



April 2013

HEALTH INSURANCE

Seven States' Actions to Establish Exchanges under the Patient Protection and Affordable Care Act

GAO Highlights

Highlights of [GAO-13-486](#), a report to the Ranking Member, Committee on the Judiciary, U.S. Senate

Why GAO Did This Study

A central provision of PPACA requires the establishment of exchanges in each state—online marketplaces through which eligible individuals and small business employers can compare and select health insurance coverage from participating health plans. Exchanges are to begin enrollment by October 1, 2013, with coverage to commence January 1, 2014. States have some flexibility with respect to exchanges by choosing to establish and operate an exchange themselves (i.e., state-based), or by ceding this authority to HHS (i.e., federally facilitated). States may also choose to enter into a partnership with HHS whereby HHS establishes the exchange and the state assists with operating various functions. According to HHS, 18 states will establish a state-based exchange, while 26 will have a federally facilitated exchange. Seven states will partner with HHS.

GAO was asked to report on (1) states' responsibilities for establishing exchanges, and (2) actions selected states have taken to establish exchanges and challenges they have encountered. To do this work, GAO reviewed PPACA provisions and HHS implementing regulations and guidance. GAO also conducted semistructured interviews with state officials in the District of Columbia, Iowa, Minnesota, Nevada, New York, Oregon, and Rhode Island. For this review, GAO refers to the District of Columbia as a state. GAO selected these states based on several criteria, such as a 3-year average of states' uninsured population and geographic dispersion. HHS and the seven states in our review provided technical comments on this report, which GAO incorporated as appropriate.

View [GAO-13-486](#). For more information, contact Stanley J. Czerwinski at (202) 512-6806 or czerwinkis@gao.gov.

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Seven States' Actions to Establish Exchanges under the Patient Protection and Affordable Care Act

What GAO Found

The Patient Protection and Affordable Care Act (PPACA) and the Department of Health and Human Services (HHS) regulations, supplemented by HHS guidance, require states and American Health Benefit Exchanges (exchanges) to carry out a number of key functions, for which state responsibilities vary by exchange type. A state that chooses to operate its exchange is responsible for: (1) establishing an operating and governance structure, (2) ensuring exchanges are capable of certifying qualified health plans and making them available to qualified individuals, (3) developing electronic, streamlined, and coordinated eligibility and enrollment systems, (4) conducting consumer outreach and assistance, and (5) ensuring the financial sustainability of the exchange. A state that partners with HHS may assist HHS with certain functions, such as making qualified health plan recommendations and conducting aspects of consumer outreach and assistance.

Despite some challenges, the seven selected states in GAO's review reported they have taken actions to create exchanges, which they expect will be ready for enrollment by the deadline of October 1, 2013. For example:

- Six states will operate as a state-based exchange, with most choosing this option as a way to maintain control of their insurance markets and better meet the needs of their state's residents. The seventh state—Iowa—will partner with HHS.
- All seven states have taken steps toward deciding which qualified health plans would be included in the exchange. Two states have decided that their exchanges will have the authority to actively select which qualified health plans may participate in the exchange, while the remaining five states will allow all qualified health plans to participate in the exchange.
- All states are in various stages of developing an information technology (IT) infrastructure, including redesigning, upgrading, or replacing their outdated Medicaid and Children's Health Insurance Program eligibility and enrollment systems. Six states are also building the exchange IT infrastructure needed to integrate systems and allow consumers to navigate among health programs, but identified challenges with the complexity and magnitude of the IT projects, time constraints, and guidance for developing their systems.
- Six of the seven states included in our review are in various stages of developing a consumer outreach and assistance program to reach out to and help enroll potential consumers. As a partnership state, Iowa has not yet decided whether and to what extent it will assume responsibility for aspects of this function.
- Officials in the six state-based exchanges reported they are considering revenue options for financially sustaining their exchange. For example, three states plan to charge fees to insurance carriers participating in the exchange. However, some states reported challenges with developing these options, given uncertainties related to exchange enrollment, on which the fees are based.

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Abbreviations

BHP	Basic Health Program
CBO	Congressional Budget Office
CCIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
EHB	essential health benefits
HCERA	Health Care Education and Reconciliation Act
HHS	U.S. Department of Health and Human Services
IT	information technology
PPACA	Patient Protection and Affordable Care Act
QHP	Qualified Health Plan
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families

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April 30, 2013

The Honorable Charles E. Grassley
Ranking Member
Committee on the Judiciary
United States Senate

Dear Senator Grassley:

The Patient Protection and Affordable Care Act (PPACA),¹ signed into law on March 23, 2010, contains a number of provisions intended to reform aspects of the private health insurance market and expand the availability and affordability of coverage. A central provision of the law requires the establishment of American Health Benefit Exchanges (exchanges) in each state—online marketplaces through which eligible individuals and small business employers can compare and select health insurance coverage from among participating health plans.² Intended to provide seamless “no wrong door” access to coverage options, in general, exchanges will need to be able to determine whether individuals and small business employees³ are eligible for a private health plan, Medicaid,⁴ or the Children’s Health Insurance Program (CHIP).^{5,6} This

¹Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (PPACA), as amended by the Health Care and Education Reconciliation Act, (HCERA) Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010). In this report, references to PPACA include any amendments made by HCERA.

²Pub. L. No. 111-148, § 1311(b), 124 Stat. at 173.

³ PPACA requires the establishment of a Small Business Health Options Program, or SHOP—exchanges where small employers can shop for and purchase coverage for their employees. Under PPACA, until 2016, states have the option to define “small employers” either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, states may allow large employers to obtain coverage through an exchange (but will not be required to do so). For purposes of our review, we did not include SHOP exchanges in the scope of our work.

⁴Medicaid is a joint federal-state program that finances health care coverage for certain categories of low-income individuals.

⁵CHIP is a federal-state program which provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirements for Medicaid.

⁶ Pub. L. No. 111-148, § 1413(c), 124 Stat. at 234.

means that no matter how an individual submits an application or which program receives the application, there will be a process by which the individual can receive an eligibility determination using the same application, without the need to submit information to multiple programs. Exchanges are to begin enrollment by October 1, 2013, with coverage to commence January 1, 2014. The Congressional Budget Office has estimated that about 7 million individuals will be enrolled in exchanges in 2014, increasing to about 26 million by 2022.

While PPACA places some requirements on the design and function of exchanges, states also have a number of operational decisions to make. A state may establish the exchange itself (referred to as a state-based exchange), cede the responsibility entirely to the Department of Health and Human Services (HHS) (referred to as a federally facilitated exchange), or enter into a partnership with HHS (referred to as a partnership exchange).⁷ Depending on the type of exchange, states are facing a number of critical policy and implementation decisions, subject to HHS regulation and approval. Such decisions involve determining individuals' eligibility and enrolling them in health insurance plans, conducting consumer outreach and assisting potential enrollees, ensuring qualified health plans are certified, and ensuring the exchange's long-term financial sustainability. In addition, states must develop information technology (IT) systems that securely facilitate the movement of information to provide enrollees with answers about their eligibility and enhance their ability to enroll in health insurance coverage. States are faced with unprecedented levels of data sharing and coordination between federal agencies, private health plans, state insurance commissioners, and state Medicaid agencies. As of March 27, 2013, the federal government has awarded states nearly \$3.7 billion in grant funding to cover some of the states' planning and implementation costs.

You asked us to report on the actions states are taking to establish exchanges. This report addresses the following questions:

1. What are states' responsibilities for establishing exchanges?

⁷A partnership exchange is a variation of a federally facilitated exchange. HHS will establish and operate this type of exchange with states assisting HHS to carry out certain functions of that exchange.

2. What actions have selected states taken to establish exchanges and what challenges have they encountered?

To identify states' responsibilities for establishing exchanges, we reviewed selected PPACA provisions and HHS implementing regulations and guidance related to the following categories of responsibilities:⁸

- establishing a governance and operating structure;
- ensuring exchanges will be capable of certifying qualified health plans;
- simplifying and streamlining eligibility and enrollment systems;
- conducting consumer assistance and outreach; and
- ensuring financial sustainability of the exchange.

During our review, we obtained status updates on the development of regulations and guidance from the Center for Consumer Information and Insurance Oversight (CCIIO) within HHS's Centers for Medicare & Medicaid Services (CMS) that oversees the implementation of exchanges. We also met with CCIIO officials to discuss the ways in which they provided guidance to the states.

To identify the actions selected states have taken to establish exchanges and the challenges they encountered, we conducted semi-structured interviews with state exchange officials in the District of Columbia and six states: Iowa, Minnesota, Nevada, New York, Oregon, and Rhode Island. For the purposes of this report, we hereafter refer to the District of Columbia as a state. We selected these states on the basis of: (1) a 3-year average of the uninsured population within states; (2) the uninsured population in states in 2011; (3) the amount of federal exchange grants awarded to states on a per capita basis; (4) geographic dispersion, and (5) whether states will have a state-based, federally facilitated, or partnership exchange.⁹ Six states in our review plan to establish and operate a state-based exchange, while one state—Iowa—opted for a partnership exchange. We also met with budget officials in some of these

⁸For purposes of this report, we focused on certain categories of responsibilities. Therefore, this list does not include all states' responsibilities related to creating and operating an exchange.

⁹ Specifically, we selected states on the basis of whether they intended to establish a state-based, federally facilitated, or partnership exchange, as of September 27, 2012. At that time, states had not yet formally declared their intention to HHS. We used the most readily available information at that time from HHS and the Kaiser Family Foundation.

states to discuss the fiscal aspects of establishing exchanges, including how states will ensure financial sustainability for their exchange. The findings from these interviews cannot be generalized to all state exchange and budget offices. We obtained additional information from interviews with officials from state associations, including the National Association of Insurance Commissioners, the National Association of State Budget Officers, and the National Conference of State Legislatures. Two states that will have federally facilitated exchanges—Florida and Maine—were initially selected for inclusion in our review. However, exchange officials in those states declined to be interviewed. Therefore, this review focuses on states' responsibilities and actions related to state-based and partnership exchanges. A more detailed description of our objectives, scope, and methodology is included in appendix I.

We conducted our work from September 2011 to April 2013 in accordance with generally accepted government audit standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Exchanges are online marketplaces where eligible individuals and small businesses can purchase health insurance. PPACA prescribes a seamless, streamlined eligibility process for consumers to submit a single application and receive an eligibility determination for enrollment in a qualified health plan through the exchange, advance payments of the

premium tax credit,¹⁰ cost sharing reductions,¹¹ Medicaid, CHIP, and the Basic Health Program (BHP),¹² if applicable.

Under PPACA, an exchange must be operational in each state by January 1, 2014. States have some flexibility with respect to exchanges, by choosing to establish and operate an exchange themselves (referred to as a state-based exchange) or by ceding this authority to HHS (referred to as a federally facilitated exchange).¹³ States choosing to establish a state-based exchange were required to submit an application “blueprint” to HHS by December 14, 2012. Subject to HHS review and approval, the blueprint detailed how the states planned to implement various functions and activities that HHS deemed essential to operating this type of exchange. HHS identified a third type of exchange states

¹⁰Beginning on January 1, 2014, a premium tax credit will be available to help eligible tax filers and their dependents pay for qualified health plans purchased through PPACA exchanges. The premium tax credit is available on an advance basis, referred to as advance payments of the premium tax credit, and any advance payments are reconciled on a tax filer’s tax return. Ultimately, tax credits will be calculated using income reported on tax returns. The credits will generally be available to eligible tax filers and their dependents who are (1) enrolled in one or more qualified health plans through an exchange, and (2) not eligible for other health insurance coverage. More specifically, to qualify for the premium tax credit, an individual or family must generally have income between 100 and 400 percent of the federal poverty level and not qualify for other health care coverage, such as Medicare, Medicaid, or employer-sponsored coverage that meets a minimum value standard specified in PPACA.

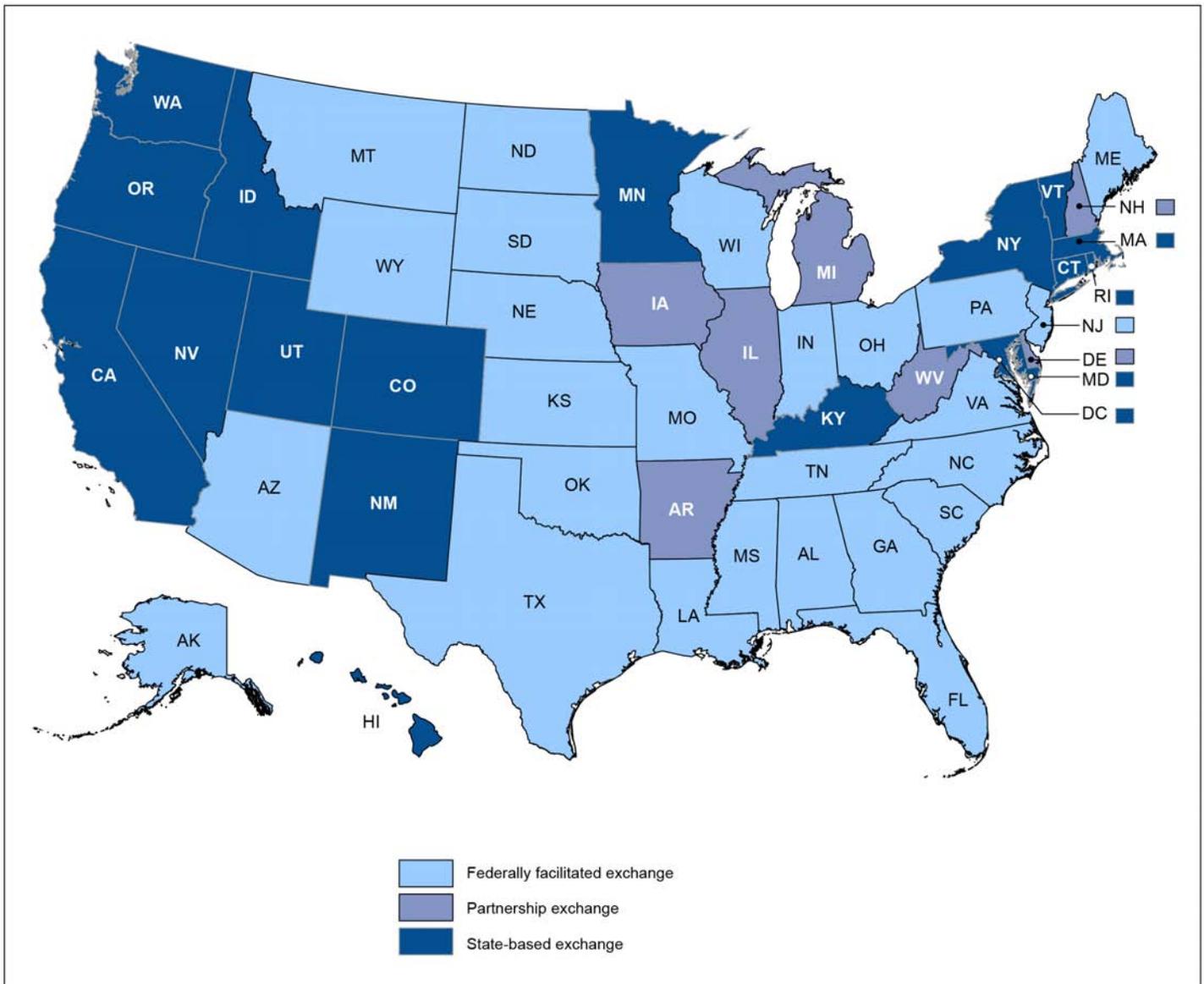
¹¹PPACA provides cost sharing subsidies to certain individuals to help them pay for costs related to the use of health services. Cost sharing generally refers to costs that an individual must pay when using services that are covered under the health plan that the person is enrolled in. Common forms of cost sharing include copayments and deductibles.

¹²The Basic Health Program (BHP) is an alternative to qualified health plans under which states may offer subsidized coverage to non-elderly individuals with incomes between 133 and 200 percent of the federal poverty level who are otherwise not eligible for other types of coverage such as affordable employer-sponsored insurance or traditional Medicaid. For operating this program, states will receive federal funding equivalent to 95 percent of the premium tax credits and cost sharing reductions that would apply to individuals if they were enrolled in exchange plans.

¹³PPACA requires states to establish exchanges by January 1, 2014. Pub. L. No. 111-148, § 1311(b), 124 Stat. 173. The Secretary of HHS must establish and operate an exchange in states that do not elect to operate an exchange or in states where the Secretary determines, by January 1, 2013, that a state has failed to take actions necessary to establish an exchange. Pub. L. No. 111-148, § 1321(c), 124 Stat. 186. Through subsequent guidance, HHS has identified options for states to partner with HHS when HHS establishes and operates an exchange. Specifically, under this model, states may assist HHS in carrying out certain functions of the exchanges.

could choose, referred to as a partnership exchange. According to HHS, a partnership exchange is a variation of a federally facilitated exchange, whereby HHS establishes and generally operates the exchange and the state assists HHS with operating various functions of the exchange. States opting for a partnership exchange were required to submit an application blueprint to HHS by February 15, 2013, detailing how the state planned to implement various functions and activities. According to HHS, as of March 14, 2013, 18 states have opted to establish a state-based exchange. In another 7 states, HHS will establish and operate a partnership exchange, with states assisting in certain functions (see figure 1). HHS's approval of these exchanges is conditional on the states' addressing a list of activities highlighted in the state's application blueprint. HHS will establish a federally facilitated exchange in the remaining 26 states.

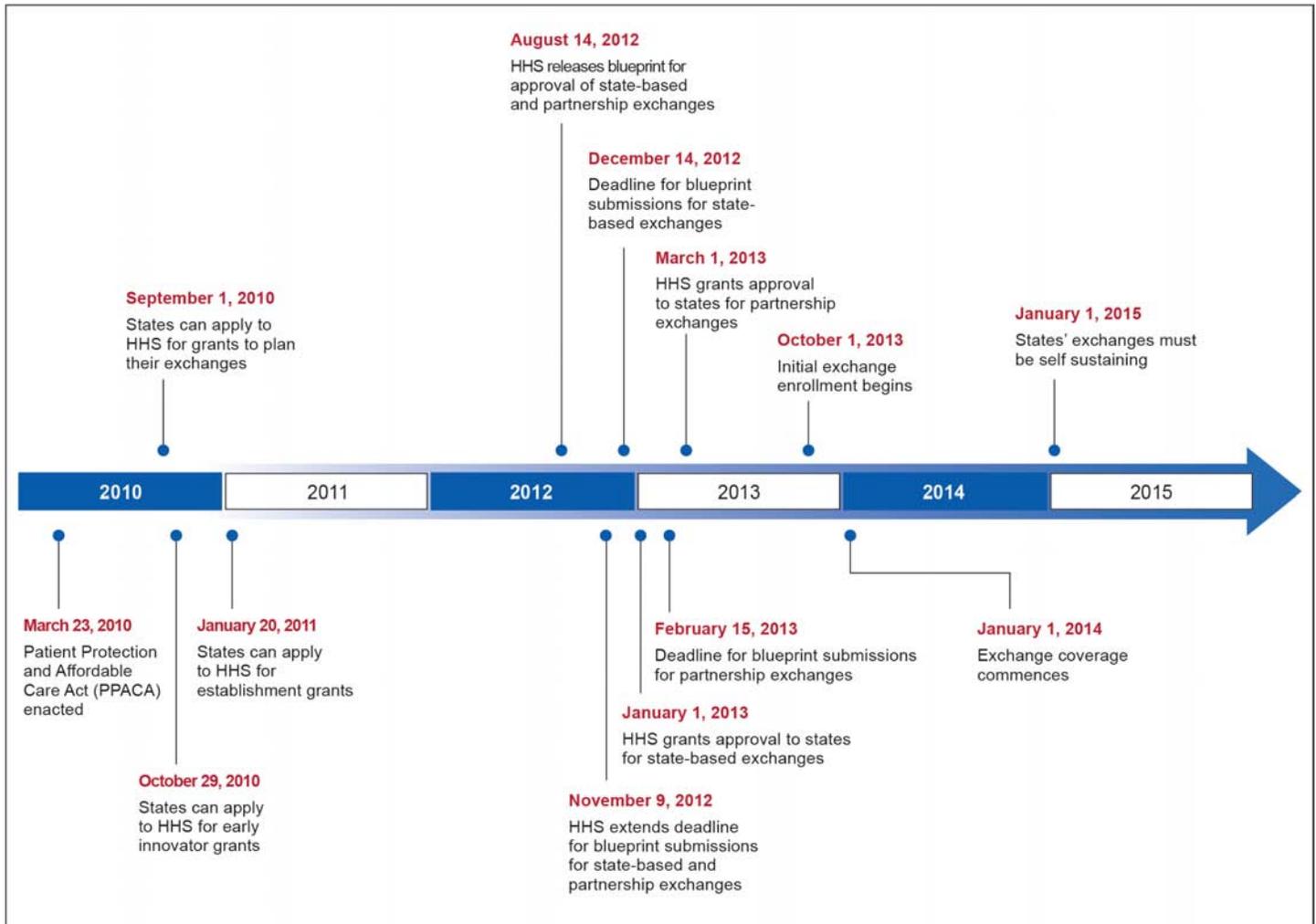
Figure 1: Distribution of State Decisions on Exchange Type, as of March 14, 2013



Sources: GAO analysis of CMS data; Map Resources (map).

Regardless of the type of exchange states plan to establish, open enrollment in the exchange is to begin on October 1, 2013. See figure 2 for a timeline of key milestones under PPACA.

Figure 2: Timeline for Key Exchange Milestones



Source: GAO analysis of relevant PPACA provisions and HHS regulations and guidance.

To help states establish an exchange, federal grants are available for planning and implementation activities, as well as for the first year of an exchange's operation. As shown in figure 2, beginning in September 2010, states could apply for up to \$1 million in planning grants to conduct

initial research and exchange planning activities.¹⁴ Establishment grants became available to eligible states to set up their own exchanges or to support activities related to the establishment of partnership exchanges or federally facilitated exchanges in the state.¹⁵ States could also apply for “early innovator” grants to help them develop and adapt technology systems to determine eligibility and enrollment. These grants were awarded in 2011 to states that demonstrated an ability to develop IT systems on a fast track schedule and a willingness to share design and implementation solutions with other states. Between September 2010 and March 2013, HHS awarded exchange grants totaling nearly \$3.7 billion to 50 states.^{16,17} Of that amount, states returned over \$98 million in grant awards.¹⁸ HHS awarded over \$1 billion dollars to the 7 states in our review—New York and Oregon were awarded the largest amounts. Figure 3 shows the range of exchange grant funding by state as of March 27, 2013.

¹⁴These grants were awarded to states in 2010 and 2011, and are no longer being awarded. These grants provided one year of funding and a state could receive only one grant.

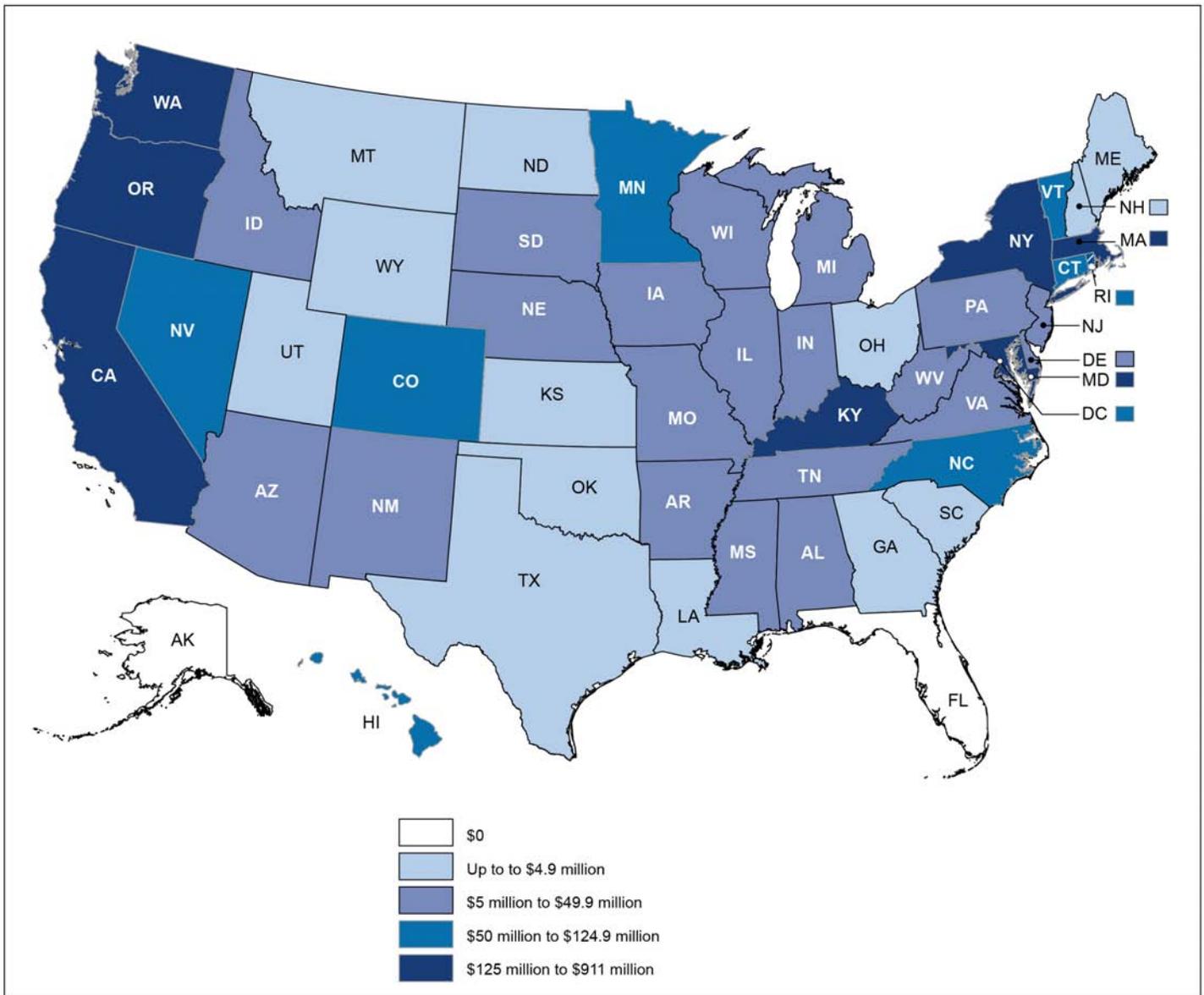
¹⁵There are two types of establishment grants. Level I establishment grants, awarded to states in 2010, were available to all states, whether they were developing a state-based exchange or participating in a partnership exchange or a federally facilitated exchange. These grants provided for one year of funding, and a state could apply for multiple grants. Level II establishment grants, awarded on a quarterly basis through 2015, are available only to states that create a state-based exchange and are moving ahead at a faster pace.

¹⁶As noted earlier, for purposes of this report, we refer to the District of Columbia as a state.

¹⁷One state, Alaska, did not apply for and was not awarded exchange grant funding.

¹⁸As of March 27, 2013, certain states had returned this funding to HHS for reasons such as the state’s decision not to pursue a state-based exchange.

Figure 3: Range of exchange grant funding by state, as of March 27, 2013^a



Sources: GAO analysis of CMS data; Map Resources (map).

^aGrant funding reflects the total amounts awarded minus amounts that a state returned. As noted earlier, certain states have returned this funding to HHS for reasons such as a state's decision not to pursue a state-based exchange.

States' Responsibilities for Establishing Exchanges Vary, Depending on the Type of Exchange

PPACA and HHS implementing regulations and guidance require states and exchanges to carry out a number of key functions, for which state responsibilities vary by exchange type. A state that chooses to run its own exchange is responsible for: establishing an operating and governance structure, ensuring QHPs are certified and available to qualified individuals,¹⁹ streamlining eligibility and enrollment systems, conducting consumer outreach and assistance, and ensuring the financial sustainability of the exchange. A state that has created a partnership exchange may assist HHS in some of these functions, such as making QHP certification recommendations and conducting aspects of consumer outreach and assistance.

States Must Establish an Operating and Governance Structure

A state choosing to operate a state-based exchange must establish the operating and governance structure through which the exchange will be run and managed. Specifically, the state must determine whether the exchange will be run as a governmental agency or a nonprofit organization. Regardless of whether the exchange will be run as a governmental agency or a nonprofit, the state has the authority to allow an exchange to contract with other entities to carry out one or more responsibilities of the exchange.²⁰

Further, a state operating an exchange as an independent state agency or nonprofit entity established by the state must establish a governance board that meets certain requirements. For example, the board must be administered under a publicly adopted operating charter or by-laws, ensure the board's membership includes at least one voting member who is a consumer representative and is not made up of a majority of voting representatives with conflicts of interest (for example, representatives of health insurance issuers), and ensure that a majority of the voting members have relevant health care experience (for example, health benefits administration or public health).

¹⁹Qualified individuals must reside in the state in which the exchange is offered and include U.S. citizens and legal immigrants who are not incarcerated.

²⁰A state exchange may contract with an eligible entity, including a state Medicaid agency or any other state agency, incorporated under and subject to the laws of at least one state, that has demonstrated experience on a state or regional basis in the individual and small group health insurance markets and in benefits coverage, but is not an issuer.

States Must Ensure Exchanges Will be Capable of Certifying Qualified Health Plans

States choosing to operate their own exchange must ensure the exchange will be capable of certifying qualified health plans (QHP) and making them available to qualified individuals. A state opting for a partnership exchange may choose to engage in this function. In a partnership exchange, health insurance issuers will work directly with the state to submit all QHP issuer application information in accordance with state guidance.²¹ An exchange may only offer health plans that are certified as a QHP. To be certified, a health plan must meet two categories of requirements: (1) the health insurance issuer must be in compliance with minimum certification requirements as defined by HHS; and (2) the availability of the health plan through an exchange must be in the interest of qualified individuals and employers. To meet the minimum certification requirements, health insurance issuers must, for example, (1) be licensed and in good standing in each state in which the insurance coverage is offered,²² (2) comply with quality improvement standards, and (3) ensure their plan networks are adequate and include essential community health providers, where available, to provide timely access to services for predominantly low-income, medically underserved individuals.

How an exchange determines whether a plan is in the interest of qualified individuals and employers may depend on how the state organizes its market. The state may choose to organize its market as an “active purchaser” or as a “passive purchaser.” As an active purchaser, the state will decide which health plans can be offered in the exchange on the basis of such factors as select criteria, quality, and price. As a passive purchaser, the state may permit all QHPs to participate in the exchange.

²¹ CMS will work with states participating in state partnership exchanges to ensure that such guidance is consistent with federal regulatory standards and operational timelines. CMS anticipates that states will choose to use the National Association of Insurance Commissioners’ System for Electronic Rate and Form Filing to collect and review QHP data. The state will review issuer applications for QHP certification for compliance with the standards and will provide a certification recommendation for each QHP to CMS. CMS will review and confirm the state’s recommendations, coordinate plan preview, make final certification decisions, and make available certified QHP plans in the exchange for the relevant state partnership exchange. CMS will work closely with states in state partnership exchanges to coordinate this process.

²² “Good standing” generally means that the insurer has no outstanding sanctions imposed by a state’s department of insurance.

In order to be certified as a QHP, plans will also need to meet certain coverage requirements. Specifically, PPACA requires that QHPs provide essential health benefits (EHB) which include coverage within 10 categories:

1. Ambulatory patient services,
2. Emergency services,
3. Hospitalization,
4. Maternity and newborn care,
5. Mental health benefits and substance abuse disorder services, including behavioral health treatment,
6. Prescription drugs,
7. Rehabilitative and habilitative services and devices,
8. Laboratory services,
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services including oral and vision care.²³

In addition, within an exchange, health insurance issuers may offer QHPs at one of four levels of coverage that reflect out-of-pocket expenses for an enrollee. The four levels of coverage correspond to a percentage paid by a health plan of the total allowed costs of benefit designated by metal tiers: 60 percent (bronze), 70 percent (silver), 80 percent (gold), and 90 percent (platinum).²⁴ At a minimum, however, a health insurance issuer must offer QHPs at both the silver and gold levels of coverage.

²³Under PPACA, states may require plans to offer benefits in addition to these categories. States are required to either make payments to individual enrollees or to the issuers to defray the costs of these additional benefits.

²⁴Pub. L. No. 111-148, §§ 1302 (d), 10104(b)(1), 124 Stat. 167, 896. Accordingly, the actuarial value of a plan represents the expected percentage of costs the plan will incur for the EHB services provided to a standard population. For example, a gold plan with an 80 percent actuarial value would be expected to pay, on average, 80 percent of a standard population's expected medical expenses for the EHB. The individuals covered by the plan would be expected to pay, on average, the remaining 20 percent of the expected cost-sharing expenses in the form of deductibles, copayments, and coinsurance.

States may choose to identify a benchmark plan for their state that, at a minimum, covers the EHB. According to HHS, the benchmark plan reflects the scope of services and limits offered by a “typical employer” plan in the state.²⁵ HHS identified four plans that a state could choose: (1) one of the three largest plans in the state’s small group market health insurance plans; (2) one of the three largest state employee health benefit plans; (3) one of the three largest national plans offered through the Federal Employees Health Benefits Program; or (4) the largest commercial non-Medicaid health maintenance organization operating in the state. If the state does not select a benchmark plan, the state will default to the largest plan by enrollment in the largest product by enrollment in the state’s small group market.²⁶

States also have the option of requiring QHPs to offer benefits in addition to EHB. If they choose to do so, states must identify which specific state-required benefits are in excess of the EHB. Under HHS regulations, if a state required QHPs to cover benefits beyond EHB on or after January 1, 2012, the state would be responsible for defraying the cost of these services.

²⁵ Each state’s benchmark plan will apply to their respective exchanges for plan years 2014 and 2015, while HHS will revisit this issue for the 2016 plan year.

²⁶ The term “small group market health plan” is defined as the health insurance market in which employers with 100 or fewer employees offer group health plans.

States Must Streamline Eligibility and Enrollment Systems

States operating their own exchanges generally must ensure that the exchanges will be able to determine an applicant's eligibility for QHPs, as well as for Medicaid and CHIP.²⁷ Specifically, under PPACA and implementing regulations, states must establish an electronic, streamlined, and coordinated system through which an individual may apply for and receive a determination of eligibility for enrollment in a QHP,²⁸ Medicaid, CHIP, or Basic Health Program, if applicable. Exchanges must be able to use a single application that can be completed online, by mail, over the telephone, or in person. This means that no matter how an individual submits an application or which program receives the application, an individual will use the same application and receive an eligibility determination, without the need to submit information to multiple programs. Thus, state IT systems must be interoperable and integrated with an exchange, Medicaid, and CHIP to allow consumers to easily switch from private insurance to Medicaid and CHIP as their circumstances change. Exchanges must also be able to transmit certain data to HHS to be verified before determining applicants' eligibility. HHS, through a "federal data services hub," will coordinate with the Department of Homeland Security, the Internal Revenue Service, and other federal agencies to verify applicant information, such as citizenship and household income. With the amount of data that states must share with HHS in order to verify eligibility, developing streamlined eligibility and

²⁷ States with either state-based exchanges or partnership exchanges have the option of (1) allowing exchanges to make eligibility determinations for Medicaid and CHIP or (2) having exchanges make an assessment, with the state Medicaid agency or other relevant state agency making the actual determinations of eligibility. In addition, PPACA and implementing regulations provide for states, regardless of whether they are establishing an exchange, to create a transitional reinsurance program for 2014 through 2016 to help stabilize premiums for coverage in the individual market. HHS will establish a reinsurance program for any state that fails to establish this program. Further, beginning with the 2014 benefit year, each state electing to operate an exchange may establish a permanent risk adjustment program for all non-grandfathered plans in the individual and small group market both inside and outside of the exchanges. HHS will establish this risk adjustment program for any state that will not operate an exchange or for states operating an exchange but which do not elect to administer the risk adjustment program. These risk-spreading mechanisms are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets. We did not include states' reinsurance and risk adjustment activities in the scope of our work.

²⁸ In determining eligibility for a QHP, exchanges must also determine whether applicants qualify for premium tax credits or cost sharing reductions for these plans. States electing to establish and operate state-based exchanges, however, may choose to rely on HHS to make these determinations.

enrollment systems is a vast undertaking requiring states to develop sophisticated IT systems.

As part of the enrollment and eligibility process, HHS directs exchanges to rely on existing electronic sources of data to the maximum extent possible to verify relevant information, with high levels of privacy and security protection for consumers. For the majority of applicants, an automated electronic data matching process should eliminate the need for paper documentation.

States Must Conduct Consumer Assistance and Outreach

States that operate their own exchange are required to conduct consumer assistance and outreach through a number of activities. States that partner with HHS may assume some aspects of this function. Specifically, exchanges must have consumer assistance functions that are available to consumers to provide help in using the exchange. Such functions are required to be accessible to individuals with disabilities and individuals with limited English proficiency. Exchanges are also required to operate a toll-free call center and maintain a website that, among other things, allows consumers to compare qualified health plan benefits, costs, and quality ratings, and select and enroll in a plan. Further, exchanges must assist consumers with accessing and obtaining coverage, including providing tools to help consumers access the exchange, determine which plan or program to enroll in, and determine their eligibility for premium tax credits and cost sharing reductions.

As part of states' consumer outreach and assistance activities, each exchange is also required to operate a navigator program, which will provide eligible organizations with grants so they can raise awareness of QHPs' availability and facilitate consumers' selection of QHPs. Navigators may include organizations such as trade associations, community and consumer-focused non-profit groups and chambers of commerce. Navigators must maintain expertise in eligibility, enrollment, and program specifications. The entity serving as a navigator must deliver information to the public in a fair, accurate, and impartial manner that is culturally and linguistically appropriate to the needs of the population they serve.²⁹ HHS

²⁹ Unlike insurance agents and brokers, navigators are not authorized to receive compensation or other forms of payment—either directly or indirectly—from any health insurance issuer in connection with the enrollment of any qualified individuals, or employees of a qualified employer, in a QHP.

afforded state-based exchanges the opportunity to use in-person assisters in certain circumstances to ensure that the full range of services that the navigator program will provide in subsequent years are provided during the exchanges' initial year of operation. State partnership exchanges in which states will assist with consumer assistance functions will be required to establish and operate an in-person assistance program. While in-person assisters may receive the same training as navigators, they are part of a separate and distinct program and can use establishment grants to fund their operation.

PPACA requires that exchanges regularly consult with certain groups of stakeholders for all activities, including establishing and operating consumer assistance programs. These stakeholders include educated health care consumers enrolled in QHPs, representatives of small businesses and self-employed individuals, advocates for enrolling hard-to-reach populations, and individuals and entities with experience in facilitating enrollment in health insurance coverage. Further, HHS provided supplementing guidance on activities states may want to consider as part of their outreach and education, including:³⁰

- performing market analysis or an environmental scan to assess outreach and education needs to determine geographic and demographic-based target areas and vulnerable populations for outreach efforts;
- developing a “toolkit” for outreach to include educational materials and information;
- designing a media strategy and other information dissemination tools; and
- submitting a final outreach and education plan to HHS.

States Must Ensure Financial Sustainability of the Exchange

States operating their own exchanges are required to ensure their exchanges will be self-sustaining by 2015—meaning that states must ensure their exchanges have sufficient funding to support ongoing operations.³¹ PPACA allows these exchanges to generate funding for

³⁰ HHS, *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*, January 20, 2011.

³¹ PPACA prohibits the awarding of establishment grants for exchanges after January 1, 2015. HHS has clarified, however, that states seeking federal funding to establish exchanges may be awarded such funds until December 31, 2014.

exchange operations in certain ways, such as charging user fees or other assessment fees to exchange-participating health insurance issuers. Under HHS guidance, states are to submit a plan to HHS to demonstrate how their exchanges will be financially sustainable by January 1, 2015.

Despite Some Challenges, Selected States Have Taken Action to Establish Exchanges and Report They Will Be Ready for Enrollment by October 2013

Nearly All Selected States Have Created an Operating and Governance Structure

Six of the seven states in our study were conditionally approved by HHS to create a state-based exchange. State exchange officials we interviewed said that, among the reasons that states chose to establish this type of exchange are that it allows the state to (1) maintain consistency between the insurance market inside and outside the exchange, (2) better control its insurance market, and (3) have opportunities to better meet the unique needs of the state's population. In contrast, Iowa officials said the state opted to partner with HHS due to the high cost of building and maintaining a state-based exchange—which the state estimated to be \$15.9 million annually. Iowa officials also reported that, by assuming responsibility over certain exchange activities, such as overseeing and certifying qualified health plans, partnering with HHS allows the state to maintain regulatory control over its insurance market. Iowa officials told us that the state plans to transition to a state-based exchange sometime in the future.

To begin building an exchange, six of the seven states have established an operating structure through state legislation or by executive order. As a partnership state, Iowa is not establishing an operating structure at this time because HHS will initially establish and operate the exchange. As Iowa switches to a state-based exchange, it will need to establish an operating structure.

As shown in table 1, states varied in how they established their exchange operating structures. For example, three states—New York, Nevada, and Rhode Island—plan to run their exchange as entities within an existing state agency. Exchange officials in New York told us that basing the exchange within an existing state agency—New York’s Department of Health—allows the state to leverage established administrative systems and procedures, thereby relieving the exchange from some of the administrative burdens common to start-up organizations. Table 1 also shows that five out of the six states that have established an exchange have also created a governance board that ranges in member composition and expertise. Consistent with HHS regulation, all five governance boards include members that represent consumer interests.

Table 1: Summary of Exchange Operating and Governance Structures in Selected States

State	Type of exchange	Operating structure	Governance structure
District of Columbia	State-based	Independent authority established by state legislation	11 Board members: 4 non-voting ex officio members (or their designees) and 7 voting members appointed by the mayor with the consent of the council with demonstrated expertise in at least 2 of 12 designated areas, such as health care financing and public health programs; at least 1 member must possess knowledge of health care consumer interest advocacy. An executive director, hired by the board, will direct, administer, and manage the operations of the authority.
Iowa	Partnership	Will defer to HHS	Will defer to HHS
Minnesota	State-based	Board established by state legislation ^a	7 Board members: the commissioner of Human Services (or a designee) and 6 members appointed by the governor with the consent of both the state Senate and the House of Representatives—1 member representing interests of individual consumers eligible for individual market coverage, 1 member representing individual consumers eligible for public health care program coverage, 1 member representing small employers, 1 member with expertise in health administration and health care finance, 1 member with expertise in public health and the uninsured, and 1 member representing health policy issues related to small group and individual markets.
Nevada	State-based	Independent public agency established by state legislation	10 Board members: 3 ex officio non-voting members (or their designees) and 7 voting members—5 appointed by the governor, 1 member appointed by the Senate majority leader and 1 member appointed by the speaker of Assembly. The Board has 5 advisory committees: (1) Finance and Sustainability; (2) Plan Certification and Management; (3) Small Business Health Options Program Exchange; (4) Reinsurance and Risk Adjustment; and (5) Consumer Assistance.

State	Type of exchange	Operating structure	Governance structure
New York	State-based	Division within the New York State Department of Health established by executive order	No board created. The New York Health Benefit Exchange established five regional advisory committees to advise and make recommendations on the exchange establishment and operations. Committee members include consumer advocates, small business representatives, health care providers, health plans, agents, brokers, insurers, labor organizations, and policy experts.
Oregon	State-based	Public corporation established by legislation ^b	9 Board members: 2 ex officio voting members (or their designees) and 7 voting members appointed by the governor with Senate confirmation. ^c At least 2 voting members must be: (1) an individual consumer purchasing health care through the exchange; and (2) a small business employer purchasing health care through the exchange.
Rhode Island	State-based	Department within executive department established by executive order	13 Board members, including the director of the Department of Administration; the Health Insurance Commissioner; the Secretary of the executive office of Health and Human Services; the director of the Department of Health; and 9 members appointed by the governor: 2 represent consumer organizations, 2 represent small businesses. ^d A director of the Division of the Rhode Island Health Benefits Exchange—appointed by the governor—will organize, administer, and manage the operations of the division. No member of the Board is affiliated with a group or organization that has a conflict of interest with the exchange.

Source: GAO analysis of state legislation and executive orders.

^aUnder Minnesota law, an agency in the executive branch who is authorized to (1) perform administrative acts, (2) issue or revoke licenses or certifications, (3) make rules, or (4) adjudicate contested cases or appeals must be designated as a “board.” The Minnesota Insurance Marketplace was established with such authorities.

^bThe Oregon Health Insurance Exchange Corporation is a public corporation performing governmental functions and exercising governmental powers. O.R.S. § 741.001 (2011).

^cThe voting members must collectively offer expertise, knowledge, and experience in individual insurance purchasing, business, finance, sales, health benefits administration, individual and small group health insurance and use of the health insurance exchange.

^dThe board must include a balance of members with expertise in a diverse range of health care areas including, but not limited to, health benefits plan administration, health care finance and accounting, administering a public or private health care delivery system, state employee health purchasing, electronic commerce, and promoting health and wellness.

States Have Taken Steps toward Certifying Qualified Health Plans

All seven states in our review reported taking steps toward certifying QHPs. Two states have decided whether their exchanges will have the authority to actively select which QHPs may participate in the exchange. As active purchasers, exchanges can select QHPs by applying additional criteria and negotiating with health insurance issuers, or by a combination of these actions. As table 2 shows, two states decided to organize their exchanges as active purchasers, while the remaining five states will organize their exchanges as passive purchasers, allowing all plans that meet the minimum requirements for QHPs to participate in the exchange.

To identify benchmark plans, all selected states analyzed the plans and considered various factors, including whether the plans offered by the state required benefits in addition to the EHB required under PPACA. In choosing their benchmark plans, all seven states identified plans that included state-mandated benefits that did not exceed PPACA's EHB requirements. Table 2 shows that five of the seven states recommended benchmark plans to HHS, while two states chose not to identify a benchmark plan and will default to the largest small group plan in their state.

Table 2: Selected States' Insurance Market Organization and Essential Health Benefits (EHB)

State	Market organization	Essential health benefits benchmark plan	Plan type
District of Columbia	passive purchaser	recommended	small group
Iowa	passive purchaser	defaulted	small group
Minnesota	passive purchaser ^a	defaulted	small group
Nevada	passive purchaser	recommended	small group
New York	passive purchaser	recommended	small group
Oregon	active purchaser	recommended	small group
Rhode Island	active purchaser	recommended	small group

Source: GAO analysis of HHS documents and the Henry Kaiser Family Foundation as of January 3, 2013 and March 13, 2013.

^aAccording to Minnesota officials, the state expects to organize its market as an active purchaser in 2015.

Definitions: "Recommended" means that a state has recommended an EHB benchmark plan to HHS or developed a preliminary EHB recommendation. "Defaulted" means that a state has not recommended an EHB benchmark plan and will default to the largest small group plan.

All seven states included in our review have taken steps to invite health insurers to participate in their exchanges. For example, in January 2013, New York released an invitation to participate and began accepting applications for licensed insurers in the state (and those expected to be licensed by October 2013) to apply for certain QHPs to be offered through the New York exchange. The exchange governing board will review the applications of individual health plans to make sure they meet all federal minimum participation standards and other requirements to be certified as QHPs. Officials reported that the exchange anticipates certifying plans by mid-July 2013, and will be ready for enrollment on October 1, 2013.

Minnesota and Oregon requested applications in October 2012 from insurers who wanted to offer QHPs in the state's exchange, while the District began accepting applications in April 2013. Insurers certified

through the exchange must demonstrate the ability to meet minimum certification requirements including providing adequate networks, care coordination, and quality measures, among other things. Oregon officials told us the state plans to certify QHPs by the summer of 2013 and begin enrolling consumers in October 2013.

States Encountered Time Constraints and Other Challenges, but Are Moving Forward in Simplifying and Streamlining Eligibility and Enrollment Systems

All seven states in our review are in various stages of developing an IT infrastructure that can support a streamlined and integrated eligibility and enrollment system. A major focus of the states' integration activities is redesigning their current Medicaid and CHIP eligibility and enrollment systems. State officials described this as the most significant and onerous aspect of developing an IT infrastructure to support the exchange, given the age and limited functionality of current state systems. All seven states in our review use outdated systems, which lack the capacity to support web-based streamlined processes.

Further, the majority of states operate multiple eligibility and enrollment systems that serve individuals enrolled not only in Medicaid and CHIP but in other public assistance programs, such as Temporary Assistance to Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). These separate systems, which may be managed by multiple entities across the state, have limited interface capabilities. For example, similar to other states in our review, Oregon operates multiple enrollment and eligibility systems, whereby only a limited amount of enrollee information is accessible and reusable across multiple programs. In addition, Oregon has multiple interfaces between these programs to support integrated business processes, making systems complex, inflexible, and expensive to maintain. To address these kinds of issues, states are using enhanced federal funding, referred to as the 90 percent match, to either upgrade or rebuild their outdated Medicaid and CHIP eligibility and enrollment systems to meet the requirements under

PPACA.³² As states upgrade their Medicaid and CHIP systems, many are also taking the opportunity to integrate enrollment and eligibility processes for other public assistance programs, such as TANF and SNAP, in order to provide shared services across programs.

In addition to upgrading eligibility and enrollment systems, six of the seven states are in various stages of building the exchange IT infrastructure needed to integrate these systems and allow consumers to navigate among health programs and purchase QHPs through a variety of access points, using a single streamlined application.³³ The integrated systems will enable states to collect information needed for eligibility determination and verification, not only from their own state systems, but from federal systems as well. These systems are to utilize a federal data services hub provided by CMS, which will serve as a single source of the federal data that are needed to determine eligibility. To use this system, state systems are to transmit requests for data through the federal data services hub to multiple federal agencies, such as the Department of Homeland Security and the Internal Revenue Service.³⁴ The federal data services hub is to return the data in near real-time back to the state systems where it can be used to verify the information the states collected for determining applicants' eligibility.

Two states—New York and Oregon—are further along in this work than the other states in our review, as they were awarded early innovator grants to develop an IT infrastructure that will integrate Medicaid, CHIP, and other programs. To develop its state integrated systems, Oregon will use a commercial framework that can be easily adopted and used by

³²States may receive an enhanced administrative federal match—90 percent—for the design, development, and installation or enhancement of eligibility determination systems until December 31, 2015. In order to qualify for the 90 percent match, states must submit an advanced planning document to CMS for review and approval. As part of its review, CMS must determine that the design, development, installation, or enhancement of a state's eligibility system meets a number of standards and conditions, including seamless coordination with the health insurance exchanges. The 90 percent match is available only for costs incurred after April 19, 2011, and before December 31, 2015. Beginning April 19, 2011, states may also qualify for a 75 percent match for the operation of eligibility systems that continue to meet applicable standards and conditions. This enhanced match is not available for systems that do not meet these requirements by December 31, 2015.

³³ As a partnership state, Iowa is not required to establish an exchange infrastructure.

³⁴Other federal agencies include the Social Security Administration, the Veteran's Health Administration, Tricare, the Peace Corps, the Office of Personnel Management, and CMS.

other states. As part of its approach and consistent with the intent of the early innovator grant, Oregon has begun working with multiple states to share this framework, including their analyses, design, and other components.

CCIIO officials indicated that readiness testing of states' eligibility and enrollment systems for the exchange will begin in March 2013 and continue through August 2013. To date, three of the states in our review—Nevada, New York and Oregon—have begun testing various aspects of their eligibility, enrollment, and federal data services hub functionality with CCIIO. According to CCIIO officials, the remaining states in our review are expected to begin testing over the next few months. Most state officials told us that because of the complexities of developing an integrated and streamlined eligibility and enrollment system, they plan to use a phased approach to implementation to ensure that key system changes are in place before 2014. Specifically, they will focus first on ensuring that new systems are capable of determining eligibility for enrollment in QHPs, Medicaid, CHIP, and the exchange, and will integrate other assistance programs—such as SNAP and TANF—during later stages.

While state officials reported they expect to be ready to enroll individuals by October 1, 2013 and are moving forward with IT-related efforts, officials in six states identified challenges they faced with developing aspects of their systems, given compressed timeframes and a lack of clear federal requirements related to the federal data services hub. For example, exchange officials expressed concerns about the timeframes for implementation, because of the complexities and large undertaking of integrating and modernizing these systems. Further, most officials reported that transitioning multiple programs into a streamlined and coordinated eligibility and enrollment system could take years to fully implement. Officials in six states told us that developing business rules for the eligibility and enrollment system was challenging because they did not have complete information on the requirements of the federal data services hub. Because of implementation timelines, however, these officials said they needed to begin IT-related activities before receiving complete federal guidance. Most officials reported they were concerned that this could lead to changes late in the development process. To address this uncertainty, a few states built in flexibility in their requests for proposals when making procurement decisions. Officials in one state also reported that, in order to meet timeframes, modifications to the IT systems will be completed in 2014 (after enrollment begins), based on guidance issued late in the development process. CMS has indicated that

while the federal data services hub is still under development, CMS has released guidance to the states on how to access or verify data through the federal data services hub through such sources as webinars, conferences, and other forums. Despite the challenges associated with developing the IT systems, officials in six states reported their systems will be ready for enrollment by October 1, 2013.

States are Developing Outreach and Assistance Programs to Help Consumers Enroll in the Exchange

Six of the seven states included in our review are in various stages of developing a consumer outreach and assistance program to reach out to potential consumers and help them enroll. As a partnership state, Iowa has not yet decided whether and to what extent it will assist HHS with aspects of this function. Most states have contracted with or plan to contract with vendors to design a program. The vendors will assist with the exchanges' branding, which will be able to translate materials into multiple languages and take into account the needs of individuals with disabilities. The vendors will also design and implement communications and marketing plans (for example, radio and television ads) with the goal of enrolling the maximum number of eligible individuals into the exchange.

As part of the consumer outreach and assistance programs, states will use a range of tools to provide potential consumers with information and assist them in enrolling in an exchange. These include:

Navigators and in-person assistors. Six of the seven states in our review plan to use navigators and assistors to provide in-person enrollment assistance to individuals applying for health insurance, such as assisting individuals with selecting QHPs or providing information to individuals in a way that is culturally and linguistically appropriate. HHS plans to assume responsibility for operating the navigator program in Iowa, since it is a partnership state. Nearly all states told us that assistance will need to be tailored to the unique needs of their populations. For example, Nevada officials told us that their program must be able to accommodate individuals who live in Nevada's remote frontier region, where population density can be as low as two people per square mile and which may lack infrastructure such as Internet access. New York officials told us they will address linguistic and cultural challenges reaching individuals in some of New York City's more diverse communities.

Four states—the District, New York, Oregon, and Rhode Island—plan to leverage state resources within existing health and human services

programs to support navigators and assistors. For example, Oregon plans to model its navigator program after a state Medicaid program that provides uninsured individuals with premium assistance and access to health care information and resources. Similarly, New York, which issued a request for application in February 2013 for in-person assistors and navigators, will model its approach after its community assistance programs and will provide assistance through a variety of access points in other local areas across the state. New York officials told us that the state plans to sign contracts with navigators and in-person assistors in the summer of 2013 and begin training them in August or September 2013.

Web portals and call centers. Six of the seven states in our review are designing web portals and contact centers as part of their consumer assistance and outreach initiatives. The seventh state, Iowa, is a partnership state and is deferring this responsibility to HHS. State planning documents in the remaining six states indicated that the web portals and the contact centers will be central to assisting residents. State officials told us that web portals, in particular, will ease comparisons among health plans by providing standardized information about each health plan's premium, benefit structure, and cost-sharing provisions. For example, District officials told us that a web portal, which is being developed in conjunction with the IT infrastructure, will be the key access point for consumers to interface with the exchange. Similarly, Minnesota is designing a contact center that will offer multiple modes of assistance through such means as Internet access, telephone, mail, and in-person assistance. State officials told us they expect the customer service functions will be ready to operate on October 1, 2013.

States Are Planning for Long-Term Sustainability with Multiple Revenue Options, but Faced Uncertainties Estimating Costs

Officials in six states in our review reported they are considering a number of revenue options for financially sustaining their exchange.³⁵ For example, as part of the planning efforts to develop these options, three states—Nevada, Minnesota, and the District—created work groups to recommend options for achieving long-term sustainability. In particular, both Minnesota and Nevada created working groups intended to review and propose financing options to enable the exchange to be self-sustaining by January 1, 2015.

³⁵ As a partnership exchange, Iowa is not responsible for carrying out this key function.

While states reported they are considering options to fund ongoing exchange costs, such as salaries and benefits, consulting services, outreach and marketing, and information technology, three states will charge fees to insurance carriers participating in the exchange. Specifically:

- Oregon will charge an administrative fee to insurance carriers participating in the exchange. In particular, carriers will be required to pay a percentage of the premiums (up to 5 percent) based on the number of enrollees in the exchange. The fee is designed to decrease as enrollment in the exchange increases. For example, if more than 300,000 individuals enroll in the exchange, the state exchange will charge carriers up to a 3 percent fee. If enrollment is at or below 175,000, the state exchange will charge carriers up to a 5 percent fee. Between 100,000 and 120,000 enrollees would be required for the exchange to be self-sustaining using the maximum administrative fee of 5 percent. Further, any excess revenues generated above the cost of operating the exchange may be placed in a reserve fund of up to 6 months of operating expenses or returned to insurance carriers.
- Nevada plans to charge insurance carriers a per member per month fee based on enrollment. In its financial sustainability plan, the state estimated the fee will amount to between \$7.13 and \$7.78 per member per month, which the state anticipates insurance carriers will build into their QHP premiums. In addition, based on the state's estimates, the state expects the fee will be paid by the advance premium tax credit. Nevada is also considering other potential sources of supplementary revenue, such as fees charged for stand-alone vision and dental plans.
- Minnesota plans to charge an administrative fee to insurance carriers participating in the exchange. Specifically, insurers will be required to pay a percentage of the premiums (about 3.5 percent) sold through the exchange. The fee will be based on the volume of insurance premiums for plans sold through the exchange.

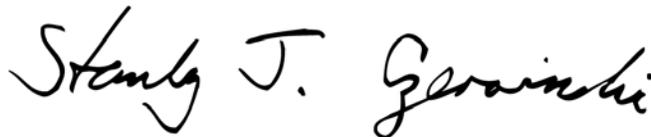
While the states in our review have developed financing options, some state officials identified challenges with developing these options, given uncertainties related to exchange enrollment. Specifically, financial sustainability will be highly dependent on the size of enrollment and the take up rate, which is the percent of individuals that are estimated to enroll in coverage out of the entire eligible population. Some state officials reported that, estimating enrollment patterns without the benefit of

historical data from the exchange, could impact revenue projections. Further, according to one state, uptake estimates among various groups are “drastically different,” so that estimating enrollment could result in significantly different per member per month carrier fees required to fund the exchange. Officials from two states reported that given these uncertainties, they expect to make adjustments to these estimates over time.

Agency Comments

We provided a draft of this report to the Secretary of HHS for review and comment. In response, HHS provided technical comments, which we incorporated as appropriate. Additionally, we provided excerpts of the draft report to exchange officials, such as the executive director and chief policy research and evaluation officer, in the seven states we interviewed for this study. We incorporated their technical comments as appropriate.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of HHS and interested congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>. If you have any questions concerning this report, please contact Stanley J. Czerwinski at (202) 512-6806 or czerwinkis@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix II.



Sincerely yours,
Stanley J. Czerwinski
Director, Strategic Issues

Appendix I: Objectives, Scope & Methodology

This report addresses the following objectives: (1) identify states' responsibilities for establishing health benefit exchanges; and (2) describe the actions selected states have taken to establish exchanges and the challenges they have encountered.¹

To identify states' responsibilities for establishing exchanges and the challenges they encountered, we reviewed selected Patient Protection and Affordable Care Act (PPACA) provisions and Department of Health and Human Services (HHS) implementing regulations and guidance related to the following categories:

- establishing a governance and operating structure;
- ensuring exchanges will be capable of certifying qualified health plans;
- simplifying and streamlining eligibility and enrollment systems;
- conducting consumer assistance and outreach; and
- ensuring the financial sustainability of the exchange.

Our review of HHS's guidance included HHS's blueprint for approval of state-based and partnership exchanges, information bulletins, questions and answers, and webinars. We also reviewed reports that have summarized state responsibilities with regard to the categories we included in our study, including those completed by federal agencies monitoring the implementation process and national associations that play a role in assisting states with implementation. Specifically, we reviewed reports from the Congressional Budget Office, the Congressional Research Service, and relevant state associations, such as the National Association of Insurance Commissioners, the National Conference of State Legislatures, the National Association of State Budget Officers, and the National Academy for State Health Policy.

To identify actions selected states have taken to create exchanges and the challenges they encountered, we conducted semistructured interviews with officials in seven states: the District of Columbia,² Iowa,

¹ For purposes of this report, we focus on certain categories of responsibilities. Therefore, this list does not include all states' responsibilities related to establishing an exchange.

² For ease of reporting and for purposes of this review, we refer to the District of Columbia as a state.

Minnesota, Nevada, New York, Oregon, and Rhode Island. We selected these states on the basis of:

1. The percentage of the uninsured population in states based on a 3-year average (2008 to 2010);
2. The percentage of the uninsured population in states in 2011;
3. The amount of exchange grants awarded to states on a per capita basis;³
4. Geographic dispersion; and
5. The type of exchange states intended to establish, based on data publicly available as of September 27, 2012.⁴

Table 3 shows the characteristics of the states selected for our review. We initially selected two states that intended to operate as federally facilitated exchanges—Florida and Maine. However, exchange officials in both states declined to be interviewed. Therefore, this review focused on states' responsibilities to establish state-based and partnership exchanges.

³We calculated the amount of total planning, establishment, and early innovator grants awarded on a per capita basis in each state as of September 27, 2012. We divided the total amount of grants awarded to states by the total state population.

⁴Specifically, we selected states on the basis of whether they intended to opt for a state-based, federally facilitated, or partnership exchange as of September 27, 2012. At that time, states had not yet formally declared their intention to HHS through the blueprint application. However, we used the most readily available information at that time from HHS and the Henry Kaiser Family Foundation.

Table 3: Characteristics of States Included in GAO Study

Selected States	Percentage of the uninsured population based on 3-year average	Percentage of the uninsured population in 2011	Exchange grants awarded on a per capita basis as of September 27, 2012	Census region	Status of intended state action, as of September 27, 2012
District of Columbia	11.4%	8.4%	\$136.6	South	State-based
Iowa	10.7	10	11.6	Midwest	Studying options
Minnesota	8.7	9.2	13.9	Midwest	Studying options
Nevada	20	22.6	27.7	West	State-based
New York	14.2	12.2	9.5	Northeast	State-based
Oregon	16.5	13.8	16.9	West	State-based
Rhode Island	11.5	12	61.5	Northeast	State-based
Florida ^a	20.7	19.8	0	South	Federally facilitated
Maine ^b	9.9	10	0.8	Northeast	Federally facilitated

Source: GAO analysis of U.S. Census Bureau and HHS data.

^a Florida was initially selected for inclusion in our review based on our selection criteria noted, but exchange officials declined to be interviewed for our study.

^b Maine was initially selected for inclusion in our review based on our selection criteria noted, but exchange officials declined to be interviewed for our study.

We conducted initial interviews in person and by telephone between October and November 2012 and follow-up interviews between February and March 2013. The interview questions focused on states' actions regarding establishing an exchange and the challenges they encountered in the following areas: establishing an operating and governance structure, developing information technology systems and infrastructure to support a streamlined eligibility and enrollment system, ensuring exchanges will be capable of certifying qualified health plans, creating consumer outreach and assistance, and ensuring the exchange's financial sustainability. We also met with budget officials in some of the states to discuss the fiscal aspects of establishing exchanges, including how states will ensure exchanges are financially sustainable. The responses to the interviews are not intended to be representative of all state exchange and budget officials.

To supplement our interviews, we reviewed state planning, budget, and implementation documents, such as state blueprint applications, business plans, exchange grant applications, and contracting documents.

In addition, we conducted interviews with officials from the Centers for Medicare & Medicaid Services (CMS) and CMS's Center for Consumer

Information and Insurance Oversight and relevant state associations, including the National Association of State Budget Officers, National Conference of State Legislatures and the National Association of Insurance Commissioners.

We conducted our work from September 2011 to April 2013 in accordance with generally accepted government audit standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Stanley J. Czerwinski, Director, Strategic Issues, (202) 512-6806 or czerwinskis@gao.gov

Staff Acknowledgments

In addition to the contact named above, Brenda Rabinowitz, Assistant Director; Kisha Clark, Analyst-in-Charge; Sandra Beattie, Amy Bowser, Robert Gebhart, Sherrice Kerns, Cynthia Saunders, Stacy Ann Spence, and Hemi Tewarson made key contributions to this report.

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