



**NEWS RELEASE**  
Embargoed for release:  
12:01 a.m. ET,  
Thursday, July 11, 2013

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## **NEW REPORT: MANY STATE HEALTH INSURANCE MARKETPLACES WILL EXCEED REQUIREMENTS FOR QUALITY REPORTING AND CHOICE FOR SMALL-BUSINESS EMPLOYEES**

### *State Exchanges Using Innovative Tactics to Create Competitive Markets and Give Consumers an Array of Plan Choices*

New York, NY, July 11, 2013—Many state-run health insurance marketplaces are poised, by 2014, to exceed federal quality-reporting requirements, offer small-business employees a choice of health plans that won't be available in states with federally run marketplaces until 2015, and promote a seamless "one-stop shop" for consumers to enroll in coverage, according to a new Commonwealth Fund report. In addition, many state-run exchanges, now referred to as marketplaces by the Department of Health and Human Services, will employ innovative strategies to provide consumers with a range of distinct plan choices exceeding the Affordable Care Act's minimum requirements.

The report, *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges*, looks at the 17 states that, along with the District of Columbia, have elected to run their own health insurance marketplaces. The marketplaces will begin to enroll consumers on October 1, 2013, for coverage beginning January 1, 2014. They are a key element of the Affordable Care Act, designed to remedy the major shortcomings of the current individual and small-business health insurance markets: high premiums, lack of health plan choice, inadequate health insurance coverage, and a complex purchasing process that leaves consumers in the dark about key features of the plans they are buying.

"The report shows that many states are testing innovations with their marketplaces aimed at improving the ability of individuals to buy health plans on their own and small businesses to offer coverage to their employees," said Sara Collins, Ph.D., vice president for affordable health insurance at The Commonwealth Fund. "Combined with new insurance market protections in the law, these approaches will encourage insurers to compete on value and better position consumers and small businesses to make informed choices."

The report's authors, Sarah Dash, Kevin Lucia, Katie Keith, and Christine Monahan of Georgetown University's Health Policy Institute, look at how the marketplaces are developing in

five key areas: structure and sustainability, fostering a competitive marketplace, providing meaningful consumer choice, improving options for small employers, and maximizing enrollment.

The researchers found that several states are using innovative tactics to improve consumers' experiences in the marketplaces, often going beyond the law's minimum requirements:

- **Reporting quality data:** Nine states—California, Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New York, Oregon, and Rhode Island—plan to display data on quality in their marketplaces in 2014. This is a full two years before the federal government requires such data to be displayed.
- **Promoting choice of plans:** Small-business employees in state-run marketplaces will have more choices sooner than required. Nearly every state-run Small Business Health Option (SHOP) marketplace will provide firms the ability to offer their employees a choice of more than one plan, starting in 2014. The federal government does not require this level of choice until 2015. In addition, eight states—Hawaii, Minnesota, Nevada, New York, Oregon, Rhode Island, Utah, and Vermont—will let employers offer workers the choice of any plan in the SHOP marketplace.
- **Promoting insurer participation:** Eight states—Colorado, Connecticut, Maryland, Massachusetts, New Mexico, New York, Oregon, and Vermont—and the District of Columbia have adopted formal rules to require or incentivize insurers to participate in the marketplaces. For example, Colorado, New Mexico, New York, and Oregon have established “waiting periods” prohibiting insurers from entering the marketplace for up to two years if they don't participate in 2014.
- **Reducing adverse selection:** Many states have taken steps beyond the Affordable Care Act requirements to encourage a balance of healthy and sicker people to enroll in the marketplaces, so that participating plans do not end up insuring mostly unhealthy people with high medical costs. California, for example, requires insurers that participate in the marketplace to offer the same coverage to consumers outside the marketplace. In Oregon and Washington, insurers will not be able to sell catastrophic coverage—an option available only to young adults and individuals otherwise unable to afford coverage—outside of the marketplace. It is hoped that this will encourage young, healthy enrollees to buy insurance.
- **Balancing choice with ease of comparing plans:** Insurance carriers may sell health plans at five different “metal tiers” of coverage in the insurance exchanges: bronze, silver, gold, platinum, and a catastrophic plan for young adults and people who cannot find an affordable health plan. While the law requires insurers to offer health plans at a minimum at the silver and gold levels, eight states—California, Connecticut, Kentucky,

Massachusetts, Maryland, New York, Oregon, and Vermont—and the District of Columbia, require insurers to sell plans at additional coverage levels.

But to ensure that consumers have a manageable number of choices, eight states limit the number of plans each insurer can sell at each metal tier in the marketplace. For example, in Nevada, insurers will only be allowed to offer up to five plans at each coverage level. In Kentucky, they will be able to offer up to four.

To further simplify consumer choice, six states—California, Connecticut, Massachusetts, New York, Oregon, and Vermont—require insurers to offer some standardized plans in the exchange, with additional specifications for plan benefits and cost-sharing.

- **Streamlining eligibility and enrollment systems:** Fourteen states—California, Colorado, Connecticut, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont, and Washington—and the District of Columbia used federal funds to adopt a one-stop-shop computer system that will be able to determine what kind of coverage potential enrollees are eligible for, whether marketplace coverage, Medicaid, or the Children’s Health Insurance Program.
- **Improving enrollment assistance:** In addition to allowing agents and brokers to sell coverage through the exchange, all states are expected to establish programs to educate consumers and help them sign up for health coverage through the exchanges. These programs include either “navigators” or “in-person assisters.” Thirteen states and the District of Columbia will have both in-person assistors and navigators; the remaining states either plan to operate only a navigator program or are still finalizing their approach.

The report highlights the need for a continued focus on the financial soundness of the marketplaces, which must be self-sustaining by 2015. Currently, seven states and the District of Columbia have yet to finalize their approach to long-term revenue. Ten state marketplaces—California, Colorado, Connecticut, Idaho, Maryland, Minnesota, Nevada, Oregon, Vermont, and Utah—have plans in place to ensure there are long-term, sustainable revenue sources. Of these states, six—California, Colorado, Idaho, Minnesota, Nevada, and Oregon—will fund their marketplaces by assessing insurers that offer coverage in the marketplace while Connecticut will assess all insurers in the individual and small-group markets regardless of whether they participate in the marketplace. Maryland, Vermont, and Utah will use existing state funds or revenue sources.

The authors conclude that the design of the state marketplaces will likely affect how well they function, how many people enroll, and how much the offered plans cost. It will be crucial, they say, that states pay attention to the real-world outcomes of their policy decisions and make adjustments as needed. In addition, the experience of these states will inform future exchange implementation efforts, at both the federal and state levels. “States have made remarkable progress to date and capitalized on the flexibility of the Affordable Care Act. We hope that an

understanding of their design decisions will be valuable for policymakers as additional states consider how to transition to a state-based exchange in the future,” Dash said.

“The level of innovation many states have displayed in creating their health insurance marketplaces is an encouraging sign that states are working to ensure that consumers will be able to get affordable, comprehensive coverage in their state exchange,” said Commonwealth Fund president David Blumenthal, M.D. “It will be critical for states to monitor their success and amend their design as needed to ensure consumers have the best possible experience.”

### **METHODOLOGY**

The report findings are based on ongoing monitoring of exchange decisions in 17 states and the District of Columbia between March 23, 2010, and May 31, 2013. The report does not include a review of state actions or decisions in the 33 states that defaulted to a federally facilitated exchange. The findings reflect analysis of state laws, regulations, subregulatory guidance, press releases, declaration letters, blueprint submissions, board and meeting minutes, media reports, other public information related to exchange development, and interviews with state regulators. The resulting assessments of state action were confirmed by state officials.

The data presented are limited to state decisions for the initial year of operation of the exchange. Because states may reevaluate these decisions in response to changes in their marketplace or the experience of other states, these data should not be construed as representing a final or long-term decision, with many states reporting that design decisions will be reconsidered as needed.

**The Commonwealth Fund is a private foundation supporting independent research on health policy reform and a high performance health system.**