Implementing the Affordable Care Act:

State Decisions about Health Insurance Exchange Establishment

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Abstract: The Affordable Care Act establishes new health insurance marketplaces, known as exchanges, in every state. States have four options for exchange establishment. States can choose to establish a state-based exchange, default to a federally facilitated exchange, or conduct certain exchange functions through a state partnership exchange or a marketplace plan management option. This issue brief identifies the exchange model chosen in all 50 states and the District of Columbia and examines how states decided among these options. Seventeen states and the District of Columbia chose to establish state-based exchanges, while 33 states chose to default to federally facilitated exchanges. Of the 33 states, seven chose to pursue formal state partnership exchanges, and another seven are pursuing a marketplace plan management option. In addition, every state and the District of Columbia took action to evaluate their exchange options, and states considered similar factors including the ability to maintain regulatory control over their insurance markets and tailor solutions to their populations, even while opting for different exchange models. These findings suggest that establishment decisions will continue to evolve as states learn from early successes and challenges and that states may transition between models after 2014.

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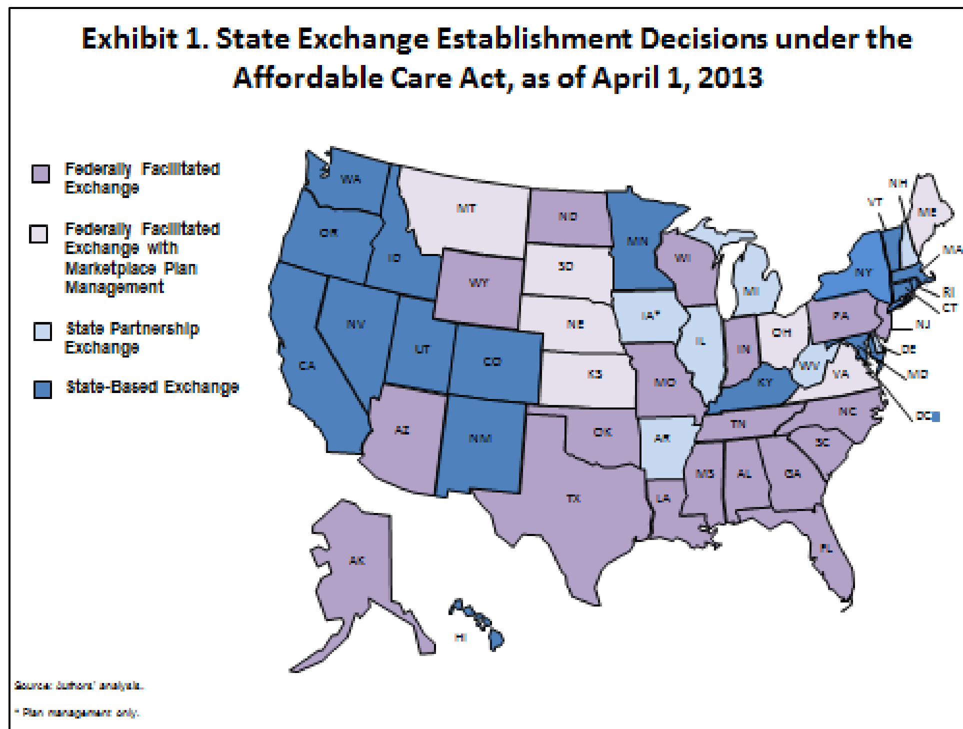
OVERVIEW

The Affordable Care Act is expected to increase access to health insurance coverage to an estimated 90 percent of U.S. residents by 2017 through expansion of the Medicaid program and the establishment of new health insurance marketplaces, or "exchanges."[1] The law requires the establishment of an exchange serving individuals and small businesses in every state, but states can choose whether to establish their own "state-based exchange" or default to a "federally facilitated exchange" established by the federal government.[2] States can also choose to pursue a variant of the federally facilitated exchange known as the "state partnership exchange" or a "marketplace plan management" option.[3] The state partnership exchange option was introduced in proposed regulations issued by the U.S. Department of Health and Human Services (HHS) in July 2011, whereas the marketplace plan management option was delineated in guidance issued in February 2013.[4] The Affordable Care Act also gave states flexibility to pursue a regional or other inter-state exchange, or multiple, subsidiary exchanges within a state.[5] Regardless of the option chosen by each state, exchanges must be operational by October 1, 2013 when individuals and small businesses can begin enrolling in coverage for the 2014 plan year.[6]

This issue brief examines actions taken by states between March 23, 2010 and April 1, 2013, in deciding among these exchange options. Authors analyzed publicly available information related to exchange development and confirmed their assessments with state officials. To better understand how states made decisions about exchange establishment, we also interviewed state officials—including exchange directors, insurance regulators, and gubernatorial staff—in Arizona, Arkansas, Connecticut, Delaware, Illinois, Kansas, Kentucky, Mississippi, Nevada, North Carolina, Tennessee, and Washington.

As of April 1, 2013, 17 states and the District of Columbia chose to establish a state-based exchange for 2014, and 33 states defaulted to the federally facilitated exchange. Of the states with a federally facilitated exchange, 19 have elected not to assume an official role in exchange operations; seven states chose to pursue the state partnership model; and seven chose the marketplace plan management option (Exhibit 1). Our analysis revealed that all 50 states and the District of Columbia took steps to evaluate their options for exchange establishment by applying for federal grant funding; relying on a working group to evaluate exchange options or conduct initial planning; soliciting public input; or engaging consultants. State officials considered a variety of factors in their deliberations, but states universally valued the ability to tailor solutions to their state and health insurance market, even when ultimately arriving at different exchange models for the initial plan year.



Exchange implementation is a dynamic, state-specific process influenced by multiple decision-makers. As implementation proceeds, states are likely to continue to evaluate whether to assume or defer additional responsibilities for the operation of the exchange in their state, including formally transitioning to another exchange model, after 2014.

BACKGROUND

In 2009, there were 50.7 million uninsured individuals in the United States.[7] Enacted in March 2010, the Affordable Care Act sought to expand coverage to the majority of these individuals through new health insurance exchanges and expansion of Medicaid. According to the Congressional Budget Office, up to 31 million individuals are projected to obtain coverage through individual and SHOP exchanges by 2019.[8]

The Affordable Care Act requires the establishment of an exchange serving individuals and small businesses in every state, but states can choose to leave some or all of this responsibility to the federal government. In delineating responsibilities, HHS has provided that states may choose among several options: a state-based exchange, a federally facilitated exchange, or variants on the federally facilitated exchange known as a state partnership exchange and a marketplace plan management option (Exhibits 2 and 3).

HHS asked states to declare their intent to establish a state-based exchange by submitting a declaration letter and a "Blueprint" application by December 14, 2012. States interested in pursuing a state partnership exchange were asked to submit a declaration letter and Blueprint by

February 15, 2013.[9] While states defaulting to federally facilitated exchanges were not required to submit a declaration letter by either date, according to guidance released February 20, 2013, states with federally facilitated exchanges wishing to conduct plan management functions through the marketplace plan management arrangement must submit a letter indicating their interest in doing so and attesting to their capability to perform the same plan management functions as are required for the state partnership exchange, although no deadline was given.[10]

Exhibit 2. Exchange Options under the Affordable Care Act

Exchange Model	Description	State Action
State-based exchange	State operates all core exchange functions; may use federal services for certain exchange functions.	State required to submit declaration letter and Blueprint application to federal government by Dec. 14, 2012.
Federally facilitated exchange	Federal government operates all core exchange functions.	No state action required.
Variant 1: State partnership exchange	State conducts plan management and/or consumer assistance, outreach and education functions on behalf of federal government; federal government operates remaining core exchange functions.	State required to submit declaration letter and Blueprint application to federal government by Feb. 15, 2013.
Variant 2: Marketplace plan management	State conducts plan management on behalf of federal government; federal government operates remaining core exchange functions.	State required to submit an attestation letter to federal government; no deadline specified, however, in guidance dated Feb. 20, 2013, federal government requested that letters be submitted as soon as possible.

Source: Authors' analysis of federal regulations and guidance.

Exchange establishment options differ primarily based on whether the state or federal government maintains responsibility for core exchange functions: eligibility and enrollment; plan management; consumer assistance, outreach, and education; and financial management. In a state-based exchange, the state is responsible for all core exchange functions, but may use federal services to assist with certain activities, such as determining eligibility for federal financial assistance determinations.[11] In a federally facilitated exchange, the federal government retains ultimate authority over operation of the exchange; however, states can opt to conduct certain exchange operations through either a state partnership exchange or a marketplace plan management exchange. In a state partnership exchange, the state can elect to conduct certain plan management functions, consumer assistance functions, or both. If the state partners on consumer assistance functions, it also has the option to conduct outreach and education activities.[12] In a marketplace plan management exchange, a state must conduct the same plan management activities as in a state partnership exchange, but was not required to submit a State Partnership Blueprint.[13]

In a federally facilitated exchange in which the state has not opted to pursue either the state partnership or the marketplace plan management options, HHS has indicated its intent to incorporate, where possible, the results of certain reviews already conducted by state insurance departments into its certification decisions for qualified health plans wishing to participate in the federally facilitated exchange.[14]

Exhibit 3. Responsibilities for Core Exchange Functions across Exchange Models

Core Exchange Function	Description	State-Based Exchange	Federally Facilitated Exchange		
			Standard	Variant 1: State Partnership Exchange	Variant 2: Federally Facilitated Exchange with Marketplace Plan Management
Eligibility and Enrollment	Determine or assess eligibility for insurance affordability programs; facilitate enrollment in appropriate coverage.	State with optional federal participation	Federal with optional state participation*	Federal with optional state participation*	Federal with optional state participation*
Plan Management	Certify QHPs for participation on the exchange; monitor for compliance.	State	Federal	Joint state-federal	Joint state-federal
Consumer Assistance, Outreach, and Education	Assist consumers with finding and enrolling in coverage; operate a website, call center and Navigator program.	State	Federal	Joint state-federal	Federal
Financial Management	Generate financial support for continued operations.	State	Federal	Federal	Federal

Source: Authors analysis of federal regulations and guidance.

* States may elect to retain authority over final Medicaid eligibility determinations. In addition, according to proposed regulations, states choosing to impose a CHIP waiting period in 2013 would be required to make final eligibility determinations of CHIP eligibility. See 78 Federal Register 4623 (Washington, D.C.: Office of the Federal Register, January 22, 2013), In instances where a state retains authority over final Medicaid and/or CHIP eligibility determinations, the federally facilitated exchange will make an initial assessment of eligibility and transfer all individuals assessed as likely eligible to the state Medicaid and/or CHIP agency for a final determination.

ABOUT THIS STUDY

This issue brief examines actions taken by states between March 23, 2010 and April 1, 2013, in deciding among the three exchange options under the Affordable Care Act. Our review includes an analysis of state laws, regulations, press releases, declaration letters, Blueprint submissions, news reports, and other public information related to exchange development. The resulting assessments of state action were confirmed by state regulators. We also conducted in-depth interviews with state officials in 12 states: Arizona, Arkansas, Connecticut, Delaware, Illinois, Kansas, Kentucky, Mississippi, Nevada, North Carolina, Tennessee, and Washington. These states were selected based on the diversity of exchange models they chose and the various approaches they took in selecting their model. This variation largely reflects the variability of approaches in all 50 states and the District of Columbia.

Because interview states for this study were selected prior to the availability of the marketplace plan management option, this study does not generally address state decisions to enter into this arrangement or how this option, formally proposed by HHS on February 20, 2013, may affect ongoing decision-making. The authors also acknowledge that state decisions to date may not necessarily reflect the final number of states operating each model in 2014.

FINDINGS

As of writing, 17 states and the District of Columbia chose to establish state-based exchanges, and 33 states defaulted to a federally facilitated exchange (Exhibit 4). Of the states with a federally facilitated exchange, 19 have elected not to pursue an official role in exchange operations; seven chose to pursue a state partnership exchange; and seven chose to pursue the marketplace plan management option. No states to date have elected to pursue a regional exchange or subsidiary exchanges within a state. States considered a variety of factors in determining which exchange model should be implemented in their state, and every state and the District of Columbia took steps to evaluate their exchange establishment options. States are expected to continue evaluating whether to transition to a different model or take on additional exchange functions in future years.

Exhibit 4. State Exchange Model Selections, as of April 1, 2013

Exchange Model to Date	Number of States	State
State-Based Exchange	17 states and DC	CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, UT, VT, WA
Federally Facilitated Exchange	19 states	AL, AK, AZ, FL, GA, IN, LA, MS, MO, NJ, NC, ND, OK, PA, SC, TN, TX, WI, WY
Variant 1: State Partnership Exchange	7 states	AR, DE, IL, IA, MI, NH, WV
Variant 2: Marketplace Plan Management	7 states	KS, ME, MT, NE, OH, SD, VA

Source: Authors analysis of state and federal communications.

Seventeen states and the District of Columbia chose to establish a state-based exchange

Seventeen states and the District of Columbia chose to establish state-based exchanges for 2014 (Exhibit 5).[15] To do so, the majority—13 states and the District of Columbia—passed new legislation to authorize an exchange that is compliant with the Affordable Care Act. Massachusetts passed legislation in 2012 to designate its existing exchange, the Massachusetts HealthConnector, as Massachusetts' state-based exchange under the Affordable Care Act.[16] New Mexico had proposed in its Blueprint that it would rely on existing legal authority,[17] but also enacted legislation establishing an exchange on March 28, 2013.[18] Three states—Kentucky,[19] New York,[20] and Rhode Island[21]—established an exchange through an executive order signed by the governor. Utah has asked federal regulators to certify its existing small business health insurance exchange as compliant with the Affordable Care Act and proposed that the federal government run the individual market exchange in its state.[22]

All 17 states and the District of Columbia submitted their declaration letter and Blueprint to HHS by the December 14, 2012 deadline. All of these states have received conditional approval from HHS to operate an exchange for plan year 2014. HHS, however, had not approved or denied Utah's revised proposal to only operate an exchange for small businesses as of writing; it had only granted conditional approval to the state's original Blueprint, which included plans to operate an individual market exchange.

To understand why states chose to establish their own exchanges, we interviewed state officials in Connecticut, Kentucky, Nevada, and Washington. Officials reported that they established a state-based exchange to ensure state control over critical establishment decisions. In the words of one official, "We did not think it was in our best interest to have the federal government run the exchange on our state's behalf. We understand the unique economic and regional needs of our state."[23] Another noted, "The state likes to control its destiny, and being able to control key features and functions of the [Affordable Care Act] was important to people."[24] State insurance regulators in particular expressed their belief that a state-based exchange allows the state to maintain its existing regulatory authority over its insurance market, building on established channels of communication between insurance carriers and state regulators while avoiding dual regulation by the state and federal government.[25]

States also pursued state-based exchanges because they valued the ability to meet the unique needs of their residents and could leverage the state's experience in doing so. As one exchange official noted, "we don't want [our residents] calling a federal call center" when they need assistance with coverage.[26] Officials also cited the opportunity to create local jobs by establishing entities such as an exchange call center within their states and better coordinate with other state entities.[27] One official noted the "critical interdependencies" that exist between the

officials in charge of the exchange, the department of insurance, and the state's Medicaid program while pointing to the "coordinated, collaborative effort with sister state agencies" as one of the reasons for the state's success so far.[28]

Exhibit 5. Summary of State-Based Exchanges, as of April 1, 2013

State	Source of Legal Authority to Establish an Exchange	Exchange Name	Date Declaration Letter(s) Submitted	Date Conditional Approval Received	Total Exchange Grant Funding Awarded*
CA	Legislation	Covered California	July 10, 2012; Dec. 14, 2012	Jan. 3, 2013	$910,606,370
CO	Legislation	Connect for Health Colorado	July 6, 2012; Oct. 8, 2012	Dec. 7, 2012	$62,685,346
CT	Legislation	Access Health CT	July 10, 2012	Dec. 7, 2012	$117,184,326
DC	Legislation	DC Health Benefit Exchange	Aug. 8, 2012; Nov. 15, 2012	Dec. 14, 2012	$82,186,049
HI	Legislation	Hawaii Health Connector	June 7, 2012	Jan. 3, 2013	$77,255,636
ID	Legislation	Idaho Health Insurance Exchange	Dec. 14, 2012	Jan. 3, 2013	$21,376,556
KY	Executive order	Kentucky Health Benefit Exchange	July 10, 2012; Nov. 14, 2012	Dec. 14, 2012	$253,698,351
MD	Legislation	Maryland Health Connection	July 10, 2012; Oct. 9, 2012	Dec. 7, 2012	$157,462,123
MA	Legislation	Massachusetts Health Connector	July 10, 2012	Dec. 7, 2012	$179,036,455
MN	Legislation	Minnesota Health Insurance Exchange	July 10, 2012; Nov. 15, 2012	Dec. 20, 2012	$110,349,697
NV	Legislation	Silver State Health Insurance Exchange	Dec. 14, 2012	Jan. 3, 2013	$74,754,285
NM	Legislation	New Mexico Health Insurance Exchange	Dec. 13, 2012	Jan. 3, 2013	$35,279,483
NY	Executive order	New York Health Benefit Exchange	July 9, 2012; Nov. 15, 2012	Dec. 14, 2012	$368,999,996
OR	Legislation	Cover Oregon	July 6, 2012	Dec. 7, 2012	$305,206,587
RI	Executive order	Rhode Island Health Benefits Exchange	July 5, 2012	Dec. 20, 2012	$74,007,528
UT	Existing legal authority	Avenue H	Dec. 14, 2012	Jan. 3, 2013	$2,000,000
VT	Legislation	Vermont Health Connect	July 9, 2012	Jan. 3, 2013	$125,437,081
WA	Legislation	Washington Healthplanfinder	July 10, 2012; July 30, 2012	Dec. 7, 2012	$151,791,012
TOTAL					**$3,109,316,881**

Source: Authors' analysis of state and federal websites and communications.

* This amount reflects only the funds awarded, and does not reflect actual state expenditures of federal funds.

Officials in the four states also reported that the availability of federal funding and flexibility from federal regulators were important catalysts to establishing a state-based exchange. As of April 1, 2013, states opting for state-based exchanges have been awarded over

$3.1 billion in funding for exchange planning and establishment.[29] Officials reported that they would not have been able to pursue a state-based exchange without the significant funding provided by the federal government.[30] An early start to the planning process and quickly gaining consensus among stakeholders were also reported as critical to moving forward with a state-based exchange and meeting stringent establishment timelines.[31] Officials also noted that flexibility from the federal government, particularly in light of unanswered regulatory questions, was essential to allowing exchange establishment to move forward. As one official noted, "I think flexibility has been the most important thing to us, which is why a state-based exchange was so important."[32] Some officials also acknowledged that establishing a state-based exchange simply seemed the natural choice given efforts pre-dating the Affordable Care Act to explore exchange development and political interest in supporting the law.[33]

Thirty-three states chose to default to a federally facilitated exchange

Thirty-three states chose to default to a federally facilitated exchange for 2014, of which 19 states elected not to pursue a formal role in exchange operations; seven chose to pursue a state partnership exchange; and seven chose to pursue the marketplace plan management option (Exhibit 6).

Nineteen states have chosen to take on no formal role in exchange operations

As of writing, 19 of the 33 states that defaulted to a federally facilitated exchange for 2014 have not taken action to pursue either a state partnership exchange or the marketplace plan management option. Although not required, most states submitted a letter to HHS indicating that the state would not establish a state-based or a state partnership exchange.[34] With the exception of Texas, which submitted a letter in July 2012, states submitted these letters in or after November 2012, indicating that some states waited on the election results before making final decisions. These states have been awarded over $340 million for exchange planning and implementation.[35]

Many of these states initially considered or began planning for a state-based or state partnership exchange. Some, such as Indiana,[36] North Carolina,[37] and North Dakota,[38] originally expressed their intent to establish or conditionally establish a state-based exchange in legislation or executive orders. In some states, such as Indiana, such initial planning did not signal a final decision to establish a state-based exchange, but rather reflected the recognition that the "stringent timelines make it prudent for any state to conditionally analyze, plan, and prepare for a state-based exchange" while thoroughly evaluating its options and in light of the political and regulatory uncertainty surrounding the Affordable Care Act.[39] In Mississippi, state-based exchange implementation was halted when HHS declined to approve the insurance commissioner's Blueprint, citing opposition from Governor Phil Bryant.[40] Other states passed

exchange legislation only to have it vetoed by the governor. For example, Governor Chris Christie of New Jersey twice vetoed legislation establishing a state-based exchange.[41]

Exhibit 6. Summary of Federally Facilitated Exchanges, as of April 1, 2013

State	Declaration Letter(s) Submitted (Y/N)	Date Declaration Letter(s) Submitted	Marketplace Plan Management Attestation Letter Submitted (Y/N)	Total Exchange Grant Funding Awarded*
AL	Y	Nov. 16, 2012	N	$9,772,451[1]
AK	N	--	N	$0
AZ	Y	Nov. 28, 2012	N	$30,877,097
FL	N	--	N	$1,000,000[2]
GA	Y	Nov. 16, 2012	N	$1,000,000
IN	Y	Nov. 16, 2012	N	$7,895,126
LA	Y	Nov. 16, 2012	N	$998,416[2]
MS	Y[3]	Nov. 14, 2012; Nov. 26, 2012; Jan. 18, 2013	N	$21,143,618
MO	Y	Nov. 16, 2012	N	$21,865,716[2]
NJ	Y	Feb. 15, 2013	N	$8,897,316
NC	Y[4]	Nov. 15, 2012	N	$87,357,315[2]
ND	N	--	N	$1,000,000
OK	Y	Nov. 19, 2012	N	$55,582,269[2]
PA	Y	Dec. 12, 2012	N	$34,832,212
SC	Y	Nov. 15, 2012	N	$1,000,000
TN	Y	Dec. 10, 2012; Feb. 15, 2013	N	$9,110,165
TX	Y	July 9, 2012; Nov. 15, 2012	N	$1,000,000[2]
WI	Y	Nov. 16, 2012	N	$38,757,139[2]
WY	Y	Nov. 17, 2012	N	$800,000
TOTAL				**$341,874,585**

Source: Authors' analysis of state and federal websites and communications.

* This amount reflects only the funds awarded and does not reflect actual state expenditures of federal funds.

1 Not all awarded federal funds were expended by Alabama.

2 State has declined or returned all or part of its exchange grant funding.

3 Mississippi's insurance commissioner submitted a declaration letter in November 2012 indicating the state's intent to pursue a state-based exchange while Governor Bryant submitted letters to HHS in November 2012 and January 2013 opposing any efforts by the insurance department to establish a state-based exchange or assist with a federally facilitated exchange unless clearly required to do so under federal law.

4 North Carolina's then-Governor Perdue submitted a letter accompanying an exchange grant application and issued a press release indicating the state's intent to pursue a state partnership exchange in November 2012, but the North Carolina General Assembly passed legislation opposing both state based exchange and state partnership exchange models, which was signed into law by Governor McCrory.

Still other states have passed laws restricting state officials from assisting with exchange implementation. In North Carolina, for example, the legislature passed a bill in February 2013 prohibiting agencies from working towards a state-based or partnership exchange.[42] In Missouri, voters approved a ballot measure restricting state officials from taking action to "implement,

establish, create, administer or otherwise operate" a state-based exchange,[43] while former Governor Brian Schweitzer of Montana vetoed legislation that would have prohibited a state-based exchange.[44]

To further understand why states defaulted to a federally facilitated exchange, we interviewed state officials in Arizona, Kansas,[*] Mississippi, North Carolina, and Tennessee. One prominent concern raised by officials was uncertainty about what would be required of state-based exchanges in future federal regulations. Officials in federally facilitated exchange states worried in particular about committing to something without knowing all the terms and potential costs. As one Tennessee official recounted, "I think getting closer and closer to the deadline with no final rules in place and lots of questions, precipitated [the Governor's] decision" to defer to a federally facilitated exchange.[45] Similar sentiment was expressed by an Arizona official who stated that federal officials "can promise you can be flexible but you have to comply with what laws are and what rules are." He also shared practical concerns, noting "insurance companies can't build their products and price their products until all the rules are done." Ultimately, Arizona found that "the timeline for making decisions and timing of the rules didn't match up."[46] Other officials, however, felt that the state-based exchange could be a tool in leveraging federal regulatory uncertainty, citing the opportunity for states to help shape federal policy; in the words of one regulator, "The absence of a rule is the definition of flexibility."[47]

As in states pursuing state-based and state partnership exchanges, officials defaulting to a federally facilitated exchange also valued state control. Some officials noted that a state-based or state partnership exchange would offer them greater control, but defaulted to a federally facilitated exchange due to other factors.[48] Others, however, raised concerns that the Affordable Care Act burdens states with too many requirements to truly offer state-tailored solutions.[49] In Mississippi, officials came down on both sides. While officials reported that the insurance commissioner identified maintaining control the over the state's insurance market as a main driver for initially pursuing a state-based exchange,[50] Mississippi Governor Phil Bryant, in writing to Secretary Sebelius of his opposition to a state-based exchange, stated that "It is inevitable that such an exchange will be controlled by the federal government, not by the state."[51] Both officials appear to agree, however, that the state would not have adequate control over a state partnership exchange to make it worth pursuing for 2014.[52]

[*] Because interview states were selected prior to the availability of the marketplace plan management option, interviews with Kansas addressed only their decision to default to a federally facilitated exchange rather than pursue a state based or state partnership exchange. They do not reflect the subsequent decision to pursue the marketplace plan management option.

Officials in federally facilitated exchange states also acknowledged that political motivations influenced their states' decisions. Officials in Tennessee and North Carolina reported that a number of their elected officials ran on opposition to the Affordable Care Act and are holding firm now in office.[53] Another official reported that opponents of the health care law are defaulting to federally facilitated exchanges as a strategic move, noting "They think that if states don't participate, the Affordable Care Act will fail and they won't get blamed."[54]

Seven states chose to establish state partnership exchanges

Seven states chose to operate state partnership exchanges for 2014 (Exhibit 7).[55] All states except Iowa proposed to perform plan management and consumer assistance functions; Iowa will only perform plan management functions. Every state performing consumer assistance functions except West Virginia also elected to perform consumer outreach and education functions.

Not all of these states initially planned to pursue a state partnership exchange. Some, such as West Virginia[56] and Illinois[57] passed legislation to establish state-based exchanges before opting for a state partnership model. However, the Illinois legislation did not create a board, financing mechanism, or other key components required to establish a state-based exchange,[58] while a governing board was not appointed in West Virginia.[59] Other states began substantial planning activities; for instance, in Arkansas, an exchange steering committee met biweekly in 2011 to plan for a state-based exchange while awaiting legislative action.[60] According to officials, the states changed course for a variety of reasons, including the inability to gain additional needed authority to establish a state-based exchange, mismatches between timing of their legislative sessions and regulatory deadlines established by HHS, and fiscal analyses that indicated a partnership exchange would be more cost-effective for the state.[61]

Exhibit 7. Summary of State Partnership Exchanges, as of April 1, 2013

State	Plan Management Partnership	Consumer Assistance Partnership		Date Declaration Letter Submitted	Date Conditional Approval Received	Total Exchange Grant Funding Awarded*
		Consumer Assistance	Consumer Outreach			
AR	Yes	Yes	Yes	Dec. 13, 2012	Jan. 3, 2013	$27,461,483
DE	Yes	Yes	Yes	Nov. 14, 2012	Dec. 20, 2012	$12,936,639
IL	Yes	Yes	Yes	Oct. 16, 2012	Feb. 13, 2013	$38,989,615
IA	Yes	No	No	Dec. 14, 2012	Mar. 5, 2013	$42,221,578
MI	Yes	Yes	Yes	Jan. 22, 2012	Mar. 5, 2013	$41,517,021
NH	Yes	Yes	Yes	Feb. 13, 2012	Mar. 5, 2013	$1,894,406[1]
WV	Yes	Yes	No	Feb. 15, 2012	Mar. 5, 2013	$10,667,694
TOTAL						**$176,688,436**

Source: Authors' analysis of state and federal websites and communications.

*This amount reflects only the funds awarded, and does not reflect actual state expenditures of federal funds.

1 State is reported to have returned its exchange planning grant award.

To further understand why states pursued state partnership exchanges, we interviewed officials in Arkansas, Delaware, and Illinois. Officials in all three states reported that the state partnership exchange allowed regulators to maintain control over key exchange functions with the benefit of federal resources and an exchange infrastructure. Consistent with reports from officials establishing state-based exchanges, avoiding dual regulation of insurers, maintaining local control, and tailoring consumer assistance functions were important factors for these states. As one official said, "we feel our consumers need local, quick action and response."[62]

Officials also reported that federal grant funding was critical to their efforts and that federal regulators have been accommodating of their needs for flexibility in operating a state partnership exchange. For example, one official praised "the openness we've gotten from [federal regulators] and their willingness to listen and have an open dialogue."[63] As of April 1, 2013, all of the seven states had received conditional approval to operate a state partnership exchange, and nearly $177 million has been awarded to conduct initial exchange planning and enhance state capacity to conduct plan management and consumer assistance functions.[64]

Officials also indicated that they decided to operate a state partnership exchange because it was more attractive than the other two options. Delaware, for example, ultimately decided to pursue a state partnership exchange because the cost of establishing and financially sustaining a state-based exchange would have been prohibitively high given the size of the state's market and the anticipated number of enrollees, potentially driving up the cost of coverage. As one official put it, "it is most financially responsible for us to take advantage of the existing federal infrastructure and services to provide support to that exchange, while also retaining control over the parts of the exchange and outreach that will most closely impact Delawareans."[65] Others favored a state partnership exchange over a federally facilitated exchange because it afforded the state greater "regulatory clout" and ability to "reach out to our consumers and serve them."[66]

In providing states with the option to enter into a state partnership exchange, HHS was clear in its intent that states could use it as a "stepping stone" to a state-based exchange in the future.[67] Indeed, some states viewed the state partnership exchange as a bridge to running a state-based exchange in future years. For instance, Illinois Governor Pat Quinn has publicly stated his intention to seek the necessary legislation for a state-based exchange,[68] and Iowa's Blueprint expressed the state's intention to "migrate to a State-Based Exchange in subsequent years."[69]

Seven states chose to pursue a marketplace plan management exchange

Seven states—Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia—chose to pursue the marketplace plan management variant of the federally facilitated exchange (Exhibit 8). Before HHS had announced a formal role for such states in plan management activities,

some states submitted letters specifying that the state intended to assist in plan management activities without taking on the full responsibilities under a state partnership exchange.[70] Since HHS released guidance on February 20, 2013 formalizing such a role for states, additional states submitted letters expressing their interest in pursuing such an option.

Exhibit 8. Summary of Marketplace Plan Management Exchanges, as of April 1, 2013

State	FFE Declaration Letter(s) Submitted (Y/N)	Date Declaration Letter(s) Submitted	Marketplace Plan Management Letter Submitted (Y/N)	Date Letter(s) Submitted	Date Approved	Total Exchange Grant Funding Awarded*
KS	N	--	Y	Feb. 15, 2013	Mar. 8, 2013	$32,537,465[1]
ME	Y	Nov. 15, 2012	Y	Mar. 18, 2013	Mar. 29, 2013	$6,877,676[1]
MT	N	--	Y	Feb. 26, 2013	Mar. 8, 2013	$1,000,000
NE	Y	Nov. 15, 2012	Y	Feb. 20, 2013	Mar. 29, 2013	$6,481,838
OH	Y	Nov. 16, 2012; Feb. 14, 2013	Y	Feb. 14, 2013	Mar. 8, 2013	$1,000,000
SD	N	--	Y	Mar. 11, 2013	Mar. 29, 2013	$6,879,569
VA	Y	Dec. 14, 2012; Feb. 14, 2013	Y	Feb. 14, 2013; Mar. 8; 2013	Mar. 29, 2013	$5,320,401
TOTAL						**$414,833,220**

Source: Authors' analysis of state and federal websites and communications.

1 State has declined or returned all or part of its exchange grant funding.

*This amount reflects only the funds awarded, and does not reflect actual state expenditures of federal funds.

While interview states were selected prior to this option becoming available, one interview state—Kansas —elected the marketplace plan management option. The Kansas Department of Insurance initially planned for a state-based exchange, and subsequently for a state partnership exchange; however, the state defaulted to a federally facilitated exchange, later electing the marketplace plan management variant, after Governor Sam Brownback declined to approve the state's application for partnership funding.[71] In her attestation letter to the Center for Consumer Information and Insurance Oversight (CCIIO), within HHS, Commissioner Sandy Praeger noted the Kansas Insurance Department's desire to "maintain its statutory and operational authority over those aspects of an exchange that are traditionally performed by state insurance regulators."[72]

Similarly, Virginia, which had originally passed legislation expressing its intent to establish a state-based exchange,[73] subsequently opted to conduct plan management under the marketplace plan management arrangement,[74] and passed legislation authorizing the State Corporation Commission, with assistance from the Virginia Department of Health, to perform

plan management functions required to certify health benefit plans for participation in a federally facilitated exchange in Virginia.[75]

States opted not to pursue regional or subsidiary exchanges

The Affordable Care Act gave states the option to establish regional exchanges with other states, or establish subsidiary exchanges (multiple exchanges within one state), but no states are currently doing so. State officials generally felt that the establishment of a regional exchange would be too difficult given the complexities and variability between state insurance markets, as well as the uncertainty about exchange development in surrounding states, and chose instead to spend limited resources on exchange establishment within their own states.[76] However, regulators left open the possibility that regional exchanges, or some multi-state sharing of certain functions, could become a possibility in the future, and some states have begun to explore the possibility of sharing certain exchange functions with other states.[77]

Every state took steps to consider exchange establishment options

While states reported many reasons for why they ultimately chose a certain exchange model, state officials and stakeholders largely adopted a proactive approach to analyzing these options. Our findings show that every state and the District of Columbia took one or more steps to analyze their exchange establishment options or conduct initial exchange planning under the Affordable Care Act (Exhibit 9). These steps included applying for federal exchange funding, relying on a working group for exchange evaluation or planning, soliciting public input, or engaging consultants. Most states utilized a combination of approaches to evaluate their options.

First, every state except Alaska applied for an exchange planning grant, with many states receiving additional establishment and early innovator funding.[78] While four states—Florida, Louisiana, New Hampshire, and Texas—publicly declined or returned all or part of their planning award,[79] and other states turned down or returned other grant funding, only one state that turned down funds—Louisiana—did not take other steps to consider establishment options.

Second, nearly every state relied on a working group to evaluate exchange options or conduct initial exchange establishment planning. These working groups were often newly-created or existing entities typically established or overseen by the legislature, the governor's office, or an executive branch agency; they included legislative study committees, interagency working groups, executive branch offices such as offices of health reform implementation or health care authorities, and multi-stakeholder working groups coordinated by state officials. In Kansas, for example, the Insurance Department established eight working groups and a steering committee to make recommendations to the insurance commissioner regarding the establishment of a Kansas Health Benefits Insurance Exchange.[80] In Washington, the Health Care Authority established an interagency workgroup to determine whether the state should pursue a national,

regional, or state-based exchange,[81] while the legislature set up the Joint Select Committee on Health Reform Implementation which formed an Advisory Group on Exchange and Insurance Reforms.[82]

Exhibit 9. Steps States Took to Analyze Exchange Establishment Options, as of April 1, 2013

Exchange Model to Date	Total Number of States That Took Action	States That Took Action	States That Did Not Take Action
State applied for federal exchange planning funding.	49 states and DC	AL, AZ, AR, CA, CO, CT, DE, DC, FL[1], GA, HI, ID, IL, IN, IA, KS, KY, LA[1], ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH[1], NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX[1], UT, VT, VA,WA, WV,WI, WY	AK
State relied on working group to evaluate options for exchange establishment and/or conduct initial planning.	47 states and DC	AL, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, UT, VT, VA, WA, WV, WI, WY	AK, LA, TX
State solicited public input.	48 states and DC	AL, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY	AK, LA
State engaged private or public consultants.	44 states and DC	AL, AK, AZ, AR, CA, CO, CT, DE, DC, GA, ID, IL, IN, IA, KY, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NJ, NM, NY, NC, ND, OH, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY	FL,HI, KS, LA, NH, OK

Sources: Authors' analysis of state websites and communications, and grant award information available at Center for Consumer Information & Insurance Oversight, Creating a New Competitive Marketplace: Affordable Insurance Exchanges, http://cciio.cms.gov/Archive/Grants/exchanges-map.html), as of April 1, 2013.

1 State publicly turned down or returned planning grant award.

Third, we found that all but two states solicited public input, which included activities such as holding public meetings on exchange establishment, conducting focus groups, and fielding stakeholder surveys. Each of the states we interviewed reported extensive efforts to solicit public input on exchange establishment options and initial planning, with most states soliciting input in more than one way.[83] In 2011, Arkansas, for example, held 66 information and listening sessions in 17 locations, held a one-day statewide stakeholder summit and fielded a survey to solicit residents' input.[84] In the words of one exchange official, "This is the type of project where you cannot over-communicate."[85]

Finally, at least 44 states and the District of Columbia engaged consultants to assist their efforts, including public entities, such as state universities, and private consulting firms. States

engaged consultants for background research, managing public outreach, facilitating deliberations, and making recommendations on exchange establishment and planning.

Our analysis found that recommendations from consultants and other advisory bodies were mixed and did not always correspond to the exchange model ultimately chosen by each state. In some states, advisory bodies could not reach a definitive recommendation, or recommended a course of action not prescribed under the Affordable Care Act. For instance, a contractor engaged by Alaska concluded in June 2012 that they "would recommend the state consider initially implementing a state-federal partnership model with transition to a state-based exchange;" however, in light of the "political debate [and] controversy" regarding exchanges, "there remain too many unknowns […] to make a recommendation."[86] In Georgia, the Health Insurance Exchange Advisory Committee supported development of a "free-market" small business exchange that "is clearly delineated from the PPACA-required SHOP Exchange."[87] Some states, such as Alabama,[88] Maine,[89] North Dakota,[90] Pennsylvania,[91] and Virginia,[92] ultimately concluded against establishing a state-based exchange despite recommendations from advisory bodies or an acknowledged public sentiment favoring a state-run exchange.

In considering which model to pursue, states also identified some of the challenges they may face in 2013 and beyond. Regarding state-based exchanges, states raised concerns about the impending deadlines for ensuring that their exchange is operational, particularly given the need to obtain answers to critical regulatory questions and connect to a federal data hub for eligibility and enrollment. For state partnership exchanges, state officials identified coordination with the federal government on outreach and enrollment as a key challenge. In particular, officials acknowledged a need for ongoing monitoring so that state and federal officials can adjust enrollment strategies and ensure the success of exchanges.[93] Officials in states with federally facilitated exchanges emphasized the need to coordinate with the federal government to avoid dual regulation of insurers.[94]

POLICY IMPLICATIONS

Our findings demonstrate that exchange establishment continues to be a dynamic process. Although conventional wisdom suggests that many states have not been active in exchange planning and establishment,[95] we found that every state took steps to analyze their options under the Affordable Care Act and that stakeholders were highly engaged in many of these processes, with significant time and resources spent on finding state-specific solutions. Our findings suggest that, while political factors were a constant backdrop to state exchange establishment decisions, multiple other factors, including costs, timing, and the availability of answers to regulatory questions, influenced states in their initial decision-making. States were also presented with new options for operating key exchange functions throughout the rulemaking process. Moreover, there were multiple decision-makers in each state, with sometimes conflicting viewpoints, and

turnover in state legislatures and governors' offices impacted state exchange decisions. Continued changes in state leadership are likely to influence future critical decisions by states on exchange implementation.

State officials universally valued the ability to maintain control over their insurance markets and tailor the exchange to the unique needs of their consumers, and states were particularly concerned about the possibility of dual regulation of insurance markets in federally-facilitated exchange states. The division of responsibility between the states and the federal government, particularly with respect to plan management functions in federally facilitated and state partnership exchanges, is continuing to emerge, and will likely operate on a continuum rather than falling into clearly delineated categories. The emergence of the marketplace plan management option after the initial HHS deadline for submitting state partnership blueprints, as well as the relatively rapid take-up of that option by seven states since February 20, 2013, indicates that states and the federal government continue to look for solutions that allow states to maintain maximum regulatory oversight of health plans sold through the federally facilitated exchange in their state. In addition, important coordination questions arise in states with federally-facilitated exchanges with regard to establishment of linkages to the federal exchange for purposes of determining Medicaid and CHIP eligibility. These findings suggest a need to closely monitor the regulatory relationship between states and the federal government, along with the experiences of consumers, in states with different exchange models.

For the 2015 plan year and beyond, states will have the opportunity to re-evaluate the exchange model and the specific exchange functions they chose for 2014. Our findings suggest that while federal funding was a critical factor enabling states to establish state-based or state partnership exchanges, it was not a sufficient incentive for states to establish a state-based or state-partnership exchange. Although states were awarded substantial federal dollars to assist with planning and establishment, a number of states defaulting to a federally facilitated exchange ultimately turned down or returned all or part of their grant awards. However, states that do wish to take advantage of additional federal funding for exchange establishment must apply prior to 2015.

As states consider their options moving forward, they are likely to look to the experiences of other states, including the successes and challenges associated with each exchange model. In addition, states are likely to be influenced by factors outside of their control, including turnover in state leadership, the flexibility, funding, and technical assistance afforded to state regulators, and the ease of coordination with federal officials.

CONCLUSION

Exchange establishment will continue to be fluid as states learn from early successes and challenges and some states are likely to pursue a different exchange model for the 2015 plan year and beyond. Our findings indicate that continued flexibility and funding, as well as technical and practical assistance to states, will be important as exchange implementation unfolds, and that policymakers will benefit from continued monitoring of state exchange implementation and the Affordable Care Act's other market reforms.

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