FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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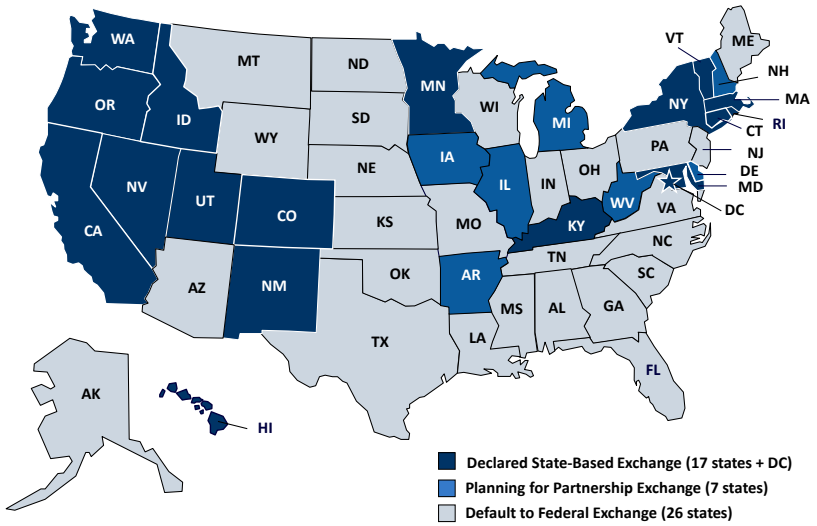
ESTABLISHING HEALTH INSURANCE EXCHANGES: AN OVERVIEW OF STATE EFFORTS

State-based health insurance exchanges, or marketplaces, are a key component of the Affordable Care Act (ACA), and the places where individuals and small businesses will be able to shop for coverage. States can build a fully state-based exchange, enter into a state-federal partnership exchange, or default to a federally-facilitated exchange. States planning to operate a state-based were required to submit an exchange blueprint to the federal Department of Health and Human Services (HHS) in December 2012, while states planning for a state-federal partnership exchange had until February 15, 2013. All exchanges, regardless of how they are administered, must be ready to begin enrolling consumers into coverage on October 1, 2013, and must be fully operational on January 1, 2014. Given these fast approaching deadlines, states face serious challenges to making the necessary policy and implementation decisions.

Seventeen states plus the District of Columbia have declared that they intend to establish a state-based exchange and have received conditional approval from HHS (Figure 1). Only Mississippi's application for a state-based exchange was rejected by HHS due to a dispute between the Governor and the Insurance Commissioner. Since receiving approval for its exchange, the Governor of Utah proposed the state run the exchange for small employers while the federal government operate the individual exchange. HHS is considering this proposal.

Figure 1

State Decisions For Creating Health Insurance Exchanges



As of March 1, 2013
SOURCE: Data compiled through review of state legislation and other exchange documents by the Kaiser Family Foundation

A majority of these states have passed legislation authorizing the establishment of a health insurance exchange. The Governors of Kentucky, New York, and Rhode Island established exchanges through executive order, while New Mexico intends to use an existing, legislatively-established entity as the basis for an exchange. Exchange authority does not yet exist in Idaho and Minnesota, though legislation is being considered by the legislatures in both states.

To date, seven states are planning to pursue a state-federal partnership exchange. Illinois has already signaled that it will move to a state-based exchange in 2015. States not ready to run their own exchanges in 2014 may transition from a partnership exchange to a fully state-based exchange at a later date.

For a state unable or unwilling to establish a state-based or a state-federal partnership exchange, HHS will assume primary responsibility for operating an exchange in that state. The federal government will seek to coordinate with state agencies on multiple fronts including plan certification and oversight functions, consumer assistance and outreach, and on streamlining eligibility determinations for the exchange and Medicaid. States' involvement with the federal exchange, while not mandatory, will be important for ensuring effective and seamless operation. Over time, this involvement may allow states in a federal exchange to transition into a partnership or state-based model. Currently, 26 states have indicated they will not create a state-based exchange and will likely default to a federally-facilitated exchange. Many of these states had decided early on to default to a federal exchange; however, some had begun laying the foundation for a state-based or partnership exchange before reversing course.

Key Design Decisions

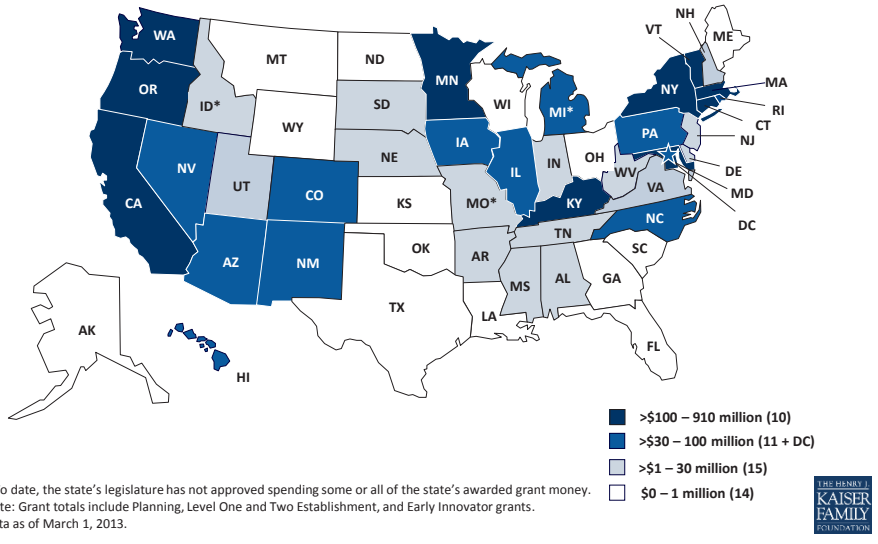
Over the past two years, many states have made a number of decisions regarding state-based exchanges, including how they will be structured, governed, and contract with health plans (Table 1). States have also begun to explore options related to consumer assistance and information technology (IT) systems. Exchanges must allow consumers to apply for and enroll in coverage online, in person, by phone, fax, or mail and provide culturally and linguistically appropriate assistance. To do this, states must provide access to telephone call centers, build a website with information about insurance options and application assistance, and create a Navigator program to improve public awareness and facilitate enrollment. The It system must seamlessly determine eligibility for public programs, such as Medicaid or the Children's Health Insurance Program (CHIP), and determine premium tax credits and cost-sharing subsidies for those purchasing insurance through the exchange.

Federal Funding

By March 1, approximately $3.5 billion was distributed to states through federal exchange Planning grants, Establishment grants, and Early Innovator grants (Figure 2). All but four states received and accepted some amount of funding to study exchange implementation. Thirty-seven states accepted at least one Level One Establishment grant. Eleven states plus the District of Columbia received Level Two Establishment grants, which fund exchange planning and implementation activities through the first year of operation. Much of the funding is being used to build the IT infrastructure necessary to support exchange functions. States can receive additional funds through the end of 2014.

Figure 2

Total Federal Grants for Health Insurance Exchanges



* To date, the state's legislature has not approved spending some or all of the state's awarded grant money.
Note: Grant totals include Planning, Level One and Two Establishment, and Early Innovator grants.
Data as of March 1, 2013.

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Table 1: Characteristics of State-Based Exchanges

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

*Utah has an Executive Steering Committee to advise operations and a Defined Contribution Risk Adjuster Board to manage risk sharing mechanisms.

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

This publication (#8213-02) is available on the Kaiser Family Foundation's website at www.kff.org.