

U.S. Health Reform—Monitoring and Impact

States Seek Greater Control, Cost-Savings by Converting to State-based Marketplaces

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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 health reform. 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 to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org.

INTRODUCTION

Eleven states and the District of Columbia currently operate their own health insurance marketplace eligibility and enrollment websites under the Affordable Care Act (ACA), but that number is slated to grow. Several states are in the midst of or contemplating a transition from the federally facilitated marketplace (FFM) platform, HealthCare.gov, to a state-run platform. Their reasons for doing so are varied, such as the potential to run the marketplace more efficiently and capture cost-savings, greater autonomy over their insurance markets, and an ability to leverage

the marketplace to achieve broader health reform goals. At the same time, federal officials have proposed several policies to encourage states to relax many of the ACA's insurance market reforms, some of which are more feasibly implemented via a state-operated marketplace. However, the transition to a state-based marketplace (SBM) comes with political and practical risks for state officials, participating insurers, and enrollees. This issue brief assesses benefits and risks associated with a transition to an SBM and outlines critical considerations for state policymakers.

BACKGROUND AND APPROACH

The ACA requires the establishment of new health insurance exchanges, or marketplaces, in each state.¹ These marketplaces are critical to the law's aim of expanding health insurance coverage. In addition to being the path through which individuals can receive financial assistance, the marketplaces were designed to help organize insurance markets, promote competition, and help consumers more effectively compare their health plan options. States have flexibility to design and run their marketplaces to meet the needs of their residents, while also meeting minimum standards and being financially self-sustaining. The marketplaces are also required to perform several critical functions, such as:

- *Eligibility and enrollment.* The marketplace must provide a mechanism for consumers to receive a determination of their eligibility for income-based premium tax credits and cost-sharing subsidies and enroll in a qualified health plan (or connect them to Medicaid or CHIP coverage, if eligible).

- *Plan management.* The marketplace must certify that health plans meet licensure and other requirements for participation, review insurers' justifications for premium rates, and exercise oversight, including de-certifying non-compliant plans.

- *Consumer assistance.* The marketplace must establish a web portal, call center, and Navigator program to help consumers find and enroll in public or private coverage.²

The ACA required states to decide whether to operate their own marketplace by 2013. For states that elected not to establish their own marketplace, the federal government stepped in to do so in that state. Conventional wisdom, and the long-standing role of states as the primary regulators of insurance, caused many to predict that most states would decide to operate their own marketplaces. Indeed, 49 states and DC applied for early planning grants from the federal government, although three states later returned all or some of these funds. Political opposition to the law as well

as operational obstacles subsequently led most states to opt out.³ By 2013, only 17 states had chosen to run their own marketplaces.

In the lead up to the marketplaces' launch, states had to build their own eligibility, plan comparison, and enrollment IT platforms. This ultimately cost close to \$5 billion in federal marketplace grants.^{4,1} Even with this expenditure, several states were plagued with glitch-ridden consumer interfaces and faulty data transfers with participating insurers.⁵ Four states failed to operationalize their IT systems or had sufficient technological challenges during the initial year that they switched to the federal IT platform, HealthCare.gov.⁶

Since 2015, state approaches to running the ACA's marketplaces have evolved. Kentucky abandoned its SBM platform in 2016 after the election of a new governor who campaigned against the ACA, while Hawaii transitioned to the FFM in 2016 after a number of technological challenges.⁷ At the same time, many FFM states perform some marketplace functions, such as plan management and consumer assistance, while continuing to use the federal eligibility and enrollment platform, HealthCare.gov (Exhibit 1).

At the time of this writing, several states using the HealthCare.gov platform are in the midst of or are considering a transition from an FFM or SBM-FP to an SBM (Exhibit 2). Nevada, which

Exhibit 1: Types of Health Insurance Marketplaces across States, August 2019

Type of Marketplace	Description	Eligibility and Enrollment Platform	Number of States
Federally Facilitated Marketplace (FFM)	Federal government performs all marketplace functions.*	HealthCare.gov	17
State Partnership Marketplace (SPM)	State conducts plan management and may administer consumer assistance; federal government performs all remaining functions.	HealthCare.gov	17
State-based Marketplace–Federal Platform (SBM-FP)	State has legal authority to run a state-based marketplace and is responsible for all marketplace functions, but eligibility and enrollment is conducted through HealthCare.gov.	HealthCare.gov	5
State-based Marketplace (SBM)	State has legal authority to run a state-based marketplace and is responsible for all marketplace functions, including eligibility and enrollment.	State platform	12**

*All but four FFM state departments of insurance review marketplace plans for compliance with the ACA.

**11 states and the District of Columbia operate an SBM.

Source: Rachel Schwab & JoAnn Volk, "States Looking to Run Their Own Health Insurance Marketplace See Opportunity for Funding Flexibility," *To the Point* (blog), Commonwealth Fund (Jun. 28, 2019), <https://www.commonwealthfund.org/blog/2019/states-looking-to-run-their-own-health-insurance-marketplace-see-opportunity>.

Exhibit 2: Overview of States Considering a Transition to an SBM, August 2019

State	Current Marketplace Model	Anticipated Sbm Implementation Date
ME	FFM	Plan year 2021*
NV	SBM-FP	Plan year 2020
NJ	FFM	Plan year 2021
NM	SBM-FP	Plan year 2022
OR	SBM-FP	N/A**
PA	FFM	Plan year 2021

*Maine intends to transition to an SBM-FP for plan year 2021.

**Oregon has issued a Request For Information on the capabilities of marketplace contractors in the arena of eligibility, enrollment, and call center technology. The state has not issued any Requests For Proposals or taken any other necessary steps towards a transition to a full SBM.

Source: Rachel Schwab & JoAnn Volk, "States Looking to Run Their Own Health Insurance Marketplace See Opportunity for Funding Flexibility," *To the Point* (blog), Commonwealth Fund (Jun. 28, 2019), <https://www.commonwealthfund.org/blog/2019/states-looking-to-run-their-own-health-insurance-marketplace-see-opportunity>.

1. The \$4.906 billion estimated cost is derived from total federal Exchange Establishment and Early Innovator grants as of October 2014. Not all states that received these grants ultimately established their own marketplaces. The use of these funds included feasibility studies, holding community forums, and updating or procuring new IT systems.

launched an SBM in 2014 but switched to the federal platform in 2015 (making it an SBM-FP) after a series of IT failures, is poised to become a full SBM again in 2019 (for plan year 2020 enrollment). The board of directors of New Mexico's SBM-FP approved a transition to a full SBM for plan year 2022. Because Nevada and New Mexico initially intended to operate full SBMs, their state legislatures had previously adopted legislation to authorize the SBMs.

Pennsylvania and New Jersey, both currently FFM states, intend to transition to an SBM-FP for plan year 2020, with the goal of becoming full SBMs by 2021. Both states adopted new legislation in 2019 to authorize the creation of full SBMs. In August 2019, Maine announced that it would transition from an FFM to an SBM-FP by 2021. Oregon's SBM-FP is researching the option of a state-based platform and has sought information from vendors about their capabilities to provide marketplace eligibility and enrollment and related consumer-support services.⁸

RESEARCH APPROACH

To assess state decision-making regarding the benefits and risks of transitioning to an SBM, we reviewed authorizing legislation, marketplace board meeting materials, and other executive branch documents in Nevada, New Jersey, New Mexico, Oregon, and Pennsylvania. We further conducted structured interviews with 22 state officials, insurers,

consumer advocates, insurance brokers, and Navigators in those five states. The states were selected because each has publicly declared its intention or interest in transitioning to an SBM. Maine's decision to transition to SBM-FP status was made too late for inclusion in this study.

FINDINGS

The primary factors driving states to switch from the HealthCare.gov platform to a full SBM are the prospect of cost savings (and the ability to redirect those savings to other state priorities), an improved consumer experience, and regaining more autonomy over their insurance markets. However, the transition involves several practical and political risks for state leaders and marketplace enrollees, including unproven IT systems, skeptical stakeholders, and inconsistent federal policymaking. With the exception that Oregon has not yet made a decision whether to proceed, the states examined in this study have concluded that the long-term benefits of a transition to a full SBM, such as the alignment with broader state health policy goals and the ability to expand coverage to more residents, outweigh those potential risks.

Transitioning states are driven by potential cost savings and greater autonomy

The states transitioning to a full SBM are doing so largely because they believe they can operate a cost-efficient and consumer-oriented marketplace that will promote more robust enrollment than HealthCare.gov. Officials and stakeholders alike believe an SBM will enable more control over their insurance markets in the midst of an evolving federal policy environment.

States seek cost savings

The prospect of cost savings was one of the most compelling reasons for state lawmakers to embrace a transition to an SBM. Since 2014, the federal agency that runs the FFM—the Centers for Medicare & Medicaid Services (CMS)—has charged a user fee of 3.5 percent of premium to operate the marketplace in FFM states. Full SBM states pay no user fees to the federal government, but SBM-FP states have experienced increases in CMS' charges for operating the federal IT platform from zero to 3 percent over five years (no user fee in 2015 and 2016, 1.5 percent in 2017, 2 percent in 2018 and 3 percent in 2019).⁹ In 2018 alone, user fees for HealthCare.gov in the five study states totaled nearly \$183 million, ranging from a low of about \$5 million in New Mexico to a high of about \$98 million in Pennsylvania.¹⁰

State officials believe they can operate a full SBM "better and cheaper" than CMS by leveraging lower cost technology and a leaner bureaucracy. For example, Nevada projects that transitioning to its own technology platform will result in \$19 million in savings (relative to using HealthCare.gov) through 2023.¹¹ Several officials reported their intention to direct cost-savings to programs that will benefit policyholders and expand coverage. Pennsylvania intends to use a portion of the

SBM's projected cost savings to fund a reinsurance pool that will compensate insurers for enrollees with extremely high health care costs, which will in turn help moderate premiums in the individual market.¹² As discussed below, some of the savings may also be invested in outreach and consumer assistance or other state policy priorities.

Some state officials were more cautious about predicting significant savings, noting that unpredictable events, policy or premium changes, or fluctuations in enrollment can affect these projections. However, most officials argued that the state will at least be able to provide insurers with greater "certainty, or at least a degree of certainty" about their costs. Another respondent noted that SBMs could eventually share technology costs across states. This would allow states to use the same platform, or pieces of the same platform, and share costs for IT modifications or new features.

States seek improved user experience

Respondents expect that a full SBM will yield many immediate operational benefits, such as a better experience for consumers, insurers, and consumer assisters. Referring to consumer support, one respondent said, "there are things we know already, just out of the gate, we will 100 percent be able to do better [than the FFM]." SBMs can use real-time data collection to monitor consumers' interactions with their website and call center and identify potential problem areas. For example, such data can help an SBM identify a page on its website where a high proportion of potential customers are spending a significant amount of time and/or leaving the site. This could prompt a correction of potentially confusing language or other improvements to site navigation. Similarly, during the open enrollment period, SBMs can use data about applicants' locations and enrollment decisions to more effectively target outreach campaigns and ad buys, or to adjust call center scripts.

This would be a significant shift for these states. Currently, states using HealthCare.gov must rely on the federal government's willingness to share application and enrollment data. Thus far, the FFM's data sharing has been characterized as too aggregated and delayed to be of much use in outreach and enrollment. Several state officials cited greater access to data—and the ability to use it in real time to improve marketplace operations, outreach, and the customer experience—as an important reason to switch to a state-run platform.

State officials and the people who assist consumers (including Navigators and brokers) reported frustration with other aspects of the FFM operations, most notably the customer call

center. Although some thought the call center had improved in recent years, others complained about poor training and lack of knowledge among call center operators. Many operators must strictly adhere to call center scripts and cannot resolve complex case-by-case issues, ultimately leading to confusion and the need for state officials to step in to resolve consumer problems. Many respondents believe that local operation of the call center would lead to better oversight, reduced wait times, and more accurate and state-specific communications with callers.

Stakeholders also identified the importance of state-specific branding and public support for the marketplace. One respondent suggested that transitioning to a state-branded SBM could help overcome continued consumer skepticism about the ACA. Another put it this way: "hav[ing] something that's wholly owned and backed by the state...can go a long way in helping us to get more people confident that they can enroll."

State officials expect to improve other features, such as the broker portal and consumer decision support tools. For example, a broker reported optimism about his state's plan to offer a "streamlined" version of the broker portal that will allow him to view his entire book of business. Officials also reported working with their IT vendors on "best in class" consumer decision-support tools that will permit plan previews and an improved window-shopping experience. Others noted that the SBM would be better able to partner with participating insurers, because the state would be the "single point of contact," rather than the two levels of state and federal oversight that exist in FFM states. Some insurers shared this view, predicting that the SBM will be easy to communicate with and will handle their technical and operational problems in a "fast, timely manner."

States seek greater control over policy

Not surprisingly, state officials indicated that having greater control over their insurance market was a primary factor in their decision to transition to an SBM. Currently, CMS has limited ability to customize HealthCare.gov to meet a particular state's needs. For example, FFM states cannot extend the annual enrollment period or special enrollment opportunities or account for state-specific subsidies or laws. Many states using the FFM have urged the federal government to permit greater customization, but thus far federal officials have been unable to make the necessary technical changes. As one state official put it, the FFM has been "slow to change, like moving the Titanic," and "not at all flexible to state-specific needs."

State officials and other stakeholders also noted that the SBMs are better positioned to counter federal policies that could result in reduced marketplace enrollment or higher premiums. Respondents noted, in particular, recent federal policies such as cutting funding for marketplace outreach and Navigator grants, decisions to expand the sale of insurance products that do not meet the ACA's minimum consumer protection standards, such as short-term plans, and the encouragement of third-party web-brokers as an alternative enrollment pathway. A majority of respondents believe their state will run their own marketplace in a manner more consistent with the ACA's objectives than the current federal administration.

Transitioning to an SBM requires management of practical, political risks

States undergoing a transition to a full SBM face several risks. A successful switch to new eligibility and enrollment systems requires significant lead-time and oversight. The marketplaces must also meet the needs of insurers whose participation is voluntary and consumers who expect a seamless enrollment process. Failure to do so could reduce enrollment, discourage insurer involvement, and increase the instability in the market. The state must also manage the marketplace within the projected budget or risk losing promised cost-savings. Moreover, transitioning states must prepare for the launch of a state technology platform and maintain market stability at a time when federal policy with respect to the ACA has been inconsistent and unpredictable.

Failure of State-run IT System "Not an Option"

In spite of a large financial investment in new marketplace IT systems, there were a series of spectacular failures for SBMs in 2014. For states considering a transition from HealthCare.gov to a state technology platform today, the financial costs and operational risks are considerably lower. They no longer need to build wholly new software systems; the transitioning states are leveraging systems that have already been built and run successfully in current SBM states. For example, Nevada has awarded its IT management contract to GetInsured, a company that currently operates the California SBM platform and managed Idaho's transition from HealthCare.gov to a state-run system in 2014.¹³

The primary challenge is to customize these platforms to meet the state's policy priorities and operational needs. That customization is not risk-free. There are countless technical interactions and data transfers that must take place to seamlessly move a consumer from the eligibility determination for premium and cost-sharing subsidies (and execute a warm hand-off to the Medicaid program, if applicable), to the selection of a plan, to the transfer of their payment and enrollment data to their chosen insurer.

Marketplaces must also meet rigorous privacy and security standards. Ensuring that these transactions work smoothly requires months of testing, tweaking, and testing again before the marketplace opens for business. For state officials that have spent months convincing legislators of the benefits of switching to a full SBM, a technology failure "is not an option."

"If It Ain't Broke, Why Fix It?"

Stakeholders' views on their state's decision to transition to a new marketplace platform were mixed. A slim majority viewed the transition as a net positive, citing potential benefits such as customization and a greater ability to make state-level adjustments to unwelcome federal policy changes. Insurers appreciated state officials' efforts to engage them early in the process, while consumer assisters were less likely to report that state officials had communicated with them about the transition, either before or after a public decision was announced.

Most insurers and consumer assisters observed that the federal IT system, after a rocky start, is now working very well, with relatively few glitches. These stakeholders have become comfortable with the HealthCare.gov interface and processes for communicating with enrollees and partners, and several queried why the state would make a transition now when users are well-accustomed to the federal platform. "I see more risks than benefits at this point," said one insurer. Stakeholders in Oregon and Nevada were particularly cautious about the transition, having lived through significant technological failures in 2013 and 2014. "Nobody wants to relive 2014," said a state official. "[Insurers] were burned badly, and we're still cleaning up that mess." Officials in another state noted they had to work hard to reassure insurers that they would only be "copying and pasting" the components of HealthCare.gov, thus "minimizing the [IT] build on the insurers' part." Some insurer stakeholders regard this claim with skepticism, noting in interviews that the required changes to IT systems and business practices would be extensive, expensive, and would require a level of vendor oversight not all states are equipped to provide.

Some insurers also expressed caution about what the state might do after becoming a full SBM. "What makes me nervous is that part of the reason [the state] wants to move away from HealthCare.gov is they want to do more things," said one. These insurers were generally resistant to establishing an SBM as a necessary predicate to broader policy goals such as standardized benefit designs, a public plan option, or cost-containment via active purchasing. On the other hand, insurers embraced Pennsylvania's plan to leverage SBM savings to fund a reinsurance program. It's a "huge, huge positive," said one insurer.

Consumer assisters and advocates generally recognized the value of an SBM in enabling greater state-level policy innovations and asserted that their state would do a better job meeting consumers' needs than a federally run platform could. Many thought that the ability to supplement the open enrollment period was a particularly appealing option not available under the FFM. Consumer advocates in several states are urging state officials to direct SBM cost savings to outreach campaigns and the Navigator program, arguing that such investments will increase enrollment and improve the stability of the market. Others may encourage state officials to leverage the SBM to provide state-funded subsidies that wrap around federal subsidies for low- and moderate-income enrollees.

Engaging CMS can be Challenging, but is Essential

Transitioning from HealthCare.gov to a state-run platform requires close cooperation and coordination with CMS. CMS must approve each state's transition and long-term sustainability plans (submitted via a state-based marketplace "Blueprint").¹⁴ In addition, the states depend on CMS' ability to timely transfer consumers' enrollment data from the HealthCare.gov platform to their new system, so that existing enrollees do not experience any hiccups in coverage or subsidies. State officials report a good partnership with CMS to date: "They've been really supportive and helpful," said one. Another noted that the launch of additional SBMs aligns with the federal administration's stated policy goal of greater state flexibility with respect to insurance market oversight.

While CMS has thus far supported the concept of states transitioning away from HealthCare.gov, state officials noted that it has been at times challenging working with an "unwieldy bureaucracy." They pointed to a lack of communication among different divisions within the agency (and between agencies, as the Internal Revenue Service must also sign off on key components of the transition), delays getting materials reviewed and approved in time for key operational deadlines, and a lack of flexibility in responding to state-specific needs. "There are always times you need to 'project manage' them a little bit," said one official. "But I think from a conceptual and philosophical point of view, they've been very supportive of us."

States Must Manage Potential Financial Risks due to Federal Policy Changes

An operating assumption for states transitioning to an SBM is that doing so will generate cost savings. However, it can be challenging for states to generate an accurate projection of potential cost-savings when the amount CMS charges to operate the marketplaces can fluctuate year-to-year. Although user fee rates for the SBM-FP states have steadily increased since 2016, beginning in 2020, CMS will lower user fees to

3 percent in the FFM states and 2.5 percent in the SBM-FP states.¹⁵ Although the SBMs are not required to mimic the federal user fee rate, it can be politically challenging to charge a higher amount. "We're happy the [user fee] rate [will go] down," said one state official, "but it's so hard to predict." For Nevada, the news of the fee reduction came in the midst of the state's transition to a full SBM, reducing the potential cost savings to the state and requiring mid-stream re-budgeting. Officials in other states planning to transition in 2021 and beyond expect to face similar challenges in forecasting budgets accurately.

Changes in federal policy can also result in unexpected new costs for the SBMs, as federal regulators require SBMs to make IT adjustments to account for new federal changes. For instance, to comply with a June 2019 rule on health reimbursement arrangements (HRAs), CMS estimated that it will cost the twelve SBMs up to \$46.8 million in initial IT changes and other one-time costs, and up to \$85 million in ongoing costs for personnel at call centers and other consumer support functions by 2022.¹⁶ Other new costs may also be coming: CMS has proposed, but has not yet finalized, new requirements for SBMs to conduct "data checks" of enrollee eligibility twice annually.¹⁷ If finalized, these requirements would increase SBMs' administrative costs.

One challenge for SBMs relative to HealthCare.gov is that they lack the economies of scale to absorb these costs. For example, while the up-front price tag of implementing the HRA rule is an estimated \$46.8 million in the twelve SBM states, CMS estimates the cost across the FFM states to be just \$3.9 million.¹⁸ Officials in the study states acknowledged the different economies of scale, but argue the benefits of transitioning—and the ability to have greater control over their insurance markets—outweigh those costs.

SBMs also face the risk that federal policy could unexpectedly reduce their enrollment, thereby reducing the premium revenue they receive to sustain operations. For example, in December 2017, Congress eliminated the penalty for failing to maintain insurance coverage (the "individual mandate").¹⁹ Economic projections vary, but have consistently estimated that this change would increase the uninsured.²⁰ CMS has also suggested it could ban insurers from a practice called "silver loading," in which insurers—often directed by states—recoup the cost of the administration's 2017 decision to end payments for the ACA's cost-sharing reduction subsidies by increasing the premium for silver-level marketplace plans.²¹ If the administration prohibits silver loading, it would decrease the amount of premium tax credits available to enrollees and likely reduce overall marketplace enrollment.²²

At the same time, SBMs are better positioned than FFM states to mitigate the fallout from adverse federal policy changes by investing more heavily in consumer outreach and assistance. Additionally, if the marketplace is state-run, legislators may have a greater investment in its success and thus be more willing to enact state-level policies, such as a state-level individual mandate, that would counter federal policy and boost enrollment. At a minimum, however, states considering a shift from the FFM to an SBM must be prepared for potential federal policy shifts and have sufficient operational and budget flexibility to respond to them.

States See Long-term Benefits to Running their Own Marketplace

Most stakeholders were focused on the immediate tasks of ensuring that the transition to a state-run marketplace platform would result in no disruption for consumers or insurers. As one state official put it, “this year is just making sure we turn the lights on.” Respondents did, however, cite a number of potential long-term benefits of establishing a full SBM, including the alignment with other state health care priorities and the opportunity for more policy experimentation.

State Flexibility and Ownership

State flexibility (and the potential for expanded marketplace capabilities that this flexibility brings) was consistently cited as a significant long-term benefit of transitioning to a full SBM. By establishing their own SBM, states can make policy decisions to suit the needs of their community and integrate more closely with other state agencies, such as those that run Medicaid and CHIP. As one state official put it, the state’s “menu of decisions” expands as local control over the marketplace expands.

Most FFM states have not yet made long-term policy decisions for new SBMs. However, transitioning to an SBM enables state leaders to consider future changes that simply would not be possible through HealthCare.gov. State officials were particularly excited to leverage SBM data to inform future policy decisions. One mentioned the potential to develop predictive models to better understand consumers’ decisions to enroll and maintain insurance coverage. Such data and modeling could inform efforts to reach the remaining uninsured and support stakeholders in better addressing issues such as churn between marketplace and Medicaid

coverage. Another respondent noted that the SBM website could ask consumers why they were canceling their coverage mid-year to better understand whether, for instance, consumers are gaining other sources of coverage or if they believe coverage to be unaffordable. As one stakeholder put it, “the more complete picture we have of our population, the better.”

Alignment with Other State Policy Priorities

Many respondents cited the long-term value of using the SBM as a tool to advance other state policy priorities. Benefits included better integration between the marketplace, the Medicaid program, and other state agencies. An SBM could allow for better interagency coordination where, for instance, the labor department helps notify consumers of their marketplace coverage options during job layoffs.

Some respondents noted the possibility of leveraging the SBM to influence the delivery of health care by improving competition and quality while lowering rates. As one insurer put it, “we want to position the [marketplace] to follow our Medicaid and public employee population on that journey as it relates to ‘bending the cost curve’ and improving quality. We can’t do that under HealthCare.gov.” Consumer advocates voiced support for SBMs to operate as “active purchasers,” where the marketplace negotiates with insurers to achieve a better value for enrollees, although some insurers expressed reservations about this model.

Opportunities to Experiment

Many respondents pointed to the need for an SBM to enable the state to pursue more ambitious health policies. One official noted that advocates and the legislature in the state were hoping to enact a proposal to allow more people to “buy in” to the Medicaid program. “I had to go to the table and say we can’t do it ... The only way to support [a Medicaid buy-in] is by a transition” to an SBM. Another cited the state’s interest in waiving certain ACA requirements to design state-specific programs. But pursuing a waiver “is just harder without your own platform.” Still, another respondent noted that it is “extremely difficult” to explore innovative ways to extend coverage — such as through additional state subsidies, a Basic Health Program, or automatic enrollment programs — without an SBM. Respondents also said that SBMs were better positioned to reduce the negative side effects of consumers churning between marketplace and Medicaid coverage.

CONSIDERATIONS FOR STATES CONTEMPLATING A TRANSITION TO AN SBM

Respondents articulated several compelling benefits of transitioning to an SBM but acknowledged that doing so is no small feat and comes with several risks. Although technology costs have decreased, launching an SBM requires a large investment of staff time and vendor oversight. There is also significant risk of financial or coverage disruptions for enrollees (as well as negative media attention and political repercussions) if the transition does not go smoothly.

State officials and stakeholders identified several key predicates to a successful SBM transition. These included:

- *Know—and be able to articulate—state goals.* Given the investment of state resources and potential risks of a transition, state leaders must clearly convey to legislators, agency officials, insurers, consumers, and the media what the state hopes to achieve by transitioning to an SBM.
- *Set realistic expectations.* One reason several states struggled with their marketplace IT platforms in 2013 and 2014 is that they were overly ambitious, attempting to do premium collection or integrate with their state's Medicaid eligibility and enrollment system. State officials and stakeholders alike argued that transitioning states should keep the technology build as simple as possible to minimize disruption in the short-term, while also maximizing flexibility for greater Medicaid integration or other improvements in the future.

- *Allow for sufficient lead-time.* States will need to build in sufficient time to work with IT vendors to customize eligibility and enrollment software, execute the necessary data transfers between CMS and insurers, and conduct sufficient end-to-end testing. Respondents emphasized the significant risks of attempting to rush this process.
- *Engage stakeholders early and often.* State officials observed that the marketplace cannot run without insurers, and their active engagement in the process is critical to a successful transition. States must also solicit input from end-users: state residents who will use the marketplace to apply for coverage and the people who help them. These individuals can provide feedback on design decisions for the website, user accounts, and communications with enrollees and the public about the impending transition.

Many respondents viewed the transition to an SBM as a natural next step in their state's broader vision to reduce the number of uninsured and make health care more affordable. As one respondent put it: "States do this transition because they're committed and want to help people have coverage." All eyes are likely to be on Nevada—the first state making the transition back to a state technology platform—as an indicator of whether a stable and more efficient marketplace is a viable option. If Nevada and the other study states succeed, it is likely that more FFM and SBM-FP states will consider a transition to gain greater control and flexibility over their markets and capture potential savings that can be used for other state priorities.

ENDNOTES

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