NGA Center for BEST PRACTICES

Issue Brief

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State Perspectives on Insurance Exchanges: Implementing Health Reform in an Uncertain Environment

The three major components of the Patient Protection and Affordable Care Act of 2010 (ACA) — insurance reform, Medicaid expansions, and the establishment of health insurance exchanges — are primarily the states' responsibilities to implement; together they impose a daunting workload. Because insurance exchanges must be wholly created in a very short time period, their implementation presents unique challenges. Additionally, the requirements for interconnected, automated systems to determine Medicaid and subsidy eligibility, pose major challenges. Tight deadlines, severely strained budgets, and human resources shortages further complicate implementation in nearly every state.

For these and other reasons, states have had a wide range of responses to the ACA exchange requirements and subsequent regulations. Some states started planning state exchanges even before adoption of the Act and have a reasonable chance of being ready by the law's implementation on January 1, 2014 (assuming many of the questions raised below are answered in time). Others have thus far chosen not to deploy a state exchange and expect to have a federal exchange implemented in their state, as the law allows. The majority of states are somewhere in between. Of them, many prefer state-run exchanges but are unsure of the implications on state operations, regulation, and finances, and are somewhat daunted by the challenge of extremely complex implementation. All of the states have concerns.

The National Governors Association (NGA) hosted a two-day workshop entitled, "Timelines, State Options, and Federal Regulations" to assist states in considering the many decisions and tasks associated with the creation of insurance exchanges and related changes to Medicaid. More than 120 state officials from more than 40 states and territories participated, including cabinet secretaries, governors' representatives, Medicaid and insurance department leaders, and exchange governing board and staff members. This meeting was designed to allow and promote the exchange of information and experiences among the many participating states. Following a day-and-a-half of working with experts and sharing experiences, lessons, and dilemmas, the group met with a panel of representatives from the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Treasury to raise key issues and pose questions regarding the implementation of exchanges.

This summary is a reporting of the concerns voiced at the meeting, incorporating some of the recurring suggestions made by representatives that would allow their state to make informed critical decisions. Despite disparate views of exchanges and various steps of implementation, several major themes emerged from the discussions at the meeting:

- **A need for timely guidance**: Federal guidance has yet to be released or finalized on many issues, confronting states with a lack of clarity on many issues – a problem frequently compounded both by insufficient detail and efforts to preserve apparently broad flexibility;
- **Uncertain and challenging timelines**: For many states, the resulting uncertainty creates significant challenges in defining the "critical path" and meeting the associated deadlines necessary to establish exchanges and obtain required federal approvals;
- **A lack of clarity and detail**: In many states, legislators and governors require more clarity about the policy issues and operational details involved in creating a state-run insurance exchange, pursuing a hybrid or "partnership" model, or accepting a federal exchange;
- **Concerns about costs**: States need to understand the short and long-term costs of exchanges under the various scenarios, which have implications for how states seek to design them; and
- **Delegating discretion to states**: Many states suggest limiting directive federal guidance to those areas where the statute specifies "shall," leaving discretion to the states in all other areas involving exchange design and in interpretation of the statute.

Moving Forward Amidst Uncertainty

The ACA apparently intended to give states broad discretion in designing health insurance exchanges and their governance. States may choose to make existing entities such as insurance or Medicaid departments responsible for their exchanges; they may contract functions, such as information technology systems to private vendors; and some functions may potentially be operated in partnership with the federal government, such as eligibility determinations for federal tax subsidies. Because of the policy implications and operational complexity of decisions regarding delegating functions, implementing any of those strategies requires ample lead time for planning and procurement. Given that the final federal regulations specifying the policies governing those activities have not been finalized or, in important instances, proposed, states are operating in a highly uncertain environment with looming deadlines.

Timely implementation places states in a position of needing to make basic decisions about how they will establish and implement insurance exchanges on the basis of incomplete guidance and regulations. At the meeting, state officials shared a concern about the capacity of the vendor community to provide timely, effective solutions to the business challenges posed by ACA implementation, especially as timeframes become increasingly compressed. The substantial ambiguity involving core elements of exchange and Medicaid implementation, especially in light of the controversies associated with ACA, greatly complicates discussions about how or whether to proceed in some states.

Nonetheless, most states are actively working to chart a provisional course forward, so that they can be operationally ready for political decisions made by their governor or legislature. Many are moving forward on the assumption that if they do not, it will be impossible to meet ACA deadlines, which would lead to a federally operated exchange in their state.

Most states began planning shortly after the passage of ACA in early 2010 with steps such as analysis of their insurance markets and information technology needs. They have conducted extensive stakeholder outreach to inform health plans, providers, employers, consumers, and others about exchange

fundamentals and to solicit their suggestions and feedback. Some have developed detailed implementation plans with timetables for standing up their capacity to manage providers and plans in the exchanges; for training brokers, Navigator programs, and other consumer assistants; and for rolling out business processes for inter-agency coordination, meeting technology needs, and other vendor contracting.

Lack of Timely Guidance Creates Roadblocks to Moving Forward

Many challenges have emerged in the course of those undertakings, according to participants in the NGA meeting. Among the concerns heard:

- ACA implementation requires major changes in existing Medicaid eligibility systems, which need to operate seamlessly with the yet to be detailed federal data hub and exchange systems, providing real-time, online eligibility determinations (under significantly reformed Medicaid income, asset, and eligibility rules). The challenge of contracting for IT systems services is particularly acute and mission-critical for the establishment of exchanges. Vendor capacity and the IT workforce are strained, especially as system adoption among providers has increased as a result of economic stimulus subsidies. Some state representatives said vendors currently supplying states with Medicaid management information systems (MMIS) would be functionally able to meet exchange needs, but others said that MMIS vendors would not be able to take on expanded responsibilities. States also expressed concern that even in the best of circumstances the development of the information systems often takes longer and is more costly than anticipated. A number of states implementing MMIS changes agreed that the scheduled time to develop the necessary systems changes took 18 to 20 months after the issuance of an RFP, a step that in most cases has yet to be taken.

- Questions remain about whether a federal data hub currently under development will be ready by October 2013 to furnish the exchanges with real-time eligibility data such as income verification through planned links to the Internal Revenue Service and other federal agencies. Some unique data do not currently exist in a consistent, national repository. For that reason, there are significant concerns that the seamless, "no wrong door" eligibility and enrollment processes that offer consumers a single portal for eligibility determinations, applications for subsidies, and enrollment in plans, may not be logistically feasible.

- Retrospective reconciliation of inaccurate determinations of Medicaid and exchange plan subsidy eligibility could result in unwelcome surprises on consumers, exchanges, and Medicaid agencies. States expressed concerns about how the federal government would compute error rates and determine liability arising under the new approaches envisioned for on-line eligibility determinations, especially given substantial policy, operational, and systems uncertainties.

- Federal rules for the Basic Health Plan have not been issued, leaving states unclear as to where that option could fit in their exchange design plans. Because decisions have ramifications for

Medicaid and the size of the risk pool that participates in the exchange, many states said the lack of information on the Basic Health Plan was a major stumbling block for their planning process.

- Guidance on the essential health benefit package is pending, which may be an important consideration in deciding the type of purchasing model a state would elect. For many states, bills must be filed as early as November, making timely release of details on essential health benefits an imperative for creating legislative authority for an exchange in the upcoming session.

Lack of Clear Timelines Complicates Decisions

Many states have established exchange entities and applied for establishment grant funding, a process which entails the creation of work plans to guide progress. The details that must be spelled out in those plans underscore the extraordinary time pressures, both for states and the federal government. In many instances, the time available is less than the time normally required to procure major IT systems or amend Medicaid state plans. The shortened timelines and limited guidance currently available are increasingly affecting design and implementation decisions.

Procurement serves as an example. Time constraints weigh heavily on IT decisions for four reasons. First, IT systems design and development presupposes specifying *in advance* the policy requirements and resulting business processes. Second, the timelines for developing major systems typically requires years, in part because of public procurement rules designed to ensure fair and efficient expenditures of public monies. Third, the multiple new systems that are simultaneously being implemented require testing of both the individual systems and the interface of federal and state systems. States repeatedly cited concerns about the lack of sufficient capacity on the part of experienced vendors to meet the "peak load" demand for Medicaid and exchange systems development. Finally, experience suggests that systems contracts frequently underestimate costs and take longer than expected to complete.

States are considering a variety of strategies to deal with those challenges. One approach entails partnerships and outsourcing, allowing states to buy capabilities they feel they do not have time to build. Another potential strategy may involve bundling procurement needs into general or modular contracts, where vendors may bid on all or just parts of a request for proposals. States expressed interest in having the federal government designate a list of approved systems or vendors, which would allow a streamlined approval process for any state adopting these systems.

But those strategies pose risks of their own, potentially presenting accountability problems, timeline disruption, and contract management headaches. States are wary that accelerating the procurement process could be costly because hastily issued RFPs could leave out or result in mismanaged important details which take more time and money to fix on the back end. State representatives expressed hopes that HHS might still be able to make some products, such as risk adjustment and eligibility and IT systems available to states as modules at minimum cost and with ready availability.

Lack of Clear Guidance: Exchanges and Medicaid Programs

Alongside the considerable challenge of greatly expanding their Medicaid programs, states are also charged by the ACA with creating a single, seamless point of entry for all of the insurance affordability programs affected by the Act – Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Plan (where offered), and advanceable tax credits for individual and Small Business Health Options Program (SHOP) exchange enrollees.

Because income changes will create constant movement in and out of those programs, it is necessary to have well-developed systems with tight integration between them. As previously discussed, systems challenges for creating integrated enrollment platforms could tax vendor capabilities in some areas and test the agility of the states that are already in the midst of Medicaid systems redesign.

Some states expressed worry that commercial plans participating in exchanges may reimburse providers more generously than Medicaid. That would aggravate problems with access to care by higher paying exchange plans drawing providers away from Medicaid.

Several states cited the importance of having more leeway to initiate meaningful beneficiary cost sharing in Medicaid before 2014. Given the expected frequency of beneficiary shifting between Medicaid, CHIP, Basic Health Plans (where available), and exchange plans, additional cost sharing would smooth transitions and facilitate cost containment in the post-ACA world.

States highlighted the need for a simplified path to gain HHS approval of exchange and Medicaid plans than the current state plan amendment process, which can be time consuming at both the state and federal levels. Additionally, some expressed concern arising from the lack of policy and operational clarity about how a federal exchange would function. For example, states worry that if a federal exchange were the single point of entry to all the state's insurance affordability programs, they may lose control of their Medicaid program.

Lack of Clear Guidance: SHOP Exchanges and Small Businesses

Depending on the regulations, the structure of the SHOP exchanges could lend itself to use of defined contribution plans. The predictability of premiums under defined contributions plans have made them increasingly popular with small businesses, many of whose employees tend to be lower income workers potentially eligible for tax credits. The degree to which a defined contribution is compatible with the federal government's definition of affordable coverage is unclear, as is how eligibility for premium subsidies may be determined in that context.

Some states raised questions about the potential for discrepancies in the rules governing individual and SHOP exchanges, especially when aligning requirements for individuals and small business pursuing a defined contribution strategy. Many states commented that the attractiveness of the SHOP exchanges will ultimately depend on how well they control costs.

Lack of Clear Guidance: Exchanges and Impact on Insurance Markets

Most states report that they are undertaking efforts to understand the characteristics of their current individual and small group markets, as well as their uninsured population. After completing market assessments, they are analyzing the expected effects of ACA insurance reforms, which affect individual and small group plans operating inside and outside exchanges. The as yet unissued rules on essential health benefit plans have the potential to substantially change currently offered benefit plans, potentially resulting in price increases in many states. For some states, new community rating standards, which limit variation in premiums to a maximum of 3:1, represent a sharp departure from their current rules and could substantially change current pricing. Rate compression may occur even in states that already have some version of community rating in place. As a result, rates may increase for large segments of the population currently enrolled in individual and small group plans. In light of expected changes in many markets, states recognized the importance of creating robust communications and outreach plans to prepare the public.

A foundational decision facing states is whether they wish to create exchanges that operate, at one end of the spectrum, as an active purchaser (e.g., selectively contracting with a limited number of plans), or, at the other end of the spectrum, as a neutral market facilitator (e.g., a "Craig's List"). State preferences vary widely on this dimension, with some expecting to function as active purchasers, others as a neutral market facilitator, while some states are either undecided or expect to fall somewhere in the middle.

States may choose among tactics for qualifying plans to meet goals of promoting competition in the health insurance marketplace. Some states are looking at factors such as provider networks, IT capabilities, or readiness for payment innovation as criteria for participation. However, they also recognize the importance of carefully calibrating requirements to create viable markets.

Lack of Clear Guidance: Questions about Federal Role

State officials at the NGA meeting exhibited differing policy preferences on many issues, including fundamental choices such as whether to pursue a state-run exchange, a federal exchange, or a mixture of federal and state responsibilities. However, nearly every state raised questions about how the federal government will support the establishment and ongoing operation of exchanges.

For some states, having a detailed understanding of the proposed federal exchange would create a useful "straw man" that would facilitate finalizing policy choices by their legislatures or governors. Other states that had already finalized key policy decisions viewed having a detailed understanding of the federal exchange as helping inform their operational decisions and implementation strategy.

States interested in sharing the responsibilities of establishing and operating exchanges with the federal government in a partnership model are eager to learn which functions states will unquestionably need to retain, and which they may be able to share, such as premium aggregation and management of a coverage appeals process for public programs. For states that may ultimately need to have the federal government fully operate their exchange or exchanges, states have large questions about what responsibilities and costs they will be asked to bear.

Concerns about Costs – Importance of No Surprises

In an opening session, a speaker from HHS raised the possibility that states would have to pay for information provided through the federal data hub. Throughout the meeting, states frequently expressed concerns about the costs of establishing and operating exchanges.

Attendees articulated the importance of having clearly and immediately identified any areas where the federal government will impose costs on states of which they are not currently aware. It is critical to states that any fees associated with interfacing with the federal government be stated clearly upfront, from both policy and operational perspective.

Limit Requirements to Those Imposed by ACA, Delegating Discretion to States in All Other Areas

Many states requested that federal rules and guidance to be directive only in those instances where the statute itself was directive. Some states also requested the authority to exercise discretion when the statute delegated discretion to the Secretary of HHS.

States expressed a mixed view of federal efforts to articulate state flexibility in proposed rules. On the one hand, states appreciated having flexibility and not having unnecessary prescription. On the other hand, allowing for a range of potential options without providing a clear decision-making authority to states greatly complicates state-federal relations and state-level policy-making. Some states indicated that this flexibility without clear transfer of authority from the outside translates into uncertainty, resulting in implementation difficulties, delays, and increased costs.

Conclusion

The states and territories participating in the NGA meeting ranged from those that will rely on a federal exchange to those that will implement a state-run exchange. States also varied on whether they have already created exchanges or still require enabling legislation. Similarly, states ranged from those awarded Early IT Innovator grants to those that have rejected federal funds. Despite these differences, many of the challenges that state officials described were echoed throughout the meeting by the entire range of states participating.

As a response to the challenges described in this report, some state representatives expressed the view that states, given appropriate flexibility and guidance, may be able to meet most ACA requirements with existing authorities and current capabilities. How that flexibility is applied may be a major determinant to how states address the challenges of the next two years.

To make informed decisions, states need as much clarity as possible, including details about essential health benefit requirements and the design of the federal exchange, among other specifics that are currently unavailable. Moreover, there is deep concern that if deadlines for federal guidance issuance move further back, states will be unable to make further progress. Addressing the issues summarized under the five themes discussed in this report, in a timely manner, would significantly enhance the chances for success.