

ACA Implementation—Monitoring and Tracking

State-Level Progress in Implementation of Federally Facilitated Exchanges: Findings in Three Case Study States

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With support from the Robert Wood Johnson Foundation, 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 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, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers and policymakers 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.¹ 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. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

INTRODUCTION

Health insurance exchanges are one cornerstone of the Affordable Care Act (ACA), offering structure and organization to the small group and non-group health insurance markets. While the law delineated a system in which each state would develop its own state-based exchange (SBE) to allow for design flexibility in accommodating local market characteristics, the ACA anticipated that some states would not be willing or able to develop a SBE. Thus the law provides for federally run exchanges as an alternative to SBEs. Over the course of implementing the law, the Center for Consumer Information and Insurance Oversight (CCIIO) has created three models for exchanges in states not developing SBEs: federally facilitated exchanges (FFE); state partnership exchanges (FFE-P); and state marketplace plan management (FFE-MPM).² The three states included in this study exemplify the full spectrum of these models with Michigan a state partnership exchange, Alabama a federally facilitated exchange, and Virginia taking the option of state marketplace plan management. CCIIO will have the responsibility of developing and implementing an exchange in all states that defer to one of these three alternatives. At the time of this writing, 33 states are expected to have federal involvement in establishing and operating exchanges, 19 being formal FFEs, 7 FFE-Ps, and 7 FFE-MPMs.³ There is inherently less opportunity for customization in a federal exchange than there is in a SBE; however, as this paper shows, not all federal exchanges will look alike.

This paper focuses on states' roles in implementation of FFEs. We start by providing an overview of recent regulations issued by CCIIO that describes the possible roles both for states and the federal government in the FFEs. We then provide in-depth descriptions of each of the specific FFE options as implemented in three states—Alabama, Michigan, and Virginia—with an eye to each

state's role in developing mechanisms to carry out their new responsibilities and progress in creating relationships with the federal government in order to ensure successful implementation of the three types of federally facilitated exchanges. Our central findings include:

1. Two out of three of the studied FFE states are actively engaged and participating in some exchange-related development, yet contacts in all three states report not receiving all of the information that they need in a sufficiently timely manner in order to prepare most effectively for reform.
2. State Departments of Insurance seem to see many of the roles delineated under exchange plan management as a continuation or modification of their traditional regulatory roles and consider them to be one part of their larger role in implementing the array of private market reforms (essential health benefits, actuarial value, modified community rating) which will apply to the insurance market outside of the exchange as well as the insurance market inside the exchange beginning in 2014.
3. Considerable variation in preparedness and effort exists across the FFE states. Some states like Michigan, planning for a full partnership exchange, had plans to run a SBE but were unable to overcome political hurdles that would have allowed for its establishment. As a consequence, some partnership states have processes and plans developed to fulfill the roles designated to them under the FFE. On the other end of the spectrum, some pure FFE exchanges, such as Alabama, seem to be at a standstill, as a result of political or administrative hurdles or a combination of the two, and have no plans to assist CCIIO in any aspect of FFE implementation.

4. Consumer assistance functions under the ACA require the development of new programs and may present more of a challenge than plan management. Access to additional federal funding for implementation of these programs is especially critical for partnership states

intending to play this role, but political challenges at the level of the state legislatures continue to create significant barriers to accessing such funds, even when governors' offices are predisposed to doing so.

BACKGROUND: FEDERALLY FACILITATED EXCHANGES AND THE RULES THAT GOVERN THEM

Under the Affordable Care Act, health insurance exchanges operate as a mechanism to increase access to health insurance coverage and improve the functioning of small group and non-group insurance markets. In order to accomplish these goals, health insurance exchanges are tasked with numerous functions. These include:

- Determining eligibility for federal subsidies or public coverage;
- Enrolling consumers and employees into qualified health coverage, or connecting individuals with enrollment processes for Medicaid or the Children's Health Insurance Program (CHIP);
- Conducting plan management;
- Providing consumer assistance; and
- Performing financial management.

For states not opting to develop an SBE, the federal government, through the Centers for Medicare and Medicaid Services (CMS), is ultimately responsible for ensuring that all of these responsibilities are fulfilled. However, the FFE-P and FFE-PMP options are avenues through which CMS is working with some states, allowing states to take on two key functions, that of plan management and consumer assistance.

Plan management responsibilities can be summarized as follows:

- Establishing standards for the plans permitted to participate in the exchange and communicating standards to insurers;
- Receiving and reviewing data from insurers in order to assess whether the insurers are complying with the standards established;
- Ongoing monitoring of insurer compliance with established standards; and

- Conducting appropriate review and analysis of market data on prices and products both inside and outside of exchanges for purposes of identifying and rectifying possible adverse selection.

Consumer assistance responsibilities can be summarized as:

- Education and outreach directed at maximizing enrollment in insurance coverage;
- Establishment of an in-person assistors program (optional);
- Management of a navigator program;
- Operation of a call center for the exchange, as well as website management; and
- Written correspondence with consumers to support eligibility and enrollment.

For FFE-P states choosing to take on consumer assistance responsibilities, the federal government assumes responsibility for the last two bulleted items, the call center and website management and consumer support for eligibility and enrollment; the state assumes responsibility for the first three bulleted items, education and outreach, in-person assistors, and navigator management.

A central role of the exchange is the certification of qualified health plans (QHP). A qualified health plan is a health plan certified to comply with all exchange requirements, including a plan structure consistent with the law's cost-sharing standards, inclusion of essential health benefits, provision of specific data elements to ensure transparency of operations, and compliant with other requirements delineated in the ACA and by the state. Many of the requirements of a QHP are also required of fully-insured small group and non-group insurance plans offered outside the exchange market

under the ACA. By 2016, exchanges must also assign quality ratings to each QHP, allowing consumers to easily compare available coverage options.

While we have provided a summary of the roles delegated to the exchange, there are many nuances and additional details.⁴ Given the enormity of the job, certain economies of scale in having the federal government run multiple exchanges can be anticipated, for example, establishing a single call center, establishing exchange web sites, and performing eligibility and enrollment functions. Other functions, such as plan management across many states, are unlikely to lead to greater efficiencies when done federally, since existing roles in state departments of insurance, such as rate and form review, could lead to duplications of efforts.

Recognizing that states would need a considerable amount of startup money to develop the programs and

mechanisms necessary to establish the exchange, pay for consumer assistance programs, and plan management functions, the law provided for exchange establishment grants, otherwise known as section 1311 grants. States can apply for these grants, which are practically unlimited in funding but are limited in scope. While 1311 funds can be used to pay for plan management functions, there are strict guidelines on how 1311 funds can or cannot be used to fund consumer assistance programs. The funds can be used by state run exchanges and FFE-PS taking responsibility for consumer assistance to fund in-person assister (IPA) programs which share similar functions as navigators, but they cannot be used to fund navigator programs themselves. The federal government cannot access 1311 funds either, even when HHS is taking responsibility for consumer assistance under the ACA. These funding issues are discussed further below.

PLAN MANAGEMENT REGULATIONS AND FUNCTIONS

The US Department of Health and Human Services (HHS) recognizes that state insurance departments have developed valuable expertise and administrative systems through their history of regulating health insurance plans. Given the complexity of each state's health insurance markets, the desire to limit administrative burdens for carriers, and the sheer number of states, CCIIO indicated in regulations and guidance that they prefer to draw on existing state functionality rather than duplicate efforts. A quote from the federal guidance on partnership exchanges issued in January 2013 provides further evidence of this. "HHS does not intend to re-review QHP data or otherwise duplicate work performed by the state."⁵ In fully federal exchange states, however, CCIIO's ability to leverage existing state functions and processes is contingent upon the amount of information the state is willing to share with CCIIO.

In a formal partnership and a marketplace plan management model, oversight and administration of the QHP certification process for plans wishing to offer coverage in the exchange encompasses responsibilities

such as: issuing the QHP application, collecting plan and issuer data to verify the submitted application as well as support exchange operations, submitting rate review data to the federal government, and assuring the timely transmission of issuer and plan information to CCIIO in order to maintain accuracy on the exchange website.⁶ While states have experience with many of the tasks delineated above, the sheer volume of information expected and the need to share information with CCIIO in a compatible format, compounded by a compressed timeline for accomplishing tasks poses a major challenge to the states. FFE-P and FFE-MPM states will also retain responsibility for issuer oversight and will remain a main point of contact for consumers wishing to voice complaints about benefit design, cost-sharing, and premium rating, among other protections. As indicated by the guidance, however, there will be a clear hand-off between states and CCIIO when it comes to answering questions for issuers related to exchange account management, plan enrollment, and premium payments from the exchange to the carrier.

CONSUMER ASSISTANCE REGULATIONS AND FUNCTIONS

Consumer assistance programs under the ACA are designed to ensure that consumers are educated about their new coverage options and, if eligible, enrolled in a plan or program most appropriate for their health and financial status. In addition, effective consumer outreach and education are critical to the exchange's sustainability. High levels of exchange participation over a broad population, including young and healthy people, can help mitigate concerns about adverse selection and make the exchange more attractive to insurers. In most states, it will be important to draw on the states' understanding of their unique constituent needs and demographics; states are uniquely positioned to tap local, community-based organizations that are trusted liaisons for target populations.

On-the-ground consumer assistance requires a considerable investment of resources, including the development and dissemination of advertising and educational messages for the public, recruitment and training of organizations and individuals with the experience and positions of trust to provide in-person assistance, as well as the funds to support potentially thousands of one-on-one assistance sessions with consumers in each state. In general, states are expecting the federal government to supply the necessary investment for consumer assistance, and are unlikely to commit any state funds to support these efforts. States not involving themselves in the consumer assistance functions are not expected to work to ensure that messaging and assistance are tailored to unique state issues related to state laws, population, demographics, or culture. Yet, if consumer assistance programs fail to inform and educate consumers of the options available to them in the exchange market and fail to facilitate enrollment in exchange plans, the exchange may suffer from low enrollment, or worse, high enrollment only among high-risk populations, resulting in adverse selection against the exchange as a result of low or health services demand-driven enrollment. Five of the seven partnership states, with the exception of West Virginia and Iowa, have indicated that they will be assuming responsibility for consumer assistance functions in their partnership exchanges.

Exchange navigators, IPAs, a call center, and a website are all key elements defining consumer assistance in the ACA. An issue brief funded by the Robert Wood

Johnson Foundation defines the role of navigators as, "individuals in community-based organizations or with unique community ties, who will link consumers to the Exchange."⁷ While the federal government has developed a framework for the navigator program, including conflict of interest provisions, cultural and linguistic competency, as well as training standards, the state responsibility in this type of partnership will involve the daily administration and management of the navigator program, ensuring that navigators follow federal standards. The standards for in-person assistors, which will share similar duties, are largely the same as those for navigators. States are allowed to develop a training program, supplemental to the federal program, which all navigator grantees in the state would be required to take. As brokers, navigators, and in-person assistors will all play a role in educating and enrolling consumers, determining the interaction between these three groups has proven to be a sensitive subject in all states.

As mentioned earlier, funding mechanisms present one major difference between the IPA program and the navigator program. While states can use establishment grant money to fund the IPAs, establishment grant money cannot be used to fund navigator contracts. FFE and FFE-MPM states are precluded from developing an IPA program and cannot use 1311 funds at all for additional consumer assistance efforts. Thus, the robustness of the navigator program—the entire consumer assistance program in FFE and FFE-MPM states—is contingent upon the federal navigator grant budget. On April 9, 2013, the Obama administration announced the budget for the navigator program as \$54 million in total to be dispersed among 33 states. While states with larger uninsured populations will receive a larger portion of money than states with smaller uninsured numbers, consumer advocates fear that the \$54 million does not come close to the amount needed to run a successful navigator program.⁸ An insufficient budget for the navigator program has the potential to undermine the goals of the ACA, especially given the high uninsured rates in many FFE states. For example, Alabama is estimated to have approximately 643,000 uninsured residents below the age of 65, and the allotment for their navigator program is less than \$1.1 million. With about 845,000 non-elderly uninsured, Virginia's navigator program has been allotted \$1.4 million. Approximately \$1.9 million dollars has been

allocated to the Michigan navigator program, intended to serve 1,145,000 uninsured. While Michigan had stated its intent to be a consumer assistance partnership state, the state legislature did not appropriate the funds necessary for the state to carry out those functions.

The ACA requires a “no wrong door” system, which “allows for enrollment and reenrollment, ensuring that individuals seeking coverage are screened for all health subsidy programs and processed through to enrollment without requiring additional application forms or multiple eligibility determinations.”⁹ However, the extent to which this ideal can be put into place will be highly dependent upon decisions by the FFE states to cooperate with the federally run exchanges. Medicaid is jointly financed by states and the federal government, but each Medicaid program is state run. As a result, states choosing not to cooperate fully with their federal exchange and integrate their Medicaid/CHIP eligibility determination and enrollment process with that of the

exchange could require that individuals make multiple contacts before being enrolled in the appropriate program. HHS has provided states with two options: one where the FFE *determines* the eligibility of an applicant for Medicaid and the state accepts that determination and enrolls the individual in the program, and one where the FFE *assesses* the eligibility of an applicant and refers that individual to the state Medicaid program for a final determination and enrollment.¹⁰ The FFE determination option requires the greatest cooperation and coordination between the state and the federal exchange. In either case, the intent is for the exchange to electronically share appropriate data with the state’s Medicaid agency in order to simplify and expedite the process. However, the greater the participation and coordination between the state and the FFE, the more likely there will be a streamlined intake and enrollment process for consumers that will maximize the increase in coverage resulting from implementation of the Act.

PERSPECTIVES FROM THE FIELD: DEVELOPMENT OF FEDERALLY FACILITATED EXCHANGES IN THREE STATES

As noted earlier, this analysis involved case study interviews in three states that have opted for FFEs to be developed in their states. Michigan is planning for a partnership approach, anticipating performing only the plan management functions within the federally operated exchange for Michigan. Alabama has chosen a full federal approach. Virginia has legislative authority under SB 922 to take on all of the plan management responsibilities delineated for a formal partnership,¹¹ but without formally declaring such a partnership via development of a blueprint document.

Alabama

Alabama had explored exchange development for a few years following passage of the ACA and conducted analyses on current market conditions. The governor created an executive exchange study commission which produced a report recommending that the state pursue development of its own exchange. While supporting the goal of an insurance marketplace driven by consumer choice early on, Governor Bentley decided after further consideration in late 2012 that Alabama would not develop or implement an exchange. The federal Department of Health and Human Services is

directly enforcing the ACA’s insurance market reforms in Alabama, as it does not have the legal authority to enforce the federal law.¹² The federal government is also performing rate review for Alabama, since the state does not have an effective rate review program for either the individual or small group markets.¹³

At the time of our interviews, the governor’s administration had made no explicit statements suggesting unwillingness to cooperate with federal authorities in the implementation of the law. However, there was no understanding of how the state agencies, such as the Department of Insurance or Medicaid, might interact with the federal exchange. State officials were unaware of any activities related to consumer outreach or education that could be underway by consumer groups outside of state government—there had been no press coverage of any education or outreach efforts, and all stakeholder groups that had formed in support of the exchange study commission had disbanded.

While CCIIO had expressed interest in possible collaborative agreements with states outside of formal partnerships, the state declined to pursue such an

agreement. How the state's traditional regulatory roles related to health insurance or even management of its Medicaid program will interact with those assumed by the federal government may present a challenge from the state's perspective, as communication with CCIO has been difficult. While state staff have participated in national calls, meetings, and webinars, they report that communicating directly with CCIO has been hampered by having been assigned six different CCIO project officers since the beginning of planning. According to the state, this constant turnover of project officers has limited the interaction and consistency of project management, as the state must re-educate federal staff on activities each time a change is made. Additionally, contacts felt that the lack of coordination between the federal offices overseeing work—CCIO and CMCS—has also proven to be problematic, and seems to send mixed messages to the state staff charged with staying abreast of ACA and exchange related developments.

Michigan

Michigan has a federally approved blueprint for performing both plan management and customer assistance tasks under a formal ACA partnership exchange. Plan management will be overseen by the Department of Insurance and Financial Services (DIFS). The consumer assistance functions were expected to be performed by the Department of Licensing and Regulatory Affairs (LARA); however, the state's performance of the consumer assistance functions was dependent upon the state legislature's appropriation of the \$30 million exchange establishment grant made by the federal government. As the state legislature chose not to appropriate these funds, consumer assistance functions in Michigan will revert to the federal government. However, organizations can still apply for federal navigator funds in response to the Funding Opportunity Announcement. The state's broker community is reported to be nervous over uncertainty related to the consumer assistance program, specifically the precise role of navigators and how the federal government will administer the program. The Michigan House and Senate are currently considering bills requiring a licensure scheme for navigators, including fingerprinting and background checks.¹⁴ These bills would also prohibit navigators from providing, "advice concerning the benefits, terms, and features of a particular health plan or offer advice about which health plan is better or worse for a particular individual or entity or recommend a particular health plan or advise consumers about which health plan to choose."¹⁵ The prohibition against offering advice to individuals or

employers may be at odds with the federal requirement that navigators "facilitate enrollment in qualified health plans."¹⁶ Such restrictions, if they become law and are not determined to be overridden by the ACA itself, would significantly impede navigators' ability to counsel consumers, particularly those new to the private insurance marketplace.

In any case, state contacts did not foresee financial constraints in performing the plan management functions, although DIFS would have received some of the establishment grant funds had they been appropriated. The department has other federal funding through rate review grants that will allow plan management to move forward, and many of the plan management roles are functions that the department would do as part of their normal responsibilities in the absence of reform, so the need for additional funding is less necessary than in the case of consumer assistance.

A key plan management function under the full ACA market reforms, thus applying both to the inside-exchange market and outside market, is the determination of plan actuarial value; this will be a new function for the state. The DIFS has a chief actuary devoted to the exchange and the ACA-associated market reforms and has hired three additional analysts specifically devoted to reviewing QHP applications. Another area where department staff has had significant prior experience is the determination of managed care network adequacy. The ACA's requirements on network adequacy have been extended by the state across the board to all commercial carriers, and additional staff are being trained to review this type of data. With the exception of one carrier, DIFS expects all plans to be offered both inside and outside the exchange market.

The state legislature recently passed legislation which has been signed by the governor relating to insurance rating standards. Substantial amounts of legislation had to be changed because Blue Cross Blue Shield of Michigan is changing its longstanding status as the state's nonprofit insurer of last resort to a mutual insurance company given the market reforms included in the ACA. This legislation includes the various modifications necessary for the Blue Cross status change as well as providing the state insurance commissioner with the necessary authority to review and enforce the ACA's new rating rules which will apply to both exchange and non-exchange plans.

State contacts report increased hiring and active communication with carriers and the consumer advocate

community. They see the partnership as feasible, but have considerable concerns with the timing of implementation given federal delays in providing guidance. They see a tremendous increase in the data required of carriers, and while meeting the deadlines may be doable for the largest carriers, they see the smaller ones at a distinct disadvantage. They also expressed concern that any IT delays or glitches on either the state or federal side could also create barriers to a timely launch.

Virginia

State contacts were consistent in reporting that Virginia would not be submitting a blueprint to become a state partnership exchange, at least not for 2014. However, they do expect to take on all of the federally delineated responsibilities associated with plan management that a formal partnership exchange will handle. CCIIO refers to this type of arrangement as a marketplace plan management exchange, but the partnership moniker is not one with which the Commonwealth of Virginia is comfortable. Virginia is one of seven states expected to play this type of role.¹⁷

SB 922 was approved by the governor on March 21, 2013, and will be effective on July 1, 2013. This state law permits the State Corporation Commission (SCC) to perform plan management functions for the FFE as instructed under the ACA, although the SCC's obligation to perform plan management functions is contingent upon receiving federal funding sufficient to pay the operating expenses necessary to carry out the functions. This funding is expected through a federal exchange establishment grant to the state.

Prior to the new legislation becoming effective, Virginia has not had full premium rate review authority; the state had authority only to review individual health insurance rates (not HMOs, small group coverage, or association rates). As a result, contacts believe that a significant investment in new staff will be required in order to transition to a fully effective rate review capacity. Currently, the Bureau of Insurance has only one part-time health insurance actuary who was originally hired with consultant funds from a previous federal rate review grant. As a result, contacts anticipate using contracted actuarial consultants to assist with actuarial reviews in the near term, cross-train some existing staff for new responsibilities such as form and rate review, and hire additional permanent staff over time.

The Bureau of Insurance has already trained current staff to review plans for compliance with Essential Health Benefits, new requirements which will apply to

small group and non-group plans sold inside as well as outside the exchange. They anticipate using the federal calculator for assessing plan actuarial value. Assessments of network adequacy will be handled by the state Department of Health, as that department is already enforcing network adequacy standards for managed care plans. The expectation is that the same network adequacy standards currently in use by the state will apply for insurers selling inside and outside the exchange, although the requirement for inclusion of essential community providers will have to be added.

Given that the final qualified health plan certification under the plan management partnership approach and presumed under the Virginia FFE-MPM rests with CCIIO, Virginia believes that appeals of any decision to decertify a plan should go through CCIIO instead of the state. Virginia also has clarified in a letter to CCIIO that the state does not anticipate being involved in consumer assistance related solely to exchange issues such as, supporting consumers with issues related to exchange administration or tax credits.¹⁸

State officials were contacted by CCIIO to collect information on the details of Virginia's small employer market. The legislature also passed legislation relating to the relationship between navigators and agents, SB 1261.¹⁹ This legislation was intended to address concerns from the broker and agent community over navigators acting as unlicensed agents and interfering with commercial functions. The state law prohibits a navigator from engaging in any activity that would require an insurance agent license, offering advice about which QHP or qualified dental plan is better or worse for a particular individual or employer, acting as an intermediary between an employer and an insurer offering exchange-based plans, violating any unfair trade practice and privacy requirements, or claiming to be a navigator without being selected or trained through applicable processes. As is the case with the legislation under consideration in Michigan, the prohibition against offering advice to individuals or employers may be at odds with the federal requirement that navigators "facilitate enrollment in qualified health plans."²⁰ As of the time of our interview, federal regulators had not formally responded to this new legislation or discussed its implications with state staff. There is no significant communication between the Bureau of Insurance and state consumer groups at this time.

The governor currently opposes expanding Medicaid eligibility under the ACA, although a state budget

passed that delineates stipulations that must be met prior to Virginia adopting an expansion.²¹ That said, staff anticipate active information exchange between the federally run non-group exchange and the state's Medicaid program. The biggest challenge for implementing this effectively is having all of the IT functions, both state and federal, and the new eligibility systems in place on time. The state will use the Modified Adjusted Gross Income (MAGI) rules and elect for the federal government to assess those contacting the

exchange for Medicaid eligibility, but the state will do the final determination of Medicaid eligibility. Likewise, if someone contacts the state Medicaid program but appears to be eligible for exchange-based subsidies, they intend to transfer information to the exchange. There is support for this type of system that streamlines information sharing between the programs, but additional communication with and information from the federal government is necessary to make the systems work.

OVERALL EXPERIENCE AND CHALLENGES TO DATE

Discussions with state staff in all three states made it clear that the actual structure of operations and functioning of the communications and interactions between states and CCIIO are evolving but are not yet clear on numerous levels, leading to significant frustration at the state level. Political considerations, such as awaiting the outcomes of the U.S. Supreme Court decision on the constitutionality of the ACA and the presidential elections, delayed state decision-making and development related to the exchanges and their operations. As a consequence, although the law passed more than three years ago, the states participating with the federal government in any capacity have an extremely compressed timeframe for putting in place the required systems, processes, and technologies for the start of open enrollment in October of 2013.

For example, state contacts noted that CCIIO had described a tool for helping states identify whether insurance plans have benefits that discriminate against the sick. This is a function required under the ACA in the small group and non-group insurance markets, but is not traditionally a role for departments of insurance in most states since most state laws prior to the ACA permit variation in pricing and benefits as a function of health status. Staff we spoke with in March of 2013 noted that they still did not know how to access such tools and they did not know when they might get access to them. This is an issue related to review of small group and non-group plans offered inside and outside the exchanges, but state departments of insurance consider it a piece of plan management.

Another area where, at the time of our interview, states continued to wait for detailed instructions from CCIIO is the definition of essential community providers. This, again, is an ACA requirement aimed at ensuring broad access to care for diverse populations—in this case, the low-income population—and is not a requirement with which the states have had prior experience. As one informant noted, “I’ve never even heard of essential community providers, that’s an entirely new term to us.” Since our interviews took place, CMS did provide additional instruction in an April 5 issuer letter.²²

The challenge that has weighed most heavily on all states since the earliest discussions over exchange development has been IT system construction and integration with existing programs.²³ Staff in Virginia and Michigan, both taking on responsibility for plan management, continue to be concerned with the details of how information will be exchanged between the state departments of insurance and the federal exchanges. They recognize that specific data elements from carriers on each QHP and information verifying that each plan meets federal exchange participation requirements must be communicated to the federal IT system, yet neither the necessary data elements nor the electronic format for transmitting them have been delineated by CCIIO. Even staff in Alabama, a fully federal FFE state, anticipate that they will have some level of interaction and cooperation with the exchange, but they do not seem to have any sense of what that interaction will look like.

CONCLUSION

Even within the context of a federally facilitated exchange, states have a number of opportunities to participate alongside the federal exchange operators; these opportunities range from formal partnerships in plan management and/or consumer assistance to informal participation that in some ways mimic the formal approaches, as well as more limited interactions. Two of the three FFE states in our analysis are actively engaged in cooperating with the federal government at multiple levels, and staff in the third are interested in better understanding what the impact will be to the state and how many issues will be addressed under a fully federally run exchange.

Many challenges remain, however, in having these exchanges fully operational for open enrollment. Political challenges at the state level and the political considerations surrounding the presidential election have led to an array of delays in guidance and implementation of systems, even given the significant lead time provided by the law. CCIO continues to make public assurances that the federal government will be ready for open enrollment in the FFEs by October 1, 2013; however, the magnitude of the task makes this a serious challenge. The success of the FFEs will be aided significantly where state government plays an active role.

ENDNOTES

1. This report focuses on three out of the ten studied states, those that are implementing a federally facilitated exchange.
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20. Public Law 111–148—Patient Protection and Affordable Care Act of 2010. Section 1311(i)(3)(C).
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