IMPLEMENTING THE AFFORDABLE CARE ACT:

KEY DESIGN DECISIONS FOR STATE-BASED EXCHANGES

Sarah Dash, Kevin W. Lucia, Katie Keith, and Christine Monahan
Georgetown University

JULY 2013

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Abstract: The Affordable Care Act requires the establishment of new health insurance marketplaces—known as exchanges—in every state by October 1, 2013. This report examines key design decisions made by the 17 states and the District of Columbia that chose to establish a state-based exchange. The analysis finds that states made significant progress in structuring their exchanges, with states varying in their design decisions. Many states expect to exceed some federal requirements—to collect and display quality data, for instance—for 2014. These findings suggest that states capitalized on the flexibility provided by the Affordable Care Act to tailor their exchanges to their unique needs and made decisions with an eye towards outcomes, such as enrollment, consumer experience, and sustainability. These findings also suggest that states' initial decisions will inform future exchange implementation and that states will adjust their decisions while continuing to adopt innovative approaches to accomplish policy goals.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts. Commonwealth Fund pub. 1696.

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ACKNOWLEDGMENTS

The authors thank the state exchange and insurance department officials who participated in this study by reviewing our findings, sharing their insights, and contributing thoughtful comments. We are also grateful for the thorough review and incisive comments by Tim Jost, Sara Rosenbaum, Sonya Schwartz, Jennifer Tolbert, and Dave Chandra.

Editorial support was provided by Deborah Lorber.

EXECUTIVE SUMMARY

The Affordable Care Act requires the establishment of new health insurance marketplaces—known as individual exchanges and Small Business Health Options (SHOP) exchanges—in each state. States must make complex decisions about how to design their exchanges in ways that reflect the unique needs of their consumers and insurance market. This report examines key structural, operational, and policy decisions made by 17 states and the District of Columbia that chose to establish a state-based exchange for 2014.

States Structured Exchanges to Reflect Needs and Capabilities

Ten states and the District of Columbia established a quasi-governmental entity to govern the exchange, with the others choosing private nonprofits or state agencies to house the exchange. Most exchanges can write rules to govern their operations. Seven states and the District of Columbia remain undecided on their long-term revenue source; most of the remaining states will assess insurers that offer coverage in the exchanges. State officials reported that decisions in these areas often reflected compressed timelines, political realities, and the state's long-term vision for the exchange.

States Adopted Formal and Informal Mechanisms to Foster a Competitive Marketplace

More than half of states selectively contracted with insurers or managed plan offerings. Ten states and the District of Columbia adopted formal requirements regarding exchange participation or alignment of coverage options inside and outside the exchange. These mechanisms include establishing a single marketplace, prohibiting insurers from entering the exchange if the insurer did not participate in 2014, and requiring insurers to offer the same coverage inside and outside the exchange. States also negotiated informally with insurers to encourage participation and aligned exchange standards with existing market standards to maintain a level playing field. State officials adopted these approaches to spur competition and limit adverse selection within and against the exchange.

States Limited or Standardized Plans and Emphasized Quality in Consumer Choice

Nine states limited the number of plans per insurer or required insurers to offer some standardized plans in the exchange. Of the remaining states, only two and the District of Columbia adopted a meaningful difference standard of review to ensure that plans are substantially distinct from other plans offered in the same market by the same insurer. State officials reported that these limits were designed to give consumers a manageable number of choices while also retaining flexibility for insurers. Despite federal delays in quality requirements until 2016, nine states plan to display quality data on the exchange in 2014 and 10 states intend to develop quality rating systems ahead of federal guidance. State officials expect quality improvement and innovation to be an ongoing priority for exchanges.

States Designed SHOP Exchanges to Minimize Market Disruption and Improve Choice

Every state defined "small employer" as 50 or fewer full-time employees; only three chose to merge the individual and small-group markets. Despite a delay in federal requirements, nearly all SHOP exchanges are expected to offer "employee choice" options that give employees a choice of more than one plan, and eight states provided maximum flexibility by allowing employers to give employees the choice of any plan on the SHOP exchange. State officials emphasized the importance of employee choice models for ensuring that the SHOP exchange is attractive to small employers and sought to balance the goal of meaningful employee choice with concerns about adverse selection.

States Promoted Consumer Assistance via Navigators, In-Person Assisters, and Producers

Thirteen states and the District of Columbia established both a navigator and in-person assistance

program while two states will operate only a navigator program for 2014. An additional two states have not yet finalized their approach and continue to consider whether their exchanges will operate navigator and/or in-person assistance programs for 2014. To initially fund navigator programs, nine exchanges planned to use state funds or private grants until exchange funds become available. Every exchange allowed producers—otherwise known as or agents and brokers—to help consumers enroll through the exchange. While some exchanges planned to set and pay commissions, most allowed insurers to set producer compensation. State officials reported that navigators, in-person assisters, and producers will be critical to exchange success in 2014.

Looking Forward

While states with federally facilitated exchanges can influence the way some exchange functions are performed, states operating their own exchanges had significant flexibility in designing their exchanges to meet state needs. Overall, states made significant progress in structuring and operationalizing their exchanges, and made design decisions with an eye toward minimizing market disruption, promoting exchange viability, and providing value for consumers.

States also built on—and, in some areas, exceeded—minimum federal requirements to accomplish policy objectives. With much at stake in 2014, these design decisions are expected to affect critical outcomes, such as enrollment, cost, consumer experience, and sustainability. While states made significant progress, many will continue to adjust their design decisions in response to implementation successes and challenges. Continued monitoring and evaluation of exchange design decisions will be critical to inform future exchange implementation.

IMPLEMENTING THE AFFORDABLE CARE ACT: KEY DESIGN DECISIONS FOR STATE-BASED EXCHANGES

INTRODUCTION

The Affordable Care Act introduces significant reforms designed to improve the accessibility, adequacy, and affordability of private health insurance. Among these, the law requires the establishment of new marketplaces—known as individual exchanges and Small Business Health Options (SHOP) exchanges—in each state.[1]

Exchanges are intended to address the current barriers to affordable and adequate health coverage in the individual and small-group markets: high premiums, limited competition, and limited transparency about coverage options.[2] To remedy these flaws, individual exchanges are expected to provide a seamless, one-stop experience for individuals to: apply for federal premium tax credits and cost-sharing subsidies; compare the cost, quality, and value of private health insurance; and ultimately purchase private coverage or enroll in public coverage.[3] Similarly, SHOP exchanges are designed to aggregate the purchasing power of small businesses, enable employers and employees to compare a wider range of coverage choices, and reduce administrative costs.[4]

Under the Affordable Care Act, states can choose to establish a state-based exchange or default to a federally facilitated exchange.[5] To date, 17 states and the District of Columbia chose to establish a state-based exchange, while 33 states defaulted to exchanges run by the federal government with varying degrees of state participation.[6] Throughout this report, we refer to Idaho, New Mexico, and Utah as having state-based exchanges. However, during the initial implementation year, Idaho and New Mexico will use the federal exchange platform to perform some core functions, such as eligibility and enrollment, as they build their own systems, while Utah will operate a state-based SHOP exchange and have the federal government operate the individual exchange.[7]

Each exchange must perform critical tasks in four core functional areas: plan management, financial management, eligibility and enrollment, and consumer

EXHIBIT 1. KEY DESIGN DECISIONS FOR STATE-BASED EXCHANGES

Categories	Key design decisions
Structuring a sustainable exchange	Governance Rulemaking authority Eligibility and enrollment functions Financing
Fostering a competitive marketplace	Plan selection approach Plan participation requirements Waiting periods to encourage plan participation Alignment of standards inside and outside the exchange Required coverage levels
Promoting meaningful consumer choices	Limits on the number of plans inside the exchange Standardization of plans Meaningful difference standards Quality reporting requirements
Improving options for small employers	Small employer definition Merging the individual and small-group markets Employer/employee choice models Minimum participation and contribution requirements
Maximizing enrollment	Navigator and in-person assistance programs Producer participation requirements Affordability initiatives

assistance and outreach.[8] To better understand the impact of these areas on the availability, affordability, and adequacy of private health insurance, we categorized the most critical exchange design decisions into five domains (Exhibit 1). Although terms are defined in the text, we also include a glossary that defines key terms as they are used in this report (Appendix A).

FINDINGS

States Structured Exchanges to Reflect Needs and Capabilities

States have significant flexibility in designing their exchanges, including in critical operational areas such as governance, eligibility and enrollment functions, and long-term financing. State decisions in these areas often reflected compressed timelines, political realities, and each state's long-term vision for the exchange.

Most States Established a Quasi-Governmental Entity

Governance can have a significant impact on an exchange's ability to make binding decisions, receive and spend resources, and coordinate with other agencies.[9] In 10 states and the District of Columbia, the exchange will be operated by a quasi-governmental entity, which is typically an independent public agency with a governing board or, as in Colorado and New Mexico, a public nonprofit (Exhibit 2). In contrast, the exchanges in Kentucky, New York, Rhode Island, Utah, and Vermont sit within state agencies and do not have governing boards with decision-making authority; many of these exchanges instead consult with advisory boards. Most but not all exchanges can write regulations to govern their operations. However, even those exchanges with rulemaking authority have had to wait for their state's legislature to develop or approve some design decisions, such as the exchange's long-term financing mechanisms.

States Capitalized on Federal Funds to Adopt Streamlined Eligibility and Enrollment Systems

To help exchanges serve as "one-stop shops" for consumers, federal funding is available to states to upgrade and streamline exchange and Medicaid eligibility and enrollment systems to meet minimum federal specifications.[10] All but three states—Idaho, New Mexico, and Utah—are developing IT systems that house and execute the eligibility determination rules for exchange coverage, federal premium tax credits and cost-sharing subsidies, Medicaid, and the Children's Health Insurance program (CHIP) in 2014 (Exhibit 2).[11]

To meet federal specifications, states must develop a "single rules engine" to calculate an individual's modified adjusted gross income (MAGI). After conducting this calculation, the state has flexibility in how it proceeds with eligibility determinations. While some states are relying on communication between

EXHIBIT 2. STATE STRUCTURAL AND OPERATIONAL DECISIONS, AS OF MAY 31, 2013*

State	Type of entity	Rulemaking authority	State IT system will conduct eligibility determinations for exchange, Medicaid, and CHIP
FFE	*N/A*	*N/A*	No[1,2]
CA	Quasi-governmental	Yes	Yes
CO	Quasi-governmental	No	Yes[1]
CT	Quasi-governmental	Yes	Yes
DC	Quasi-governmental	Yes	Yes
HI	Private nonprofit	Yes	Yes
ID	Quasi-governmental	No	No[1,2]
KY	Existing state agency	Yes	Yes
MD	Quasi-governmental	Yes	Yes[1]
MA	Quasi-governmental	Yes	Yes
MN	Quasi-governmental	Yes	Yes
NV	New state agency	Yes	Yes
NM	Quasi-governmental	No	No[1,2]
NY	Existing state agency	Yes	Yes[1]
OR	Quasi-governmental	Yes	Yes[1]
RI	Existing state agency	Yes	Yes
UT	Existing state agency	No	No[1,2]
VT	Existing state agency	Yes	Yes
WA	Quasi-governmental	No	Yes[1]

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.
FFE = federally facilitated exchange.
[1] The exchange plans to rely on the federal system to make the final eligibility determination for exemptions from the individual mandate.
[2] The exchange plans to rely on the federal system to make the final eligibility determination for the payment of premium tax credits and cost-sharing subsidies through the exchange.

the exchange and other state eligibility engines—such as the databases that determine if individuals are eligible for programs like Medicaid and CHIP— to make such determinations, many states are building a single, consolidated system to determine eligibility for exchange coverage, Medicaid, or CHIP. Most of these single, streamlined systems will make final determinations of eligibility for Medicaid or CHIP.[12] In contrast, the exchange system in California expects to assess a consumer's eligibility for Medicaid or CHIP but then transmit this information to a separate agency for a final determination.[13]

Exchange officials in many states hope to incorporate eligibility determinations for other programs, such as the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program) in the future. State officials reported that a streamlined system will be critical to maximizing administrative efficiencies and consumer experience.

Many States Undecided on Long-Term Revenue Sources for the Exchange

Despite significant federal funding for states to establish exchanges, the Affordable Care Act requires exchanges to be self-sustaining by 2015.[14] Seven states and the District of Columbia, however, have not finalized their long-term revenue strategies (Exhibit 3). Of these eight, some are awaiting legislative action while others are considering how and whether to use existing funding mechanisms. State officials continue to consider the added cost to consumers of any new fees and the need to maintain similar costs inside and outside the exchange.

Six states—California, Colorado, Idaho, Minnesota, Nevada, and Oregon—will assess only those insurers that offer coverage in the exchange while Connecticut will assess all insurers in the individual and small-group markets regardless of whether they participate in the exchange. Others will use financing mechanisms that predate the exchange: Maryland, for example, will reallocate a portion of an existing premium tax.[15] Some states plan to use multiple revenue mechanisms. Colorado, for example, will initially rely on multiple sources of funding, including high-risk pool funds and an unclaimed property tax fund; Nevada plans to generate additional revenue by allowing organizations that meet certain requirements to advertise on the exchange's website.[16]

EXHIBIT 3. LONG-TERM EXCHANGE FINANCING MECHANISMS, AS OF MAY 31, 2013*

Long-term revenue source to support the exchange	States
Assessment on insurers offering coverage in the individual and small-group markets	CA, CO, CT[1], ID, MN, NV, OR
Preexisting state assessment or premium tax	MD, VT, UT[2]
Undecided on long-term revenue source	DC, HI, KY, MA[3], NY, NM, RI, WA

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.
[1] In Connecticut, the exchange will be funded through an assessment that applies to all insurers in the individual and small-group markets, both inside and outside the exchange.
[2] In Utah, the federal government will collect an assessment on insurers for the individual exchange. The SHOP exchange will be funded through state appropriations and a monthly charge to employees enrolled through the exchange.
[3] In Massachusetts, the exchange has historically been funded through state appropriations and by charging an administrative fee on insurers that participate in the exchange; however, future long-term financing mechanisms remain undecided.

States Adopted Formal and Informal Mechanisms to Foster a Competitive Marketplace

States had flexibility in adopting strategies to encourage insurers to offer plans in the exchange and foster a competitive marketplace to bring better value to consumers. More than half of states selectively contracted with insurers or managed plan offerings. Few states required insurers to participate in the exchange, although most adopted formal requirements to provide incentives for participation or to align their markets. States also noted the importance of informal negotiation with insurers to ensure exchange participation and promote a level playing field.

More Than Half of States Selectively Contracted or Managed Plan Choices

States have significant flexibility in designing their certification criteria for the exchange and can be selective about the plans they allow to be offered on the

EXHIBIT 4. STATE APPROACHES TO SELECTION OF EXCHANGE PLANS, AS OF MAY 31, 2013*

Plan selection approach	Definition	States
Selective contractor	Contracts only with insurers that advance exchange goals and may manage plan choices through limits on the number or type of plans that an insurer can offer.	CA, MA, RI, VT
Market organizer	Manages plan choices through limits on the number or type of plans that an insurer can offer but does not selectively contract with insurers.	CT, KY, MD, NV, NY, OR
Clearinghouse	Allows all plans meeting minimum criteria to participate on the exchange; does not selectively contract with insurers or manage plan choices.	CO, DC, HI, ID, MN, NM, UT, WA

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years. The federally facilitated exchange will operate as a clearinghouse in 2014.

exchange. State exchanges can operate as a "clearinghouse"—that is, the state would certify all plans that meet minimum criteria to participate in the exchange. Alternatively, a state can act as a "selective contractor" and choose to contract only with insurers that advance overarching exchange goals.[17] Even if an exchange does not selectively contract with insurers, it can act as a "market organizer" and adopt additional requirements to manage plan choices by limiting the number or types of plans that an insurer can offer.

Four states—California, Massachusetts, Rhode Island, and Vermont—chose to operate their exchanges as selective contractors, while six chose to operate as market organizers (Exhibit 4). In California, for example, the exchange evaluated plans based on factors such as affordability, access to quality care, and efforts to reduce health disparities.[18] The remaining seven states and the District of Columbia will operate as clearinghouses, but some states may transition to different models after 2014. For example, Maryland and Minnesota have the authority to adopt a selective contractor model in future years.[19]

States Adopted Formal Requirements to Promote Insurer Participation and Align Their Markets

Ten states and the District of Columbia adopted formal requirements regarding exchange participation or market alignment (Exhibit 5). State officials adopted these requirements to facilitate robust competition among insurers and to limit adverse selection within and against the exchange.

Three states and the District of Columbia formally required insurers to offer coverage in the exchange and adopted varied approaches in doing so. Maryland, for example, was the only state to explicitly require certain insurers to participate in the exchange, while Massachusetts requires insurers to apply to offer coverage in response to a solicitation and then selects plans to be offered on the exchange.[20] The District of Columbia and Vermont required all individual and small-group coverage to be sold through a single marketplace.[21]

Five states sought to provide incentives for plans to enter and remain in the exchange by establishing "waiting periods" for entry if an insurer failed to participate in 2014 or voluntarily withdraws from the exchange. For example, New York will not allow insurers that did not offer coverage on the exchange in 2014 to participate until 2016 unless doing so is determined to be in the best interest of consumers.[22] California—while not imposing formal waiting periods—planned to limit opportunities for insurers not participating in 2014 to enter the exchange in 2015, with the exception of Medicaid plans.[23]

Five states sought to reduce adverse selection—the disproportionate enrollment of individuals likely to incur high medical costs—by requiring insurers to offer similar coverage inside and outside the exchange. California, for example, required all coverage offered inside the exchange to also be offered outside the exchange.[24] Some states also prohibited or required the sale of certain plans outside the exchange, even if an

insurer is not participating in the exchange. For example, Oregon and Washington prohibited insurers from offering catastrophic coverage—which is less comprehensive coverage than bronze coverage and is only available to young adults and individuals otherwise unable to afford coverage—outside the exchange.[25] By limiting catastrophic coverage to the exchange, these states hope to encourage the enrollment of young adults and limit adverse selection against the exchange. Washington similarly prohibited insurers from offering only bronze coverage outside the exchange; instead, insurers that offer bronze coverage must also offer silver and gold coverage.[26]

States also established requirements for insurers to offer a range of coverage levels within the exchange. While the Affordable Care Act requires insurers that participate in the exchange to offer at least silver and gold plans,[27] eight states and the District of Columbia required insurers to offer plans at additional coverage levels (Exhibit 6). States reported doing so to ensure that coverage was available at most metal tiers and to limit adverse selection within the exchange.

States Adopted Informal Mechanisms to Promote Insurer Participation in the Exchange

Officials also reported using informal mechanisms to foster insurer participation and promote market alignment. Many states noted the importance of maximizing exchange participation by minimizing the requirements on insurers. Some states negotiated with insurers directly to balance the need for meaningful protections with the importance of participation.

Other mechanisms to promote participation included aligning exchange standards with the state's existing insurance laws or coordinating with the state's insurance department. Such strategies help ensure that insurers in the exchange did not face dramatically different requirements than insurers outside the exchange.

EXHIBIT 5. FORMAL EFFORTS TO PROMOTE PARTICIPATION AND MARKET ALIGNMENT, AS OF MAY 31, 2013*

Type of decision	Description	State
Requiring insurers to participate in the exchange	State required certain insurers that offer coverage in the individual or small-group markets to participate in the exchange or submit a bid to participate in the exchange.	MA[1], MD[2]
	State established a single marketplace where all individual and small-group coverage must be sold through the exchange.	DC[3], VT
Encouraging insurers to participate in the exchange	State prohibited an insurer from entering the exchange for up to two years if the insurer did not participate in 2014.	CO, NM, NY, OR
	State prohibited an insurer from re-entering the exchange for two years if the insurer voluntarily ceases to participate in the exchange.	CO, CT
Aligning coverage options inside and outside the exchange	State required exchange insurers to also offer certain coverage outside the exchange.	CA[4], MA[5], MD[6]
	State required exchange insurers that offer certain plans outside the exchange to also offer the same or similar coverage inside the exchange.	MD[6], MN[7], NY[8]

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.

[1] In Massachusetts, the exchange requires insurers that cover 5,000 or more lives to respond annually to a solicitation for fully insured product proposals. It then selects plans from these solicitations to be sold in the exchange.

[2] In Maryland, insurers that offer individual or small-group coverage must also offer coverage in the exchange, with exemptions for insurers that do not meet a specified revenue threshold or those that offer only student health plans.

[3] In the District of Columbia, the exchange board approved a strategy that would establish a single marketplace for all individual coverage in 2014 with a transition period for some small-group coverage through 2015.

[4] In California, insurers that participate in the exchange and sell any plans outside of the exchange must offer all exchange plans outside the exchange.

[5] In Massachusetts, all plans offered in the exchange must also be offered outside the exchange, except for subsidized "wrap" plans, which are available outside the exchange but without the subsidy.

[6] In Maryland, insurers that offer coverage inside and outside the exchange must also offer a silver and gold plan outside the exchange, and insurers that offer catastrophic plans outside the exchange must also offer a catastrophic plan in the exchange.

[7] In Minnesota, insurers that participate in the exchange that offer coverage outside the exchange must offer plans at the same metal tier and for each service area inside the exchange as are offered outside the exchange.

[8] In New York, insurers that participate in the exchange that offer out-of-network products outside the exchange must also offer an out-of-network product inside the exchange for the same county and market.

EXHIBIT 6. MINIMUM COVERAGE LEVEL REQUIREMENTS IN THE EXCHANGE, AS OF MAY 31, 2013*

Number of minimum levels required	Description	State
5	Insurers in the exchange must propose or offer all five coverage levels: catastrophic, bronze, silver, gold, and platinum coverage.	CA, MA[1], NY[2]
4	Insurers in the exchange must offer at least bronze, silver, gold, and platinum coverage.	VT
3	Insurers in the exchange must offer at least bronze, silver, and gold coverage.	CT, DC, MD, OR
3	Insurers in the exchange must offer at least catastrophic, silver, and gold coverage.	KY

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years. The Affordable Care Act requires insurers that participate in the exchange to offer at least silver and gold coverage. Note that Hawaii has additional requirements with respect to the Prepaid Health Care Act.

[1] In Massachusetts, insurers may request, and subsequently exercise, the option to withdraw their proposed catastrophic plan should the exchange receive a sufficient number of qualifying catastrophic plans per service area from insurers wishing to make such plans available.

[2] In New York, if the Department of Health determines there is adequate catastrophic coverage in a particular county, the exchange may allow insurers in the same county the option of not offering the required catastrophic plan.

For example, many exchanges deferred to existing state standards on network adequacy—standards used to ensure that plans include a sufficient number and type of health care providers—and relied on their insurance department to review insurance rates. However, a few exchanges expect to negotiate rates directly with insurers or augment the department's review by, for example, conducting an additional review of rates.[28]

States Limited or Standardized Plans and Emphasized Quality in Consumer Choice

States also took steps to allow consumers to make meaningful comparisons between plans by limiting the number of plans that each insurer can offer in the exchange, standardizing some of the plans offered, and ensuring that the differences between plans are meaningful. States also implemented quality requirements even though not required to do so until 2016.

Nine States Chose to Limit or Standardize Plans

Consistent with research that shows that consumers have difficulty identifying important distinctions among health insurance plans when faced with many similar choices,[29] states sought to balance the need for sufficient choice with the risk of overwhelming consumers. To do so, states limited the number of plans that each insurer can offer in the exchange, standardized the plans offered, or adopted a standard to ensure that differences between plans are meaningful. Eight states limited the number of plans that each insurer can offer (Exhibit 7). Five of these states, as well as California, also required insurers to offer some standardized plans in the exchange. Of the remaining eight states and the District of Columbia—which neither limited the number of plans nor required standardized plans—only Colorado, the District of Columbia, and Utah adopted a "meaningful difference" standard to ensure that the plans offered on the exchange by the same insurer have substantive distinctions between benefit design features, such as cost-sharing levels and benefit limits.

Eight states—Connecticut, Kentucky, Maryland, Massachusetts, Nevada, New York, Oregon, and Vermont—limited the number of plans that each insurer can offer or propose on each metal tier. For example, Nevada limited insurers to five plans in each metal tier per service area while Kentucky opted for no more than four plans per metal tier.[30] State officials reported that limiting the number of plans gives consumers a manageable number of choices while retaining flexibility for insurers. Other states reported "soft limits" by encouraging insurers to offer fewer plans.

Six states—California, Connecticut, Massachusetts, New York, Oregon, and Vermont—required insurers to offer standardized plans in the exchange. Plan standardization typically takes the form of requiring similar benefits and cost-sharing across

EXHIBIT 7. STATE DECISIONS TO LIMIT OR STANDARDIZE PLANS AND PROMOTE QUALITY, AS OF MAY 31, 2013*

State	Limited the number of plans per insurer	Required some standardized plans	Adopted a meaningful difference standard	Required display of quality data
FFE	—	—	*X*	*X*[1]
CA	—	X	X	X
CO	—	—	X[2]	X
CT	X	X	X	X
DC	—	—	X	—
HI	—	—	—	—
ID	—	—	—	—
KY	X	—	—	—
MD	X	—	—	X
MA	X	X	X	X
MN	—	—	—	X
NV	X	—	X	TBD
NM	—	—	—	—[3]
NY	X	X	—	X
OR	X	X	—	X
RI	—	—	—	X
UT	—	—	X	—[4]
VT	X	X	X	—[4]
WA	—	—	—	—[3]

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.
FFE = federally facilitated exchange.
[1] Prior to 2016, federally facilitated exchanges will only display existing Consumer Assessments of Healthcare Providers and Systems indicators. States may also request the exchange to display a link to existing state quality data.
[2] In Colorado, the Department of Insurance will apply a meaningful difference standard to individual and small-group plans offered both on and off the exchange.
[3] New Mexico and Washington will not publicly report quality information during the initial open enrollment period; however, they expect to begin collecting this information from health insurers in 2014.
[4] In Utah and Vermont, the exchange will include a link to existing quality reports but will not incorporate or otherwise display this information into the exchange for 2014.

or within each metal tier.[31] For 2014, the number of standardized plan designs ranges from three plans in Oregon to 17 in California.[32] While insurers may also offer nonstandardized plans in these states, all states except California explicitly limited the number of nonstandardized plans per insurer.[33] Other states may require some standardized plans in the future; the District of Columbia intends to do so for 2015.[34]

To prevent insurers from offering an overwhelming number of similar plans and to give consumers meaningful distinctions between plans, seven states and the District of Columbia adopted a "meaningful difference" standard (Exhibit 7). For example, in evaluating plans to ensure a meaningful difference, Connecticut plans to consider factors such as differences in the amount of out-of-pocket costs that consumers face for medical and pharmacy services.[35] Ten states did not adopt such a standard. Of these 10 states, six did not adopt any of the three tools (i.e., limiting the number of plans insurers may offer in the exchange, requiring some standardized plans, or adopting a meaningful difference standard), in part because state officials were concerned that doing so would negatively impact insurers' participation in the exchanges.

Many States Proceeded with Quality Requirements Ahead of Federal Guidance

To provide consumers with comparable information on health plan quality and value, the Affordable Care Act requires exchanges to collect and display quality

ratings and data, among other measures.[36] This requirement does not go into effect until 2016;[37] however, many states planned to display quality measures for 2014 (Exhibit 7). State officials reported that quality improvement and innovation will be an ongoing priority for exchanges.

Nine states—California, Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New York, Oregon, and Rhode Island—plan to display quality data on their exchanges in 2014. Most plan to display national quality measures while some states are developing their own metrics or incorporating existing state-specific measures. New York's exchange, for example, will leverage the state's existing quality reporting system, which includes national and state-specific measures, while Rhode Island's exchange is developing unique metrics to help plans identify ways to improve health outcomes.[38]

The Affordable Care Act also directs federal regulators to develop a rating system to summarize and display a plan's quality metrics to encourage consumers to select high-quality plans.[39] While this rating system is being developed for display in 2016, 10 states—California, Connecticut, Maryland, Minnesota, New York, Oregon, Rhode Island, Utah, Vermont, and Washington—are developing state-specific quality rating systems ahead of federal guidance. Many states are also taking a proactive approach to the law's requirements for insurers to implement a quality improvement strategy to achieve outcomes such as reducing hospital readmissions. Most states are requiring insurers to submit a written narrative of their quality improvement strategy or meet state-specific quality improvement standards.

States Designed SHOP Exchanges to Minimize Market Disruption and Improve Choice

Given significant flexibility in designing the SHOP exchange, states adopted standards that reflect existing market requirements, but varied on the "employee choice" options through which employees may choose a plan. State officials reported that these decisions were largely the result of efforts to minimize market disruption, maximize economies of scale, and improve coverage choices and value for small businesses.

States Largely Structured SHOP Exchanges to Reflect Existing Market Standards

Most states declined to make major deviations from existing market standards when defining "small employer," deciding whether to merge the individual and small-group markets, and adopting participation and contribution requirements in the SHOP exchange. Although the Affordable Care Act defines small employer as an employer with 100 employees or fewer, states may limit this definition to 50 employees or fewer for plan years beginning before January 1, 2016.[40] As of May 31, 2013, every state except Hawaii defined small employer as having 50 or fewer full-time employees until 2016; since then, Hawaii enacted legislation to define "small employer" as 50 or fewer employees.[41] Only two states—Massachusetts and Vermont—and the District of Columbia chose to merge the individual and small-group markets.[42] While not required, many states also established or maintained existing minimum participation and contribution requirements, which specify the percentage of employees that must purchase coverage and the employer's contribution toward an employee's coverage.

States Exceeded Federal Requirements to Make Employee Choice Available to Small Employers

To provide small employers with a wider range of coverage options than is typically available in today's market, the Affordable Care Act requires SHOP exchanges to enable employers to choose a metal tier of coverage (such as bronze or silver) and allow employees to select any plan from that tier.[43] While this requirement was delayed until 2015,[44] nearly every state-based exchange is expected to offer at least one employee choice option in 2014, with most allowing multiple types of employee choice models (Exhibit 8). Eight states—Hawaii, Minnesota, Nevada, New York, Oregon, Rhode Island, Utah, and Vermont—provided maximum flexibility by

allowing employers to give employees the choice of any plan on the SHOP exchange.

In 2014, all states except Washington will allow employers who opt to provide their employees with one of the "employee choice" models to select a reference plan on which to base employer contributions.[45] For example, in its Employee Choice option, Massachusetts allows employers to select a reference plan from one of the metal tiers.[46] Using the reference plan as a guide as to how much the employer will contribute toward each employee's coverage, employees then choose among plans on the same metal tier and pay the difference between the price of the plan they selected and the price they would have paid for the reference plan.[47]

In making design decisions, state officials emphasized the importance of employee choice in ensuring the SHOP exchange is attractive to small employers and sought to balance the goal of meaningful employee choice with concerns about adverse selection. States also cited challenges in operationalizing the SHOP exchanges, such as ensuring robust insurer participation and developing an IT system that enabled officials to offer maximum choice to employers

EXHIBIT 8. SHOP EMPLOYEE CHOICE SELECTION MODELS, AS OF MAY 31, 2013*

		Employee choice plan selection models[1]			
State	**Single plan**	**One tier, multiple insurers**	**Multiple tiers, one insurer**	**Multiple tiers, multiple insurers**	**All tiers, all insurers**
FFE	*X*	—	—	—	—
CA	—	X	—	—	—
CO	X	X	X	X[2]	—
CT	X	X	X	—	—
DC	X	X	X	—	—
HI	—	X	—	X[3]	X[3]
ID	X	—	—	—	—
KY	X	X	—	X[4]	—
MD[5]	—	X	X	—	—
MA	X	X[6]	X[6]	—	—
MN	X	X	X	X	X
NV	X	X	X	X	X
NM	TBD	TBD	TBD	TBD	TBD
NY	X	X	X	X	X
OR	X	X	X	X[2]	X[7]
RI	X	—	—	—	X
UT	—	X	—	—	X
VT	—	X	—	—	X
WA[8]	X	X	—	—	—

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.

FFE = federally facilitated exchange.

[1] Employee choice models include: 1) allowing employers to choose a single metal tier and employees select plans from different insurers; 2) allowing employers to choose a single insurer and employees select plans at different metal tiers; 3) allowing employers to select multiple insurers and employees select plans from multiple insurers at different metal tiers; or 4) allowing employees to select any plan on the SHOP exchange.

[2] In Colorado and Oregon, employees are limited to choosing plans on the SHOP exchange on metal tiers that are adjacent to the reference plan chosen by the employer (i.e., if the employer selects a silver plan, employees can only choose a plan from among bronze, silver, and gold options).

[3] In Hawaii, the two models are only available for employers not subject to the requirements of the Prepaid Health Care Act.

[4] In Kentucky, employers are limited to choosing plans on the SHOP exchange on metal tiers that are contiguous (i.e., the employer may not select only the bronze and gold levels for employees).

[5] In Maryland, the SHOP exchange will not open until January 1, 2014.

[6] In Massachusetts, the employee choice models may not be available by January 1, 2014, but are expected to be available in 2014.

[7] In Oregon, this model is available only if the employer selects a gold or platinum plan as its reference plan.

[8] In Washington, the SHOP exchange will operate as a pilot program in 2014 with only one insurer.

and employees. Because of these and other challenges, Maryland and Washington, for example, delayed or scaled back their SHOP operations for 2014.[48]

States Promoted Consumer Assistance via Navigators, In-Person Assisters, and Producers

With millions of Americans expected to enroll in coverage through the individual and SHOP exchanges, consumer outreach and assistance will be critical to achieving expanded access to coverage. The Affordable Care Act requires every exchange to establish a navigator program, and states can use federal exchange funding for planning and training navigators, but not for compensating navigators.[49] To supplement the navigator program in early years, state-based exchanges can also use federal funds to establish an in-person assistance program.[50] In most states, both programs are expected to conduct public outreach and education, distribute fair and impartial information regarding enrollment in coverage through the exchange, and provide information in a culturally and linguistically appropriate manner, among other duties.

Exchanges placed few requirements on agents and brokers (known as "producers") to promote producer participation. State officials expect navigators, in-person assisters, and producers to be critical to the exchanges' success in 2014. In addition, some states will promote exchange participation through state-based initiatives that supplement federal financial assistance available through the exchanges.

Thirteen States and the District of Columbia Established Both Navigator and In-Person Assistance Programs in 2014

In addition to the District of Columbia, 13 states—all study states except Idaho, Kentucky, Massachusetts, and Utah—established an in-person assistance program in addition to the federally required navigator program in 2014 (Exhibit 9). In Massachusetts and Utah, the exchanges will operate only a navigator program in 2014 (and Utah's state-run navigator program will function only in the SHOP exchange).[51] As of this writing, Idaho and Kentucky had not yet finalized their approach to consumer assistance programs and continue to consider whether their exchanges will operate navigator and/or in-person assistance programs in 2014.

State officials reported that limitations on the use of federal funds for navigator programs were challenging. Because of this limitation, some states expect to operate limited navigator programs for 2014 but will transition to a more robust program in the future. Other states identified state-based funding sources to fill this gap. Six states—Maryland, Massachusetts, Minnesota, Nevada, Oregon, and Vermont—initially planned to use state funds for their navigator programs while Colorado, Connecticut, and Hawaii looked to private grants until exchange revenue becomes available.

Despite the different funding streams for navigator and in-person assistance programs, state officials viewed the programs as components of a unified consumer assistance effort with largely consistent training requirements and functions. In most states operating both programs, the primary distinction between the navigator and in-person assistance programs is the funding source (with federal exchange funding for in-person assistance programs and state-based funding for navigator programs). Officials also reported that the programs are likely to be administered jointly and have common training requirements, with the main differences based on the ways that navigators and in-person assisters will be compensated and whether the exchange limits the duties of in-person assisters to, for example, outreach and education only.

States Expect Producers to Play a Significant Role in Exchange Success

Every exchange allowed producers to assist consumers in enrolling in an insurance plan through the exchange, and state officials hoped to encourage producers' participation on the exchange by adopting few additional restrictions or requirements on producers. Exchanges in nine states elected to set or pay producers' commissions or set rules guiding the relationship between insurers and producers. This relationship is known as an "appointment" and allows producers to sell an insurer's

EXHIBIT 9. STATE DECISIONS ON CONSUMER ASSISTANCE, AS OF MAY 31, 2013*

	Navigator and in-person assistance programs			Producer rules		
State	Navigator program	In-person assistance program	Planned training hours	Exchange pays commissions	Appointment or affiliation rules	Planned training hours
FFE	*X*	—	*Up to 30 hours*[1]	—	—	*TBD*[1]
CA	X	X	16–24 hours	X[2]	X[2]	TBD
CO	X	X	43 hours	—	X[3]	20 hours
CT	X	X	30 hours	—	X	16 hours
DC	X	X	30 hours	—	—	TBD
HI	X	X	60 hours	X	—	TBD
ID	TBD	TBD	TBD	—	—	TBD
KY	TBD	X	23 hours	—	X	8–10 hours
MD	X	X	120 hours	—	—	4–6 hours
MA	X	—	30 hours	X	X	—
MN	X	X	Variable	—	—	Variable
NV	X	X	20 hours	—	—	20 hours
NM	X	X	TBD	—	TBD	TBD
NY	X	X	40 hours	—	—	TBD
OR	X	X	Variable	—	X[4]	8.5–9 hours
RI	X	X	TBD	—[5]	X[5]	TBD
UT[6]	X	—	TBD	—	X	2 hours
VT	X	X	24 hours	—	—	24 hours
WA	X	X	25–35 hours	—	—	8 hours

* These data reflect state-based exchange design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based exchange may be considering for future years.
FFE = federally facilitated exchange.
[1] States may adopt additional training or certification requirements for navigators, in-person assisters, and producers.
[2] In California, standards apply only to the SHOP exchange, which is licensed as a business entity.
[3] In Colorado, appointment requirements apply unless an insurer does not use producers.
[4] In Oregon, the exchange is licensed as a business entity and producers affiliate with the exchange in lieu of being appointed by insurers.
[5] In Rhode Island, while insurers set and pay commissions, the exchange will pay an additional per-person payment for enrolling small businesses in the SHOP exchange. Producer appointment standards apply only to the SHOP exchange.
[6] In Utah, these standards apply only to the SHOP exchange, which will operate only a limited navigator program. Producer appointment standards apply only to the SHOP exchange, which will require a minimum of two hours of training. (The federal government may require additional producer training for the individual exchange.)

plans and be compensated by that insurer (Exhibit 9). States typically imposed fewer training requirements on producers than on navigators or in-person assisters.

The vast majority of states will defer to existing state rules on producer compensation. California, Hawaii, and Massachusetts are the only states in which SHOP exchanges will set and pay agent and broker commissions directly. The SHOP exchange in Rhode Island will provide a per-person payment to producers that enroll small employers.[52]

To ensure that consumers have access to coverage offered by all insurers in the exchange, states can require insurers to appoint all participating producers or require producers to be appointed by all participating insurers. Only four exchanges—Colorado, Connecticut, Rhode Island, and Utah—adopted such rules. Kentucky required producers to be appointed by at least two insurers participating in the exchange. Massachusetts expects producers to be appointed by more than one exchange insurer as well, but had not yet specified a minimum number. California's SHOP exchange and Oregon's individual and SHOP exchanges are expected to operate as licensed business entities, which will

allow the exchange itself to appoint or affiliate with producers.[53]

States Opt to Improve Affordability and Access to Coverage to Further Maximize Participation

To enhance the affordability of coverage for low-income consumers purchasing coverage through the exchange, some states pursued state-funded initiatives to supplement federal subsidies. Massachusetts and Vermont, for example, will use state funds to further subsidize premiums for individuals with incomes up to 300 percent of the federal poverty level, while New York will fully subsidize premiums for parents with incomes up to 150 percent of the federal poverty level and who are currently covered by the state's Medicaid program but who will transition to exchange coverage in 2014.

POLICY IMPLICATIONS

The Affordable Care Act established a national framework for reform while retaining significant flexibility for states and providing resources to implement its provisions. While states with federally facilitated exchanges can influence the way some functions are performed, states operating their own exchanges had significant flexibility to design their exchanges in ways that reflect the unique needs of their consumers and insurance markets.

Given the rapid time frame for exchange implementation, states made design decisions with an eye toward minimizing market disruption and promoting exchange viability. To this end, states were selective when making major changes. For example, most states declined to merge their individual and small-group markets. Yet, states also built on—and, in some areas, exceeded—minimum federal requirements to accomplish policy objectives such as offering employee choice, establishing consumer assistance programs, and implementing long-standing policy goals such as modernizing IT infrastructure.

While states made significant progress, most state exchange officials would have liked to achieve additional objectives for 2014. However, the lack of timely federal guidance, the complexity of building a new IT system, and political realities hindered the range of policy decisions that states were able to consider. With most federal requirements now finalized and the first generation of exchange IT systems in place, state officials thought that states that opt to transition to a state-based exchange in the future would be able to look to and choose components from existing exchanges that best meet their needs.

The opportunity to understand the lessons learned in these states will be critical for additional states that transition to state-based exchanges in 2015 and for those with already existing state-based exchanges. Indeed, most states expect to adjust their design decisions as implementation unfolds to accomplish additional policy goals, such as adding new features to enhance consumer experience and advancing quality and delivery system reform.

The design of state-based exchanges—along with other important decisions such as whether to expand Medicaid and how to enforce the Affordable Care Act's market reforms—could affect key outcomes, such as enrollment, cost, consumer experience, and sustainability. As we enter the first year of exchange operations, continued monitoring of exchange design decisions will be critical to help a range of stakeholders, including state and federal officials, Congress, and researchers, assess the impact of these policy decisions on real-world outcomes.

METHODOLOGY

This report examines critical structural, operational, and policy decisions made by 17 states (California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington) and the District of Columbia that chose to establish state-based exchanges. This report does not include a review of state action or decisions in the 33 states that defaulted to a federally facilitated exchange.

Throughout this report, we refer to Idaho, New Mexico, and Utah as state-based exchanges. However, Idaho and New Mexico will leverage federal

infrastructure as they build their own systems, with Idaho leveraging this infrastructure for both its individual and SHOP exchanges and New Mexico doing so only for its individual exchange. Utah will only operate the SHOP exchange and the federal government will operate its individual exchange.

Our findings are based on ongoing monitoring of exchange decisions between March 23, 2010, and May 31, 2013, and reflect our 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 here are limited to state decisions for the initial operation of the exchange through 2014. 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.

APPENDIX A. GLOSSARY

Catastrophic coverage: Health coverage that is less comprehensive than bronze coverage and is only available to individuals under the age of 30 or individuals who have received an exemption from the individual mandate on the basis of affordability or hardship.

Clearinghouse: An exchange that allows all plans meeting minimum criteria to participate on the exchange and does not selectively contract with insurers or manage plan choices through limits on the number or type of plans that an insurer can offer.

Employee choice: Plan selection models in the SHOP exchange that give employees more than one choice of health plan. Employee choice models may allow employees to choose among multiple plans on one or multiple metal tiers; among multiple plans or tiers offered by one insurer; among any plan on the SHOP exchange; or among a combination of those options. If multiple employee choice models are available, an employer may select one or more models to use for their employees.

Federally facilitated exchange: A type of exchange model, also known as a federally facilitated marketplace, where the federal government operates all core exchange functions and retains ultimate authority over operation of the exchange. No state action is required for states with a federally facilitated exchange, but states can choose to conduct certain exchange operations.

In-person assistance program: An optional, federally funded program that an exchange can set up before its navigator program is fully functional. In-person assisters may perform the same functions as navigators, including providing assistance with eligibility and enrollment in exchange coverage and public programs as well as conducting consumer outreach and education. Consumers may also access exchange call centers where assistance may be administered in person, online, or via telephone.

Market organizer: An exchange that manages plan choices through limits on the number or type of plans that an insurer can offer, but does not selectively contract with insurers.

Meaningful difference standard: A review standard used by insurance regulators or exchange officials to ensure that a plan's benefit design, such as cost-sharing levels and benefit limits, is substantially distinct from other plans offered in the same market by the same insurer.

Metal tier (bronze, silver, gold, platinum): A designation of the level of financial protection a plan offers based on the expected share of health care costs a plan covers for a typical enrollee. Bronze plans cover the lowest share of health care costs (60%) while platinum plans cover the highest share of health care costs (90%).

Minimum participation and contribution requirements: Standards that specify the minimum percentage of employees (and, in some cases, dependents) that must purchase coverage and the employer's minimum contribution toward an employee's coverage in order for the group to enroll in exchange coverage.

Navigator program: A program that an exchange must establish to provide assistance with eligibility and enrollment in exchange and public coverage as well as to conduct consumer outreach and education. Unlike the in-person assistance program, operation of the navigator program may not be funded through federal grants. Consumers may also access exchange call centers where assistance may be administered in person, online, or via telephone.

Network adequacy standards: Standards used to ensure that health plans include a sufficient number and type of health care providers. These standards can vary significantly by state.

Producer: A person or entity licensed by a state as an insurance agent or broker. Producers typically have an affiliation with an insurer, known as an "appointment," to sell that insurer's plans and be compensated by the insurer.

Quasi-governmental entity: A form of exchange governance in which the exchange is not set up within an existing state agency, as a new a state agency under the executive branch, or as a private, nonprofit entity. In this instance, the exchange is set up as an independent public entity governed by a board of directors and is often exempt from some, but not all, state administrative rules and procedures.

Selective contractor: An exchange that certifies and contracts only with insurers that advance exchange goals. The state exchange may manage plan choices through limits on the number or type of plans that an insurer can offer.

Single rules engine: A software system that houses and executes all the rules to calculate an individual's modified adjusted gross income (MAGI), on which eligibility determinations for exchange subsidies, Medicaid, and the Children's Health Insurance Program are based.

Standardized plan: A plan that complies with benefit and cost-sharing standards established by an exchange or state to limit variation among plans within and across coverage levels and to facilitate consumer selection of plans.

NOTES

[1] Pub. L. 111-148, 124 Stat. 782 (2010) § 1321 (codified at 42 U.S.C. § 18041 (2012)).

[2] S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act* (New York: The Commonwealth Fund, April 2013); and T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).

[3] Jost, *Health Insurance Exchanges*, 2010.

[4] S. R. Collins, K. Davis, J. L. Nicholson, and K. Stremikis, *Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Sept. 2010).

[5] Pub. L. 111-148, 124 Stat. 782 § 1321(c) (codified at 42 U.S.C. § 18041); 45 C.F.R. §§ 155.100 et seq.

[6] S. Dash, C. Monahan, and K. Lucia, *Implementing the Affordable Care Act: State Decisions About Health Insurance Exchange Establishment* (Washington, D.C.: Georgetown University Health Policy Institute, April 2013).

[7] C. L. Otter, "Implementing State Insurance Exchange Requires Moving Quickly, Creatively," Press Release, May 23, 2013, gov.idaho.gov/mediacenter/press/pr2013/5%20May/pr_28.html; B. Massey, "New Mexico Changing Its Plans for Health Exchange," *Las Cruces Sun-News,* May 20, 2013, www.lcsun-news.com/las_cruces-news/ci_23284657/nm-changing-its-plans-health-exchange; and Avenue H, "Utah's Solution for State-Based Health Exchange Moves Forward," Press Release, May 10, 2013, www.avenueh.com/news/item/68-utah-s-solution-for-state-based-health-exchange-moves-forward.

[8] Dash, Monahan, and Lucia, *Implementing the Affordable Care Act,* 2013.

[9] P. N. Van de Water and R. P. Nathan, *Governance Issues for Health Insurance Exchanges,* Health Policy Brief No. 1 (Washington, D.C.: National Academy of Social Insurance, Jan. 2011), http://www.nasi.org/research/2011/governance-issues-health-insurance-exchanges; and M. Tutty and J. Himmelstein, *Establishing the Technology Infrastructure for Health Insurance Exchanges Under the Affordable Care Act: Initial Observations from the "Early Innovator" and Advanced Implementation States* (Washington, D.C.: National Academy of Social Insurance, Sept. 2012), http://www.nasi.org/research/2012/establishing-technology-infrastructure-health-insurance-exch.

[10] Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1311, 1411, 1412, 1413 (codified at 42 U.S.C. §§ 13031, 18081, 18082, 18083 (2012)). The U.S. Department of Health and Human Services made funding available for the development of upgraded IT systems through exchange establishment funding and Medicaid matching funds.

[11] As noted above, Idaho and New Mexico will use the federal IT system in 2014 as they prepare their own state systems, while Utah will defer to operation of its individual exchange to the federal government.

[12] States can choose between allowing the exchange system to make an assessment or a final determination of Medicaid and CHIP eligibility. This decision applies only to so-called "MAGI Medicaid" populations which are eligible for Medicaid on the basis of modified adjusted gross income (MAGI). With the exception of Kentucky and Massachusetts, exchange systems are not expected to conduct eligibility determinations for non-MAGI Medicaid populations (e.g., low-income seniors, people with disabilities, etc.) in 2014. The exchange system in Massachusetts is expected to make an eligibility determination for MAGI Medicaid populations and non-MAGI Medicaid populations with the exception of those that require long-term care.

[13] Personal correspondence with exchange officials, Covered California (May 15, 2013) (on file with authors).

[14] Pub. L. 111-148, 124 Stat. 782 (2010) § 1311 (codified at 42 U.S.C. § 13031 (2012)); 45 C.F.R. § 155.160.

[15] 2013 Md. H.B. 228.

[16] 2013 Colo. H.B. 1245; 2013 Colo. H.B. 1115; Colorado Health Benefit Exchange, *Application for a Cooperative Agreement to Support Establishment of a State Health Insurance Exchange (Level 2)* (Denver, Colo.: Colorado Health Benefit Exchange, May 2013), http://www.connectforhealthco.com/?wpfb_dl=660; and Silver State Health Insurance Exchange, *Advisory Committee Recommendations Approved by the Board* (Carson City, Nev.: Silver State Health Insurance Exchange, May 10, 2013), http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/About/Board_Approved_Recommendations_5.10.13.pdf.

[17] This concept has been referred to elsewhere as "active purchasing." However, because this term suggests that the state is procuring health plans using state or exchange dollars—which is strictly not the case—we instead adopt the term "selective contracting." This term applies to exchanges that contract only with insurers that advance exchange goals.

[18] Covered California, *Health Insurance Companies and Plan Rates for 2014: Making the Individual Market in California Affordable* (Sacramento, Calif.: Covered California, May 23, 2013), http://coveredca.com/news/PDFs/CC_Health_Plans_Booklet.pdf.

[19] In Maryland, the exchange has the authority to employ selective contracting strategies beginning in 2016, while Minnesota's exchange has the authority to do so beginning in 2015. Md. Ins. Code § 31-110(e); 2013 Minn. H.B. 5.

[20] Md. Ins. Code §§ 15-1204.1, 15-1303(b); Mass. Code 176J, § 3; personal correspondence with exchange officials, Massachusetts Health Insurance Connector (May 15, 2013) (on file with authors).

[21] In the District of Columbia, the exchange board approved a strategy that would establish a single marketplace for all individual coverage in 2014 with a transition period for some small-group coverage through 2015.

[22] New York State Department of Health, Office of the New York Health Benefit Exchange, *Invitation for Health Insurer and Dental Plan Participation in the New York Health Benefit Exchange* (Albany, N.Y.: New York State Department of Health, Jan. 2013), http://www.healthbenefitexchange.ny.gov/invitation.

[23] Personal correspondence with exchange officials, Covered California (June 10, 2013) (on file with authors).

[24] Calif. Code § 100503(f); Calif. Health & Safety Code § 1366.6; Calif. Ins. Code § 10112.3

[25] O.R.S. § 743.826; and Washington Health Benefit Exchange, *Guidance for Participation in the Washington Health Benefit Exchange* (Olympia, Wash.: Washington Health Benefit Exchange, Feb. 2013), http://wahbexchange.org/wp-content/uploads/HBE_Guidance_for_Participation1.pdf.

[26] R.C.W.A. § 48.43.700.

[27] Pub. L. 111-148, 124 Stat. 782 (2010) § 1301 (codified at 42 U.S.C. § 18021 (2012)); 45 C.F.R. § 156.200(c).

[28] In the District of Columbia, for example, the exchange will use actuarial support to review rates in addition to the review conducted by the insurance department. D.C. Health Benefit Exchange Authority, *Carrier Reference Manual v.4* (Washington, D.C.: Health Benefit Exchange Authority, May 2013); and personal correspondence with exchange official, District of Columbia Health Benefit Exchange Authority (May 10, 2013, May 15, 2013) (on file with authors).

[29] L. Quincy and J. Silas, *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making* (Washington, D.C.: Consumers Union, Nov. 2012), http://consumersunion.org/research/report-the-evidence-is-clear-too-many-health-insurance-choices-can-impair-not-help-consumer-decision-making/.

[30] Kentucky Health Benefit Exchange, *Board Meeting Minutes* (Lexington, Ky.: Kentucky Health Benefit Exchange, Feb. 2013); and Silver State Health Insurance Exchange, *Advisory Committee Recommendations Approved by the Board*.

[31] S. Corlette, D. Downs, C. H. Monahan et al., "State Insurance Exchanges Face Challenges in Offering Standardized Choices Alongside Innovative Value-Based Insurance," *Health Affairs,* Feb. 2013 32(2)418–26.

[32] Covered California, *Standard Benefit Plan Designs—Final: Summary of Benefits and Coverage* (Sacramento, Calif.: Covered California, March 2013), http://www.healthexchange.ca.gov/BoardMeetings/Documents/March21_2013/Regulations%28Chart%29-QHP_Standard_Plan_Design.pdf; and Oregon Insurance Division, *Exhibit to OAR 836-100-0200 (SB 91 Standard Plan Designs)* (Durham, Ore.: Cover Oregon), http://insurance.oregon.gov/rules/prop_admin_rules.html#metal-plans.

[33] As a selective contractor, the exchange in California may choose to limit the number of plans during its plan certification process.

[34] D.C. Health Benefit Exchange Authority, *Resolution of the Executive Board: To Establish Further Essential Health Benefit Standards and to Establish Additional Qualified Health Plan (QHP) Certification Standards to Promote Benefit Standardization in the District of Columbia Health Benefit Exchange* (Washington, D.C.: D.C. Health Benefit Exchange Authority, March 2013), http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/Resolution-EHBandPlanOfferingStandardsmk_0.pdf.

[35] Access Health Connecticut, *Amendment to: Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges* (Hartford, Conn.: Connecticut Health Insurance Exchange, Dec. 2013).

[36] Pub. L. 111-148, 124 Stat. 782 (2010) § 1311 (codified at 42 U.S.C. § 13031 (2012)); and Department of Health and Human Services, "Request for Information Regarding Health Care Quality for Exchanges," *Federal Register,* 77(228):70786 (Washington, D.C.: U.S. Department of Health and Human Services, Nov. 2012).

[37] U.S. Department of Health and Human Services, Center on Consumer Information and Insurance Oversight, *Letter to Issuers on Federally-Facilitated and State Partnership Exchanges* (Washington, D.C.: U.S. Department of Health and Human Services, April 2013).

[38] Personal correspondence with exchange official, New York Health Benefit Exchange (May 15, 2013) (on file with authors); personal correspondence with exchange official, Rhode Island Health Benefit Exchange (May 14, 2013) (on file with authors).

[39] Pub. L. 111-148, 124 Stat. 782 (2010) § 10329.

[40] Pub. L. 111-148, 124 Stat. 782 (2010) § 1304(b)(2)-(3).

[41] 2013 Ha. H.B. 848 was signed into law on June 25, 2013, and becomes effective as of July 1, 2013.

[42] In the District of Columbia, the exchange adopted a modified merged market where the individual and small-group markets remain separate for some requirements (e.g., federal reporting standards) but not others (e.g., rating and single risk pool requirements).

[43] 45 C.F.R. § 155.705(b)(2).

[44] U.S. Department of Health and Human Services, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program," *Federal Register,* March 11, 2013 78(47):15553, 15557, www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04952.pdf.

[45] Employers offering their employees a single plan will, by definition, base their contributions toward employee coverage on that plan.

[46] Commonwealth Health Insurance Connector Authority, (Feb. 15, 2013).

[47] Ibid.

[48] Maryland Health Connection, *Maryland Health Benefit Exchange Board of Trustees Meeting Minutes* (Baltimore, Md.: Maryland Health Connection, March 29, 2013), marylandhbe.com/wp-content/uploads/2013/03/MHBE_Board_Minutes_032913.pdf; and Washington Health Benefit Exchange Board, *Small Business Health Options Program (SHOP) Implementation—2014* (Olympia, Wash.: Washington HealthPlanFinder, May 8, 2013).

[49] 45 C.F.R. § 155.210. States may use exchange operating funds to compensate navigators once these funds become available.

[50] U.S. Department of Health and Human Services, *Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges* (Washington, D.C.: Department of Health and Human Services, June 29, 2012), https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=15353.

[51] In Utah, federal regulators will establish and operate the navigator program for the individual exchange.

[52] Mass. Code 176Q, § 11, as amended by 2011 Mass. H.B. 4144, § 48; personal correspondence with exchange officials, Rhode Island Health Benefit Exchange (May 14, 2013) (on file with authors).

[53] Covered California, *Qualified Health Plan Contract for 2014* (Sacramento, Calif.: Covered California, May 6, 2013), http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%207,%202013/QHP%20Model%20Contract%20Clean.pdf; and Oregon Health Insurance Exchange, *Level 2 Establishment Grant Narrative* (Durham, Ore.: Oregon Health Insurance Exchange, Nov. 2012).

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