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Health Policy Brief

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Federally Facilitated Exchanges. States that do not establish an insurance exchange or 'partnership' model will have the federal government run one for them.

WHAT'S THE ISSUE?

One of the key mechanisms for expanding health coverage under the Affordable Care Act is the creation of new state-based health insurance exchanges. Starting with an "open enrollment" period in October 2013, people who do not have access to affordable insurance through an employer and who do not qualify for Medicaid or the Children's Health Insurance Program (CHIP) will be able to purchase "qualified health plans" through these exchanges, most likely to be accessed by many consumers through new websites. Federal subsidies will be available through exchanges to make coverage more affordable for low-income people. The new coverage purchased through exchanges will take effect in January 2014.

States have several options for organizing and operating these exchanges. A state can establish and operate its own exchange, work with other states to establish regional exchanges, run an exchange in partnership with the federal government, or let the Department of Health and Human Services (HHS) operate a "federally facilitated exchange" for the state. As of the publication date of this brief, 25 states have decided not to establish and run their own exchanges.

The result is that the federal government will now have a major role in expanding insurance coverage in the individual and small-business insurance markets in at least half the states. This policy brief explores the issues now arising as the federally facilitated exchanges are being shaped.

WHAT'S THE BACKGROUND?

The Affordable Care Act aims to increase health insurance coverage primarily through a combination of reforms to health insurance and the health insurance market. Critical to these new arrangements is the creation of health insurance exchanges—marketplaces where people can compare and purchase coverage. There will be two main types of insurance exchanges: one for individuals and their families, and one for small businesses and their employees. (See two previous Health Policy Briefs for additional background on insurance market reforms, published on April 30, 2010, and on the Small Business Health Options Program (SHOP) exchanges, published on February 9, 2012.

'ONE-STOP' SHOPPING: Many consumers will likely access the exchanges through websites. Exchanges are designed to allow "one-stop" shopping, so that consumers can determine whether or not they are eligible for Medicaid/CHIP or exchange-based coverage—and if the latter, whether they are eligible for federal subsidies to help defray the cost. Although insurance coverage will continue to be sold outside exchanges, consumers can't obtain the federal subsidies unless they buy coverage through an exchange.

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States with a federally facilitated exchange
As of now, 25 states have decided not to establish and run their own exchanges, preferring to let HHS do it for them.

"In operating the federally facilitated exchanges, the federal government will have to be cognizant of the variety of state insurance laws and regulations."

Whether an exchange is run by a state, by the federal government, or as a partnership between the two, the law mandates that exchanges fulfill five core functions: eligibility, enrollment, plan management, consumer assistance, and financial management, as follows.

- **Eligibility.** Exchanges have a host of responsibilities in this arena. They must provide a single application that can be filled out online, by mail, over the telephone, or in person. Exchanges are required to determine whether a person is eligible for federal subsidies, including assistance in paying premiums in the form of tax credits, and reductions in cost sharing, such as deductibles and copayments. Exchanges must verify whether people have access to affordable insurance coverage through an employer, which would make them ineligible for premium assistance. Exchanges also must screen applicants to determine whether they are eligible for coverage through Medicaid or CHIP instead of receiving a premium subsidy to buy coverage on the exchange.

Exchanges also have to put in place a process for determining continued eligibility over time. They must have an appeals process for those denied eligibility. And employers must be able to appeal when it is determined that their employees do not have access to affordable coverage and can enroll in coverage through an exchange, which could subject the employer to penalties.

- **Enrollment.** Once it is determined whether or not individuals or families are eligible for federal subsidies, the exchanges must help them enroll in a plan. They must also help enroll people who are eligible for Medicaid or CHIP in those programs.

- **Plan management.** Exchanges must certify that the health plans available for purchase on the exchanges are "qualified" health plans, which means that they meet a list of specifications. Among these specifications are that the plans offer "essential health benefits" (see the Health Policy Brief published on April 25, 2012, for more information). Exchanges also must collect and review health plans' rate and benefit information, regulate health plan marketing, assign quality ratings to plans, and maintain ongoing oversight of health plans in tandem with state insurance departments and federal regulators.

- **Consumer assistance.** Exchanges are required to offer in-person assistance, maintain a website and call center, conduct outreach and education, and operate a so-called Navigator program to help people and small employers understand their options. The exchange's website must help people shop for qualified health plans, compare premiums, calculate the applicable tax credit, and choose a plan.

- **Financial management.** Exchanges are required to perform a number of functions to oversee finances, including accounting, auditing, and reporting. They can collect premiums directly, serve as an electronic "pass-through" that channels premiums directly to health plans, or take no part in premium collection at all and have consumers transmit premiums directly to health plans. Exchanges are required to be financially self-supporting by January 2015 and can generate revenue to operate through user fees from health plans or other means.

EXCHANGE MODELS: The objective of the Affordable Care Act was to have each state set up its own exchange. As of the publication date of this brief, 18 states and the District of Columbia have notified the federal government that they will establish a state-based exchange. According to an analysis by the Kaiser Family Foundation, seven states are planning to form a partnership exchange with HHS, although more may come forward before a mid-February 2013 deadline. Under the partnership model, these states will perform plan management functions or consumer assistance, or both, while leaving other functions to the federal government (Exhibit 1).

At this point, it appears that 25 states will let HHS run an exchange for them (Exhibit 2). Exchanges in these states will be the federally facilitated exchanges—a bit of a misnomer, since in essence they will be run, not just "facilitated," by the federal government. What's more, the arrangementsare likely to vary. Depending on the agreements that individual states strike with the federal government, for example, federally facilitated exchanges will either determine whether people are eligible for Medicaid or CHIP, or assess their eligibility but allow states to make the final determination.

WHAT ARE THE ISSUES?

Establishment and operation of federally facilitated exchanges are likely to involve a number of complicated issues, as described below.

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States with a state-based exchange
Eighteen states and the District of Columbia have notified the federal government that they will establish a state-based exchange.

STATE AND FEDERAL REGULATION: A number of issues arise because of the existence of both state and federal regulation of health plans. The Affordable Care Act created a number of new federal regulations on health insurance and gave states funding to expand certain oversight responsibilities. Now, in operating the federally facilitated exchanges, the federal government will have to be cognizant of the variety of state insurance laws and regulations.

For example, the Affordable Care Act allows the exchanges to choose which qualified health plans may participate in the exchange and negotiate with them on price, or to allow all qualified health plans in the state to participate and at whatever price. In the federally facilitated exchange, however, HHS intends to allow all qualified health plans in a state to participate—a decision no doubt made out of both political and practical considerations. However, HHS has farmed out the responsibility for deciding which plans in a state are "qualified," selecting the National Committee for Quality Assurance and URAC, formerly known as the Utilization Review Accreditation Commission, two widely used accrediting organizations, to do the job.

ADVERSE SELECTION THREAT: States can choose whether they want to regulate health plans purchased through exchanges in the same way as health plans sold outside the exchanges. In the case of federally facilitated exchanges, the federal government doesn't have that option; it can only regulate the plans sold through the exchanges. There are concerns that this could lead to instability in the health insurance market.

For example, if health plans sold outside the exchange offer less-comprehensive coverage that is cheaper than that through federally facilitated exchanges, relatively healthy people may choose plans outside the exchange, while sicker people may opt for the broader exchange coverage, an outcome known as "adverse selection." Over time, the coverage sold through exchanges will thus become more expensive as the sicker population incurs more claims—deterring more people from buying coverage through the exchange. The Affordable Care Act creates a number of risk-adjustment mechanisms designed to minimize the effects of adverse selection, but these mechanisms may take a while to work. (See the Health Policy Brief published on August 30, 2012, for more information on risk adjustment.)

Finally, there are concerns about the sheer number of different state laws that the federally facilitated exchanges may try to comply with. HHS says that it will try to harmonize exchange policy with existing state programs and laws whenever possible. But because HHS will be operating the exchange in 25 states, it will be difficult for the agency to tailor an exchange to meet each state's unique insurance market needs.

IMPLICATIONS OF STATES NOT EXPANDING MEDICAID: The Supreme Court's June 2012 decision largely upholding the constitutionality of the Affordable Care Act nonetheless gave states the option of not expanding Medicaid as the law required (to individuals and families up to 138 percent of the federal poverty level). Many of the states that will not set up their own exchanges are also resisting expanding Medicaid. For example, of the 25 states that declined to set up exchanges and will now have federally facilitated exchanges, only four have announced that they will expand Medicaid.

In states that do not expand Medicaid coverage, people with incomes between 100 percent and 138 percent of the federal poverty level will be eligible to purchase coverage through exchanges. It is likely that many of these people will also be eligible for federal subsidies. Because subsidized private coverage through an exchange is likely to cost more than Med-

EXHIBIT 1

State and Federal Functions and Responsibilities in the Exchanges

State-based exchange	State partnership exchange	Federally facilitated exchange
State operates all exchange activities but may rely on HHS for these activities: •Premium tax credit and cost-sharing reduction determination •Exemptions •Risk-adjustment program •Reinsurance program	State operates activities for: •Plan management, or •Consumer assistance, or •Both States may perform these functions or rely on HHS: •Reinsurance program •Medicaid/CHIP eligibility determination or assessment	HHS operates; states may perform either or both of these activities: •Reinsurance program •Medicaid/CHIP eligibility determination or assessment

SOURCES Department of Health and Human Services, "Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges," August 13, 2012; HHS, "Guidance on the State Partnership Exchange," January 3, 2013. **NOTES** Decisions and protocols on Medicaid/CHIP eligibility are to be coordinated with the Center for Medicaid and CHIP Services. CHIP is Children's Health Insurance Program.

icaid coverage, total federal costs for covering these people are likely to be higher than if they were able to enroll in an expanded Medicaid program.

AVAILABILITY OF SUBSIDIES: There is a dispute over the legality of subsidies to low-income people and small businesses purchasing coverage through federally facilitated exchanges, and it may not become clear until courts issue rulings as to how well grounded in solid legal principles the dispute actually is.

Some who have long opposed the Affordable Care Act argue that the law's wording makes premium assistance tax credits available only to people who purchase coverage through state-based exchanges, not through federally facilitated exchanges. If this interpretation is found to be valid in court, it could leave the residents of states with partnership or federally facilitated exchanges ineligible for federal subsidies. The Internal Revenue Service has issued regulations stating that tax credits are available through all exchanges, regardless of how the exchange is administered.

MEDICAID AND CHURNING: Because their incomes can often fluctuate over the course of a year or more, lower-income people are likely to gain or lose eligibility for public programs. Thus, they are also likely to "churn" between Medicaid or CHIP coverage and the private health insurance coverage available through exchanges. (See the Health Policy Brief published on November 15, 2012, for more information on reducing churning between the exchanges and Medicaid.)

States can make this churning less disruptive by requiring the plans offered through its exchange and those offered under Medicaid and CHIP similar in terms of benefits and provider networks. States can even require Medicaid-managed care plans to participate in their state-based exchange as a condition of participating in Medicaid. Some states are exploring other ways to minimize disruption of coverage, for example, by offering "bridge" plans in their state-based exchanges. These are Medicaid-managed care plans that offer coverage only to people who move between Medicaid and the exchange. In addition, states can offer a premium assistance option in which Medicaid or CHIP funds are used to pay for a qualified plan in the exchange. This type of close collaboration between Medicaid and the exchange is much more difficult in a federally facilitated exchange, especially in states that oppose the law.

CONSUMER ASSISTANCE: Although HHS has issued a variety of regulations and guidance documents affecting federally facilitated exchanges, many states, insurers, and consumer advocates continue to have concerns. For example, the law requires exchanges to have "navigators" to help people and small businesses purchase insurance. These navigators must have experience working with small employers and consumers and be highly knowledgeable about local markets and plans. In a December 2012 guidance document, HHS said it will develop and administer a navigator training program starting in 2013 for the federally facilitated and partnership exchanges. However, HHS noted that the number of navigators working in in a federally facilitated exchange will depend on the availability of training grant funds in the federal budget as well as the number of applicants in each state.

FUNDING THE EXCHANGES: All state exchanges under the Affordable Care Act are to be financially self-sustaining by 2015. To fund the federally facilitated exchanges, HHS recently proposed assessing a 3.5 percent user fee on all insurance plan premiums sold through the exchanges. Here again, HHS will be at a disadvantage compared to state-run exchanges because states, if they choose, can assess user

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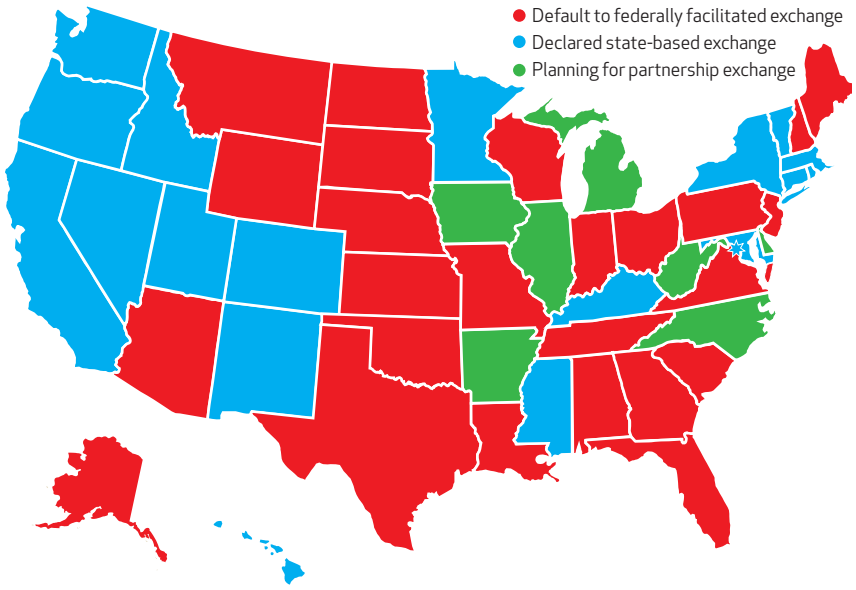
States with a partnership exchange
Seven states are planning to form a partnership exchange with HHS, although more may do so in the future.

EXHIBIT 2

State Action Toward Creating Health Insurance Exchanges



SOURCE Kaiser Family Foundation. **NOTES** Data accurate as of January 4, 2013. Mississippi's application for a state-based exchange was submitted by the state insurance commissioner but is being challenged by the governor. Ohio and South Dakota intend to retain control over plan management functions in the federally facilitated exchange in their states.

fees on all policies sold in the state, not just those sold through the exchanges.

WHAT'S NEXT?

Because many exchange-related deadlines set by the Affordable Care Act were pushed back following the November 2012 elections, much remains in flux. HHS continues to award grants to states to support exchanges, and it recently awarded $1.5 billion to 11 states to help support the establishment of state-based exchanges. Although states have deadlines to submit applications and blueprints for state-based and partnership exchanges, HHS has stated a willingness to continue working with states beyond those deadlines. HHS has also signaled that states will have until the end of 2014 to obtain and use "establishment" grants from the government, so it is possible that some states that initially decided on the partnership or federally facilitated model may ultimately replace those with a state exchange.

Clearly, HHS will continue to face challenges in planning and implementing federally facilitated exchanges ahead of the October 2013 open enrollment deadline. A separate set of challenges will arise in the creation of partnership exchanges, and there is also the possibility that a federal exchange will evolve, as authorized under the law. These issues will be explored in forthcoming Health Policy Briefs.■

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