ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

December 4, 2015

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Subcommittee Hearing on "An Overdue Checkup Part II: Examining the ACA's State Insurance Marketplaces"

On Tuesday, December 8, 2015, at 10:00 a.m., in room 2322 of the Rayburn House Office Building, the Subcommittee will hold a hearing on the Centers for Medicare & Medicaid Services (CMS) oversight of state health insurance marketplaces under the Affordable Care Act (ACA). This brief memo updates the hearing memo from the September 29 hearing on the implementation of state health insurance marketplaces.

I. THIRD OPEN ENROLLMENT SEASON

On November 1, 2015, the state and federal health insurance marketplaces (collectively, the Marketplaces) officially opened to individuals for 2016 enrollment. Early reports indicate that the open enrollment season launched smoothly.[1]

This year, the federally-facilitated marketplace (FFM), HealthCare.gov, is streamlining processes to renew coverage, and offering prospective enrollees a cost calculator to estimate and compare their total costs under different health plans.[2] Similarly, new or enhanced "shop-and-compare" tools in a number of state-based marketplaces (SBMs), such as California,

[1] National Academy for State Health Policy, *And They're Off: New State-based Marketplace Consumer Services and Supports Launch for OE3* (Nov. 10, 2015); *Revamped HealthCare.Gov Opens With New Tools for Gauging True Cost of Insurance*, New York Times (Oct. 26, 2015).

[2] *Revamped HealthCare.Gov Opens With New Tools for Gauging True Cost of Insurance*, New York Times (Oct. 26, 2015).

Connecticut, Kentucky, Massachusetts, Minnesota, and the District of Columbia enable consumers to make more informed choices across their coverage options.[3]

The average premium of the second-lowest cost silver plan offered in the Marketplaces will increase by a relatively modest 7.5 percent, on average for the 2016 plan year. This rate increase is significantly less than what had been the norm prior to enactment of the Affordable Care Act: annual, double-digit percentage increases in premiums, on average.[4]

Additionally, the availability of advance premium tax credits will continue to make coverage affordable and accessible. Nearly 80 percent of the uninsured who are eligible for coverage through the Marketplaces have incomes between 100 percent and 400 percent of the Federal Poverty Level (FPL) and may be eligible to receive tax credits for plan year 2016. More than seven in ten (72 percent) current Marketplace enrollees can find a plan for $75 in premiums or less per month, after applicable advance premium tax credits. Nearly eight in ten (78 percent) current Marketplace enrollees can find a plan for $100 or less per month, after tax credits.[5]

According to CMS, over two million consumers have selected coverage through the FFM since open enrollment began on November 1, 2015.[6] Overall, the Department of Health and Human Services (HHS) projects between 9.4 million and 11.4 million effectuated enrollments in the state and federal marketplaces at the end of 2016.[7]

II. CMS OVERSIGHT OF STATE-BASED MARKETPLACES

CMS's oversight process for the SBMs includes a variety of mechanisms through which project officers regularly review information reported by grantees and communicate with grantees. Agency oversight is supplemented by independent verification using internal analysis and periodic reviews. Mechanisms of oversight include:

[3] National Academy for State Health Policy, *And They're Off: New State-based Marketplace Consumer Services and Supports Launch for OE3* (Nov. 10, 2015).

[4] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace* (Oct. 30, 2015).

[5] *Id.*

[6] Centers for Medicare & Medicaid Services, *Health Insurance Marketplace Open Enrollment Snapshot- Week 3* (Nov. 25, 2015).

[7] Department of Health and Human Services, *How Many Individuals Might Have Marketplace Coverage At the End of 2016?* (Oct. 2015) (online at aspe.hhs.gov/basic-report/how-many-individuals-might-have-marketplace-coverage-at-the-end-of-2016).

- **Progress reports.** As a condition of receiving exchange grants, CMS requires grantees to prepare and submit regular progress reports covering programmatic activities, progress in meeting program goals, and expenditure details.[8]

- **Continuous monitoring and technical assistance for SBMs.** CMS conducts weekly meetings with SBMs to discuss IT development, customer service issues, Medicaid eligibility integration, operational issues, issuer relationships, and consumer and market trends and dynamics. Additionally, CMS holds bi-weekly meetings with SBM chief executives to discuss a variety of business, budget and regulatory issues.[9]

- **Financial monitoring.** Project officers oversee and assess exchange grantees' financial activities by monitoring the amount and pace of the states' drawdown of grants. If review of weekly financial reports highlights potential issues, CMS will follow up with grantees and determine whether further action is warranted.[10]

- **On-site reviews.** CMS officials conduct site visits to assess exchange grantees' activities, examine infrastructure, operations, budget, marketing, staffing, and key business functions. CMS also provides technical assistance to states through on-site visits and reviews.[11]

- **Tracking of states' financial sustainability and programmatic information.** SBMs must submit to HHS a State-Based Marketplace Annual Reporting Tool (SMART), which helps oversee SBM compliance with key regulatory reporting requirements and monitors states' transitions from grant funding to self-sustainability. Reporting requirements include requirements for financial statements, reports on eligibility determination errors, performance monitoring data, and consumer satisfaction data.[12]

- **Independent audits to ensure compliance with all applicable grant conditions and regulations.** All recipients of establishment grants are required to obtain an independent audit of their financial statements annually. CMS reviews the audit for

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[8] Government Accountability Office, *Patient Protection and Affordable Care Act: HHS's Process for Awarding and Overseeing Exchange and Rate Review Grants to States* (May 2013) (GAO-13-543).

[9] Government Accountability Office, *State Health Insurance Marketplaces* (Sept. 2015) (GAO-15-527).

[10] Government Accountability Office, *Patient Protection and Affordable Care Act: HHS's Process for Awarding and Overseeing Exchange and Rate Review Grants to States* (May 2013) (GAO-13-543).

[11] Government Accountability Office, *State Health Insurance Marketplaces* (Sept. 2015) (GAO-15-527).

[12] *Id.*

each grantee. Grantees are required to address any significant findings from the audit and to develop plans for mitigating future problems.[13]

III. WITNESSES

Andy Slavitt
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Centers for Medicare & Medicaid Services

[13] *Id.*