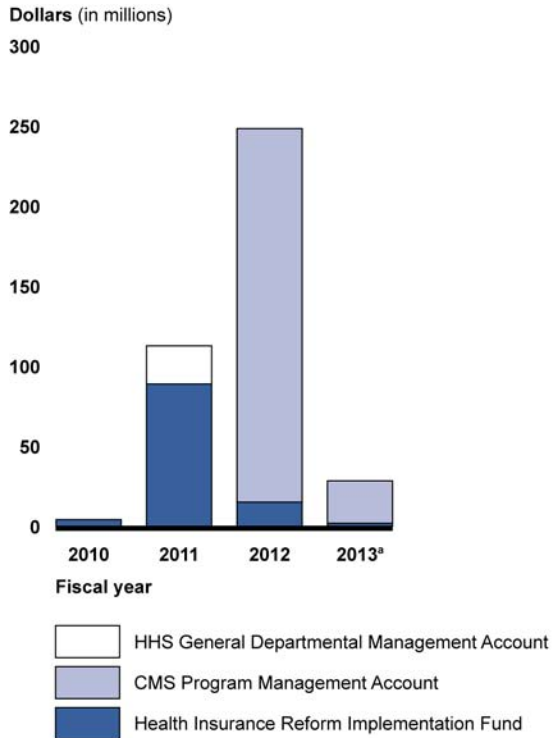
CMS Spent Almost \$394 Million through Contracts to Support Establishment of the FFEs and Data Hub and to Carry Out Certain Other Exchange-Related Activities as of March 2013

CMS data indicated that the agency spent almost \$394 million from fiscal year 2010 through March 31, 2013, through contracts⁴⁶ to complete activities to establish the FFEs and the data hub and carry out certain other exchange-related activities.⁴⁷ CMS officials said that these totals did not include CMS salaries and other administrative costs, but rather reflected the amounts obligated for contract activities. The majority of these obligations, about \$248 million (63 percent), were incurred in fiscal year 2012. The sources of the \$394 million in funding were three appropriation accounts: HHS's General Departmental Management Account, CMS's Program Management Account, and the Health Insurance Reform Implementation Fund. The majority of the funding came from the CMS Program Management Account (66 percent) followed by the Health Insurance Reform Implementation Fund (28 percent). (See fig. 5.)

⁴⁶In this report, we use the term "contract" to include contracts with private entities to carry out activities to establish the FFEs and the data hub, as well as certain other exchange-related activities, task orders for such activities under contracts with private entities that may encompass a broader range of activities, and interagency agreements for such activities. References to CMS "spending" are to the amounts obligated under these contracts, task orders, and interagency agreements. This total also includes amounts obligated by HHS under contracts, task orders, and interagency agreements in fiscal years 2010 and 2011, before HHS transferred oversight of exchange implementation to CMS. An obligation is a definite legal commitment that will give rise to payment at some point in the future. An agency incurs an obligation, for example, when it awards a contract.

⁴⁷CMS indicated that certain of these contracts supported activities, such as state oversight, financial management, and risk adjustment model and development, in which CMS would have engaged even if all states planned to operate their own exchanges in 2014.

Figure 5: CMS Obligations for Contracts That Support the Establishment of Federally Facilitated Exchanges (FFE) and the Data Hub, by Appropriation Account, through March 31, 2013



Source: CMS.

Note: These totals include amounts obligated for contracts, task orders, and interagency agreements to complete activities to establish the FFEs and the data hub and carry out certain other exchange-related activities. The totals also include some obligations incurred by HHS in fiscal years 2010 and 2011, before HHS transferred oversight of exchange implementation to CMS.

*For fiscal year 2013, the totals reflect amounts obligated only through March 31, 2013.

CMS reported that the almost \$394 million supported 64 different types of projects through March 31, 2013. The highest volume of obligations related to the development of information technology systems for the FFEs. The 10 largest project types in terms of obligations made through March 31, 2013, accounted for \$242.6 million, 62 percent of the total obligations. (See table 3.)

Table 3: CMS Obligations for Contracts That Support the Establishment of Federally Facilitated Exchanges (FFE) and the Data Hub by Largest Project Type, through March 31, 2013

CMS project type	Amount obligated (dollars)
Federally Facilitated Exchanges Information Technology	\$84,273,137
Federal Health Care Exchange Technical Assistance and Support	27,587,482
Federal Health Care Exchange Hub	24,732,087
Exchange Consumer Call Center	21,999,974
Small Business Health Options Program (SHOP) and Employer Support	17,112,098
Data Architectural Contract—Requirements Support, Enterprise Data & Design Support (Incorporated the Multidimensional Data Analytics System)	13,979,845
Exchanges State Grants, Technical Assistance, Oversight	13,910,068
Enterprise Project Management Operations	13,277,422
Federal Health Care Exchange Web Portal and Support	13,013,171
Exchange Plan Management, Support & Integration	12,716,744

Source: CMS.

Note: These totals include amounts obligated for contracts, task orders, and interagency agreements to complete activities to establish the FFEs and the data hub and carry out certain other exchange-related activities. The totals also include some obligations incurred by HHS in fiscal years 2010 and 2011, before HHS transferred oversight of exchange implementation to CMS.

These activities were carried out by 55 different contractors.⁴⁸ Of these, 10 contractors accounted for \$303.4 million (77 percent of total obligations) for activities to support establishment of FFEs and the data hub and carry out certain other exchange-related activities. (See table 4.) Their contracts were for projects related to information technology, the healthcare.gov website, call center, and technical assistance for the FFEs. For one contract, with CGI Federal, CMS obligated about \$88 million for activities to support establishment of the FFEs, such as information technology and technical assistance. For another contract, with Quality Software Services, Inc., CMS obligated about \$55 million for related activities, including to support development of the data hub. (See app. I for each contract by the contractor, the amount obligated, the fiscal year in which funds were obligated, and the source of funding.)

⁴⁸Other federal agencies, such as SSA and other HHS components, that conducted activities to support establishment of the FFEs and the data hub under interagency agreements, are included in the number of contractors. Through these interagency agreements, CMS obtained technical assistance and support to establish FFEs and support for administering the Navigator grants, among other activities.

Table 4: CMS Obligations for Contracts That Support Federally Facilitated Exchanges (FFE) and Data Hub Establishment by Largest Contractor, through March 31, 2013

Contractor	Examples of activities	Amount obligated (dollars)
CGI Federal Inc	FFE information technology and healthcare.gov	\$87,997,938
Quality Software Services Inc	Data hub	55,098,237
Booz Allen Hamilton	Enrollment and eligibility planning and state grant technical assistance	37,737,550
National Government Services Inc	Consumer call center and Small Business Health Options Program (SHOP) premium aggregations	31,590,846
The Mitre Corporation	Project management and Information technology security	22,028,672
Logistics Management Institute	Health plan management, rate analysis, and benefit package review	19,107,667
DEDE Inc DBA Genova Technology	Information technology	16,026,915
Terremark Federal Group	Cloud computing services	15,539,713
IDL Solutions	Enterprise data and design support	9,342,512
Navigant Consulting Inc	Outreach and collection activities	8,949,560

Source: CMS.

Note: These totals include amounts obligated for contracts, task orders, and interagency agreements to complete activities to establish the FFEs and the data hub and carry out certain other exchange-related activities. The totals also include some obligations incurred by HHS in fiscal years 2010 and 2011, before HHS transferred oversight of exchange implementation to CMS.

Concluding Observations

FFE along with the data services hub services are central to the goal under PPACA of having health insurance exchanges operating in each state by 2014, and of providing a single point of access to the health insurance market for individuals. Their development has been a complex undertaking, involving the coordinated actions of multiple federal, state, and private stakeholders, and the creation of an information system to support connectivity and near real-time data sharing between health insurance exchanges and multiple federal and state agencies. Much progress has been made in establishing the regulatory framework and guidance required for this undertaking, and CMS is currently taking steps to implement key activities of the FFEs, and developing, testing, and implementing the data hub. Nevertheless, much remains to be accomplished within a relatively short amount of time. CMS's timelines and targeted completion dates provide a roadmap to completion of the required activities by the start of enrollment on October 1, 2013. However, certain factors, such as the still-unknown and evolving scope of the exchange activities CMS will be required to perform in each state, and the large numbers of activities remaining to be performed—some close to the start of enrollment—suggest a potential for implementation challenges going forward. And while the missed interim deadlines may not affect

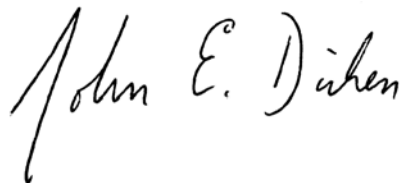
implementation, additional missed deadlines closer to the start of enrollment could do so. CMS recently completed risk assessments and plans for mitigating identified risks associated with the data hub, and is also working on strategies to address state preparedness contingencies. Whether CMS's contingency planning will assure the timely and smooth implementation of the exchanges by October 2013 cannot yet be determined.

Agency Comments

We received comments from HHS on a draft of this report (see app. II). HHS emphasized the progress it has made in establishing exchanges since PPACA became law, and expressed its confidence that on October 1, 2013, exchanges will be open and functioning in every state. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have questions about this report, please contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



John E. Dicken
Director, Health Care

Appendix I: Contractors Supporting the Federally Facilitated Exchanges and Data Hub and Amounts Obligated

Table 5 provides information on the amounts the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) obligated for contract activities to support the establishment of the federally facilitated exchanges (FFE) and the data hub and carry out certain other exchange-related activities by individual contractors.¹ The funds were obligated from fiscal year 2010 through March 31, 2013. The information presented in this table was obtained from CMS. Due to the large number of contractors, we did not edit the information to correct typographical or grammatical errors, or clarify the information provided. We reprinted the abbreviations and acronyms provided by CMS.

Table 5: Contractors Supporting Establishment of the Federally Facilitated Exchanges (FFE) and Data Hub and Amounts Obligated, Fiscal Year 2010 through March 31, 2013

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
A Reddix and Associates Inc	2012	Stake Holder Training, Program & Technical Assistance Support	\$5,551,242	CMS Program Management Account
Acumen LLC	2011	Exchanges Payment & Financial Management	1,698,054	HHS General Departmental Management Account
Acumen LLC	2012	Financial Management & Operational Analytics Contract	675,000	CMS Program Management Account
Acumen LLC	2013	Financial Management & Operational Analytics Contract	21,141	CMS Program Management Account
Acumen LLC	2013	Financial Management & Operational Analytics Contract	750,729	CMS Program Management Account
Acumen LLC	2013	Financial Management & Operational Analytics Contract	1,645,133	CMS Program Management Account

¹CMS indicated that certain of these obligations supported activities, such as state oversight, financial management, and risk adjustment model and development, in which CMS would have engaged even if all states planned to operate their own exchanges in 2014. In this report, we use the term "contract" to include contracts with private entities to carry out activities to establish the FFEs and the data hub, as well as certain other exchange-related activities, task orders for such activities under contracts with private entities that may encompass a broader range of activities, and interagency agreements for such activities. References to CMS "spending" are to the amounts obligated under these contracts, task orders, and interagency agreements. This total also includes amounts obligated by HHS under contracts, task orders, and interagency agreements in fiscal years 2010 and 2011, before HHS transferred oversight of exchange implementation to CMS. An obligation is a definite legal commitment that will give rise to payment at some point in the future. An agency incurs an obligation, for example, when it awards a contract.

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
Aquilent	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	2,262,701	CMS Program Management Account
Aquilent	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	2,992,430	CMS Program Management Account
Blast Design Studio Inc	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	197,625	CMS Program Management Account
Booz Allen Hamilton	2011	Exchanges Enrollment & Eligibility	1,000,000	HHS General Departmental Management Account
Booz Allen Hamilton	2011	Exchanges Enrollment & Eligibility	1,217,735	HHS General Departmental Management Account
Booz Allen Hamilton	2011	Exchanges State Grants, TA, Oversight	885,396	HHS General Departmental Management Account
Booz Allen Hamilton	2011	Exchanges State Grants, TA, Oversight	13,024,672	HHS General Departmental Management Account
Booz Allen Hamilton	2011	SHOP & Employer	366,200	HHS General Departmental Management Account
Booz Allen Hamilton	2012	Eligibility & Enrollment Strategy	453,477	CMS Program Management Account
Booz Allen Hamilton	2012	Eligibility & Enrollment Strategy and Planning	1,452,350	CMS Program Management Account
Booz Allen Hamilton	2012	Eligibility Appeals Strategy & Research	1,027,313	CMS Program Management Account
Booz Allen Hamilton	2012	Exchange IT integration support for Enterprise Project Management Operations	6,129,727	CMS Program Management Account
Booz Allen Hamilton	2012	Exchange Plan Management, Support & Integration (including Coverage Appeals, Research Monitoring & Prescription Drug Formulary Review & Assessment)	8,579,473	CMS Program Management Account
Booz Allen Hamilton	2012	Exchange Quality Activities (Sec. 1311/1321/1343)	500,000	Health Insurance Reform Implementation Fund
Booz Allen Hamilton	2012	State Grants, Technical Assistance & Oversight	1,605,430	CMS Program Management Account
Booz Allen Hamilton	2013	Eligibility & Enrollment Strategy and Planning	883,102	CMS Program Management Account
Booz Allen Hamilton	2013	Eligibility Appeals Strategy & Research	612,675	CMS Program Management Account
Carasoft Technology Group	2012	IT Security - Security Oversight, Equipment, New Systems Testing, and Security Program Support	238,349	CMS Program Management Account

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
CGI Federal Inc	2011	Federally-facilitated Exchanges IT	55,744,082	Health Insurance Reform Implementation Fund
CGI Federal Inc	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	580,000	CMS Program Management Account
CGI Federal Inc	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	1,999,832	CMS Program Management Account
CGI Federal Inc	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	2,979,030	CMS Program Management Account
CGI Federal Inc	2012	Federal Health Care Exchange (HIX) technical Assistance & Support	24,771,690	CMS Program Management Account
CGI Federal Inc	2013	Rate Benefit Information System (RBIS)	1,923,304	Health Insurance Reform Implementation Fund
Corporate Executive Board	2012	CEB Subscription, Enterprise Architecture Operational Support	186,738	CMS Program Management Account
Creative Computing Solutions	2012	IT Security - Security Oversight, Equipment, New Systems Testing, and Security Program Support	222,444	CMS Program Management Account
Creative Computing Solutions	2012	IT Security - Security Oversight, Equipment, New Systems Testing, and Security Program Support	5,082,411	CMS Program Management Account
DEDE Inc DBA Genova Technology	2011	Exchanges IT	2,828,148	HHS General Departmental Management Account
DEDE Inc DBA Genova Technology	2012	Business Requirements for PMO & Governance	1,110,327	CMS Program Management Account
DEDE Inc DBA Genova Technology	2012	Business Requirements for PMO & Governance	437,929	CMS Program Management Account
DEDE Inc DBA Genova Technology	2012	Business Requirements for PMO & Governance	1,799,851	CMS Program Management Account
DEDE Inc DBA Genova Technology	2012	Business Requirements for PMO & Governance	4,579,104	CMS Program Management Account
DEDE Inc DBA Genova Technology	2012	Data Architectural Contract -Requirements Support, Enterprise Data & Design Support (Incorporated the Multidimensional Data Analytics System (MIDAS))	4,195,450	CMS Program Management Account
DEDE Inc DBA Genova Technology	2013	Business Requirements for PMO & Governance	1,076,106	CMS Program Management Account
Deloitte Consulting	2012	Enterprise Project Management Operations	670,486	CMS Program Management Account
Deloitte Consulting	2012	Health Plan Bid Review, Management & Oversight (Sec. 1311/1321/1343)	750,000	Health Insurance Reform Implementation Fund
Deloitte Consulting	2012	SHOP & Employer	709,230	Health Insurance Reform Implementation Fund

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
DHHS / Office of the Secretary	2012	Health Information Exchange	1,346,831	CMS Program Management Account
DHHS Program Support Center ^a	2010	Program Support Center Services Bill	94,582	Health Insurance Reform Implementation Fund
DHHS Program Support Center ^a	2011	IT Services for CAG Tool with Team Triple-i	42,999	Health Insurance Reform Implementation Fund
DHHS Program Support Center ^a	2011	Program Support Center Services Bill	25,000	Health Insurance Reform Implementation Fund
DHHS/ACF	2013	Navigator Grants Administration & Support	748,280	CMS Program Management Account
DHHS/NIH/NCI	2012	Enterprise Architecture Operational Support	53,460	CMS Program Management Account
DHHS/NIH/NCI	2012	Enterprise Data & Design Support (Incorporated the Multidimensional Data Analytics System (MIDAS))	301,583	CMS Program Management Account
DHHS/NIH/NCI	2012	Federal Health Care Exchange (HIX) technical Assistance & Support	1,528	CMS Program Management Account
DHHS/NIH/NCI	2013	Federal Health Care Exchange (HIX) technical Assistance & Support	1,452	CMS Program Management Account
DHHS/PSC	2013	CMS Analysis of Payment Notice Summaries	447,926	CMS Program Management Account
Duty First Consulting LLC	2012	Exchange Plan Management, Support & Integration (including Coverage Appeals, Research, Monitoring & Prescription Drug Formulary Review & Assessment)	141,836	CMS Program Management Account
Econometrica Inc	2012	Post-Reform Consumer Landscape Market Analytics and Implementation (Sec. 1311/1321/1343)	993,236	Health Insurance Reform Implementation Fund
Econometrica Inc	2013	Post-Reform Consumer Landscape Market Analytics	572,613	CMS Program Management Account
Fedresults Inc	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	901,476	CMS Program Management Account
Foresee	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	45,000	CMS Program Management Account
General Services Administration ^a	2010	Rent-Bethesda Office	244,230	Health Insurance Reform Implementation Fund
George Washington University (through Program Support Center)	2012	Commercial health insurance Research	262,574	CMS Program Management Account

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
Global Tech Inc DBA EglobalTec	2012	Cloud Computing, Enterprise Architecture Operational Support	646,532	CMS Program Management Account
Government Acquisitions Inc	2012	Enterprise Architecture Operational Support	1,721,378	CMS Program Management Account
Government Printing Office ^a	2010	Federal Register Notice Charge	3,097	Health Insurance Reform Implementation Fund
Homeland Security/Federal Law Enforcement Training Center ^a	2010	Building Security	2,252	Health Insurance Reform Implementation Fund
IDL Solutions	2012	Enterprise Data & Design Support (Incorporated the Multidimensional Data Analytics System (MIDAS))	209,416	CMS Program Management Account
IDL Solutions	2012	Enterprise Data & Design Support (Incorporated the Multidimensional Data Analytics System (MIDAS))	9,133,096	CMS Program Management Account
Innosoft Corporation	2012	Enterprise Project Management Operations	1,000,532	CMS Program Management Account
ISOM Events	2012	Stake Holder Outreach	67,925	CMS Program Management Account
KPMG LLP	2012	Audit & Validation, Program Integrity and Financial Oversight	4,771,142	CMS Program Management Account
KPMG LLP	2012	SHOP & Employer Support	3,193,793	CMS Program Management Account
KPMG LLP	2013	Employer Database	162,476	CMS Program Management Account
L&M Policy Research	2012	Consumer Information & Outreach (Sec. 1311/1321/1343)	1,353,969	Health Insurance Reform Implementation Fund
L&M Policy Research	2012	Consumer Research Enhancing Web-based Tools on Health Insurance Exchanges Portal	1,353,720	CMS Program Management Account
Lockheed Martin	2012	Enterprise Architecture Operational Support	10,500	CMS Program Management Account
Lockheed Martin	2012	Enterprise Architecture Operational Support	69,007	CMS Program Management Account
Lockheed Martin	2012	Enterprise Architecture Operational Support	244,713	CMS Program Management Account
Lockheed Martin	2013	Enterprise Architecture Operational Support	396,000	CMS Program Management Account
Lockheed Martin Services Inc	2012	Enterprise Architecture Operational Support	1,523,600	CMS Program Management Account
Lockheed Martin Services Inc	2012	Exchange Consumer Call Center	4,327,433	CMS Program Management Account

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
Lockheed Martin Services Inc	2012	Federal Health Care Exchange (HIX) Hub	10,013	CMS Program Management Account
Lockheed Martin Services Inc	2012	Federal Health Care Exchange (HIX) Hub	49,223	CMS Program Management Account
Lockheed Martin Services Inc	2012	Federal Health Care Exchange (HIX) Hub	168,811	CMS Program Management Account
Lockheed Martin Services Inc	2012	Federal Health Care Exchange (HIX) technical Assistance & Support	200,000	CMS Program Management Account
Lockheed Martin Services Inc	2013	Enterprise Architecture Operational Support	7,507	CMS Program Management Account
Lockheed Martin Services Inc	2013	Federal Health Care Exchange (HIX) Hub	12,062	CMS Program Management Account
Lockheed Martin Services Inc	2013	Federal Health Care Exchange (HIX) Hub	17,499	CMS Program Management Account
Lockheed Martin Services Inc	2013	Federal Health Care Exchange (HIX) Technical Assistance & Support	31,164	CMS Program Management Account
Logistics Management Institute	2012	Health Plan Bid Review, Management & Oversight (Sec. 1311/1321/1343)	449,765	Health Insurance Reform Implementation Fund
Logistics Management Institute	2012	Health Plan Bid Review, Management & Oversight (Sec. 1311/1321/1343)	2,675,507	Health Insurance Reform Implementation Fund
Logistics Management Institute	2012	Health Plan Bid Review, Management & Oversight (Sec. 1311/1321/1343)	2,964,739	Health Insurance Reform Implementation Fund
Logistics Management Institute	2012	SHOP & Employer -Exchange Operations & Health Plan Rate Benefit Package	336,686	Health Insurance Reform Implementation Fund
Logistics Management Institute	2012	SHOP & Employer-Exchange Operations & Health Plan Management	459,979	Health Insurance Reform Implementation Fund
Logistics Management Institute	2013	Health Plan Management, Rate Analysis & Benefit Package Review	2,624,342	CMS Program Management Account
Logistics Management Institute	2013	Health Plan Management, Rate Analysis & Benefit Package Review	9,596,649	CMS Program Management Account
National Government Services Inc	2012	Exchange Consumer Call Center	17,672,541	CMS Program Management Account
National Government Services Inc	2012	SHOP Premium Aggregations & Employer	13,918,305	CMS Program Management Account
National Opinion Research Center ^a	2011	Technical Assistance - Commercial Health Insurance and Public Sector Health Coverage	969,514	Health Insurance Reform Implementation Fund
Navigant Consulting Inc	2012	Outreach and Collection Activities Under the Affordable Care Act- Reinsurance Entity	8,949,560	CMS Program Management Account

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
Noblis Inc	2013	Health Information Exchange	350,000	CMS Program Management Account
NORC (through Program Support Center)	2012	Commercial health insurance Research	96,792	CMS Program Management Account
NORC (through Program Support Center)	2012	Commercial health insurance Research	1,009,756	CMS Program Management Account
Northrop Grumman Information Technology	2012	Enterprise Eligibility Service (EES) - Integrated Care Data and Application - Federal Health Care Exchange (HIX) Hub	1,365,829	CMS Program Management Account
Northrop Grumman Information Technology	2012	Federal Health Care Exchange (HIX) technical Assistance & Support	549,058	CMS Program Management Account
Office of Personnel Management ^a	2011	Security Badges	2,772	Health Insurance Reform Implementation Fund
Onix Networking Corp	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	44,340	CMS Program Management Account
Opera Solutions, LLC	2012	Operational Analytics & Fraud Surveillance, Financial Management	3,999,260	CMS Program Management Account
Professional and Scientific Associates Inc ^a	2010	Meeting and Conference Support Contract	407,780	Health Insurance Reform Implementation Fund
Quality Software Services Inc	2011	Affordable Care Act System Testing Support for Data Services Hub	25,700,907	Health Insurance Reform Implementation Fund
Quality Software Services Inc	2012	Enterprise Architecture Operational Support	199,364	CMS Program Management Account
Quality Software Services Inc	2012	Enterprise Project Management Operations	4,516,369	CMS Program Management Account
Quality Software Services Inc	2012	Federal Health Care Exchange (HIX) Hub	23,017,077	CMS Program Management Account
Quality Software Services Inc ^a	2010	Exchange IT Support Contract	1,595,480	Health Insurance Reform Implementation Fund
Quality Software Services Inc ^a	2011	Base Year Modification - Exchange IT Support Contract	69,040	Health Insurance Reform Implementation Fund
Quality Technology Inc	2012	Operational Support Center Support Contractor	1,610,233	CMS Program Management Account
Quality Technology Inc	2013	Operational Support Center Support Contractor	5,436,471	CMS Program Management Account
Research Triangle Institute	2011	Exchanges Research and Support	2,427,141	HHS General Departmental Management Account

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
Research Triangle Institute	2012	Part C, Part D, and State Exchange Risk Adjustment Model Research Development (previously funded out of Project #7194)	1,218,408	CMS Program Management Account
SAIC	2012	Enterprise Architecture Operational Support	109,406	CMS Program Management Account
SAIC	2012	Enterprise IT Operations	2,762,088	Health Insurance Reform Implementation Fund
Salter Mitchell Inc	2012	Consumer Information & Outreach for technical professional services to assist in research around the Exchanges (Sec. 1311/1321/1343)	2,141,588	Health Insurance Reform Implementation Fund
Salter Mitchell Inc	2012	Exchange Consumer Research	9,813	CMS Program Management Account
Salter Mitchell Inc	2012	Exchange Consumer Research	2,203,831	CMS Program Management Account
Spherecom Enterprises Inc	2012	Federal Health Care Exchange (HIX) technical Assistance & Support	708,417	CMS Program Management Account
Spherecom Enterprises Inc	2012	IT Security - Security Oversight, Equipment, New Systems Testing, and Security Program Support	1,282,431	CMS Program Management Account
SSA	2012	Eligibility & Enrollment Strategy	500,000	CMS Program Management Account
SSA	2012	Interagency Agreement with SSA	400,000	Health Insurance Reform Implementation Fund
Tantus Technologies Inc	2012	Health Care Exchange/HIGLAS	4,097,719	CMS Program Management Account
Terremark Federal Group	2012	Cloud Computing	11,587,701	CMS Program Management Account
Terremark Federal Group ^a	2011	Cloud Computing Services	3,952,012	Health Insurance Reform Implementation Fund
The George Washington University ^a	2010	Exchange Analytical Support Contract	695,007	Health Insurance Reform Implementation Fund
The Mitre Corporation	2012	CMS Modernization Support, Exchange Plan Management, Support & Integration (including Coverage Appeals, Research, Monitoring & Prescription Drug Formulary Review & Assessment)	3,995,435	CMS Program Management Account
The Mitre Corporation	2012	Enterprise Architecture Operational Support	156,781	CMS Program Management Account
The Mitre Corporation	2012	Enterprise Data & Design Support (Incorporated the Multidimensional Data Analytics System (MIDAS))	51,453	CMS Program Management Account

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
The Mitre Corporation	2012	Enterprise Data & Design Support (Incorporated the Multidimensional Data Analytics System (MIDAS))	88,847	CMS Program Management Account
The Mitre Corporation	2012	Enterprise Project Management Operations	6,477,209	CMS Program Management Account
The Mitre Corporation	2012	Exchange Procurement & Acquisition Support	6,097,155	CMS Program Management Account
The Mitre Corporation	2012	Federal Health Care Exchange (HIX) Exchange Web Portal & Support	1,010,738	CMS Program Management Account
The Mitre Corporation	2012	Federal Health Care Exchange (HIX) technical Assistance & Support	550,000	CMS Program Management Account
The Mitre Corporation	2012	Health Insurance Assistance database (HIAD)	51,453	CMS Program Management Account
The Mitre Corporation	2012	IT Security - Security Oversight, Equipment, New Systems Testing, and Security Program Support	102,906	CMS Program Management Account
The Mitre Corporation	2013	CALT Security Testing & Evaluation (Now CALT Security Controls and Assessment (SCA)) and code reviews for Federal Health Care Exchange (HIX) Hub	91,573	CMS Program Management Account
The Mitre Corporation	2013	IT Security - Security Oversight, Equipment, New Systems Testing, and Security Program Support	91,573	CMS Program Management Account
The Mitre Corporation	2013	IT Security - Security Oversight, Equipment, New Systems Testing, and Security Program Support	110,968	CMS Program Management Account
The Mitre Corporation ^a	2010	OCIIO Modernization Support	750,036	Health Insurance Reform Implementation Fund
The Mitre Corporation ^a	2011	Option Period - OCIIO Modernization Support	2,402,545	Health Insurance Reform Implementation Fund
Truven Health Analytics Inc	2012	Financial Management & Operational Analytics	30,000	CMS Program Management Account
Truven Health Analytics Inc	2012	Training, Program & Technical Assistance Support	1,867	CMS Program Management Account
Truven Health Analytics Inc	2012	Training, Program & Technical Assistance Support	7,120	CMS Program Management Account
Truven Health Analytics Inc	2012	Training, Program & Technical Assistance Support	21,012	CMS Program Management Account
Turning Point Global Solutions	2012	Enterprise Project Management Operations	3,040,032	CMS Program Management Account
Urban Institute (through Program Support Center)	2011	Health Plan Bid Review, Management & Oversight (Sec. 1311/1321/1343)	300,000	HHS General Departmental Management Account
Verizon	2013	Federal Health Care Exchange (HIX) technical Assistance & Support	774,174	CMS Program Management Account

**Appendix I: Contractors Supporting the
Federally Facilitated Exchanges and Data Hub
and Amounts Obligated**

Contractor	Fiscal year	Project description	Amount obligated (dollars)	Funding source
Wakely Consulting Group ^a	2010	Exchange Consultant Contract	432,093	Health Insurance Reform Implementation Fund

Source: CMS.

Notes: These totals include amounts obligated for contracts, task orders, and interagency agreements to complete activities to establish the FFEs and the data hub and carry out certain other exchange-related activities.

^aThis total includes some obligations by HHS before it transferred oversight of exchange implementation to CMS.

Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUN 6 2013

John E. Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dicken

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, entitled, "PATIENT PROTECTION AND AFFORDABLE CARE ACT: Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges" (GAO-13-601).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO)
DRAFT REPORT ENTITLED, "PATIENT PROTECTION AND AFFORDABLE CARE
ACT: STATUS OF CMS EFFORTS TO ESTABLISH A FEDERALLY FACILITATED
HEALTH INSURANCE EXCHANGES" (GAO-13-601)**

The Department appreciates the opportunity to review and comment on this draft report.

On October 1, 2013 a Health Insurance Marketplace will be open and functioning in every state. In the more than three years since the law was passed we have made tremendous progress. Earlier this year we successfully administered the qualified health plan submission process for the federal facilitated Marketplace. We published the final single streamlined application and we have announced several grant and contract programs that provide consumer assistance functions. We are in the final stages of finalizing and testing the IT infrastructure that will support the application and enrollment process. HHS is extremely confident that on October 1 the Marketplace will open on schedule and millions of Americans will have access to affordable quality health insurance.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact name above, Randy Dirosa and Teresa Tucker, Assistant Directors; Tonia Brown; Sandra George; Jawaria Gilani; William Hadley; Thomas Murphy; and Laurie Pachter made key contributions to this report.

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Report to the Chairman, Committee on
Small Business, House of
Representatives

June 2013

PATIENT
PROTECTION AND
AFFORDABLE CARE
ACT

Status of Federal and
State Efforts to
Establish Health
Insurance Exchanges
for Small Businesses

GAO Highlights

Highlights of [GAO-13-614](#), a report to the Chairman, Committee on Small Business, House of Representatives

Why GAO Did This Study

The Patient Protection and Affordable Care Act (PPACA) requires SHOPs—exchanges or marketplaces where small employers can shop for health coverage for their employees—to be established in all states. PPACA also requires similar exchanges to be established for individuals. CMS oversees the establishment of the SHOPs, approving states to operate one or establishing and operating one itself in states that will not do so. Enrollment is to begin October 2013, with coverage effective January 2014, although a key requirement related to employee choice was deferred for 1 year. GAO was asked to examine federal and state readiness to establish the SHOPs. In this report, GAO describes (1) the roles of the federal government and states in establishing SHOPs and (2) the status of actions taken and planned by the federal government and states in preparing to establish SHOPs.

GAO reviewed CMS regulations and guidance on the roles of CMS and states in establishing both SHOPs and individual exchanges, as progress establishing the two exchanges is related. GAO reviewed CMS planning documents used to track the progress of key activities to be conducted by CMS to establish FF-SHOPs and FFEs. GAO also reviewed target completion dates for key activities CMS established for states and obtained updates from CMS on state progress. GAO interviewed CMS officials and relied largely on documentation from CMS—including information CMS developed on the basis of its contacts with states—and did not interview states.

View [GAO-13-614](#). For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

June 2013

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Status of Federal and State Efforts to Establish Health Insurance Exchanges for Small Businesses

What GAO Found

For 2014, the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) granted conditional approval to 18 states to establish state-based Small Business Health Options Programs, or SHOPs, and to 17 states to operate health insurance exchanges for individuals. CMS is required to operate a federally facilitated SHOP (FF-SHOP) and a federally facilitated exchange for individuals (FFE) in the remaining states. Of the 33 states with FF-SHOPs and 34 states with FFEs, 15 states are expected to assist CMS to carry out certain functions of the exchange. However, the activities that CMS plans to complete in these 15 exchanges have evolved, and CMS activities in these and other exchanges may continue to change. For example, CMS approved state roles in SHOPs and individual exchanges on the condition that they ultimately complete key activities for exchange establishment. CMS indicated that it would assume more responsibilities in these exchanges if any state did not adequately progress towards completion of all required activities.

CMS and states have made progress in establishing SHOPs, although many activities remain to be completed and some were behind schedule. CMS issued regulations and guidance necessary to establish SHOPs and took steps to establish processes and data systems necessary to operate the FF-SHOPs. Many activities remain to be completed in the core functional areas of eligibility and enrollment, plan management, and consumer assistance, and while the agency has established timelines for completion of these activities, some were behind schedule. For example, funding awards and development of a training curriculum for a key program that will provide outreach and enrollment assistance to small employers and employees have been delayed by about 2 months. Regarding states, CMS data showed that most had completed preliminary activities such as obtaining the necessary authority to operate an exchange, and many had made progress in each of the core functional areas. Many key activities remained to be completed—some scheduled for near the start of enrollment in October 2013—and, as of May 2013, states were behind schedule in completing some key activities. In particular, about 44 percent of the key activities CMS initially targeted for completion by March 31, 2013, were behind schedule, although CMS reported that it had revised many target dates and other delays were not expected to affect exchange operations.

Much progress has been made, but much remains to be accomplished by CMS and states within a relatively short amount of time. CMS's timelines for the remaining key activities provide a roadmap for completion; however, factors such as the still-evolving scope of CMS's required activities in each state and the many activities yet to be completed—some close to the start of enrollment—could suggest the potential for future challenges. And while missed interim deadlines may not affect implementation, additional missed deadlines could do so. CMS said it is working on strategies in each state to address contingencies. Whether CMS's contingency planning will assure the timely and smooth implementation of the exchanges by October 2013 cannot yet be determined.

In commenting on a draft of this report, HHS emphasized the progress it has made in establishing exchanges, and expressed its confidence that exchanges will be open and functioning in every state by October 1, 2013.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
FFE	federally facilitated exchange
FF-SHOP	federally facilitated Small Business Health Options Program
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	U.S. Department of Health and Human Services
IT	information technology
PPACA	Patient Protection and Affordable Care Act
QHP	qualified health plan
SHOP	Small Business Health Options Program

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June 19, 2013

The Honorable Sam Graves
Chairman
Committee on Small Business
House of Representatives

Dear Mr. Chairman:

The Patient Protection and Affordable Care Act (PPACA),¹ requires the establishment in all states² of Small Business Health Options Programs (SHOP)—exchanges, or marketplaces, where small employers can shop for and purchase health coverage for their employees.³ PPACA also requires the establishment of individual exchanges in each state where eligible individuals can compare and select private insurance coverage from among participating health insurance plans. The SHOPS and individual exchanges are intended to provide single points of access to enroll employees of small businesses and individuals into private health plans.⁴ The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing the establishment of these exchanges. PPACA requires that enrollment for the exchanges begin on October 1, 2013, and that the exchanges become operational and offer health coverage starting on January 1, 2014.⁵ The Congressional Budget Office estimated in May 2013 that

¹Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 119, 173, 186 (Mar. 23, 2010) (hereafter, "PPACA"), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010) (hereafter, "HCERA"). In this report, references to PPACA include any amendments made by HCERA.

²In this report, the term "state" includes the District of Columbia.

³Under PPACA, until 2016, states have the option to define "small employers" either as those with 100 or fewer employees or 50 or fewer employees.

⁴Individual exchanges will also be the access point to determine eligibility for income-based premium subsidies and assess eligibility for other health coverage programs, such as Medicaid or the State Children's Health Insurance Program. Medicaid is a joint federal-state program that provides health care coverage for certain low-income individuals. The Children's Health Insurance Program is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirements for Medicaid.

⁵PPACA, § 1311(b), 124 Stat. at 173.

about 2 million individuals will enroll in employer-based coverage through SHOPs and 7 million individuals will enroll in individual exchanges by 2014, respectively, increasing to about 4 million and 24 million by 2022, respectively.⁶

PPACA directed states to establish state-based exchanges by January 1, 2014.⁷ In states electing not to establish and operate such an exchange, PPACA requires the federal government to establish and operate an exchange in the state, both a federally facilitated SHOP (FF-SHOP) and a federally facilitated exchange (FFE) for individuals.⁸ As a result, the federal government's role with respect to an exchange for any given state—and, in particular, whether it will establish an exchange or oversee a state-based exchange in the state—is dependent on state decisions. As directed by PPACA, FF-SHOPs and FFEs must carry out the same functions as exchanges established and operated by a state. The federal government bears responsibility for establishing and operating the FF-SHOP and FFE; however, in establishing the framework within which an FF-SHOP and FFE in a particular state will be established and operated, CMS has invited states to assist with certain FF-SHOP and FFE operations. CMS refers to FF-SHOPs and FFEs in these states as partnership exchanges. States seeking to operate a state-based exchange were required to submit an application to CMS that attests to when the state would complete specific activities CMS deemed essential to operating an exchange. States electing not to establish a state-based exchange, but seeking to participate in a partnership exchange were required to complete an abbreviated version of that application tailored to the particular activities that the state would carry out for the FF-SHOP and FFE. On the basis of this documentation, CMS conditionally approved states to establish a state-based exchange or to participate in a partnership exchange on the basis that they complete key activities by targeted completion dates, and take other steps necessary for the operation of an exchange. States' decisions to operate an exchange generally apply to both the SHOP and individual exchanges—states

⁶Congressional Budget Office, *Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline* (Washington, D.C.: May 14, 2013).

⁷PPACA, § 1311(b)(1), 124 Stat. at 173.

⁸PPACA, § 1321(c), 124 Stat. at 186.

generally do not operate just one or the other.⁹ States electing not to establish a state-based exchange or participate in a partnership exchange were not required to submit any documentation to CMS.

As the October 1, 2013, required start of health plan enrollment draws nearer, an important question is whether the SHOPs will be ready to begin accepting applications on that date and be fully operational by January 1, 2014. You asked that we examine state and federal readiness to establish the SHOPs. In this report, we describe

1. the roles of the federal government and states in establishing SHOPs, and
2. the status of actions taken and planned by the federal government and states in preparing to establish SHOPs.

Our objectives were to focus on the SHOPs, rather than the individual exchanges; however, the progress made in establishing the SHOPs and the individual exchanges is interrelated. Fundamental elements of the exchanges, such as the entities that will operate them, the governance structure, and the IT infrastructure, are largely common to both types of exchanges with limited exceptions, so progress on these exchange elements generally applies to both SHOPs and individual exchanges. Therefore, throughout this report, our discussion of the status of efforts to establish SHOPs generally relates to both the SHOPs and the individual exchanges unless otherwise noted.¹⁰

To describe the roles of the federal government and states in establishing SHOPs, GAO reviewed HHS regulations, guidance, and other documents

⁹Although PPACA directs states to establish both an individual exchange and a SHOP exchange, the law allows states to operate only one exchange for providing individual and SHOP exchange services. PPACA, § 1311(b)(2), 124 Stat. at 173-4. However, CMS announced a proposed rule that, if finalized, would permit a state to operate a SHOP while CMS operates the individual exchange in the state. This proposed rule was released by CMS on June 14, 2013, and will be published in the Federal Register on June 19, 2013.

¹⁰GAO reported on actions taken by seven states in establishing their individual exchanges. See GAO, *Health Insurance: Seven States' Actions to Establish Exchanges Under the Patient Protection and Affordable Care Act*, [GAO-13-486](#) (Washington, D.C.: Apr. 30, 2013). GAO is also reporting on the progress made by CMS in developing the FFE. See GAO, *Patient Protection and Affordable Care Act: Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges*, [GAO-13-601](#) (Washington, D.C.: June 19, 2013).

issued by CMS—including an application that CMS required states seeking to establish a state-based exchange or participate in a partnership exchange in 2014 to complete. This application describes the roles of CMS and states in establishing both SHOPS and individual exchanges, as establishment of the two types of exchanges is closely related. We also interviewed CMS officials to clarify these documents and obtain updated information on the evolving decisions related to federal and state responsibilities for specific activities to be performed in each state.

To describe the status of federal actions taken and planned to establish FF-SHOPS, we examined planning documents and timelines used by CMS to track the status of key activities to be conducted by the federal government to establish FF-SHOPS and FFEs. In addition, we developed a data collection instrument for CMS to complete about its key activities underway or planned in establishing the FF-SHOPS and FFEs. The instrument asked CMS to provide information on the activities that it had completed and the completion dates, and a description of key activities remaining to be completed and the expected completion dates. To describe the status of state actions taken and planned towards establishing the SHOPS, we reviewed the conditional approval letters in which CMS highlighted targeted completion dates for key activities for exchange establishment in each of the states conditionally approved by CMS to operate state-based exchanges or participate in partnership exchanges.¹¹ To determine the extent to which prior targeted completion dates had been met, CMS provided us with updated data on the status of the key activities that were targeted for completion through March 31, 2013. Additionally, we reviewed other publically available information from organizations tracking progress towards exchange establishment, such as the State Refor(u)m¹²—an online network for health reform implementation. We also interviewed CMS officials to better understand the status of the FF-SHOP and state-based SHOPS. To describe both federal and state actions in establishing exchanges, we relied largely on information and documentation provided to us by CMS—including

¹¹CMS noted in its letters that these key activities and targeted completion dates would function as a gauge of progress, but did not represent all that the states must do to operate as a state-based exchange.

¹²State Refor(u)m, <http://www.statereform.org>, is an initiative of the National Academy for State Health Policy, funded by the Robert Wood Johnson Foundation.

information CMS developed on the basis of its contacts and information exchanges with states—and did not interview or collect information directly from state officials.

We conducted this performance audit from February 2013 through June 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

SHOPs are intended to allow eligible small businesses and their employees to obtain health insurance, and all SHOPs, whether state-based or established and operated by the federal government, will be required to perform certain functions. The federal government's role with respect to a SHOP in any given state is dependent on the decisions of that state.

Overview of SHOPs

PPACA required that SHOPs be established in each state to allow small employers in that state to compare health insurance options available and facilitate the enrollment of their employees in coverage. Once the SHOPs are established, employers and employees will be able to access the SHOPs through a website, toll-free call centers, or in person. The SHOP in a particular state will present the qualified health plans (QHP) approved by the SHOP for the small-employer market and offered in the state by the participating issuers of health coverage.¹³ The benefits, cost-sharing features, and premiums of each QHP are to be presented in a manner that facilitates comparison shopping of plans by small employers and their employees. Employers will determine their contribution towards employee coverage and choose which QHP or QHPs will be offered to their employees. Both employers and employees will complete an application—through the SHOP website, over the phone, in person, or by

¹³The QHPs offered through the exchanges are required to meet certain benefit design, consumer protection, and other standards. In addition, all issuers or members of the same issuer group with a market share greater than 20 percent in the state's small group health insurance market must participate in a state's FF-SHOP if they wish to participate in its FFE.

mail—that collects the information necessary to screen the small employer’s eligibility and the eligibility of each of its employees to enroll in a QHP.¹⁴ Small employers and employees may receive assistance to compare coverage options and complete an application through an insurance agent, broker, or a Navigator.¹⁵ CMS has noted that brokers will play a vital role in the SHOPS, as they currently do in the small-group health coverage market, providing service at the time of plan selection and enrollment and customer service throughout the plan year.

SHOPS have various options regarding how to allow employers to select coverage for their employees. A SHOP may allow a qualified employer to select a specific level or “tier” of coverage —bronze, silver, gold, or platinum—and allow the employer to make all QHPs within that tier available to the employee.¹⁶ A SHOP may also allow an employer to offer broader employee choices among multiple plans across different tiers. The ability of employees to choose a plan that best meets their needs among multiple plans offered to them by their employer is referred to as

¹⁴Under PPACA, until 2016, states have the option to define “small employers” either as those having from 1 through 100 full-time equivalent employees or those having from 1 through 50 full-time equivalent employees. Beginning in 2016, small employers will be defined in all states as those with 100 or fewer full-time equivalent employees. Beginning in 2017, states may allow issuers of health insurance coverage in the large group market—issuers offering coverage to groups of 101 or more full-time equivalent employees—to offer QHPs through an exchange and, in turn, may allow large employers to obtain coverage through the exchange. To be eligible for SHOP coverage, a small employer must also offer, at a minimum, all full-time employees coverage in a QHP through a SHOP, and may either offer coverage to all eligible employees through the SHOP serving the area in which the employer has its principal business address or offer coverage to each eligible employee through the SHOP that serves that employee’s primary worksite. Sole proprietors are considered individuals and will purchase through the individual exchange, not through a SHOP. To be eligible to enroll in a QHP through a SHOP, an individual must have been offered health insurance coverage by a qualified employer through a SHOP.

¹⁵Navigators are individuals and entities, such as community and consumer-focused nonprofit groups, to which exchanges award grants to provide information and services in a fair and impartial manner. The duties of a Navigator include providing public education to raise awareness about the exchange, facilitating selection of a QHP, and, as appropriate, referring consumers for assistance with complaints or questions regarding their health coverage.

¹⁶PPACA sets standards for the percentage of total average costs for covered benefits that most health plans including QHPs offered on an exchange are required to cover. For example, for a bronze plan, on average, an employee would be responsible for 40 percent of the costs of all covered benefits, while for a platinum plan, on average, an employee would be responsible for 10 percent of the costs of all covered benefits.

“employee choice.” CMS had noted that employee choice was a fundamental new benefit of SHOPS, in that small employers would now be able to offer multiple plans from more than one issuer of health coverage—much in the way large employers traditionally have, and SHOPS were required to have the capacity to allow employers to provide employee choice beginning in 2014. Under a final rule issued in June 2013, however, SHOPS will not be required to have this capacity until 2015.¹⁷ State-based SHOPS may voluntarily offer this option in 2014, but FF-SHOPS will not make it available until 2015, when all SHOPS will be required to allow a qualified employer to select a single tier of coverage and make all QHPs within that tier available to employees. To make it more administratively efficient for employers to provide their employees a choice of QHP, CMS also required SHOPS to aggregate the QHP premiums for multiple employees enrolling in a particular QHP, provide the relevant qualified employer with a bill identifying the total amount that is due to a particular QHP, and collect the relevant amount from each employer and pay QHP issuers directly.¹⁸ However, like the deferral on employee choice, this requirement was deferred until 2015; state-based SHOPS may voluntarily provide this premium aggregation in 2014, but FF-SHOPS will not.¹⁹

Some small employers may also be eligible for a small business premium tax credit when they offer health coverage.²⁰ Through 2013, small employers may be eligible for a credit of up to 35 percent of the employers’ share of the employees’ premiums. Starting in 2014, the maximum tax credit increases to 50 percent, but is available only to small employers who purchase coverage through the SHOP. Small employers are eligible for this larger tax credit for a maximum of 2 years. Nonprofit employers meeting the eligibility criteria can receive credits for 25 percent

¹⁷78 Fed. Reg. 33233, 33239 (June 4, 2013).

¹⁸77 Fed. Reg. 18310, 18464 (Mar. 27, 2012).

¹⁹78 Fed. Reg. at 33239 (June 4, 2013). In the proposed rule, CMS noted that this delay was in response to concerns expressed by issuers of health coverage that they would not be able to complete enrollment and accounting system changes required to interact with the SHOP enrollment and premium aggregation systems required by employee choice; and whether there would be adequate time to educate employers, employees, and brokers about the employer and employee choices available in the SHOP.

²⁰To be eligible, an employer must: (1) have fewer than the equivalent of 25 full-time workers, (2) have an average annual employee wage below \$50,000, and (3) cover at least 50 percent of the cost of health insurance coverage for employees.

of the employer's share of premium costs through 2013 and, beginning in 2014, 35 percent of these premium costs for coverage purchased through a SHOP for a maximum of 2 years.

Core Functions of SHOPS

To establish the SHOPS, the federal government and states will be required to perform certain activities, many of which can be grouped into three core exchange functional areas: eligibility and enrollment, plan management, and consumer assistance. These functional areas are the same for the SHOPS and individual exchanges, although some activities may vary.

- *Eligibility and enrollment:* All SHOPS will be required to have the capacity to determine small employer and employee eligibility for QHP enrollment and to enroll employers and their employees into the applicable QHPs. The SHOPS will use a streamlined enrollment-eligibility system to collect information from employer and employee applications and verify that information. To carry out these functions, states and the federal government will need to develop complex information technology (IT) systems that securely facilitate the movement of information between various entities such as small employers, employees, and issuers of health coverage.
- *Plan management:* SHOPS will be required to develop and implement processes and standards to certify health plans for inclusion as QHPs and recertify or decertify them, as needed.²¹ As part of this, the SHOP must develop an application for issuers of health coverage that seek to offer a QHP. The SHOP must review the health plan data to ensure it meets certification standards for inclusion in the SHOP as a QHP. For example, the SHOP is to ensure that the health plan will accept payment from the SHOP on behalf of an employer and enroll an employee in accordance with the employer's annual employee open enrollment period. The SHOP must also conduct ongoing oversight

²¹A SHOP may initially certify a plan as a QHP if the plan meets the required minimum criteria and if the exchange determines that it is in the best interest of eligible employers and employees to have such a plan available. The annual recertification process, at a minimum, must include a review of the general certification criteria and must be completed on or before September 15 of the applicable calendar year. The SHOP must also have the ability to decertify a plan at any time if the SHOP determines that the QHP no longer meets the certification requirements.

and monitoring to ensure that the QHPs comply with all applicable regulations.

- *Consumer assistance:* SHOPs will be required to provide a call center, website, and in-person assistance to support small employers and their employees in filing an application, obtaining an eligibility determination, comparing coverage options, and enrolling in a QHP.²² Other consumer assistance activities that SHOPs must conduct are outreach and education to raise awareness of and promote enrollment in QHPs.

Federal and State Roles in Operating SHOPs

The role of the federal government with respect to a SHOP for a state is dependent on whether the state seeks to operate a state-based exchange. States can choose to establish exchanges as directed by PPACA and seek approval from CMS to do so. States electing to establish and operate a state-based exchange, including a SHOP, were required to submit to CMS, by December 14, 2012, the “Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchange.” Through this Blueprint application, the state attests to how its exchange meets, or will meet, all legal and operational requirements.²³ For example, the state must demonstrate that it will establish the necessary legal authority and governance, oversight, financial-management processes, and the core exchange functions of eligibility and enrollment, plan management, and consumer assistance. For each activity in the Blueprint application, the state must attest to either the completion of the activity or its expected completion date and provide a timeline and work plan. Depending on the activity, the state may also be required to provide supporting documentation. Although a state assumes responsibility for the exchange when it elects to operate a state-based SHOP and individual exchange, it can choose to rely on the federal

²²In general, SHOPs are required to provide in-person assistance only for the purpose of assisting small employers and employees to complete an application. CMS notes that licensed agents and brokers will provide much of the in-person assistance for FF-SHOP enrollees.

²³A state that elects to operate its own exchange has a number of legal and operational decisions to make, including decisions related to its organizational structure (governmental agency or a nonprofit entity) and governance (governing board and standards of conduct).

government for certain exchange-related activities, including having the federal government operate activities related to risk adjustment.²⁴

Under PPACA, if a state did not elect to establish a state-based exchange or is not approved by CMS to operate its own exchange, then CMS is required to establish and operate an FF-SHOP and FFE in that state. Although the federal government retains responsibility to establish and operate the FF-SHOPS and FFEs, CMS has identified possible roles for states to play in the day-to-day operation of these exchanges.

- CMS indicated that a state can choose to participate in an FF-SHOP and FFE through a partnership exchange by assisting CMS with plan management, consumer assistance, or both. According to CMS, the overall goal of a partnership exchange is to enable the FF-SHOP and FFE to benefit from efficiencies to the extent states have regulatory authority and capability to assist with these functions, help tailor the FF-SHOP and FFE to that state, and provide a seamless experience for consumers. The agency also noted that a partnership exchange can serve as a path for states toward future implementation of a state-based exchange.²⁵ Although the states would assist in carrying out plan management or consumer assistance, or both, on a day-to-day basis, CMS would retain responsibility for these activities and the activities within other functional areas. By February 15, 2013, states seeking to participate in a partnership exchange had to submit a Blueprint application to CMS regarding expected completion dates for required activities related to their participation.
- CMS indicated in guidance issued on February 20, 2013 that an FF-SHOP and FFE state choosing not to submit a Blueprint application for a partnership exchange by the February 15, 2013,

²⁴PPACA and implementing regulations provide that, beginning with the 2014 benefit year, states electing to operate a state-based exchange may establish a permanent risk-adjustment program for all nongrandfathered plans in the individual and small-group markets both inside and outside of the exchanges. HHS will establish this risk-adjustment program for any state that will have an FFE, including a partnership exchange, or for states operating a state-based exchange but that do not elect to administer the risk-adjustment program. This risk-spreading mechanism is designed to mitigate the potential effect of adverse selection and provide stability for health insurance issuers in the individual and small group markets.

²⁵Through regulation, CMS has outlined a process for states, regardless of whether they participate in a partnership exchange, to seek approval to establish a state-based exchange after 2014.

deadline could still choose to assist with the plan management function.²⁶ CMS officials said that, operationally, the activities performed by these states will be no different than the activities performed by states as part of a partnership exchange. Instead of a Blueprint application, states interested in participating in this alternative arrangement had to submit letters attesting that the state would perform all plan management activities in the Blueprint application.²⁷

- Even in states in which CMS will operate an FF-SHOP and FFE without states' assistance, CMS plans to rely on states for certain information. For example, it expects to rely on state licensure of health plans as one element of its certification of a QHP. Additionally, CMS has indicated that for states in which an FF-SHOP will operate, including as part of a partnership exchange, it will adopt the states' upper threshold of 50 or 100 full-time equivalent employees for its small group market in 2014 and 2015 for the purpose of determining whether a small employer is qualified to participate in the SHOP.

After a state submits an application to operate a state-based SHOP and individual exchange or participate in a partnership exchange, CMS may approve or conditionally approve the state for that status. Conditional approval indicates that the state had not yet completed all steps necessary to carry out its responsibilities in a state-based exchange or partnership exchange, but its SHOP and individual exchange are expected to be ready by the beginning of initial enrollment on October 1, 2013. To measure progress towards completing these steps, CMS officials indicated that the agency created a set of typical dates for when specific key activities would need to be completed in order for the exchanges to be ready for the initial enrollment period. The agency then

²⁶For the purposes of this report, we refer only to states that have been conditionally approved to participate in partnership exchanges as partnership states.

²⁷CMS officials said that they considered whether to offer FF-SHOP and FFE states this type of arrangement for other functional areas. However, they noted that there are differences between plan management and consumer assistance that made plan management a better candidate for such an arrangement. In particular, they said that many elements of plan management are similar to those activities that states engage in as a part of their traditional role as an insurance regulator. Therefore, according to these officials, these states would not have to take many additional steps to assist with an FF-SHOP's and FFE's plan management function. They said that, in contrast, consumer assistance, which is not a function that states previously performed, is more likely to be resource-intensive for the states.

adapted those dates for each state establishing a state-based SHOP and individual exchange or participating in a partnership exchange. CMS officials said that if the state indicated in its Blueprint application that it planned to complete an activity earlier than CMS's typical target completion date, CMS accepted the state's earlier date. If the state proposed a date that was later than CMS's typical target date, the state had to explain the difference, and CMS determined whether that date would allow the exchange to be ready for the initial enrollment period. The agency indicated that a state's conditional approval continues as long as it meets the key activity target dates agreed to with the individual state and demonstrates its ability to perform all required exchange activities.

The federal government's role in operating a SHOP and individual exchange in a particular state may change in future years if states reassess and alter the roles they play in establishing and operating exchanges. For example, a state may be approved to participate in a partnership exchange in 2014 and then apply, and receive approval, to run a state-based SHOP and individual exchange in 2015. Although the federal government would retain some oversight over the state-based exchanges, the responsibility for operating the exchange would shift from the federal government to the state.

CMS and State Roles and Activities in Establishing SHOPs Vary and May Continue to Evolve

CMS conditionally approved 18 states to operate state-based SHOPs in 2014, and expects to operate FF-SHOPs in 33 states in 2014. However, the nature of the activities that CMS and the states will conduct has not been finalized and may continue to evolve.

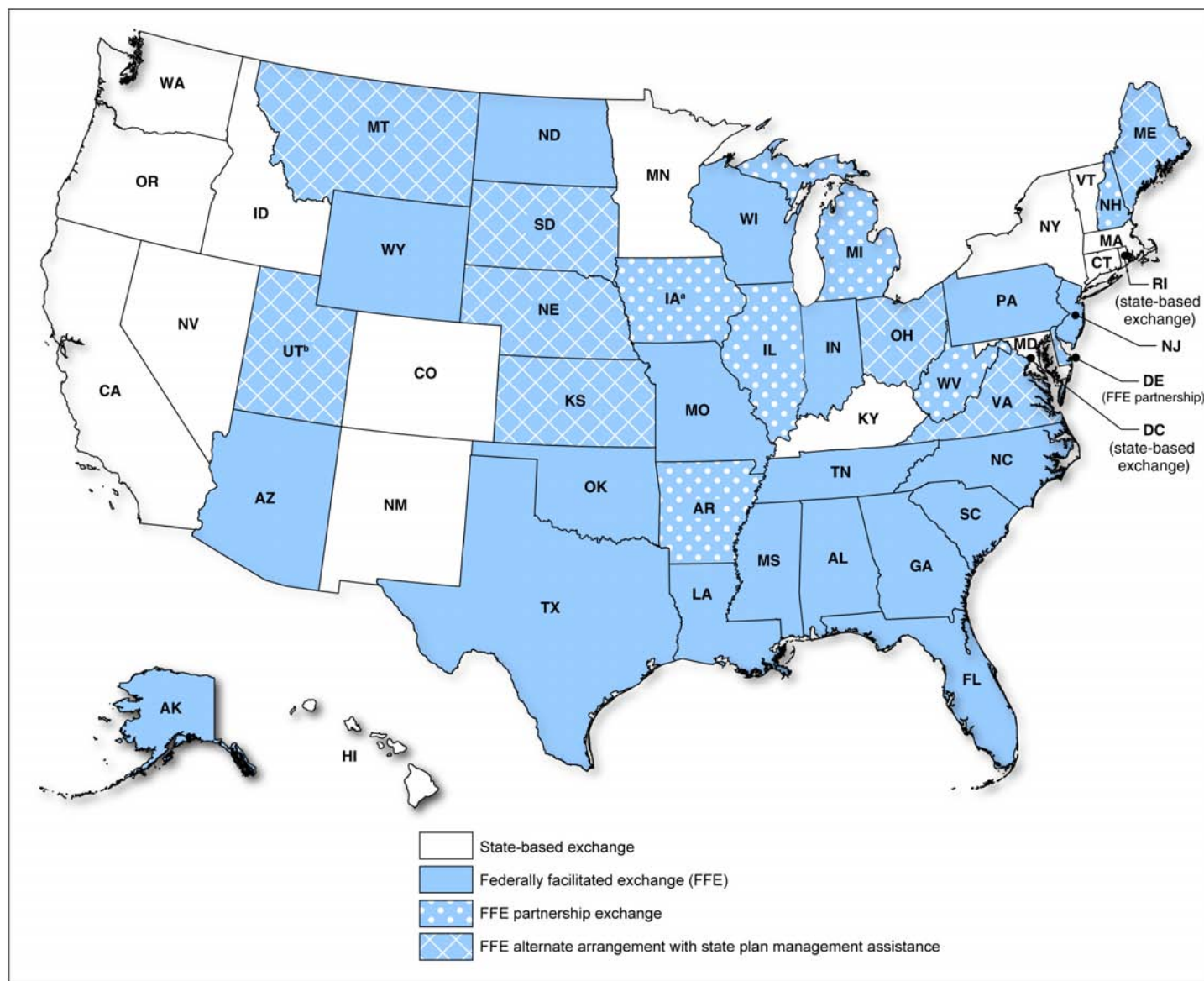
CMS Conditionally Approved 18 States to Operate State-Based SHOPS, and Expects to Operate FF-SHOPS in the Remaining 33 States in 2014

For 2014, CMS conditionally approved 18 states to operate state-based SHOPS and individual exchanges.²⁸ CMS issued conditional approval letters to these states from December 2012 to January 2013. While Utah was originally conditionally approved to operate a state-based exchange, in February 2013, the governor of Utah proposed that the federal government operate the individual exchange, and the state build upon and operate its existing small business health insurance marketplace as a SHOP. On May 10, 2013 CMS indicated that it planned to issue a proposed rule that, if finalized, would permit Utah to adopt this approach. On June 14, 2013, CMS released this proposed rule, which will be published in the Federal Register on June 19, 2013. In the remaining states that did not apply to operate state-based exchanges or were not conditionally approved to do so, CMS is required to operate an FF-SHOP and FFE. While CMS will retain full authority over each of the 33 FF-SHOPS and 34 FFEs, it plans to allow 15 of these states to assist in carrying out certain exchange functions. Specifically, as of May 2013, CMS granted the 7 states with an FF-SHOP and FFE conditional approval to participate in a partnership exchange. CMS issued these conditional approval letters from December 2012 to March 2013. Of those states participating in a partnership exchange, 6 (Arkansas, Delaware, Illinois, Michigan, New Hampshire, and West Virginia) indicated that they planned to assist with both the plan management and consumer assistance functions of the exchange and 1 (Iowa) indicated that it would only assist with the plan management function. In an alternate arrangement, CMS plans to allow the other 8 states (Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, Utah,²⁹ and Virginia) to assist with the plan management function. (See fig. 1 for a map of exchange arrangements for 2014.)

²⁸The 18 state-based SHOPS include California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, Washington, and the District of Columbia.

²⁹CMS intends to permit Utah to operate a state-based SHOP, while it operates an FFE for individuals in the state.

Figure 1: Health Insurance Exchange Arrangements for 2014, as of May 10, 2013



Source: GAO analysis of CMS information; Map Resources (map).

Note: Unless otherwise indicated, the exchange arrangement shown for each state applies to both the Small Business Health Options Program (SHOP) and the individual exchange.

^aIowa intends to assist with the plan management function, and not the consumer assistance function.

^bOn May 10, 2013, CMS indicated that it planned to issue a proposed rule that, if finalized, would permit Utah to operate a state-based SHOP, while CMS would operate the individual exchange as an FFE, for which Utah would assist with plan management. On June 14, 2013, CMS released this proposed rule, which will be published in the Federal Register on June 19, 2013.

Some states also informed CMS of whether or not they chose to carry out certain other activities related to the exchanges.³⁰ For example, CMS indicated that Massachusetts would operate a risk-adjustment program for benefit year 2014, leaving CMS to operate programs in the remaining states.

Planned CMS and State Activities to Establish SHOPs Have Evolved Recently and May Continue to Change

Although decisions about the roles of CMS and the states in the exchanges have been made, the activities that CMS and the states each plan to carry out have evolved recently. CMS was required by statute to certify or conditionally approve any state-based SHOPs and individual exchanges by January 1, 2013.³¹ CMS extended application deadlines leading up to that date to provide states with additional time to determine whether they would operate a state-based SHOP and individual exchange. On November 9, 2012, CMS indicated that in response to state requests for additional time, it would extend the deadline for submission of the application for states that wished to operate state-based exchanges in 2014 by about 1 month to December 14, 2012. The agency noted that this extension would provide states with additional time for technical support in completing the application. At the same time, the agency also extended the application deadline for states interested in participating in a partnership exchange by about 3 months to February 15, 2013. In addition, the option for FFE states to participate in an alternate arrangement to provide plan management assistance to the

³⁰Although not specifically related to exchange operation, states are also informing CMS whether they are enforcing, or plan to enforce, new health insurance market reforms enacted under PPACA. Some of these reforms, including a provision prohibiting lifetime limits on the dollar value of benefits provided under a group or individual health plan, are already in effect; others, including a provision prohibiting issuers of group and individual health coverage from denying coverage or charging higher premiums because of preexisting conditions, do not take effect until 2014. These provisions apply whether a plan is offered on an exchange or outside of an exchange. States were asked to notify CMS whether they would enforce PPACA's health insurance market reforms. As required under a 1999 rule implementing the Health Insurance Portability and Accountability Act of 1996, CMS is required to enforce these and other health insurance market regulations under the Public Health Service Act in states that do not have authority to enforce them or otherwise fail to enforce them. CMS indicated that, as of April 8, 2013, 11 states notified CMS that they do not have the authority to enforce or are not otherwise enforcing PPACA insurance market provisions, leaving CMS to assume an enforcement role. CMS officials indicated that there is no deadline for this notification, but a notification is required of all states.

³¹There was no statutory deadline for approvals of partnership exchanges, as such exchanges were not specifically identified in PPACA.

FFE was made available to states by CMS in late February 2013. CMS did not provide states with an explicit deadline for them to indicate their intent to participate in this arrangement, but CMS officials said April 1, 2013, was a natural deadline because issuers of health coverage had to know by then to which entity—CMS or the state—to submit health plan data for QHP certification.

The specific activities CMS will undertake in each of the state-based and partnership exchanges may continue to change if states do not make adequate progress toward completion of their key activities. When CMS granted conditional approval to states, it was contingent on states meeting several conditions, such as obtaining authority to undertake exchange activities and completing key activities by specified target dates. For example, in April 2013, CMS officials indicated that Michigan—a state that had been conditionally approved by CMS to participate in a partnership exchange—had not been able to obtain the legislative authority needed to use federal grant funds to pay for exchange activities, which has been a requirement of its conditional approval. As of May 2, 2013, CMS officials expected that Michigan would participate in a partnership exchange, but indicated that Michigan may not be able to conduct consumer assistance without funding authority.³² They noted, however, that a final decision about Michigan’s responsibilities had not been determined. In addition, on May 10, 2013, CMS indicated that it intended to operate Utah’s individual exchange—which was conditionally approved as a state-based exchange in January 2013—as an FFE. Officials indicated that final approval for state-based and partnership exchanges will not be granted until the states have succeeded in completing all of their key activities, and that some of these exchanges may still be under conditional approval when enrollment begins on October 1, 2013.

CMS officials indicated that they are working with each state to develop mitigation strategies to ensure that all applicable exchange functions are operating in each state on October 1, 2013. Agency officials said that they are assessing the readiness of each state as interim deadlines approach.

³²CMS officials noted that it is generally more resource intensive for states to implement consumer assistance activities than plan management activities, because, unlike plan management activities which are similar to traditional state insurance functions, consumer assistance is not a function in which states previously participated and would represent a significant new investment for the states.

For example, issuers began submitting applications to exchanges for QHP certification on April 1, 2013. Therefore, CMS officials said that they began assessing state readiness for this activity in March 2013. They also indicated that they are doing this kind of assessment for each state as deadlines approach for other activities—such as those related to eligibility and enrollment and consumer assistance functions. If a state is not ready to carry out a specific activity, CMS officials said the agency will support them in this area. As of May 2, 2013, CMS had not granted final approval to any state to operate a state-based exchange or to participate in a partnership exchange. If any state conditionally approved to operate a state-based exchange or participate in a partnership exchange does not adequately progress towards completion of all required activities, CMS has indicated that it would carry out more exchange activities in that state. CMS officials indicated that exchanges receiving this assistance would retain their status as a state-based or partnership exchange.

CMS and States Have Made Progress Establishing SHOPS and FF-SHOPS, but Many Key Activities Are Yet to Be Completed and Some Were Behind Schedule

CMS has made progress in core functional areas towards establishing the FF-SHOPS and FFEs; CMS has many activities yet to complete; and completion of certain activities was behind schedule. Similarly, states have completed many required activities towards establishing the SHOPS and individual exchanges, although many activities remained to be completed and some activities were behind schedule.

CMS Completed Many Activities to Establish State-Based SHOPS and FF-SHOPS; CMS Has Many Activities Yet to Complete; and Some Activities Were Behind Schedule

CMS issued regulations and guidance to set a framework within which the federal government, states, issuers of health coverage, and others can participate in the exchanges, including state-based SHOPS and FF-SHOPS. For example, in March 2012 CMS issued a final rule on establishment of exchanges that, among other things, outlined the minimum required functions for a SHOP and the standards that employers must meet to participate in the SHOP.³³ In June 2013, CMS issued a final rule that created transitional policies for employee choice and premium aggregation requirements for 2014, and aligned special enrollments periods to those used in state small group markets today.³⁴ CMS also issued guidance specifically related to the establishment of FF-SHOPS and FFEs to assist states seeking to participate in a partnership exchange and issuers seeking to offer QHPs in an FF-SHOP and FFE, including a partnership exchange. For example, the agency issued general guidance on FF-SHOPS and FFEs in May 2012, and issued guidance on partnership exchanges in January 2013. On April 5, 2013, the agency issued guidance to issuers of health coverage seeking to offer QHPs through FF-SHOPS and FFEs, including partnership exchanges.

In addition to establishing the basic exchange framework for state-based SHOPS and FF-SHOPS, CMS also completed activities needed to establish the core FF-SHOP functions—eligibility and enrollment, plan management, and consumer assistance—many of which are related to FFE functions.

- *Eligibility and Enrollment:* In late January 2013, CMS released a draft of the online and paper applications that small employers and employees will use to apply for health care coverage in the FF-SHOPS. Following a public comment period, the final applications were issued on May 31, 2013. CMS indicated that, since May 2012, it has consulted with, received feedback from, and provided training to issuers on the eligibility and enrollment process standards for the FF-SHOPS and FFEs.

³³77 Fed. Reg. 18310 (Mar. 27, 2012).

³⁴78 Fed. Reg. 33233 (June 4, 2013).

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- *Plan management:* CMS indicated that it completed development of the IT systems necessary for it to carry out the plan management function and awarded a contract to help the agency certify QHPs that will be offered in the FF-SHOPs and FFEs.³⁵ Officials said that the contractor will review plan data, perform quality-assurance checks, and help CMS determine whether issuers applying for QHP certification are in full compliance with PPACA requirements. Officials also said that submission of plan information by issuers of health coverage to CMS for QHP certification began on April 1, 2013.
 - *Consumer assistance:* In 2010, CMS awarded Consumer Assistance Program grants to 36 states and 4 territories,³⁶ including 23 states with FF-SHOPs and FFEs. The agency awarded a contract on February 28, 2013, for the development of training and quality assurance metrics for the call center that will provide consumer assistance for FF-SHOPs and FFEs.

CMS has many key activities remaining to be completed across the core functional areas—eligibility and enrollment, plan management, and consumer assistance—and has established timelines to track its completion of the remaining activities necessary to establish FF-SHOPs and FFEs, but the agency has faced delays in the completion of certain activities.³⁷

³⁵In FFEs where the state will assist with plan management, the state will review plan data and make recommendations for certification to CMS.

³⁶PPACA appropriated \$30 million to the Secretary of HHS for the award of federal grants to states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsmen programs. PPACA, § 1002, 124 Stat. at 138. Consumer Assistance Program grants are to be used to assist consumers with filing health insurance coverage complaints and appeals, assist consumers with enrollment into health insurance coverage, and educate consumers on their rights and responsibilities with respect to such coverage. According to CMS, as of June 2013, there were Consumer Assistance Programs operating in 22 states and one territory.

³⁷The CMS activities for which we report progress here are not exhaustive. In particular, CMS also tracks its progress in developing the federal data services hub and related IT tasks. It also tracks the progress of states participating in partnership exchanges, which is also relevant to CMS's progress in establishing the FFEs. Progress in establishing the FFEs and the federal data services hub is examined more closely in a related report. See [GAO-13-601](#).

Eligibility and Enrollment

CMS expects to complete development and testing of the IT systems necessary for the FF-SHOPs and FFEs to determine eligibility for enrollment into a QHP and to enroll employees by October 1, 2013, when enrollment is scheduled to begin for the 2014 plan year. However, as of April 2013, CMS indicated that it still needed to complete some steps in order to enable the FF-SHOPs and FFEs to determine eligibility. CMS indicated that these steps will be completed in July 2013.

Plan Management

The activities that CMS needs to complete for the plan management function primarily relate to the review and certification of the QHPs that will be offered in the FF-SHOPs and FFEs. CMS has set time frames that it anticipates will allow it to certify and upload QHP information to the FF-SHOP and FFE websites in time for initial enrollment. CMS indicated that issuers of health coverage were to submit their applications for QHP certification by May 3, 2013.³⁸ Once received, CMS, with the assistance of its contractor, expects to evaluate and certify eligible plans as QHPs by July 31, 2013. CMS will then allow issuers to preview and approve QHP information that will be presented on the exchange website by August 26, 2013. CMS then expects to finalize the QHP information and load it into the exchange website by September 15, 2013. In the 15 states in which states will assist with the plan management function, the states will evaluate health issuer plan applications and submit recommendations to CMS regarding the plans they recommend should be certified as QHPs. CMS indicated that the states are expected to submit their recommendations by July 31, 2013, which is also when CMS expects to complete its evaluation of QHPs for the other FF-SHOP and FFE states.³⁹

³⁸CMS officials said that on April 30, 2013, the deadline for issuers to submit their applications was pushed back from April 30, 2013, to May 3, 2013.

³⁹Seven of the 15 states submitted an application to CMS and were approved to assume this responsibility on the condition that they complete certain required activities by targeted completion dates. In contrast, an additional 7 states were not required to submit an application and CMS officials indicated that the agency has no formal monitoring relationship with the state. Instead, CMS conducted a one-day review of these states in February and March to determine the states' operational plans and capacity to assist with the plan management functions. The last state, Utah, was originally conditionally approved to operate a state-based exchange. On May 10, 2013, CMS indicated that it intended to allow the exchange to instead operate as an FFE and the state attested that it would be able to assist with all aspects of the plan management function.

Consumer Assistance

CMS has yet to complete many activities related to assistance and outreach to small employers and employees, and some initial steps were behind schedule. Specifically, several steps necessary for the implementation of the Navigator program in FF-SHOPs and FFEs were delayed by about 2 months. CMS had planned to issue the funding announcement for the Navigator program in February 2013 and have two rounds of awards, in June and September 2013. However, the announcement was delayed until April 9, 2013, and CMS officials indicated that there would be one round of awards, with an anticipated award date of August 15, 2013. CMS did not indicate the number of awards it expected to make, but noted that it expects, consistent with federal regulations, to make awards to at least two different applicants in each of the 33 FF-SHOP and 34 FFE states.⁴⁰ CMS officials indicated that, even with these delays, they planned to have Navigator programs operating in each FF-SHOP and FFE state by October 1, 2013.

Before any federally funded in-person assisters, including Navigators, can begin their activities, they will have to be trained and certified.⁴¹ For example, these individuals are required to complete an HHS-approved training program and to receive a passing score on all HHS-approved certification exams before they are able to assist with enrollment activities. While CMS had planned to begin Navigator training in July 2013, under its current plan the agency will not have awarded Navigator grants by this date. In coordination with the Navigator training, CMS is also developing web-based training for other types of in-person assistance programs, such as agents, brokers, and the state partnership exchange in-person assistance programs. CMS officials said that the overall content of the training for these groups of individuals will be similar to that of the Navigator training. CMS indicated that it plans to complete development of the training curriculum and certification exam by August

⁴⁰CMS indicated that it would award up to \$54 million to organizations and individuals in the 34 FFE, including partnership exchange, states. It indicated that award funds would be allocated among states on the basis of their numbers of uninsured people, but at least \$600,000 would be available for award in each state. Texas was allocated the largest share of funding for award at approximately \$8.2 million. CMS gave applicants until June 7, 2013 to submit their applications. Federal regulations require exchanges to award Navigator grants to at least two types of entities, including a community and consumer-focused nonprofit organization. 45 C.F.R. § 155.210(c)(2).

⁴¹In addition to establishing a Navigator program, exchanges may also establish an in-person assister program to provide similar in-person assistance to consumers.

2013 and noted that training can begin when the training curriculum is made available.

CMS and states with partnership exchanges have also begun and established time frames for implementing other outreach and assistance activities that are necessary to implement FF-SHOPs and FFEs. Examples of key activities that remain to be completed include the federal call center, healthcare.gov website, media outreach, and the consumer complaint tracking system for the FF-SHOPs and FFEs. CMS recommended that in-person outreach activities begin in the summer of 2013 to educate small employers and employees in advance of the open enrollment period. CMS has indicated that it expects agents and brokers to play a large role in working with small employers. Additionally, CMS reported in April 2013 that SHOP-focused training and materials were currently under development to assist small employers in understanding the PPACA provisions that relate to them. CMS also reported that the Small Business Administration will play a role in educating small employers about how PPACA affects them and providing basic information to them about SHOPs.

States Have Completed Many Activities to Establish SHOPs; Many Key Activities Remain to Be Completed; and Some Activities Were behind Schedule

In late 2012 and early 2013, CMS provided each state that was conditionally approved to operate a state-based exchange with a list of key activities and target completion dates that CMS would use to gauge that state's progress. These key activities were a subset of the more than 100 required activities listed in the Blueprint application. Some of the key activities specific to SHOPs include establishing enabling authority and developing a coordination strategy with the individual exchange. The total number of key activities each state had to complete varied from as few as 20 for Maryland, to as many as 56 for Idaho.⁴² See table 1. CMS officials told us that the number and type of key activities assigned to each state varied because not all key activities are applicable to each state's specific circumstances, and because some states had already completed certain key activities when these target completion dates were established.

⁴²The original number of key activities was provided in state conditional approval letters. CMS provided us with updated information on each state's number of key activities in April and May of 2013, noting that some activities no longer applied for certain states.

Table 1: CMS-Identified Key Activities to Be Completed by Each State-based Small Business Health Options Program (SHOP) and Individual Exchange, as of May 13, 2013

State	Total number of key activities to be completed
California	45
Colorado	37
Connecticut	42
District of Columbia	45
Hawaii	48
Idaho	56
Kentucky	39
Maryland	20
Massachusetts	40
Minnesota	47
Nevada	40
New Mexico	53
New York	39
Oregon	43
Rhode Island	47
Utah	39
Vermont	41
Washington	39

Source: GAO analysis of CMS data.

States have completed many required activities in developing their SHOPs and individual exchanges. For example, many states have completed preliminary activities such as obtaining the necessary authority to operate an exchange, conducting initial analyses of current and required IT capabilities and hiring an exchange executive director or equivalent. In addition, according to CMS data updated as of March 31, 2013, states had completed between 3 and 14 of the key activities, representing, on average, about 15 percent of each state's total number of key activities. In the functional areas of eligibility and enrollment, plan management, and consumer assistance, states had made varying degrees of progress by the end of March.

- *Eligibility and enrollment:* Many states had developed a coordination strategy with relevant state agencies and the SHOP.

-
- *Plan management:* Most states had already completed key activities such as establishing a QHP certification timeline and standard operating procedures and making their QHP application and certification standards publicly available.
 - *Consumer assistance:* Some states had awarded a call-center contract, begun outreach and education-material dissemination, released a Navigator grant application, and established policy for agents and brokers, where applicable.⁴³ Other key activities related to consumer assistance generally will not be completed until closer to the launch of open enrollment in October 2013.

With regard to key activities remaining to be completed for establishment of state-based SHOPS and individual exchanges, the total number and target completion dates varied by state. Specifically, according to CMS data updated through March 31, 2013, states had between 16 and 52 key activities remaining to be completed, or on average, about 85 percent of their total key activities. Among these key activities that were not completed, states may have nevertheless made significant progress towards their completion. We separately reported in more detail on the range of actions selected states have taken to establish their individual exchanges.⁴⁴

- *Eligibility and enrollment:* Most remaining eligibility and enrollment key activities were targeted to be completed by states by July 31; however, a few states had target completion dates ranging from August to October 2013. For example, by July 31, 2013, all states were targeted to have SHOP applications approved (if not using CMS-developed applications), while almost all states were targeted to have necessary data-sharing agreements signed by that time. Similarly, most states were targeted to have completed key activities related to eligibility and enrollment technology by July 31, 2013, such as demonstrating the functionality and verifying the code for eligibility and enrollment exchange components.

⁴³The state may permit agents and brokers to assist employers with the application process and enroll employees in a QHP in the SHOP. Such agents and brokers must agree to comply with the SHOP's privacy and security requirements.

⁴⁴See [GAO-13-486](#).

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- *Plan management:* Many key activities related to plan management were targeted to be completed in July through September, closer to the October 2013 launch of open enrollment. For example, most states were targeted to complete their QHP certification process in July through September, and post their plan options on-line in August or September.
 - *Consumer assistance:* Many key activities related to consumer assistance were targeted to be completed in the 3 months leading up to the launch of open enrollment in October 2013, with some key activities not expected to be completed for most state-based exchanges until August or September. For example, most states were targeted to launch their campaigns not before May, or to begin call center training not before July. Similarly, key consumer support activities such as call centers and websites going live, and Navigators, agents, and brokers beginning work, were generally not targeted to be completed until August or September 2013.
 - *SHOP-specific key activities:* State-based exchanges had only one SHOP-specific key activity, which related to capabilities for aggregating premiums. Most states were targeted to complete this key activity by the end of June 2013.⁴⁵

See figure 2 for examples of the target completion dates for remaining key activities by functional area.

⁴⁵Under a June 2013 final rule, CMS postponed the requirement that SHOPs provide premium aggregation in 2014, and this key activity now only applies to states that choose to offer premium aggregation in 2014. As of April 2013, CMS officials did not have a count of such states, but indicated that most state-based SHOPs intended to offer premium aggregation in 2014.

Figure 2: Examples of Remaining Key Activities Required for States to Establish Exchanges and the Target Completion Dates, as of April 24, 2013

Key Activities for State-based Exchanges	2013 Target Completion Date						
	April	May	June	July	August	September	October
Eligibility and enrollment							
• Data-sharing agreements signed	•	••••••••	••		•		
• Related technology in place, such as functionality demonstrated and code verified ^a	•	•••••	•••	•	••		
• Eligibility application published		•••••	••	•	•••	•	•
• Appeals business-process model and functional capabilities established		••	•	•••••	•	••	••
Plan management							
• Qualified Health Plan (QHP) certification process completed		••	••	•••••	••	••	
• Plan options posted online			•	•••	••	•••••••	•
• Complaint-tracking system selected			•••••				
Consumer assistance							
• Exchange branding and marketing campaign launched	••	•	•••••	•••		•	
• Call-center training begins	•••	••	••	•••••	••		
• Website launched			•••		••	•••••••	•
• Agents/brokers begin work			•	•••	•••	•••••	•••
Small Business Health Options Program (SHOP)							
• SHOP premium aggregation functional capabilities established		•	•••••		•	•	•

• One of the 18 state-based exchanges

Source: GAO analysis of CMS data.

Notes: The 18 state-based exchanges include California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah (SHOP only), Vermont, Washington, and the District of Columbia. CMS determined the key activities necessary for each state to complete in order to operate a state-based exchange. These key activities vary by state, and thus not every key activity listed applied to each of the 18 state-based exchanges.

^aAs of April 24, 2013, one additional state was scheduled to complete this key activity, however the target completion date was yet to be determined.

CMS officials told us that the number of key activities remaining to be completed and their target completion dates provide only a partial measure of state progress in establishing their exchanges. They noted that another measure would include the extent to which states were completing key activities by the targeted completion dates. Therefore, we examined the extent to which key activities originally scheduled for completion from December 2012 through March 31, 2013, met their target completion dates, on the basis of data provided by CMS in April and May 2013. While state timeliness varied, overall, about 44 percent of all states' key activities scheduled for completion during this period (89 of 201) were behind schedule. CMS data showed that the share of each states' key activities that were behind schedule ranged from as low as about 17 percent to as high as 75 percent. Among all states, about 40 percent of the key activities that were behind schedule (36) were related to CMS—either the agency revised the target completion dates (26), such as where CMS reported it had improved the specificity of new targeted completion dates for a particular activity, or CMS's own actions required states to delay completion of an activity (10), such as where state activities had to await CMS issuance of enrollment or QHP applications. The remaining 60 percent of the activities that were behind schedule (53) related to state factors, such as delays states had incurred in issuing regulations or guidance, coordinating between state agencies, or procuring contract support. While most of these delayed activities were rescheduled to be completed during May and June of 2013, about 17 percent (15) were rescheduled for July through September or did not have new completion dates established as of May 13.

While 44 percent of states' key activities were delayed, states may have nevertheless made progress on them, and CMS noted that many of the delays were not expected to affect exchange operational readiness. Additionally, CMS reported that most states were on track for initial open enrollment beginning October 1, 2013; however, the agency noted that some states may need to continue to build their capabilities and improve their operations during the year. CMS said it would continue to monitor state exchange operations, including the outreach, testing, and implementation of necessary improvements, during the critical start-up year.

Concluding Observations

Successfully establishing SHOPs at both the federal and state level by the start of 2014 is central to PPACA, as these exchanges are intended to serve as a new point of access to health insurance markets for small employers and their employees in each state. The establishment of exchanges has been a complex undertaking, involving the coordinated actions of multiple federal and state stakeholders, as well as private stakeholders such as issuers of health insurance coverage. Much progress has been made in establishing the regulatory framework and guidance required for this undertaking, and CMS and states are continuing to take steps necessary to complete activities required for establishing the SHOPs and individual exchanges. Nevertheless, much remains to be completed within a relatively short amount of time. CMS's timelines and targeted completion dates provide a roadmap to completion of the required activities by the start of enrollment on October 1, 2013. However, certain factors, such as the still-unknown and evolving scope of the exchange activities to be performed in each state by CMS, and the large numbers of activities remaining to be completed—some close to the start of enrollment—suggest a potential for implementation challenges going forward. And while the interim deadlines missed by CMS and states thus far may not affect progress, any additional missed deadlines closer to the start of enrollment could do so. CMS said it will monitor progress to establish exchanges, and is working on strategies in each state to address contingencies. Whether CMS's contingency planning will assure the timely and smooth implementation of the exchanges by October 2013 cannot yet be determined.

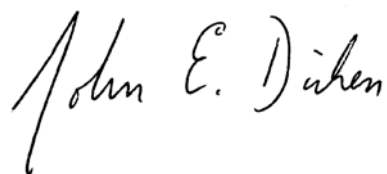
Agency Comments

We received comments from HHS on a draft of this report (see app. I). HHS emphasized the progress it has made in establishing exchanges since PPACA became law, and expressed its confidence that on October 1, 2013, exchanges will be open and functioning in every state. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Sincerely yours,

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large, stylized "J" and "D".

John E. Dicken
Director, Health Care

Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUN 10 2013

John E. Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "PATIENT PROTECTION AND AFFORDABLE CARE ACT: Status of Federal and State Efforts to Establish Health Insurance Exchanges for Small Businesses" (GAO-13-614).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink, reading "Jim R. Esquea", is positioned above the printed name.

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO)
DRAFT REPORT ENTITLED, "PATIENT PROTECTION AND AFFORDABLE CARE
ACT: STATUS OF FEDERAL AND STATE EFFORTS TO ESTABLISH HEALTH
INSURANCE EXCHANGES FOR SMALL BUSINESSES" (GAO-13-614)**

The Department appreciates the opportunity to review and comment on this draft report.

On October 1, 2013, a Health Insurance Marketplace will be open and functioning in every state. In the more than three years since the law was passed we have made tremendous progress. Earlier this year, we successfully administered the qualified health plan submission process for the federal facilitated Marketplace. We published the final single streamlined application, the SHOP application, and we have announced several grant and contract programs that provide consumer assistance functions. We are in the final stages of finalizing and testing the information technology infrastructure that will support the application and enrollment process. HHS is extremely confident that on October 1 the Marketplace will open on schedule and millions of Americans will have access to affordable quality health insurance.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact name above, Randy DiRosa, Assistant Director; Ashley Dixon; Jawaria Gilani; William Hadley; Sandra George; Laurie Pachter; and Christina Ritchie made key contributions to this report.

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