FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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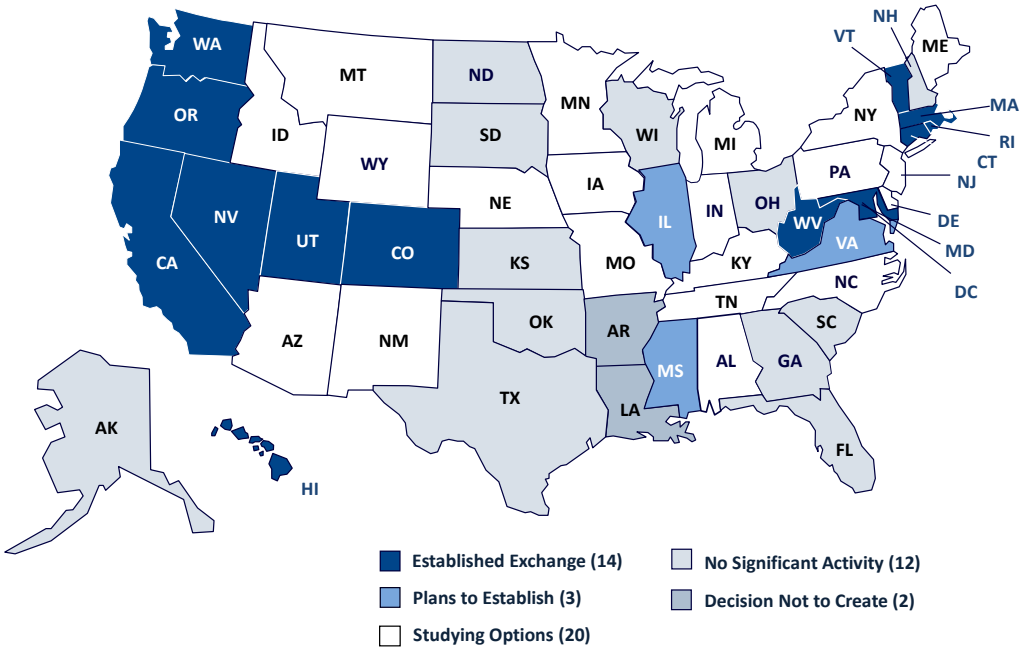
Establishing Health Insurance Exchanges: An Overview of State Efforts

State-based health insurance exchanges are a key component of the Affordable Care Act (ACA) and will facilitate expanded access to private health insurance coverage for millions of individuals and employees of small businesses. Exchanges will be the mechanism through which low and moderate-income individuals- from 133-400% of the federal poverty level- receive premium and cost-sharing subsidies to make health coverage more affordable.[1] Exchanges are required to be fully operational in every state by January 1, 2014, and their readiness will be evaluated by the federal Department of Health and Human Services (HHS) one year prior to opening. With evaluation and implementation deadlines fast approaching, 2012 is a critical year for states to make the necessary legislative and policy decisions.

To date, 13 states plus the District of Columbia have established state-based exchanges (Figure 1). Three more states have signaled their intent to create an exchange and continue to plan for implementation. Most states that established exchanges in 2011 are making progress this year to better define their exchange's financing structure, essential health benefits package, plan carrier requirements, and information technology systems. States continue to issue Requests for Proposals to solicit subcontractor's assistance in building key exchange components. In some states, advisory committees and subcontractors have completed further analyses to support the development of additional exchange recommendations.

Figure 1

State Action Toward Creating Health Insurance Exchanges



Some state legislatures have moved on these recommendations and begun to debate a second wave of exchange legislation. As of early March 2012, the Oregon legislature approved a proposed business plan outlined by the Exchange Board. This was a necessary step in moving Oregon's exchange implementation forward. The Washington legislature also passed similar follow-up legislation. Four other states are debating at least one proposed bill which will supplement existing exchange legislation. For example, legislation pending in Vermont builds on Exchange Board recommendations to define small employers as having up to 100 employees and

merges the individual and small-group markets. Similarly, Maryland's pending legislation builds on Board recommendations around carrier participation, contracting with health plans, and keeping small-group and individual markets separate.

Although much attention has been focused on state legislative activity, a number of states have taken steps to implement exchanges without legislation. In all cases, states have used enacted laws or previously established government entities to anchor the exchange. In the case of Rhode Island, where the legislature failed to enact establishment legislation in 2011, the Governor issued an Executive Order to establish an exchange utilizing the authority of a previously established health care fund. Mississippi is utilizing an existing non-profit high risk pool association. New Mexico began building a state-based exchange using the New Mexico Health Insurance Alliance, which appears to provide sufficient legal authority for planning and development activities though additional legislation or an executive order may be needed to fully comply with federal regulations. For states that cannot anchor their exchange on prior legislation, an executive order may not be a viable option and new legislation may be the only mechanism to establish an exchange.

In the absence of legislation, a number of states continue to make progress in planning for an exchange. In some states establishment legislation is pending but has been stymied by ongoing political disagreements. Such has been the case in New York and Minnesota where the Governors' offices have moved forward to organize significant planning efforts around exchange structure, governance, and information technology systems without establishment legislation in place. While not on the same scale, Tennessee, a state in which establishment legislation has yet to be proposed, has steadily gathered together the necessary stakeholder input to inform the exchange planning process.

As of March 1, 2012, a growing number of states show no significant planning activity. Some of these states had been making significant progress in 2011, but ended their exchange planning efforts due to increasing political pressure. In Kansas, Oklahoma, and Wisconsin significant planning momentum was halted when the Governors announced the return of Early Innovator grant funding. Others states such as Texas, Florida, and New Hampshire never began planning for a state exchange, citing the uncertainty created by ongoing legal challenges to the law.

Louisiana and Arkansas are the only two states to have announced their intention to stop pursuing a state-based exchange. However, both are moving in very different directions. Louisiana returned federal planning grant funds and relinquished control of its exchange to the federal government in early 2011; since then there has been no significant planning activity. Arkansas on the other hand, announced it was ending state-run exchange planning in December 2011, and then moved quickly to begin defining their role in a federal-state partnership exchange. Arkansas intends to maintain control over the exchange's plan management and consumer assistance functions while having the federal government control the eligibility and enrollment portal.

Key Design Areas

The ACA allows for flexibility over exchange design so that states can tailor exchanges to their specific populations and insurance markets. As states proceed with establishing their exchanges, they must make a number of important decisions, including how their exchange will be structured and governed, how it will contract with health plans, and how it will be financed (Table 1).

Exchange Structure

The ACA gives states options for how to structure their exchanges, including establishing within an existing or new state agency, as an independent public entity, or as a non-profit. There are various considerations associated with each option.[2] Basing the exchange within an existing state agency enables the entity to efficiently leverage established administrative systems and procedures. An exchange that is a state agency is more closely tied to the government and accountable to elected officials. However, there may be value in maintaining independence and having the ability to define the administrative processes that best meet the needs of the exchange. Depending on the structure and governance, an exchange that is established as a quasi-governmental or non-profit entity may

be more insulated from political influence and particular interest groups. Unlike a quasi-governmental exchange, a non-profit exchange may find it challenging to perform functions that are typically viewed as governmental.

Eight states plus the District of Columbia have chosen a quasi-governmental structure, four will house the exchange within a state agency, and one has opted to create the exchange as a non-profit corporation. Most exchanges to date have been created with some independence from state government. For example, Washington's exchange is "a public-private partnership separate and distinct from the state,"[3] while Maryland's exchange is a "public corporation and independent unit of state government."[4]

Contracting Relationship with Qualified Health Plans

Another important consideration for states is defining the relationship between the exchange and participating qualified health plans (QHPs). States can opt to require the exchange to contract with all QHPs which meet specified criteria, commonly referred to as the clearinghouse model, or states can require the exchange to be an active purchaser and selectively contract with only certain QHPs, possibly to achieve stated goals around plan choice, quality or value. The Board may choose, for example, to require plan certification criteria beyond what is defined in the ACA or may negotiate with plans for better pricing or different product offerings. Boards can also use selective contracting to improve plan quality or can encourage plans to implement strategies to better coordinate health care services.[5] Of the 14 established exchanges, seven have decided to act as active purchasers while three others will serve as clearinghouses. The remaining states have yet to define the contracting relationship.

Exchange Governance

Exchanges established as independent state agencies or as non-profit entities, must have a clearly-defined governing Board overseen by the state.[6] Nearly all states with established exchanges have created independent governing Boards to direct their exchanges, and most have appointed members to these Boards. The Boards range in size from 5 to 15 members, often representing both stakeholders and subject matter experts in an attempt to balance the political interests and management skills needed to operate an exchange.[7] Common subject matter experts include health economists, health actuaries, and people with experience purchasing or managing health benefits. Exchanges that require stakeholder representation on the Board may specify the number of representatives of individual consumers or small employers, insurers, brokers, and/or health care providers. Some states without stakeholder representation on the Board have included a provision in the legislation requiring the Board to create advisory groups to facilitate feedback on issues ranging from plan certification to consumer protections.

Conflict of Interest

Whether to allow representatives of insurers and brokers to serve on the Board has been a contentious issue in some states. Nearly all states included conflict of interest provisions for Board members in the legislation that establishes the exchanges, though some are more restrictive than others. The Boards are responsible for planning and operating the exchanges, as well as implementing the certification process to identify QHPs that may participate in the exchanges.

Conflict of interest provisions are important when entities that might financially benefit from contracting with an exchange are represented on the Board and may gain unfair advantage over competitors.[8] These provisions are even more important when the Board is expected to behave as an active purchaser and negotiate with plans. Typically, states with active purchaser exchanges prohibit industry representation. For example, the conflict of interest provisions are among the most restrictive in Maryland, California, and Connecticut, where the exchange Boards are meant to act as active purchasers. In these states, Board members cannot have relationships with a variety of players in the health care sector, such as carriers, insurance producers, third-party administrators, managed care organizations, health care providers, facilities or clinics, and/or entities contracting with the exchange. Seven states explicitly prohibit representation of health insurance carriers and brokers on their Exchange Board, one state prohibits health insurers but not brokers, and an additional three states limit the number of industry representatives that can be appointed to the Board.

Exchange Financing

States must be able to fully finance the costs of exchange operation by January 1, 2015. Various financing options in any combination are available to states including, assessing fees on participating health insurance carriers, appropriating state funds to the exchange, or allowing for other public or private funding sources. Nearly all exchanges were authorized to apply for public or private grants. Nine states allow for fees to be collected from insurance carriers operating in their exchanges. One state, Colorado, explicitly prohibits the appropriation of state funds for the exchange, while others have opted to allow for state funding, if necessary. Maryland's exchange is authorized to collect fees from plans within the exchange, but not to the extent that the fees create a competitive disadvantage with plans offered outside the exchange.

Information Technology

The ACA requires states to create a seamless, user-friendly interface which allows for eligibility determinations and health insurance enrollment for anyone up to 400% of the federal poverty level. To accomplish this goal, states must coordinate exchange and Medicaid/Children's Health Insurance Program (CHIP) eligibility determination and enrollment functions. Many states will perform significant upgrades to their Medicaid eligibility systems as well as build new information technology (IT) systems necessary to support exchange functions. A few states envision building an integrated eligibility system that will make determinations for the Exchange, CHIP, Medicaid and eventually other public programs. Many states have already started to solicit subcontractors to upgrade or build the necessary IT infrastructure.

TABLE 1: Key Characteristics of Established State Exchanges

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

*Description of Hawaii's Interim Board, which will be replaced on June 30, 2012. The ultimate Board of Directors will include eleven members.
**Although Utah's exchange doesn't have a formal Governing Board, the state has created an Executive Steering Committee to advise exchange staff on operations and transparency issues and a Defined Contribution Risk Adjuster Board to manage risk sharing mechanisms.

Federal Funding

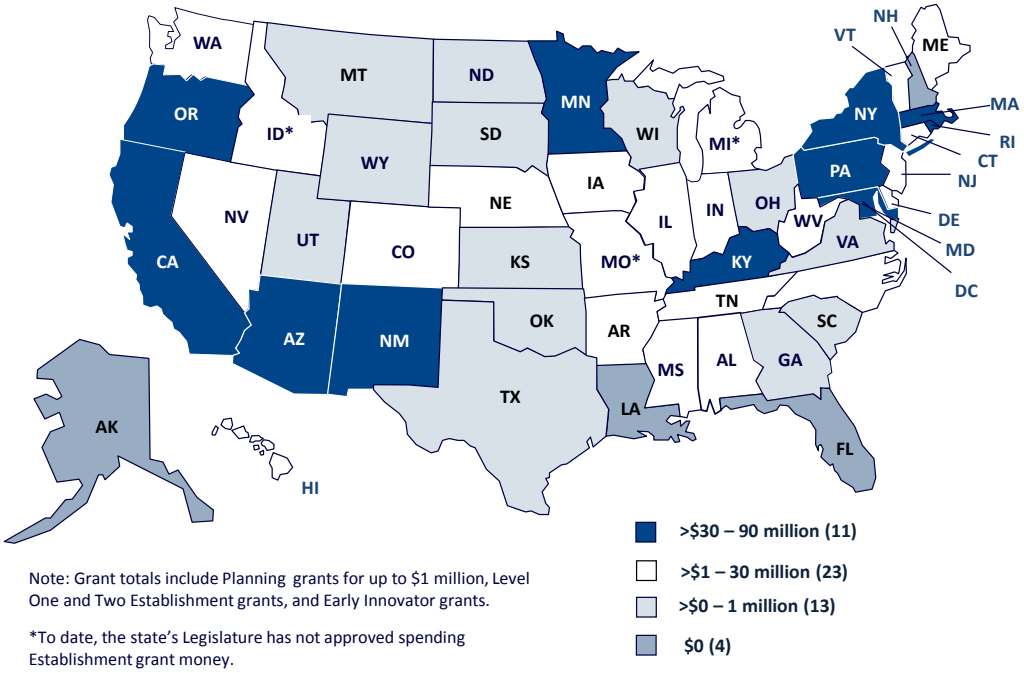
As of March 2012, over $830 million has been distributed to states through federal Exchange Planning grants, Establishment grants, and Early Innovator grants (Figure 2). Almost every state received some amount of funding to study exchange implementation. Thirty-four states have received Level One Establishment grants, which provide up to one year of funding for states that have made some progress under their planning grant. States may reapply for a second year of Level One funding and to date five states have taken advantage of this option. One state, Rhode Island, has received a multi-year Level Two Establishment grant that can only be awarded to states with established exchanges. Level Two grants can provide funding through the first year of a state's exchange operation.

While the deadline to apply for federal funds was previously set for June 29, 2012, states now have the opportunity to submit applications on a quarterly basis through the end of 2014. At this time, states have allocated a sizable portion of federal grant money towards building the IT infrastructure necessary to support exchange functions.

In a handful of states, the Governor or Legislature has pushed back against the use of federal grant money for exchanges. While Alaska was the only state which did not apply for a federal Exchange Planning grant, three additional states, Florida, Louisiana, and New Hampshire, returned their Planning grant money in 2011. For some states that have been awarded Level One Establishment grants, tension over spending has created significant deadlock, in effect, halting exchange planning. For example, Governors in Missouri, Michigan, and Idaho have yet to receive approval from their legislatures to begin spending awarded Level One Establishment grant funds.

Figure 2

Total Federal Grants for Health Insurance Exchanges



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

*To date, the state's Legislature has not approved spending Establishment grant money.

Future Exchange Prospects

Many states have demonstrated a strong commitment towards establishing a state-based exchange. Of those with established exchanges, the majority have appointed Boards, hired staff, and solicited subcontractors to begin planning and building their exchange infrastructure. However, significant work remains for many states aiming to be ready by 2014. Even a state like Maryland, which has been moving aggressively to implement an exchange, has delayed making certain fundamental decisions around exchange financing and health plan contracting.

While a sizeable number of states have established or plan to establish an exchange, others are moving much more cautiously and continue to study their options. Reasons for the slow pace are numerous, but a critical issue is the uncertainty that continues to surround the ACA. The Supreme Court is scheduled to address multiple issues, including the constitutionality of the individual mandate and its severability from the rest of the health reform law in March 2012. A ruling by the Court is expected by late June. Some states are reticent to take any steps toward creating an exchange until the legal challenges have been resolved. Currently, 26 states are involved in the lawsuits to be argued before the Supreme Court.

However, a majority of states' legislative sessions will end before the Supreme Court ruling. States that elect to wait until after June 2012 to begin exchange planning may find there are few legislative options remaining given the short timeline. On January 1, 2013, HHS will certify state exchanges as fully or conditionally operational. If not approved, the federal government will assume responsibility for running a health insurance exchange in those states. Once a state's regular legislative session has concluded, it will have to weigh alternative strategies to establish an exchange, including exploring non-legislative options (e.g., executive order), a special legislative session, or a federal-state partnership.

The 2013 deadline to demonstrate an operational exchange is fast approaching, and even those states moving more aggressively may find it difficult to put all the pieces into place in time to meet it. Recognizing this challenge, HHS has offered several strategies to promote the formation of state-based exchanges.[9] One option is the federal-state partnership model, which would allow for combined state and federal business functions, such as eligibility and enrollment, financial management, and health plan management systems and services.[10] While few states have explored the possibility of a partnership, it may be an increasingly viable option for states that have delayed establishing an exchange. HHS will also grant conditional approval for state exchanges that may not be able to demonstrate complete readiness on January 1, 2013, but that are expected to be operational by January 2014. Finally, states not ready to run their own exchanges beginning in 2014 may transition from a federal exchange to a state exchange when they have the capability, though they must receive approval for their exchange at least 12 months prior to the start of coverage.

There is no single path toward establishing state-based exchanges, as is evidenced by the myriad approaches states have taken to date. For those states interested in running their own exchanges, the next two years provide a unique opportunity to plan a health insurance exchange tailored to the needs of their state with the support of federal funding.

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

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[1] In 2012, 133% of the Federal Poverty Level (FPL) was $14,856 for an individual and $30,657 for a family of four; 400% of FPL was $44,680 for an individual and $92,200 for a family of four.

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

[3] Washington Senate Bill 5445, 2011. http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Senate%20Passed%20Legislature/5445-S.PL.pdf

[4] Maryland Health Benefit Exchange Act of 2011. Senate Bill 182. http://mlis.state.md.us/2011rs/chapters_noln/Ch_1_sb0182T.pdf

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

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

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

[8] Ibid.

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

[10] Bachrach, D and Boozang, P. "Federally-Facilitated Exchanges and the Continuum of State Options." National Academy of Social Insurance. December 2011. www.nasi.org/sites/default/files/research/Federally_Facilitated_Exchanges_and_the_Continuum_of_State_Options.pdf

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

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