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ONE HUNDRED FOURTEENTH CONGRESS

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

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MEMORANDUM

September 29, 2015

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

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

On Tuesday, September 29, 2015, at 10:00 a.m. in room 2123 of the Rayburn House Office Building, the Committee will hold a hearing on the implementation of state health insurance exchanges under the Affordable Care Act (ACA). Although some states have faced technological and operational challenges, many are making great strides in lowering the uninsured rate and expanding access to high quality, affordable health insurance.

I. BACKGROUND

The ACA is working and improving access to affordable, high quality health insurance coverage, as well as transforming the nation's healthcare delivery system.

- About 9.9 million consumers had effectuated enrollments in the state and federally facilitated exchanges as of June 30, 2015. Approximately 2.7 million of these people used state exchanges to select private plans.[1]

- Since passage of the law more than five years ago, an estimated 17.6 million uninsured people have gained health coverage through the ACA's various coverage provisions.[2]

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[1] Department of Health and Human Services, *June 30, 2015 Effectuated Enrollment Snapshot* (Sept. 8, 2015) (online at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html).

[2] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage and the Affordable Care Act* (Sept. 22, 2015) (online at

- According to newly-released data from the U.S. Census Bureau, the uninsured rate fell from 13.3 percent to 10.4 percent from 2013 to 2014, representing the largest single-year reduction in the uninsured rate since 1987.[3]

- In 2014, hospital uncompensated care costs were $7.4 billion lower than 2013 levels as a result of exchange coverage and Medicaid expansion.[4]

- The ACA has also improved health care delivery systems: hospital readmissions are down, and indicators of patient safety, such as hospital-acquired conditions, have improved significantly.[5]

II. STATE IMPLEMENTATION OF THE ACA

The ACA gives each state the option of establishing its own state-based health insurance marketplace, known as a state-based marketplace or exchange.[6] Although several states have faced technical challenges in implementing state-based marketplaces (SBMs), at present 12 states plus the District of Columbia operate state-run marketplaces. An additional four states operate their own marketplaces but utilize the federal website.[7]

While the IT infrastructure of SBMs is clearly important, other crucial components exist including: an established governance and financing structure, a clear regulatory scheme encompassing carrier eligibility to offer plans on an exchange, collaborative relationships between multiple agencies, and an infrastructure for consumer outreach and assistance.[8]

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http://aspe.hhs.gov/basic-report/health-insurance-coverage-and-affordable-care-act-september-2015).

[3] Center for Budget and Policy Priorities, *Census Data Show Historic Coverage Gains in 2014* (Sept. 18, 2015) (online at www.cbpp.org/research/health/census-data-show-historic-coverage-gains-in-2014).

[4] Department of Health and Human Services, *Insurance Expansion, Hospital Uncompensated Care, and the Affordable Care Act* (Mar. 23, 2015) (online at aspe.hhs.gov/pdf-document/insurance-expansion-hospital-uncompensated-care-and-affordable-care-act).

[5] Department of Health and Human Services, *The Affordable Care Act is Working* (June 24, 2015) (online at www.hhs.gov/healthcare/facts/factsheets/2014/10/affordable-care-act-is-working.html).

[6] Centers for Medicare and Medicaid Services, *State Health Insurance Marketplaces* (online at www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html) (accessed Mar. 30, 2014).

[7] The Commonwealth Fund, *The Affordable Care Act's Health Insurance Marketplaces by Type* (online at www.commonwealthfund.org/interactives-and-data/maps-and-data/state-exchange-map) (accessed Aug. 28, 2015).

[8] Sarah Dash et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges,* The Commonwealth Fund (July 11, 2013) (online at

States occupy different points along a spectrum based on their respective decisions as to the scope of their operational participation and involvement. One cluster of states is comprised of the 12 states plus the District of Columbia that operate completely independently— generally referred to as an SBM—to another cluster of 18 states that defer all responsibilities to the federally facilitated marketplace. The remaining 20 states retain varying degrees of independence and cooperation with the federal government on issues such as IT infrastructure, consumer assistance and plan management.[9] This hybrid arrangement is often referred to as a state-partnership marketplace.[10] The partnership model involves a formal agreement between the state and the Department of Health and Human Services (HHS).[11]

A. Establishment Grants

Section 1311 of the ACA provides funding for states establishing state-based marketplaces through two different levels of establishment grants:

- Level one grants provide up to one year of funding to states that have made some progress in undertaking specific SBM establishment activities. States may seek additional years of level one funding to meet criteria to apply for level two funds.
- Level two grants provide up to three years of funding to states that have demonstrated capacity and commitment to establish the full set of core Exchange activities.[12]

To date, HHS has awarded roughly $5 billion in establishment grants. States invited to appear before the Committee have received the following amounts in establishment grants, a portion of which was spent on IT:

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www.commonwealthfund.org/publications/fund-reports/2013/jul/design-decisions-for-exchanges).

[9] The Commonwealth Fund, *The Affordable Care Act's Health Insurance Marketplaces by Type* (online at www.commonwealthfund.org/interactives-and-data/maps-and-data/state-exchange-map) (accessed Aug. 28, 2015).

[10] Department of Health and Human Services, *Addendum to the Health Insurance Marketplace: March Enrollment Report* (Mar. 11, 2014) (online at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Mar2014/ib_2014Mar_enrollAddendum.pdf).

[11] *Id*. In the State Partnership option, states have primary responsibility for overseeing and certifying Qualified Health Plans (QHPs), conducting consumer assistance/outreach, or both functions. *See* Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Guidance on the State Partnership Exchange* (Jan. 3, 2013) (online at www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/partnership-guidance-01-03-2013.pdf).

[12] Congressional Research Service, *Federal Funding for Health Insurance Exchanges* (Oct. 29, 2014).

	Total Grant Funding Awarded	Amount authorized for IT
Oregon:	$305 million	$ 79 million
Hawaii:	$205 million	$128 million
Minnesota:	$189 million	$ 76 million
Massachusetts:	$234 million	$ 95 million
Connecticut:	$176 million	$116 million
California:	$1.07 billion	$324 million[13]

1. HHS Approval Process for SBMs

To receive HHS approval for a state-based marketplace and receive level two funding, a state must complete and submit an Exchange Blueprint that documents how the marketplace will meet all legal and operational requirements.[14] The state must conduct specified activities among 10 different dimensions, including: 1) establishing legal authority and a governance structure; 2) conducting consumer and stakeholder engagement and support activities; 3) conducting eligibility determinations and enrolling beneficiaries; 4) overseeing and certifying Qualified Health Plans; 5) establishing a Small Business Health Options Program (SHOP); 6) funding an organizational structure and staffing resources to perform exchange activities; 7) engaging in long-term operational cost, budget, and management plans; 8) establishing technology systems that comply with HHS IT guidance regarding required functionality 9) establishing privacy and security standards and policies; and 10) conducting oversight and monitoring.[15]

2. HHS Grant Stipulations

Section 1311 requires that marketplaces must be self-sustaining by January 1, 2015, and provides that no grant shall be awarded after January 1, 2015, for states to establish marketplaces.[16] In April 2015, the HHS-OIG issued an "early alert" recommending that CMS develop clearer guidance to ensure that marketplaces do not use grant funds to support ongoing operations.[17] On June 8, 2015, CMS issued guidance clarifying allowable uses of establishment

[13] Government Accountability Office, *State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects* (Sept. 16, 2015) (GAO-15-527); Kaiser Family Foundation, Total Health Insurance Exchange Grants (online at kff.org/health-reform/state-indicator/total-exchange-grants) (accessed Sept. 22, 2015).

[14] U.S. Department of Health and Human Services, *Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges* (online at www.cms.gov/CCIIO/Resources/Files/Downloads/hie-blueprint-11162012.pdf).

[15] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges* (Dec. 6, 2013).

[16] Patient Protection and Affordable Care Act, Pub. L. No.111-148, §1311 (2010).

[17] U.S. Department of Health and Human Services, Office of Inspector General, *Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law* (Apr. 27, 2015).

funds after January 1, 2015, which includes such establishment activities as stabilizing marketplace IT systems, outreach and education to support enrollment, and long-term capital planning.[18]

B. State Successes in Expanding Access to Healthcare

Although much attention regarding the SBMs has focused on technical difficulties several states encountered in setting up their marketplaces, overall the SBMs have performed well in expanding access to health care. States that chose to expand Medicaid and run their own marketplaces saw the greatest decreases in the uninsured rate.[19] For instance, California reduced its uninsured rate from 17.2 percent to 12.4 percent from 2013 to 2014, a decrease of 28 percent. Kentucky reduced its uninsured rate from 14.3 percent to 8.5 percent, a decrease of 41 percent. States such as Oregon and Minnesota, which experienced technical difficulties with their SBMs, still were able to reduce their uninsured rates by 34 percent and 28 percent, respectively.[20] States with already low insurance rates, many of which were offering robust Medicaid programs prior to 2014, saw moderate but important decreases, as uninsured rates dipped below six percent in the District of Columbia, Hawaii, and Vermont.[21]

C. State Innovation in State-Based Marketplaces

Many states have utilized the flexibility afforded by the SBM model to tailor their exchanges to the needs of their populations with the goal of improving quality, access, and the consumer experience.[22]

First, states have utilized the marketplace as a mechanism to streamline government operations and maximize efficiency of their social service eligibility and delivery systems. For example, Kentucky, Rhode Island, and the District of Columbia have all fully integrated their

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[18] Centers for Medicare & Medicaid Services, *FAQs on the Clarification of the Use of 1311 Funds for Establishment Activities* (June 8, 2015) (online at www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf).

[19] National Academy for State Health Policy, *According to U.S. Census Bureau report, Uninsured Rates Drop in All 50 States and the District of Columbia* (Sept. 16, 2015) (online at www.nashp.org/according-to-us-census-bureau-report-uninsured-rates-drop).

[20] *Id.*

[21] *Id.*

[22] Sarah Dash et. al., *Implementing the Affordable Care Act: State Action on Quality Improvement in State-based Marketplaces*, The Commonwealth Fund (July 29, 2014) (online at www.commonwealthfund.org/publications/issue-briefs/2014/jul/state-action-quality-improvement-marketplaces); Christina Cousart et al., *The State-Based Marketplaces: A Focus on Innovation, Flexibility, and Coverage*, National Academy for State Health Policy (July 22, 2015) (online at www.nashp.org/wp-content/uploads/2015/07/SBM1.pdf).

health insurance exchanges with human services programs such as the Supplemental Nutritional Assistance Program and Temporary Assistance for Needy Families to create a "one-stop shop" to improve consumer experience and minimize bureaucracy.[23]

In addition to improving social service integration, states have utilized the marketplace to act as a laboratory for IT innovation. For example, California was one of the first states to offer the ability for consumers to sort and filter plans based on premiums, deductibles, out-of-pocket costs as well as providers available on particular plans. Other states, such as Connecticut, are experimenting with more advanced technologies, such as a highly popular mobile app.[24]

Finally, the individualized approach of a state-based exchange allows states to perform marketing and outreach personalized for each state's population. A unique example is the state of New Mexico, which has partnered with tribal governments to improve education and provide outreach to Native American communities.[25] Other states' exchanges have partnered with insurance companies to co-brand official documents to improve beneficiary understanding of insurance benefits and decrease confusion. Others have used data gained from their marketplace to identify specific hard-to-reach populations for targeted enrollment efforts.[26]

1. Some Examples of States Pursuing Innovative Approaches:

California

California's SBM, Covered California, serves as a model for local innovation in health system delivery. The exchange includes many unique features designed to improve the quality, costs, and access of plans available on the marketplace.[27] Notably, Covered California acts as an "active purchaser" in their exchange and only contracts with select carriers that uphold a specific set of criteria. Importantly, Covered California requires plans to participate in payment reform and quality collaboratives, provide coordinated care for chronic diseases, develop programs that reduce health disparities, and adhere to a number of other requirements.

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[23] Christina Cousart et. al., *The State-Based Marketplaces: A Focus on Innovation, Flexibility, and Coverage*, National Academy for State Health Policy (July 22, 2015) (online at www.nashp.org/wp-content/uploads/2015/07/SBM1.pdf).

[24] *Id.*

[25] Native American Professional Parent Resources, *New Mexico Health Insurance Exchange Approves Native American Navigator Entity* (online at www.nappr.org/new-mexico-health-insurance-exchange-approves-native-american-navigator-entity) (accessed Sept. 22, 2015).

[26] Christina Cousart et. al., *The State-Based Marketplaces: A Focus on Innovation, Flexibility, and Coverage*, National Academy for State Health Policy (July 22, 2015) (online at www.nashp.org/wp-content/uploads/2015/07/SBM1.pdf).

[27] Covered California, *Delivering on the Promise of the Affordable Care Act*, Alliance for Health Reform National Congressional Forum (July 1, 2015) (online at www.allhealth.org/briefingmaterials/LEE_Z0.PDF).

Beyond active purchasing, Covered California has engaged in a number of forward-thinking features. California was the first state in the nation to allow patients to compare plans based on customer quality ratings using a four star system.[28] Beyond this, the exchange requires participating insurers to adhere to a documented quality improvement strategy, a feature that goes beyond what the federally facilitated marketplace requires.[29] These quality ratings and other features are incorporated in a consumer-directed "shop and compare" tool developed to facilitate consumer understanding and ease of use. Finally, Covered California has developed local partnerships with community organizations that are fluent in 13 languages for consumer assistance and outreach.[30]

California has also taken important steps to protect consumers against the rising costs of specialty drugs and ensure consumer access to vital medications. Under rules that go into effect in 2016, the vast majority of Covered California consumers will see their specialty drug costs capped at $250 per month, per prescription.[31]

New York

New York has also established an independent marketplace referred to as the "NY State of Health." NYSOH has created a customized feature that promotes plan transparency when patients comparison shop on the exchange. Beyond patient satisfaction, NYSOH rates plans based on a combination of 20 distinct measures customized to the state's needs.[32] Like California, NYSOH also requires insurers to develop quality improvement strategies. Finally, New York has used its exchange IT infrastructure to identify individuals at risk of inappropriately being deemed ineligible for Medicaid. This has successfully reduced the so-called "churn" of individuals who experience frequent disruptions in insurance status.[33]

Oregon

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[28] Anna Gorman, *California Marketplace Among First to Post Customer Health Plan Ratings*, Kaiser Health News (Jan. 30, 2014) (online at khn.org/news/california-marketplace-among-first-to-post-customer-health-plan-ratings/).

[29] Sarah Dash et al., *Implementing the Affordable Care Act: State Action on Quality Improvement in State-based Marketplaces*, The Commonwealth Fund (July 29, 2014) (online at www.commonwealthfund.org/publications/issue-briefs/2014/jul/state-action-quality-improvement-marketplaces).

[30] Covered California (online at www.coveredca.com) (accessed Sept. 22, 2015).

[31] Covered California, *Covered California Board Protects Consumers Against Skyrocketing Specialty Drug Costs to Ensure Access to Vital Medications* (May 21, 2015) (online at news.coveredca.com/2015/05/covered-california-board-protects.html).

[32] New York State of Health (online at nystateofhealth.ny.gov/) (accessed Sept. 26, 2015).

[33] *Health Exchange Adds 1.1 Million to Medicaid*, Associated Press (July 19, 2015) (online at bigstory.ap.org/article/a9fba66742604912948603a0a247917f/ny-health-exchange-adds-11-million-medicaid).

OregonHealthcare.gov is utilizing the exchange to improve the health of Oregonians. They also have initiated a star rating system to assist consumers when faced with purchasing decisions.[34] This rating system is very much individualized and includes measures such as rates of breast cancer screening, flu shots, avoidable hospital stays, and patient ratings of care. Similar to California, the marketplace requires participating insurers to develop a quality improvement strategy.[35] Beyond quality, OregonHealthcare.gov has developed an online assistance tool to connect consumers with local partnerships representing 26 different languages.[36]

D. Technical and Operational Challenges Facing State-Based Marketplaces

The technological difficulties faced by a number of SBMs in both the first and second enrollment seasons are well-documented. In the first year of open enrollment, Maryland, Massachusetts, Oregon, Hawaii, Minnesota, Nevada, Vermont, and New Mexico all struggled to stand up the technology required to successfully enroll individuals in qualified health plans.[37] In the second year of open enrollment, some states improved functionality, but others continued to struggle with some IT challenges.[38]

New Mexico, Nevada, Oregon have switched to using the federal IT platform, Healthcare.gov. These states have retained control over most insurance exchange functions, such as conducting consumer outreach and marketplace oversight, while outsourcing the IT functions to the federal government.[39] Hawaii has also recently announced its intent to use

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[34] Sarah Dash et al., *Implementing the Affordable Care Act: State Action on Quality Improvement in State-based Marketplaces*, The Commonwealth Fund (July 29, 2014) (online at www.commonwealthfund.org/publications/issue-briefs/2014/jul/state-action-quality-improvement-marketplaces).

[35] *Id.*

[36] Oregon Healthcare.gov (online at www.oregonhealthcare.gov/get-help-2.html) (accessed Sept. 22, 2015).

[37] *See, e.g.*, Reid Wilson, *Nevada Will Join Federal Healthcare.gov Exchange*, Washington Post (May 21, 2014) (online at www.washingtonpost.com/blogs/govbeat/wp/2014/05/21/nevada-will-join-federal-healthcare-gov-exchange/); Virgil Dickson, *Oregon's Exchange Closing After a History of Tech Woes*, Modern Healthcare (Mar. 9, 2015) (online at www.modernhealthcare.com/article/20150309/NEWS/150309912).

[38] Abby Goodnough, *In Vermont, Frustrations Mount Over Affordable Care Act*, New York Times (June 4, 2015) (online at www.nytimes.com/2015/06/05/us/in-vermont-frustrations-mount-over-affordable-care-act.html?_r=0); David Montgomery, *MNSure Year 2: Better, But Problems Persist*, Twin Cities.com (Feb. 2, 2015) (online at www.twincities.com/politics/ci_27569977/year-later-mnsure-is-better-but-not-good).

[39] *Supported State-Based Marketplaces: The Point of Convergence?*, Health Affairs Blog (June 11, 2015) (online at healthaffairs.org/blog/2015/06/11/supported-state-based-market-places-the-point-of-convergence).

Healthcare.gov in the third open enrollment season.[40] CMS has yet to issue formal guidance on how these Supported State Based Marketplaces (SSBMs) are expected to work and what a leasing arrangement with the federally-facilitated exchange would look like, but is expected to address the question through the rule-making process.[41] This arrangement may be a path forward for some states, particularly small states facing financial sustainability challenges.

Smaller states, and particularly those that had small uninsured rates to begin with, like Hawaii, have faced particular difficulties in ensuring enough revenue to operate state-based marketplaces. States are considering a range of options to address projected budget gaps, including licensing successful technologies to other state marketplaces, banding together under a regional approach, or, as noted above, switching to the Healthcare.gov platform.[42]

E. GAO Report

The Government Accountability Office (GAO) released a report on September 16, 2015, titled "State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects." The report made several findings. First, the report summarized the development and operations difficulties SBMs faced during the first enrollment period. These difficulties included: 1) poor system performance and delays in addressing information security; 2) partially completed software functionality; 3) hardware problems; 4) enrollment errors causing long wait times and applications getting stuck in the system; 5) difficulties getting individuals' identities verified; and 6) the inability to easily make changes to individuals' coverage in response to events such as births or income changes.[43]

Second, the report also made a number of findings on states' use of federal funds. Overall, SBMs spent $1.37 billion in federal marketplace grants (from September 2010 through March 2015) to establish, support, and connect marketplace IT systems.[44] GAO found that as of February 2015, the 14 states with SBMs had developed and were operating systems to support

[40] *Hawaii Health Connector Board Oks Transition to Federal Exchange, Staff Eliminations*, Pacific Business News (June 5, 2015).

[41] *Supported State-Based Marketplace Model May Gain Traction*, High Roads (Oct. 15, 2014) (online at www.highroads.com/newsroom/supported-state-based-marketplace-model-may-gain-traction); *New Mexico's State-Based Marketplace: An Emerging Model*, National Academy for State Health Policy (June 2015).

[42] *Almost Half of Obamacare Exchanges Face Financial Struggles In the Future*, Washington Post (May 1, 2015).

[43] Government Accountability Office, *State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects*, GAO-15-527 (Sep. 16, 2015) (online at www.gao.gov/assets/680/672565.pdf).

[44] *Id*.

their marketplaces; however, not all IT functions were complete.[45] Specifically, the 14 states' marketplace systems "were performing some, but not all, key functions, including those related to eligibility and enrollment, financial management, hub services, and IRS reporting."[46]

In response to the report, several states registered disagreement with GAO's characterization of functionality issues. The DC Health Benefit Exchange Authority stated that GAO's characterization of DC's program as "partially operational" is misleading; they stated that DC should be characterized as "fully operational."[47] MNSure also stated that GAO's determination that the exchange is "partially operational" is unclear and misleading, because it "gives no indication of whether a health insurance exchange is in fact delivering the required service."[48] Finally, the Washington Health Benefit Exchange also disagreed with the characterization that their system is only "partially operational" for financial management, hub services, and IRS reporting file submissions.[49]

V. WITNESSES

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[45] *Id.* This count of 14 states, based on the second enrollment period (plan year 2015), includes the District of Columbia and Hawaii. As noted above, Hawaii recently announced its intent to use Healthcare.gov in the third open enrollment season.

[46] *Id*.

[47] Government Accountability Office, *Appendix IV: Comments from the District of Columbia Health Benefit Exchange Authority, State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects*, GAO-15-527 (Sep. 16, 2015).

[48] Government Accountability Office, *Appendix V: Comments from MNSure, State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects*, GAO-15-527 (Sep. 16, 2015).

[49] Government Accountability Office, *Appendix VI: Comments from the Washington Health Benefit Exchange, State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects*, GAO-15-527 (Sep. 16, 2015).

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