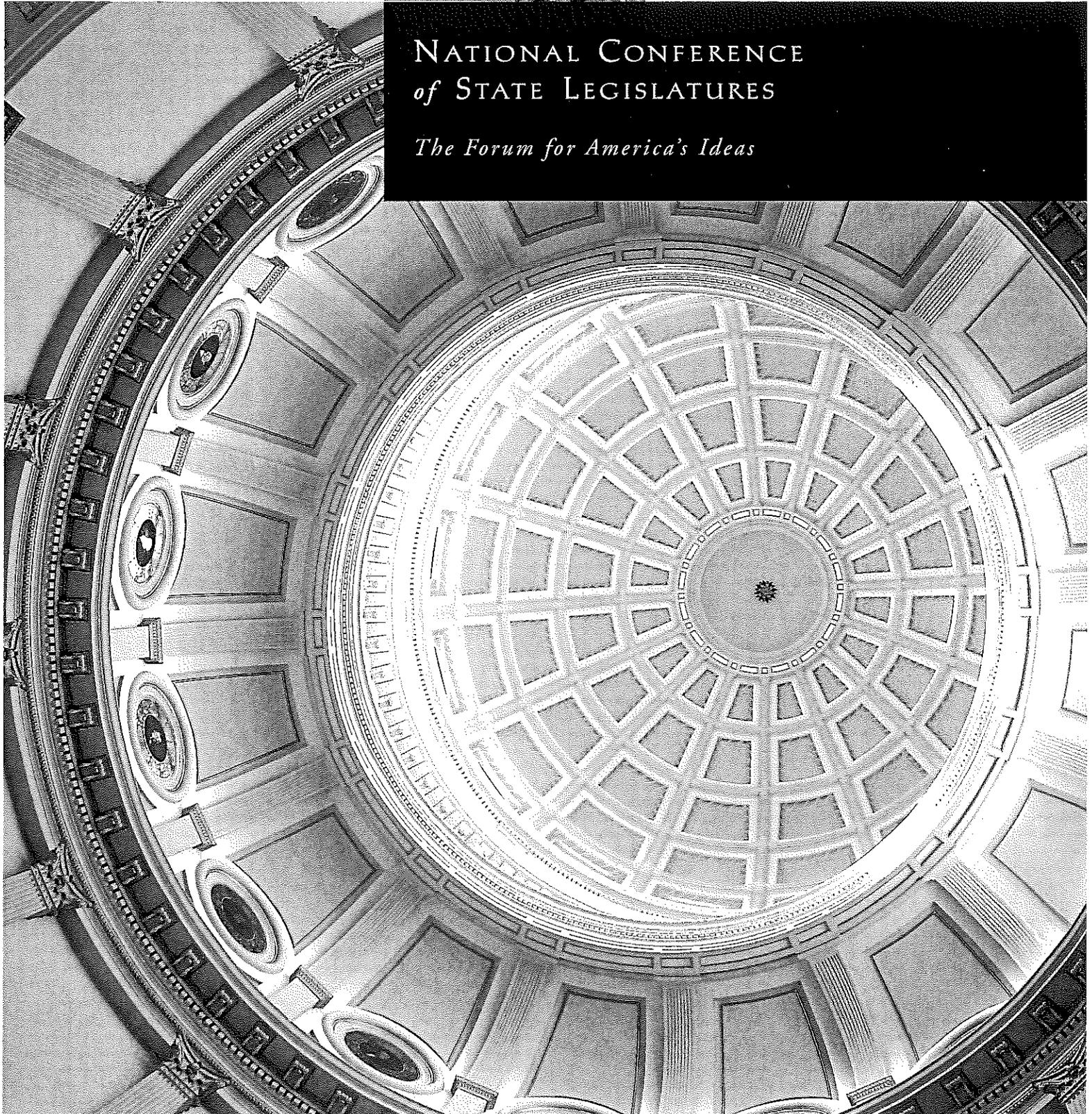


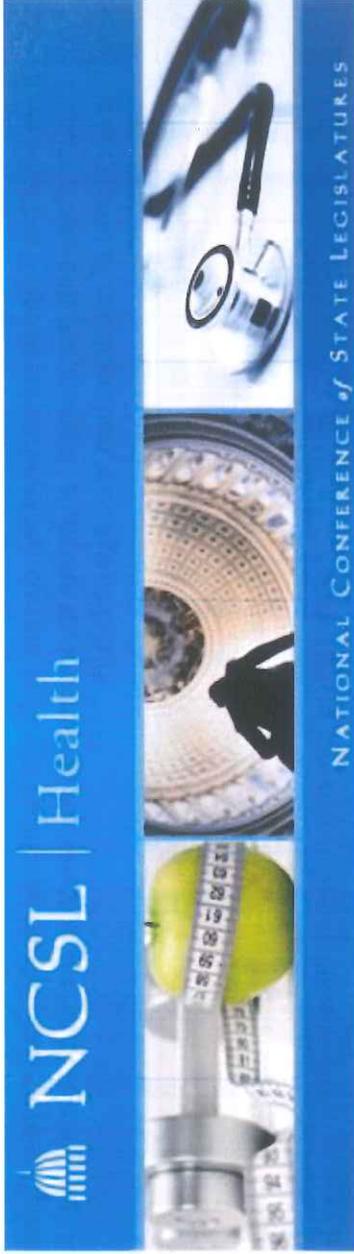
NATIONAL CONFERENCE
of STATE LEGISLATURES

The Forum for America's Ideas



**STATE-RUN HEALTH EXCHANGES:
AN NCSL INTERIM PROGRESS REPORT
Toolkit Table of Contents**

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2015 State Legislation on Health Exchanges / Marketplaces Structure

Compiled March 6, 2015

The pending U.S. Supreme Court case, *King v. Burwell*, has renewed interest in states' health insurance exchange structures. The court case centers on whether people enrolled in federally facilitated exchanges (or "marketplaces") qualify for federal subsidies.

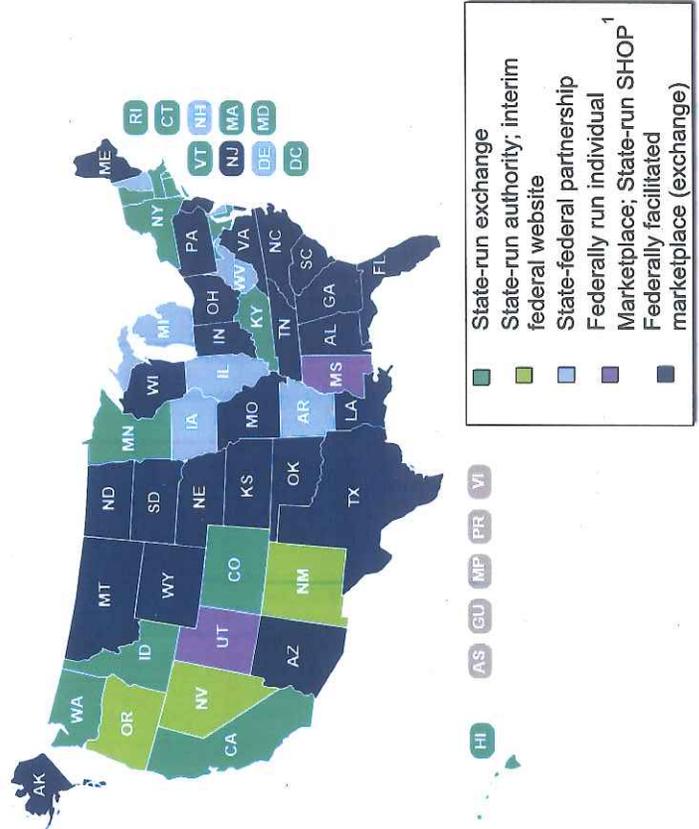
The Affordable Care Act (ACA) defines three structural exchange categories:

1. State-run exchanges
2. "Federally facilitated" exchanges
3. "Federal-state partnership" exchanges

As of March 2015, 16 states and the District of Columbia have state-run exchanges. At least 34 are classified as federally facilitated exchanges, and among these, several states are operating a hybrid version. See the map and NCSL's [50-state report](#).

States may change the administrative responsibilities for their exchanges—by legislative or executive action—depending on each state's process and subject to federal approval for state-run exchanges. Regardless of the court's ruling in June, almost all the state bills listed in this report remain valid options for legislatures.

Status of Health Insurance Exchanges/Marketplaces, 2015



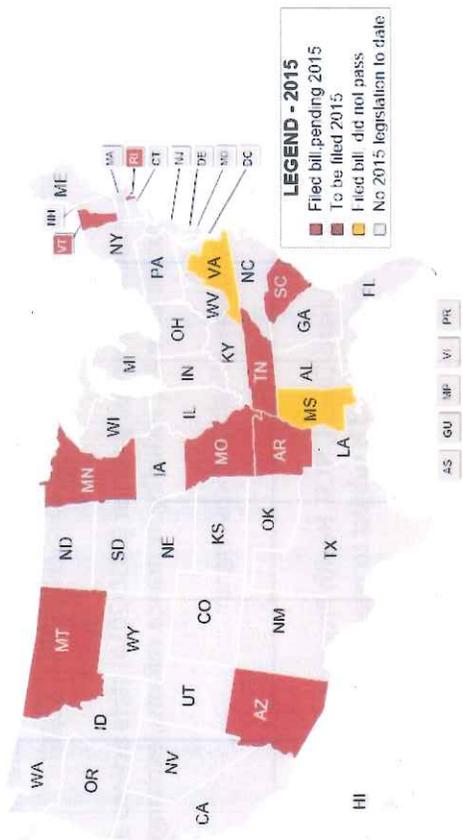
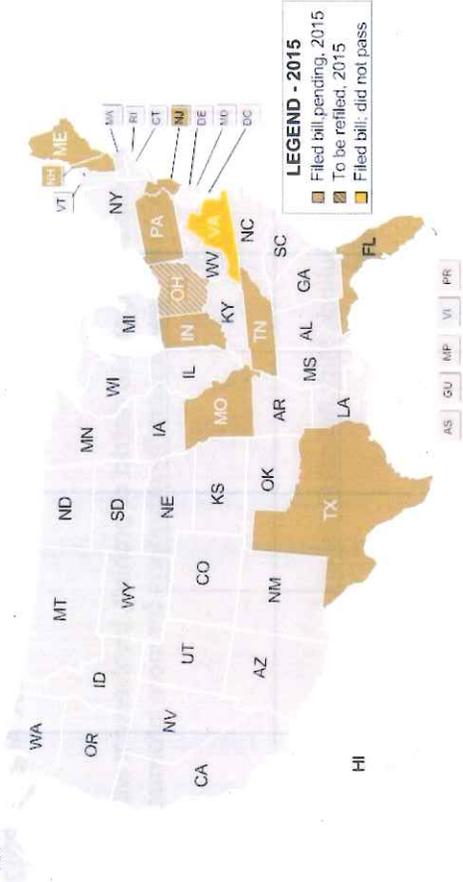
In 2015, at least 10 to 11 states have bills that propose converting their current federally facilitated marketplaces into state-run or state-federal partnership exchanges. At least 11 states have bills proposing to eliminate their state-run exchange or prohibit forming one. As usual, proposed legislation is not an indicator of the likelihood of consideration, passage or failure.

| *2015 bills to change federally facilitated to state-run exchanges | *2015 bills to prevent or eliminate state-run exchanges |
|--|--|
| <p>Florida (Federally facilitated (FFM) to state-run): S 1498 by Senator Soto (D) Pending</p> <p>Indiana (FFM to state-run): S 417 by Senator Tallian (D) Pending</p> <p>Maine (FFM to partnership or state-run): S. 152, resolve by Senator Gratwick (D) Pending</p> <p>Missouri (FFM to state-run): H 870 by Representative McNeil (D) Pending</p> <p>New Hampshire (Partnership to state-run): H 548 by Representative Butler (D) Pending</p> <p>New Jersey (FFM to state-run): S 540 and A 3953 by Senator Gill (D) and Assemblyman Conaway (D) Pending</p> <p>Ohio (FFM to state-run): S 88 of 2014 refile by Senator Skindell (D) Introduction pending</p> <p>Pennsylvania (FFM to state-run): H 330 by Representative Deluca (D) Pending</p> <p>Tennessee (FFM to state-run, if the court eliminates FFM subsidies): HB 1209 and SB 1124 by Representative Love (D) and Senator Yarbro (D) Pending</p> <p>Texas (FFM to state-run): HB 817 and HB 818 by Representative Turner (D) Pending</p> <p>Virginia (FFM to state-run): SB 1328 and SB 1363 by Senator Watkins (R) and Senator Alexander (D) Did not pass</p> | <p>Arizona (keep FFM): HCR 2026 by Representative Thorpe (R) Pending</p> <p>Arkansas (prohibit state-run; move to FFM): SB 343 by Senator Hendren (R) Passed Senate 3/4/2015; pending HB 1492 by Representative Bentley (R) Filed; withdrawn 3/6/2015</p> <p>Minnesota (repeal state-run to FFM) S 1232 by Senator Gazelka (R)</p> <p>Missouri (keep FFM): S 51 and H 601 by Senator Onder (R) and Representative Frederick (R) Pending</p> <p>Mississippi (keep FFM): S 2768 by Senator McDaniel (R) Did not pass</p> <p>Montana (keep FFM): HB 256 by Representative Monforton (R) Pending</p> <p>Rhode Island (state-run to FFM): H 5329 by Representative Morgan (R) Pending</p> <p>South Carolina (keep FFM): H 3020 and S 103 by Representative Chumley (R) and Senator Bright (R) Pending</p> <p>Tennessee (keep FFM): HB 61 and SB 72 by Representative Durham (R) and Senator Kelsey (R) Pending</p> <p>Vermont (state-run to FFM): H 177 by Representative Gage (R) Pending</p> <p>Virginia (repeal 2011 Partnership authorization; keep FFM): HB 1530 by Delegate Berg (R) Did not pass.</p> |

* As usual, proposed legislation is not an indicator of the likelihood of consideration, passage or failure.

2015 State Legislation or Action to Establish a State-Run Exchange*

2015 State Legislation or Action to Prevent a State-Run Exchange*



*As usual, proposed legislation is not an indicator of the likelihood of consideration, passage or failure. Updated 3/6/2015 © NCSL

State Variations

Three states—Missouri, Tennessee and Virginia—have bills with opposing goals, one proposing to have only a federally facilitated exchange and another proposing to move to a state-run exchange.

A bill in West Virginia would authorize only the legislature to create a state-based exchange | [HB 2216](#) by Delegate Ellington (R) | Pending

Related Resources

- In 2014 legislative sessions, at least 14 states considered 24 bills to convert their current federally facilitated marketplaces into a state run or state-federal partnership. Measures were passed in **Maine** and **New Jersey** but none of the 14 states formally moved to a state-run exchange. [NCSL's 2014 report is online.](#)
- [State Actions to Address Health Insurance Exchanges.](#) This NCSL online report contains detailed information on state actions and responses to implementing exchanges as outlined in the Affordable Care Act, between 2010 and the present. This material includes links to activities, with 2015 deadlines and early enrollment figures by state. It also includes current state information about insurers and premiums
- [Blueprint for Approval of Affordable Health Insurance Marketplaces](#) (Updated for 2014), CMS/HHS – online at: <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1254283.html> [link verified 2/23/2015]

- **Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA).** This 2012 Congressional Research Service (CRS) report outlines the required minimum functions of the marketplace, and explains how marketplaces are expected to be established and administered under the ACA. Aug. 15, 2012. <http://www.ncsl.org/documents/health/CRS-ExchRpt81512.pdf>

NCSL has additional resources describing earlier (2010-2014) state actions and decisions, to expand or implement, and to restrict or prohibit, involvement with the provisions of the Affordable Care Act, including insurance reforms, exchanges, Medicaid and other topics. Visit www.ncsl.org/healthreform for more information.

1 – SHOP refers to the Small Business Health Options Program

For information contact: Richard Cauchi, NCSL Health Program, Denver For media inquiries, contact Mick Bullock, Mick.Bullock@ncsl.org
This summary is a work in progress and is subject to regular updates – request latest edition via dick.cauchi@ncsl.org



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Washington

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Washington, D.C. 20001
Tel: 202-624-5400 | Fax: 202-737-1069.

State Based Exchanges – Welcome pages on the Web

CALIFORNIA

CONNECTICUT

Compiled by NCSL – Screenshots from mid-April 2015. May not include all information displayed.

COLORADO

DISTRICT OF COLUMBIA

State Based Exchanges – Welcome pages on the Web

Compiled by NCSL; Screenshots from mid-April 2015. May not include all information displayed.

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Coverage Solutions for Small Businesses
Get health insurance to protect your business and your employees. At the Hawaii Health Connector, we're here to help you choose the right plan for your business, your employees, your budget, and your needs. You can find the plan that matches your needs and your budget.

We're here to help, call us at 1-877-628-5076 or
HELP AND SUPPORT CENTER

Help Near You
Our certified brokers and licensed insurance agents get you all the information you need to know about the plans that match your needs and your budget.

Individuals & Families
Did you see the Feb. 15 deadline to enroll in health insurance? Don't miss your chance to enroll for a future enrollment period due to a qualifying life event.

2014 Federal Taxes
Need help understanding the new federal income tax law (implementing) "earn-credits, tax breaks, and other provisions for

Customer Support Center

KENTUCKY

kynect

Welcome Individuals & Families Small Business Businesses & Agencies Appointments

Welcome to Kynect, Kentucky's Healthcare Connection.
Quality health coverage. For every Kentuckian.

ONE-STEP SHOPPING
Kynect makes it easy to find health insurance for you, your family or your business. Kynect's online marketplace allows you to compare and select an insurance plan. You can also enroll in a plan through Kynect.

Tax Questions?

IDAHO

Your Health IDAHO

Search Your Health Exchange

Call 1-855-741-IDAHO (1-855-744-6346) | About Us | Information in Español

New 2015 Enrollment Resources News & Events Our Partners Rates & Operations

Welcome

Open Enrollment has ended. See if you can still get coverage.

Check an Account & Apply
Tax Information

Find Agents, Brokers or Enrollment Consultants Near You
Information for Individuals & Families
Information for Small Businesses

Convenient Connectors Training & System Account Login

MARYLAND

maryland health Connector

Maryland's Official Health Insurance Marketplace

Welcome

Open Enrollment for 2015 Has Ended
See if you can still get coverage now

- Certain life changes and special circumstances
- If you owe the 2014 tax penalty
- Enroll in Medicaid or renew your coverage

Learn what to do and expect after you enroll

Watch & Learn
Check videos get you ready to apply

Search for Free Help
Find a person available near you

Realt Life Stories
1 Enrolled
1 year later, affordable insurance with monthly costs

MASSACHUSETTS

Renewed Information for MassHealth Members:
Learn what you need to know to get started.

HEALTH CONNECTOR
The right place for the right plan

Open Enrollment for Individuals and Families is Now Closed

You can apply at any time of the year if you are applying for dental plans or help paying for health coverage including MassHealth, Children's Medical Security Plan (CMSP), Health Safety Net, or ConnectorCare. Or, if you experienced a qualifying event.

[Learn More](#) [Start Your Application](#)

MassHealth Members

If you are a current MassHealth member and got a letter in the mail to renew your coverage, you can get started right away. You can use this website to submit an application so MassHealth can determine what you are eligible for.

MISSISSIPPI (SHOP)

health link

Individuals & Families · Employers

2015 Enrollment Process

Open enrollment has ended. See if you qualify for your plan.

[Get Started](#)

Manage Your Plan

Do you have an existing plan? You can manage your coverage online.

Get Help

Find the contact information you're looking for with our assistance tools.

MINNESOTA

search MNSure

sign in

Learn More News & Events

FAQ

Where you choose health coverage

Individuals & Families · Small Business (SHOP) · Get Help

Calculate Your Cost

See if you qualify for low cost or no cost insurance.

Estimate your monthly premium.

MNSure Minute

Keep up with the latest developments and information about MNSure.

Sign up for MNSure alerts.

Stay Informed

Keep up with the latest developments and information about MNSure.

Sign up for MNSure alerts.

Quick Links

- Financial Assistance
- Form Directory
- IRS Form 1098-A
- Enrollment Tips
- Deadlines & Penalties
- Individual Exemptions

NEVADA (Federally-Supported, State Run)

Silver State Health Insurance Exchange

Home About Help Resources Reports Media Contact Stay Informed

Need help enrolling?

Click here for assistance.

Community

Self-organized peer support groups with common interests and social interaction.

What is New

- Consumer Assistance Center Software Solution Solicitation
- Check Strategic Outreach for Proposals
- Nevada Health Link 2015 Update
- Agent and Broker Information Sheet
- 2015 Open Enrollment

State Based Exchanges – Welcome pages on the Web

NEW MEXICO (Federally-Supported, State Run)

be well nm

nmhix NEW MEXICO'S HEALTH INSURANCE EXCHANGE

1.855.566.6445

Special Enrollment

Open Enrollment has ended - find out if you qualify for Special Enrollment.

Browse Plans

Individuals & Families Apply Now

Small Business

Take Our Survey

Tax Season, Special Enrollment

If you qualify for a Special Enrollment Period, you can enroll in health insurance outside the annual Open Enrollment

OREGON

LEARN MORE

GET HELP

Open enrollment is over. Find out if you can still get coverage.

FIND OUT MORE

SEE PLANS & PRICES

GET HELP

Need to purchase health insurance for your employees?

RHODE ISLAND

<https://healthrhode.ri.gov/HIXWeb3/DisplayHomePage>

Health Source

GET COVERAGE FOR YOU OR YOUR FAMILY.

RENEW YOUR MEDICAID OR RITE SHARE

ARE YOU AN EMPLOYER?

ARE YOU AN EMPLOYER?

Compiled by NCSL; Screenshots from mid-April 2015. May not include all information displayed.

NEW YORK

<https://mystateofhealth.ny.gov/>

mystateofhealth

NEW YORK'S STATE OF HEALTH

Find Us in Your Community!

Individuals & Families

GET STARTED

State Based Exchanges – Welcome pages on the Web

Compiled by NCSL; Screenshots from mid-April 2015. May not include all information displayed.

VERMONT

<https://portal.healthconnect.vermont.gov/>

WASHINGTON

<https://wahbexchange.org>

About the Washington Health Benefit Exchange

The Washington Health Benefit Exchange is responsible for the creation of Washington HealthConnect – an online marketplace for individuals, families and small businesses in Washington State to compare and enroll in quality health insurance plans and access important cost savings. [Visit Washington HealthConnect.](#)

Washington HealthConnect System Status Center

Budget Enactment from Washington HealthConnect Health Benefit Exchange Chair Ken Stone
 Approved Washington HealthConnect System Status Center
 April 10, 2015 - Ken Stone, Board Chair for the Washington Health Benefit Exchange issued the following statement regarding the Washington Health Benefit Exchange System Status Center.

Sign up for email updates

Email Address

Submit

Upcoming Events

Exchange Benefit Meeting
 Tuesday, April 14, 2015
 2015 State 17th Street Ballroom
 17th Street, Seattle, WA 98101

Health Connect TAG Meeting
 Tuesday, April 14, 2015
 17th Street Ballroom

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APPENDIX TABLE B4

| Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in States Using the HealthCare.gov Platform, By State, 2015 (1) <i>11-15-2014 to 2-15-2015 (including SEP activity through 2-22-15)</i> | | | | |
|---|---|--|--|--|
| State Name | Number of Individuals Determined Eligible to Enroll through the Marketplace for 2015 Coverage | | Number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (4) | Number of Individuals With 2015 Plan Selections Through the Marketplaces (5) |
| | Total Eligible to Enroll in a Marketplace Plan (2) | Eligible to Enroll in a Marketplace Plan with Financial Assistance (3) | | |
| | Number | Number | Number | Number |
| States Using the HealthCare.gov Platform | | | | |
| State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (6) | | | | |
| Nevada | 90,696 | 77,228 | 28,290 | 73,596 |
| New Mexico | 62,905 | 49,378 | 15,522 | 52,358 |
| Oregon | 140,994 | 111,139 | 61,828 | 112,024 |
| Subtotal - SBMs Using the HealthCare.gov Platform | 294,595 | 237,745 | 105,640 | 237,978 |
| Federally-Facilitated Marketplace (FFM) States | | | | |
| Alabama | 222,610 | 166,768 | 10,408 | 171,641 |
| Alaska | 27,056 | 21,779 | 3,613 | 21,260 |
| Arizona | 245,307 | 192,805 | 49,814 | 205,666 |
| Arkansas | 78,948 | 65,808 | 23,006 | 65,684 |
| Delaware | 29,682 | 23,992 | 5,985 | 25,036 |
| Florida | 1,909,132 | 1,632,571 | 126,181 | 1,596,296 |
| Georgia | 664,646 | 528,944 | 63,083 | 541,080 |
| Illinois | 408,019 | 323,657 | 86,560 | 349,487 |
| Indiana | 252,834 | 209,754 | 66,539 | 219,185 |
| Iowa | 57,110 | 47,154 | 15,474 | 45,162 |
| Kansas | 121,007 | 89,471 | 10,512 | 96,197 |
| Louisiana | 228,809 | 180,933 | 7,915 | 186,277 |
| Maine | 88,598 | 73,370 | 5,327 | 74,805 |
| Michigan | 387,618 | 333,890 | 82,135 | 341,183 |
| Mississippi | 132,596 | 106,478 | 10,699 | 104,538 |
| Missouri | 316,984 | 248,697 | 34,679 | 253,430 |

| Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in States Using the HealthCare.gov Platform, By State, 2015 (1) <i>11-15-2014 to 2-15-2015 (including SEP activity through 2-22-15)</i> | | | | |
|---|---|--|--|--|
| State Name | Number of Individuals Determined Eligible to Enroll through the Marketplace for 2015 Coverage | | Number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (4) | Number of Individuals With 2015 Plan Selections Through the Marketplaces (5) |
| | Total Eligible to Enroll in a Marketplace Plan (2) | Eligible to Enroll in a Marketplace Plan with Financial Assistance (3) | | |
| | Number | Number | Number | Number |
| Montana | 64,632 | 52,823 | 2,683 | 54,266 |
| Nebraska | 90,915 | 73,371 | 7,218 | 74,152 |
| New Hampshire | 60,664 | 44,068 | 9,294 | 53,005 |
| New Jersey | 307,849 | 245,148 | 60,757 | 254,316 |
| North Carolina | 668,702 | 557,164 | 47,920 | 560,357 |
| North Dakota | 21,313 | 18,129 | 2,013 | 18,171 |
| Ohio | 279,722 | 229,459 | 79,963 | 234,341 |
| Oklahoma | 156,795 | 118,248 | 12,946 | 126,115 |
| Pennsylvania | 539,023 | 433,287 | 126,853 | 472,697 |
| South Carolina | 257,282 | 205,800 | 21,106 | 210,331 |
| South Dakota | 27,626 | 22,496 | 2,861 | 21,393 |
| Tennessee | 306,785 | 222,782 | 40,373 | 231,440 |
| Texas | 1,535,857 | 1,177,520 | 146,548 | 1,205,174 |
| Utah | 164,262 | 141,539 | 29,017 | 140,612 |
| Virginia | 470,998 | 355,017 | 36,569 | 385,154 |
| West Virginia | 40,358 | 33,409 | 5,063 | 33,421 |
| Wisconsin | 237,426 | 205,697 | 27,628 | 207,349 |
| Wyoming | 26,180 | 21,633 | 847 | 21,092 |
| TOTAL – States Using the HealthCare.gov Platform | 10,721,940 | 8,641,406 | 1,367,229 | 8,838,291 |

Notes:

"N/A" means that the data for the respective metric are not yet available for a given state.

(1) Unless otherwise noted, the data in this table represent cumulative Marketplace enrollment-related activity for 11-15-14 to 2-15-15 (including SEP activity through 2-22-15). These data also do not include any enrollment-related activity relating to individuals who may have applied for and/or selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes information, please refer to Appendix D of this report.

APPENDIX TABLE C3

| Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in State-Based Marketplaces Using Their Own Marketplace Platforms, By State, 2015 (1) <i>11-15-2014 to 2-15-2015 (including SEP activity through 2-21-15)</i> | | | | |
|---|---|--|--|--|
| State Name | Number of Individuals Determined Eligible to Enroll through the Marketplace for 2015 Coverage | | Number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (4) | Number of Individuals With 2015 Plan Selections Through the Marketplaces (5) |
| | Total Eligible to Enroll in a Marketplace Plan (2) | Eligible to Enroll in a Marketplace Plan with Financial Assistance (3) | | |
| | Number | Number | Number | Number |
| State-Based Marketplaces (SBMs) Using Their Own Marketplace Platforms | | | | |
| California (6) (7) | 1,138,456 | 535,032 | 1,056,164 | 1,412,200 |
| Colorado (7) (8) | 132,077 | N/A | 85,432 | 140,327 |
| Connecticut (9) | 167,193 | 124,803 | 277,336 | 109,839 |
| District of Columbia | 7,539 | 1,714 | 9,355 | 18,465 |
| Hawaii | 24,568 | 12,306 | 32,854 | 12,625 |
| Idaho | 215,145 | 163,829 | 314,398 | 97,079 |
| Kentucky | 223,335 | 138,320 | 152,529 | 106,330 |
| Maryland | 120,632 | 85,345 | 154,194 | 120,145 |
| Massachusetts | 246,397 | 164,849 | 276,060 | 140,540 |
| Minnesota (10) | 71,451 | 38,382 | 106,654 | 59,704 |
| New York (11) | 1,006,505 | 498,707 | 357,456 | 408,841 |
| Rhode Island | 44,097 | 33,604 | 65,396 | 31,337 |
| Vermont | 57,533 | 22,660 | 16,922 | 31,619 |
| Washington | 239,848 | 176,295 | 818,697 | 160,732 |
| TOTAL - SBMs Using Their Own Marketplace Platforms | 3,694,776 | 1,995,846 | 3,723,447 | 2,849,783 |

Notes:

"N/A" means that the data for the respective metric are not yet available for a given state.

(1) Unless otherwise noted, the data in this table represent cumulative Marketplace enrollment-related activity for 11-15-14 to 2-15-15 (including SEP activity through 2-22-15). These data also do not include any enrollment-related activity relating to individuals who may have applied for and/or selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes information, please refer to Appendix D of this report.

(2) "Individuals Determined Eligible to Enroll in a Plan Through the Marketplace" (i.e., enrollment through the Marketplaces for a 2015 Marketplace plan) represents the total number of individuals for whom a Completed Application has been received for the 2015 plan year (including any individuals with active 2014 Marketplace enrollments who returned to the Marketplaces and updated their information), and who are determined to be eligible for plan enrollment through the Marketplaces during the

reference period, whether or not they qualify for advance payments of the premium tax credit or cost-sharing reductions. These individuals may or may not have enrolled in coverage by the end of the reference period. Individuals who have been determined or assessed eligible for Medicaid or CHIP are not included. Note: With the exception of states that treated all of the individuals who selected 2015 coverage through the Marketplaces, this number only includes data for individuals who applied for 2015 Marketplace coverage in completed applications. It does not include individuals who were automatically reenrolled. Thus, the number determined eligible for 2015 coverage may be lower than the total number of 2015 plan selections (which includes reenrollees).

(3) “Individuals Determined Eligible to Enroll in a Plan Through the Marketplace with Financial Assistance” (i.e., enrollment through the Marketplace for a 2015 Marketplace plan with Financial Assistance) represents the total number of individuals determined eligible to enroll through the Marketplace in a Marketplace plan who qualify for an advance premium tax credit (APTC), with or without a cost-sharing reduction (CSR) for the 2015 plan year (including any individuals with active 2014 Marketplace enrollments who returned to the Marketplace and updated their information). These individuals may or may not have enrolled in coverage by the end of the reference period

(4) “Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace” represents the number of individuals who have been determined or assessed by the Marketplace as eligible for Medicaid or CHIP based on their modified adjusted gross income (MAGI). In some states, completed applications for individuals, whom the Marketplace has assessed as potentially eligible for Medicaid or CHIP, based on MAGI, are transferred to the relevant state agency for a final eligibility determination. In these “assessment states” the data include those accounts where a final decision is pending. In other states, the Marketplace has been delegated the final Medicaid/CHIP eligibility determination responsibility for these individuals. Thus, this data element includes FFM determinations and assessments, regardless of the state Medicaid/CHIP agency’s final eligibility determination, if applicable. These data may vary from accounts transferred via “flat file” to states by the FFM. Quality assurance continues on Medicaid assessments and determinations. Note: Marketplace Medicaid/CHIP eligibility determination and assessment data in this report cannot be added to eligibility determination data in the most recent monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment report (available on Medicaid.gov) which covers data through December 2014. In the Marketplaces, some of the individuals assessed or determined eligible for Medicaid or CHIP by the Marketplace and reported in this report may also be reported in the monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Report when the state has made an eligibility determination based on the information provided by the Marketplace. Total Medicaid/CHIP enrollment is reported in the monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Report, and is a point-in-time count of total enrollment in the Medicaid and CHIP programs at the end of the monthly reporting period.

(5) “Individuals With 2015 Marketplace Plan Selections” represents the total number of individuals determined eligible to enroll in a plan through the marketplace” who have selected a 2015 Marketplace medical plan for enrollment through the Marketplaces or, after December 15, have been automatically reenrolled in Marketplace coverage (with or without the first premium payment having been received directly by the issuer) during the reference period. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. These data do not include a count of the number of individuals who have selected a standalone dental plan; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). Except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data.

(6) California reports data through 2/22/15.

(7) Reported Medicaid + CHIP eligibility assessment totals may be underreported, as CA and CO employ processes that do not capture all Medicaid + CHIP eligibility assessments.

(8) Colorado data for individuals applying and those eligible for a QHP does not include individuals automatically reenrolled. Therefore, the number of individuals completing applications, and those eligible for a QHP, is less than the total number of individuals enrolled. Colorado’s Marketplace, Connect for Health Colorado, and the Medicaid Agency, use the Shared Eligibility System to determine eligibility for Medicaid, APTC/CSR, and CHIP. Therefore, the data provided by Colorado for “Individuals Assessed Eligible for Medicaid/CHIP” only include new individual determinations for the Medicaid and CHIP programs processed between 11/15/14 – 2/21/15. These data do not include redeterminations, recertifications, and renewals for Medicaid and CHIP.

(9) Connecticut’s number of individuals assessed eligible for Medicaid/CHIP is greater than the number of individuals applying. This results from Medicaid redeterminations for individuals who already have an initial application with the exchange.

(10) Minnesota data for number of individuals assessed eligible for Medicaid/MinnesotaCare represents data through 2/22/15.

(11) New York eligibility data represent individuals who have an active eligibility determination on or after 11/15/14. The number of individuals applying represents individuals in accounts that were created on or after 11/15/14. This figure does not include renewals, or other eligibility determinations for accounts created before 11/15/14.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

Legislative Health & Human Services

December 5, 2014



Open-Enrollment Kick-Off



ALBUQUERQUE JOURNAL

ALBUQUERQUE PRESS

AGENDA

- Open Enrollment 2015 Update
- Financial Sustainability Planning Update
- Individual Marketplace Technology Development
- Integrated Project Plan Update

Native American Updates



- Appointment of Native American Liaison, Scott Atole
- Completed and Posted the Native American Enrollment and Outreach RFP
 - Provide final recommendations at December 19th Board of Directors Meeting
 - Effective date January 1, 2015
- Site visits to Jemez, San Felipe and Santa Ana
- Presentation to Jicarilla General Meeting
 - Estimated 500-550 in attendance

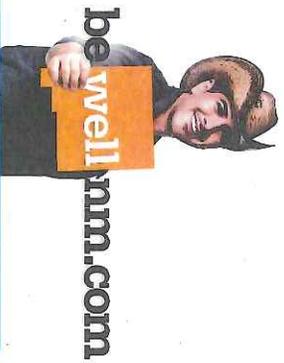


Financial Sustainability Planning Update

Proposed Financial Sustainability Plan for Public Comment



- **Proposal:** Adopt a market-wide assessment of specific health insurance issuer premiums (based on each issuer's current market share) to raise the revenue needed to support the Exchange.
- **Issuers Subject to Proposed Assessment** (In Accordance with NMSA 1978, § 59A-23F- 4(B)): Issuers offering major medical plans on and off Exchange and dental issuers offering products on the Exchange.
- **Proposed Premiums to be Assessed** (BeWellNM would only assess dental issuers offering products on Exchange) :
 - **Option 1:** Major medical, Medicaid and dental premiums.
 - **Option 2:** Major medical, Medicaid, dental, vision, life, Medicare supplement, long-term care, disability income, specified disease, accident-only and hospital indemnity policies



Individual Marketplace Technology Update

Technology Development



- **BeWellNM/HSD Vision:** BeWellNM and HSD will work in close partnership to implement a CMS compliant and integrated consumer friendly **individual marketplace technology system** in the fall of 2015 that has been fully tested and allows for an easy renewal process.
- **Governance Structure:** HSD and BeWellNM are in alignment on the structure needed to ensure we are successful in launching an integrated technology solution which involves:
 - Development of a **Project Steering Team (PST)** with representation from key stakeholders including BeWellNM, HSD, OSI and Carriers to vet key exchange design and policy decisions
 - Development of a **Proposal Evaluation Team (PET)** with representation from all parties on the Project Steering Team to evaluate vendor proposals.
- **Today's Updates**
 - **Integrated Project Plan & Timeline** - Development of one project plan to develop integrated system that provides for a seamless consumer experience.

Integrated Medicaid and Health Plan Enrollment

Presented by Bob Pearson, Deputy Secretary



HUMAN SERVICES DEPARTMENT

Sean Pearson, Acting Deputy Secretary

The Affordable Care Act (ACA) and Eligibility

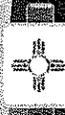
- Applies to all Insurance Affordability Programs (Medicaid, CHIP, and Exchange Subsidies)
- Meant to simplify eligibility
 - Modified Adjusted Gross Income (MAGI) standard
 - Use of electronic sources for verification
 - No wrong door approach
- Centers for Medicare and Medicaid Services (CMS) promulgated two rules
 - Medicaid eligibility
 - Exchange eligibility



NEW MEXICO HUMAN SERVICES DEPARTMENT

ACA and CMS Requirements

| | |
|---------------------------------------|---|
| Single, streamlined application | Verification plan |
| Modified Adjusted Gross Income (MAGI) | Seamless experience and electronic referral |
| Federal Data Services Hub (FDSH) | Reasonable compatibility standard |
| Federally managed services | Open enrollment period |



NEW MEXICO HUMAN SERVICES DEPARTMENT

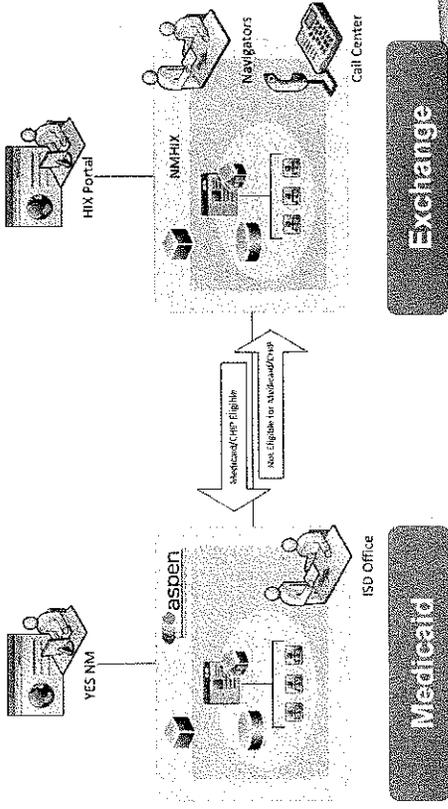
Fundamental Problems with the ACA and Eligibility

- Medicaid Eligibility
 - Utilizes current income information for verification
 - Does not require the use of federal tax information
 - No specified reasonable compatibility standard
- Exchange Eligibility
 - Must use federal tax information
 - Verification is based on IRS reported income
 - Ten percent (10%) reasonable compatibility standard



NEW MEXICO HUMAN SERVICES DEPARTMENT

Integrated Medicaid and Exchange Enrollment



5

Change in CMS Direction

- Single Door vs. No Wrong Door Approach
- Potential change in Medicaid eligibility
 - Use of Federal Data Services Hub
 - Use of federal tax information
- Potential impact to federal funding
 - Exchange grants
 - CMS enhanced funding

6

Impact to Medicaid

- Additional development and testing required
- Phased implementation required
- Exchange more dependent on HSD systems
- Adding additional short and long term costs
- Adding risk to success of Exchange and Medicaid integration

8

Potential Benefits

- Single portal for constituents for insurance affordability programs and HSD programs
- Creates opportunities to expand portal to other health and human services programs
- Creates opportunities to expand shared services across health and human services programs

9

Act No. 4. An act relating to fiscal year 2015 budget adjustments.

[excerpt]

Sec. 89. VERMONT HEALTH BENEFIT EXCHANGE; REPORTING

On or before March 11, 2015, the Chief of Health Care Reform in the Executive Office shall provide to the House Committees on Appropriations, on Health Care, and on Ways and Means and the Senate Committees on Appropriations, on Health and Welfare, and on Finance the following:

(1) a full accounting of the State and federal expenditures through December 31, 2014, on the development and implementation of the Vermont Health Benefit Exchange;

(2) the projected remaining development and implementation costs through December 31, 2015;

(3) the remaining balance in any federal grants awarded to Vermont for the development and implementation of the Vermont Health Benefit Exchange; and

(4) the projected expenditures for fiscal years 2015 and 2016 for the sustainable operations of the Vermont Health Benefit Exchange by funding source and by department, delineating the recurring and nonrecurring cost components for operation of the Vermont Health Benefit Exchange in the respective fiscal years.

OREGON

Technology Transition Update

Senate Interim Committee on Health Care and Human Services

Tina Edlund
Transition Project Director
Office of the Governor
September 15, 2014

Transition Project Goal:
November 15, 2014

- 1. Oregonians eligible for commercial coverage and tax credits can apply, shop and choose a plan online at healthcare.gov
- 2. Oregonians eligible for Medicaid will have a more streamlined process to apply online

To Accomplish Project Goal

Use the federal technology for qualified health plan (QHP) eligibility and enrollment

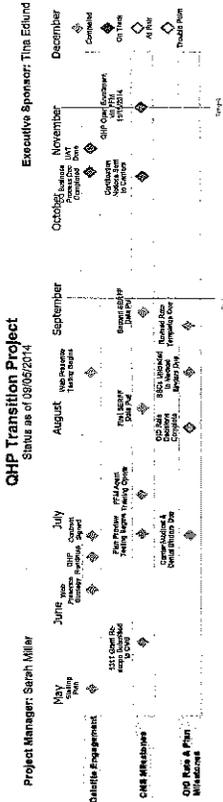
OHA will use federal technology for most new Medicaid applications starting November 15th, 2014 while building on existing technology investment for a public facing, self-service Medicaid eligibility portal

Project update

1. Development for new application landing page: on track for Nov. 15, 2014
2. Transition of commercial enrollment from Cover Oregon to healthcare.gov: on track for Nov. 15, 2014
3. Transition of Medicaid application and eligibility determination from Cover Oregon: Improved plan for Nov. 15, 2014

Key Components of moving commercial enrollment to healthcare.gov

1. No new technology development
2. Transition project: Update business processes to work with federal process
3. CMS: Works directly with plans to connect them to healthcare.gov



Risk Summary:

- Responsibility:** Executive sponsor is involved in direct oversight and review of project activities and responsibility is shared between the program manager and the project manager. Regularly with Cover Oregon management team.
- Scope:** Scope for November 15, 2014 is defined. Majority of additional work happens between the Federally Facilitated Marketplace (FFM) and Oregon's Centers.
- Resources:** Key resources have been identified and assigned to the project. Team includes staff from the Business Office.
- Timeline:** Centers for Medicare & Medicaid Services requires Oregon to provide information to the FFM. The information is provided to the FFM and the FFM will provide the information to the unit. Information approval is required.
- Budget:** Active monitoring of Oracle's System Integration contract is underway. Contract for Marlin's services was awarded on 07/25/2014.
- Contracts:**

Notes:

- 10 of the 15 participating Centers have completed contracting with the Federally Facilitated Marketplace (FFM). Ten Centers have successfully completed boundary setting and are moving into production.
- All of the participating Centers' business have been completed and closed. All remaining work is being completed by the FFM. The FFM is currently working on the FFM and the FFM is currently working on the FFM.
- Contract amendments for medical and dental coverage have been finalized and released for central execution.
- The Centers for Medicare & Medicaid Services (CMS) issued its final 2014 Annual Reporting Program. Oregon is awaiting a complimentary, Oregon-specific testing program.
- Development of updates and other document deliverables for the Oregon Exchange CMS Blueprint is underway.
- Announced the creation of OregonHealthCare.gov as a landing page with a secondary tool where consumers can evaluate the best place for them to apply for health insurance coverage.
- Decide the initial delivery sessions with State resources as needed for the OHP Business Process Engineering Document delivery.

Current Project Status – OHP Transition

- Development stopped on anything dependent on Oracle
- Improved plan through partnership with CMS for new enrollments and renewals
- Application landing page – OregonHealthCare.gov - will connect Oregonians to best place for Medicaid application: healthcare.gov or OHA
- Est. 25,000 month. For majority of people, the better option will be to apply through healthcare.gov
- PDF will remain in place for some populations: pregnant women, refugees, people with disabilities. Will be processed with current hybrid system.
- Until Nov. 15, current renewal and redetermination process continues
- People who apply for Medicaid at OHA but are eligible for tax credit instead will be redirected to healthcare.gov

MAGI Medicaid Transition Project



Risk Summary:

- Responsibility:** Project sponsor is involved in direct oversight and review of project activities and responsibility is shared between the program manager and the project manager. Regularly with Cover Oregon management team.
- Scope:** Scope for November 15, 2014 is defined. Majority of additional work happens between the Federally Facilitated Marketplace (FFM) and Oregon's Centers.
- Resources:** Key resources have been identified and assigned to the project. Team includes staff from the Business Office.
- Timeline:** Centers for Medicare & Medicaid Services requires Oregon to provide information to the FFM. The information is provided to the FFM and the FFM will provide the information to the unit. Information approval is required.
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State Auditor's Report On The Hawai'i Health Connector

January 29, 2015 [News](#)

HONOLULU, HAWAII – The Hawai'i Health Connector released the following statement on the State's Auditor report from Executive Director Jeffrey Kissel:

"The audit acknowledges the Connector's pivotal role in protecting Hawai'i's regulatory control over its own health care policies in lieu of a federal system.

The audit findings detailed many of the challenges the Connector encountered during its first year of business. They included deficiencies in the planning process, procurement, and governance. The recommendations are reasonable and have been addressed."

The Management and Board of the Connector are working with the Auditor to make certain that the organization operates in a manner that assures compliance with applicable statutory and regulatory guidelines, and, is transparent and efficient as it continues to develop this important resource for the community.

In its response to the Audit, the Connector noted that since the State Auditor began working on its report in January 2014, numerous changes have been made to address the concerns contained in the audit. The Connector has completed a Strategic and Sustainability Plan focused on a specific mission, vision, and value proposition of "harmonizing the Affordable Care Act with the provisions of Hawai'i's Prepaid Health Care Act of 1974," which was submitted to the Legislature on December 31, 2014, and made public on the Connector's website.

Strict controls on the procurement process are in place, and the relationship with certain contractors and service providers has either been terminated or revised. The Connector is also working closely with its Legislative Oversight Committee to ensure that it continues to improve its operations as enrollment increases and costs are reduced.

The Hawai'i Health Connector continues to enroll residents across the state in high quality, low cost health coverage. More than 16,500 residents have enrolled for health insurance through the Connector since October 2013. Open enrollment for individuals ends on February 15, 2015 for health coverage this year.

###

About the Hawai'i Health Connector

The Hawai'i Health Connector is the online health insurance marketplace for Hawai'i residents. The Connector is here to provide a place for individuals and small businesses to find affordable, quality coverage for the long-term future. It allows residents full-time access to the Connector's Kolu'a assisters, the ability to compare health insurance plans online, and the opportunity to receive tax credits. In compliance with the federal Affordable Care Act (ACA), the Connector was established as a non-profit organization in 2011 in order to provide health insurance coverage that preserves the unique culture of Hawai'i and builds on Hawai'i's 40-year history of ensuring health insurance coverage for residents through the Prepaid Health Care Act. The Connector is committed to a better health future for every resident of Hawai'i. For more information, visit www.HawaiiHealthConnector.com.



Connecticut's Official Health Insurance Marketplace

**Testimony of Access Health CT
Before the
Connecticut General Assembly Insurance and Real Estate Committee
March 3, 2015**

Senate Bill 1025: AN ACT AUTHORIZING THE CONNECTICUT HEALTH INSURANCE EXCHANGE TO ESTABLISH SUBSIDIARIES.

Good Afternoon Senator Crisco and Representative Megna, members of the Insurance and Real Estate Committee.

My name is Jim Wadleigh, Chief Executive Officer of Access Health CT, the Connecticut State Health Insurance Exchange.

Thank you for the opportunity to give testimony before your committee.

I'm here today to speak in strong support of Senate Bill 1025, which was submitted by Access Health CT and seeks to allow our organization the legal ability to establish subsidiaries. Many other governmental and quasi-public entities in the state of Connecticut have the authority to create and have created legal subsidiaries to help further their public purposes. Those entities that have established subsidiaries have the legislative authority to do so in their enabling legislation. The reasons for Access Health CT pursuing this path are (i) to support the exchange's need to be financially self-sustaining, and (ii) to allow the exchange to offer ancillary lines of business that will also support the exchange's operations. State and federal law require the exchange to be financially self-sustaining, and while the exchange is currently charging a market-wide carrier assessment, this funding alone may be insufficient to fund the exchange's operations. Therefore, the exchange will need to generate other sources of revenue to support its public purpose.

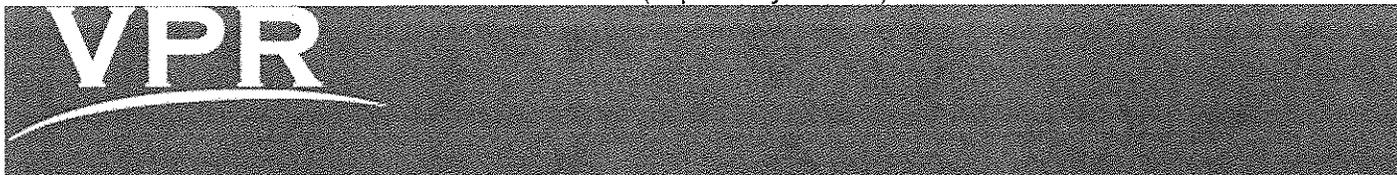
The expertise, business processes and technology developed by the exchange over the past three years have significant value. This value can be captured for the benefit of the exchange through active marketing of these services to entities such as other state exchanges, public or private health insurance marketplaces, or third party vendors serving these exchanges or marketplaces, as examples.

As we look to pursue this avenue, these types of activities can be conducted most efficiently, and risks to the exchange more effectively managed, if such activities are conducted by subsidiaries of the exchange.

To date we have seen robust interest in Access Health CT's offerings, with states like Maryland already utilizing portions of our underlying IT code, and taking advantage of Access Health CT's training materials and curriculum. Conversations with other states and organizations are ongoing, taking place under the direction of Peter VanLoon who is the director of Access Health Exchange Solutions, the current division within Access Health CT which is pursuing this innovative concept. The exchange is also interested in offering ancillary products, such as vision benefits and adult only dental insurance products, but federal regulation prohibits the exchange from offering such other lines of business unless they are offered through separate legal entities.

As the exchange continues to serve the residents of the state of Connecticut by providing improved access to health care coverage, and in turn health care services, and as it leads the nation in the development and deployment of a state based marketplace, allowing for the expansion of Access Health CT's services through the creation of legal subsidiaries will help ensure the organization's long term self-sustainability so that it may continue to support the residents of Connecticut.

For all these reasons I ask for your support in moving Senate Bill1025 forward.



Health Connect's Poor Functioning Causes Millions Of Dollars Of Billing Discrepancies

By NEAL GOSWAMI ·
APR 8, 2015

Because automated functions on the state's online insurance exchange are not working, the state's carriers - Blue Cross Blue Shield and MVP Health Care - have billed for millions in premiums that have not been paid. - Screen shot/ Vermont Health Connect

The screenshot shows the Vermont Health Connect website interface. At the top left is the Vermont Health Connect logo with the tagline "Find the plan that's right for you." To the right are several utility links: "Need in-person help? Find an Assistant in your community", "Need Help? Call 855-899-9600 TTY/TDD 855-834-7898", and "Internet Explorer user? Click here". Below these are navigation links: "Help Center", "Health Plans", "About VHC", "News & Events", "FAQ", and "Sign in". The main content area features three large buttons with corresponding text: "NEED TO SIGN UP FOR HEALTH INSURANCE?" with the subtext "Open Enrollment has ended, but you may still be able to sign up now." and a "GET STARTED" button; "GET THE MOST FROM YOUR PLAN" with the subtext "Learn about health insurance and how to use your coverage to improve your health." and a "LEARN MORE" button; and "NEED TO REPORT A LIFE CHANGE?" with the subtext "Get the right amount of financial help by promptly reporting changes in your family or income." and a "REPORT A CHANGE" button.

The Shumlin administration is working with the state's health insurance carriers to reconcile millions of dollars in billing discrepancies resulting from Vermont Health Connect's lack of key functions.

The reconciliation process has been going on for about three weeks, according to Lawrence Miller, Gov. Peter Shumlin's chief of health care reform. Because automated functions on the state's online insurance exchange are not working, the state's carriers — Blue Cross Blue Shield and MVP Health Care — have millions in premiums on their books that they have not received payment for.

The state has been scrambling to manually process paperwork to make up for the lack of automation on the website since its launch in October 2013. Miller said the focus has been on signing people up for coverage and helping them retain it.

"They were not necessarily processing terminations or cancellations as a very high priority," Miller said.

As a result, the insurance carriers in many cases were not told by the state that they should stop billing customers. They are now working with the state and its contractors to compare records and determine if they are really owed money for the unpaid premiums on their books.

There is also a pool of money collected by Benaissance, a health care benefits administration firm the state uses to process payments, that has not been distributed. The money represents premium payments sent by customers but without enough information to apply the credit to an account. There are at least "a few hundred checks" in that category, according to Miller.

All sides are hesitant to say for sure how much money is at stake. But Health Care Reform Chief Lawrence Miller said at one point Blue Cross Blue Shield thought it could be as high as \$4 million.

All sides are hesitant to say for sure how much money is at stake. But Miller said at one point BCBS thought it could be as high as \$4 million.

"I hesitate to quantify it until they've actually gone through the work," Miller said. "It represents maximum exposure because if there are claims in there where people were covered and they do actually owe money, then we'll go ahead and work with them to collect that."

Cory Gustafson, director of government and public relations for BCBS, said the company does not have a clear idea of how large the discrepancy is.

"It continues to change, and the reconciliation process changes that even further," he said.

Miller said about 70 percent of the cases that have been resolved were the result of customers' terminating their policies without the carriers knowing. If that percentage were to hold for all of the cases in question, the carriers could still be owed a significant amount of money.

"There is a chance," Gustafson acknowledged.

The amount in question is significantly higher for BCBS than for MVP. Blue Cross sells more insurance plans in Vermont, but it also had a policy of keeping those plans on the books rather than risk mistakenly canceling them. MVP canceled policies more freely to avoid such a risk, Miller said.

"They didn't want that exposure. We had a bunch of people that we had to intervene with — hundreds — where MVP didn't check with Vermont Health Connect," Miller said. "They just did it."

"We had a bunch of people that we had to intervene with - hundreds - where MVP didn't check with Vermont Health Connect." - Lawrence Miller

Still, Gustafson said clearing up the discrepancies remains a priority for Blue Cross Blue Shield. And he said the company is counting on the Shumlin administration to deliver on its promise to complete work on the automated systems that the exchange now lacks.

"To us, our accounts receivable balance really symbolizes how important it is for the governor's plan to be implemented to get to a fully functional exchange. The exchange isn't going anywhere," Gustafson said.

The administration has said those automated functions will be in place by the end of May. If not, the administration has said it will abandon the state exchange and transition to one managed by the federal government.

Miller said the next version of the website is expected by May 30, at which time he expects all of the 2014 billing issues to be resolved, as well as any created this year.

"It all has to be wrapped up before go live," he said. "We want a clean and stable data set."

Both the state and the insurance carriers said they were aware that issues were likely when the exchange launched without all of the automated functions working.

"To us, our accounts receivable balance really symbolizes how important it is for the governor's plan to be implemented to get to a fully functional exchange. The exchange isn't going anywhere." - Cory Gustafson, BCBS director of government and public relations

"We all knew we were going to have to go through the reconciliation process, and we all knew it would be a bear the first year," Miller said. "... This is not a dispute between the state and Blue Cross right now, or MVP."

Some "differences of opinion" could emerge once the reconciliation process is completed if the carriers' books are not balanced, Miller said.

"If there is some bad debt at the end of that process it's going to be a question of what's the expected rate of bad debt accumulation at a carrier," Miller said. "We shouldn't cover what's normal."

MVP spokeswoman Jacqueline Marciniak issued a brief statement Tuesday.

"MVP Health Care is committed to working with exchange officials to reconcile discrepancies and develop a solution that is mutually beneficial to our members and to the state of Vermont," she wrote in an email.

This story originally appeared in the Rutland Herald and has been republished through a partnership with the Vermont Press Bureau.



Tax Season Special Enrollment Periods

The second open enrollment period (OEP) under the Affordable Care Act ended on February 15, with more than 11.4 million people enrolled in coverage through the Federal and state Marketplaces.¹ Attention now turns to the 2014 tax season. Many tax filers who were uninsured for all or part of 2014 are learning for the first time that they must pay a penalty, and have missed the opportunity to enroll in 2015 coverage. A recent analysis by the Urban Institute finds significant percentages of uninsured adults who may be subject to the penalty have heard little or nothing about it, did not expect or did not know if they would have to pay the penalty, and did not know about the Marketplace enrollment deadlines, if they had heard of the Marketplaces at all.²

The Federal government and eight State-based Marketplaces – in California, Connecticut, Kentucky, Maryland, Minnesota, New York, Washington and Vermont – have already announced plans to establish a Special Enrollment Period (SEP) to permit individuals subject to the tax penalty to enroll in 2015 coverage outside of this year's OEP, thereby minimizing the penalty they could incur when filing their 2015 taxes.³

The Affordable Care Act requires that all Marketplaces provide initial and annual open enrollment periods (OEPs), during which individuals may enroll in coverage. Additionally, Marketplaces must offer certain "special enrollment periods," generally triggered by changes in life circumstances – such as marriage, the birth of a child and involuntary loss of coverage – that permit individuals to enroll in coverage outside of the annual OEP. Marketplaces have discretion, however, to establish additional enrollment periods beyond the federal minimums.⁴

The "tax season SEPs" announced thus far include the following:

- **Federal.** The Centers for Medicare and Medicaid Services established a SEP to run March 15 through April 30 for individuals living in states with a Federally-facilitated Marketplace and not currently enrolled in coverage through the FFM for 2015 who attest to: (1) paying the penalty for not having health coverage in 2014 when they filed their tax return; and (2) first becoming aware of, or understanding the implications of, the requirement to have coverage after the end of open enrollment and in connection with preparing their 2014 taxes.⁵
- **California.** Covered California announced a SEP available from February 23 to April 30 for "consumers who did not know or understand there was a tax penalty for being uninsured in 2014 or who learned

¹ U.S. Department of Health and Human Services, Open Enrollment Blog. 2/18/15.

<http://www.hhs.gov/healthcare/facts/blog/2015/02/open-enrollment-week-thirteen.html>

² Michael Karpman, Genevieve Kenney, Sharon Long and Stephen Zuckerman. "QuickTake: As of December, Many Uninsured Adults Were not Aware of Tax Penalties for Not Having Coverage, the Marketplaces, or the Open Enrollment Deadline." Urban Institute Health Policy Center. 2/19/15. <http://hrms.urban.org/quicktakes/As-of-December-Man-Uninsured-Adults-Were-Not-Aware-of-Tax-Penalties.html>

³ The Special Enrollment Period does not impact individuals' requirement to pay the penalty for being uninsured in 2014.

⁴ 45 CFR §155.420

⁵ Centers for Medicare and Medicaid Services Press Release, 2/20/15.

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-02-20.html>



they may face a penalty for 2015.” Applicants must attest that they did not know there was a tax penalty by selecting “Informed of Tax Penalty Risk” when submitting an application online.⁶

- **Connecticut.** Access Health CT’s CEO announced that a month-long special enrollment period, likely in April, will take place for those who are learning for the first time that they face a tax penalty for being uninsured in 2014.⁷
- **Kentucky.** Governor Steve Beshear announced that kynect will provide a SEP from March 2 through April 30 for individuals “unaware of possible tax penalties.”⁸
- **Maryland.** Maryland Health Connection established a SEP to run March 15 through April 30 for Marylanders “who must pay the penalty for lacking health insurance in 2014 and who attest that they became aware of the penalty during this income tax filing season after the Feb. 15 close of open enrollment for 2015 coverage.”⁹
- **Minnesota.** MNsure has established a SEP from March 1 through April 30 for “individuals who are required to pay a penalty for being uninsured in 2014 as they file their 2014 tax return.”¹⁰
- **New York.** To apply for coverage during the NY State of Health’s SEP, open from March 1 through April 30, individuals must attest that upon filing their 2014 taxes, they paid the penalty for not having health insurance in 2014 and first became aware of or understood the implications of not having health insurance.¹¹
- **Washington.** The Washington Health Benefit Exchange directs “customers who were unaware of the tax penalty” to complete an online application and to call the Marketplace’s Customer Support Center when prompted to select a type of SEP. The SEP began on February 17 and ends on April 17. Individuals must select a plan and submit payment by the deadline to effectuate coverage.¹²
- **Vermont.** Vermont Health Connect’s SEP is available to those “who learn about the new federal fee when they file their 2014 taxes.” Individuals must apply and select a plan within 60 days of discovering their penalty, but no later than May 31.¹³

⁶ Covered California Press Release. 2/20/15. <http://news.coveredca.com/2015/02/covered-california-offers-consumers.html>

⁷ Matthew Sturdevant. “This Time Around, Access Health CT Enrolled 204,358, Most of Them in Medicaid.” Connecticut Now. 2/23/15. <http://www.ctnow.com/business/hc-access-health-ct-enrollment-20150223,0,6319148.story>

⁸ Governor’s Steve Beshear’s Communications Office Press Release. 2/24/15. <http://migration.kentucky.gov/Newsroom/governor/20150224kynect.htm>

⁹ Maryland Health Connection Media Release. 2/25/15. <http://marylandhbe.com/wp-content/uploads/2015/02/02252015-SpecialTaxEnrollment.pdf>

¹⁰ MNsure Press Release, 2/18/15. <https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-156688>

¹¹ NY State of Health Press Release, 2/24/15. <http://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-announces-special-enrollment-period-uninsured-new-yorkers-facing>

¹² Washington Health Benefit Exchange Press Release, 2/16/15. <http://wahbexchange.org/news-resources/press-room/press-releases/wa-healthplanfinder-spring-sep>

¹³ Vermont Health Connect. <http://info.healthconnect.vermont.gov/QualifyingEvents>

King v. Burwell: Unpacking The Supreme Court Oral Arguments

Timothy Jost

March 5, 2015 (excerpt of blog post at Health Affairs)

On March 4, 2015, the United States Supreme Court heard oral arguments in *King v. Burwell*.

Plaintiffs' Argument

Standing. Mr. Carvin had hardly taken the podium when Justice Ginsburg began raising questions about the standing of the plaintiffs. The federal courts are limited by the Constitution to hearing “cases or controversies,” which has been interpreted to mean that they cannot hear cases that are solely political arguments in which no one has suffered injury. There have been a number of media reports in recent days questioning whether the plaintiffs in this litigation have been injured in any way, and Ginsburg asked Carvin to address this. Although the lower courts had decided the plaintiffs had standing, the question is jurisdictional and the Supreme Court can dismiss a case on its own on the basis of standing even though neither party raises it.



.....

The meaning of exchange in the ACA. Justice Breyer did move on to press Carvin, repeating the key argument of the government that “exchange” is a defined term under the ACA. It is defined as a 1311 exchange, which in turn is defined as an exchange “established by a state.” Section 1321 requires HHS to set up “such exchange,” that is a “required” 1311 state exchange when a state elects not to do so.

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Interpreting the ACA to avoid unconstitutional coercion. And here they reached what may well prove to be the turning point of the argument. Justice Sotomayor pointed out that if the plaintiffs’ argument is right, states that elect not to operate their own exchanges face tremendous penalties. Not only do their residents lose the tax credits, but their nongroup insurance markets will collapse and they will be blocked from reducing Medicaid eligibility (and states that already have may lose Medicaid funding altogether). This is clearly, Sotomayor argued, unconstitutionally coercive under recent Supreme Court cases.

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Mouse holes. Mr. Carvin argued that there was a great deal of legislative history suggesting that exchanges were valuable as one-stop shopping markets, but no legislative history suggesting that premium tax credits were essential for them to work. Justice Sotomayor responded, however, that Congress would have not hid a provision this threatening to the states in a “mouse hole,” like the section of the law dealing with calculation of tax credits, since its consequences were potentially so great.

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The consequences of the competing statutory interpretations. Justice Breyer moved on to point out a number of anomalies caused by Carvin’s interpretation of the statute: employers in a federal exchange state do not have to pay the employer mandate penalty unless they have an employee in a state-exchange state, in which case they do; federal exchange states must maintain their 2010 Medicaid eligibility standards forever while states with state-operated exchanges do not; federally facilitated exchanges cannot have qualified individual enrollees.

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A key point of contention. As Mr. Carvin’s opening argument drew to a close, a key disagreement came into focus. As Mr. Carvin tried to explain what “qualified individual” could mean other than an individual eligible to enroll through an exchange; he contended that, having established his interpretation of “Exchange established by the State” as a fixed star in the firmament, it was only necessary to interpret the remainder of the statute to avoid an absurd result. Justice Kagan responded,

But we are interpreting a statute generally to make it make sense as a whole, right? We look at the whole text. We don’t look at four words. We look at the whole text, the particular context, the more general context, try to make everything harmonious with everything else.

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The Government's Argument

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The government's statutory interpretation approach. His merits argument was that, first, the only way to read the text of the ACA to make sense was to conclude that federally facilitated exchanges could grant premium tax credits; and, second, that this reading was compelled by the Act's structure and purpose. The plaintiffs' reading of the statute would create "rump exchanges doomed to fail," and "make a mockery of the statute's . . . express textual promise of State flexibility." It would lead to insurance death spirals and deprive millions of affordable care.

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Coercion redux. Justice Alito then asked whether General Verrilli agreed that the plaintiff's interpretation of the statute made it unconstitutionally coercive. This question put General Verrilli in a difficult position, as the Solicitor General's job is to defend statutes against claims of unconstitutionality, but General Verrilli did admit that this was a "novel issue." Justice Kennedy rejoined the debate at this point, contending that the plaintiff's argument did raise an issue of unconstitutional coercion, and that the doctrine of constitutional avoidance would seem to apply. Without conceding unconstitutionality, General Verrilli assented that constitutional avoidance should apply, and not just because the plaintiff's interpretation was coercive but also because the states were not given adequate notice of the consequences of failing to operate their own exchange.

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An interesting approach from Justice Alito. At this point Justice Alito made a truly novel suggestion. What if we ruled for plaintiffs but delayed the mandate to the end of the tax year? Verrilli questioned the authority of the Court to do this — the Court cannot simply create tax credits not authorized by Congress — but also pointed out the tremendous practical problems of establishing an exchange in this short a time frame.

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What did Congress want? General Verrilli moved on, refocusing the discussion on the objective, textual, indications of what Congress in fact did in 2010. First, it created federal exchanges, which made no sense if Congress thought every state would establish its own exchange. This scheme, Verrilli contended in response to an interjection from Justice Kennedy, promoted federalism by giving the states a choice as to how to participate in the implementation of the act. Second, the title of section 1321, which creates the federal exchange, refers to state flexibility, which makes no sense if the states are effectively given no choice but to operate their own exchange. And third, if Congress really meant to bludgeon the states into creating exchanges under threat of losing the premium tax credits, it would not have buried the threat in a section on calculating tax credits where no one would see it.

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The heart of the matter. Justice Alito then asked the central question in the litigation: "If Congress meant to empower federal exchanges to grant tax credits, why did it use the phrase "established by the State," rather than "established under the Act," or "established within the State"? Why not say that a federally facilitated exchange is a state exchange? General Verrilli responded by saying that the statute in fact says "established by the State under section 1311," and that 1311 includes federal exchanges.

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Chevron deference. At this point Justice Kennedy asked if General Verrilli was contending that the statute was ambiguous and that therefore the Chevron rule should cause the Court defer to the agency. If so, continued Justice Kennedy, it seems like a drastic step to defer to the IRS when billions of dollars in subsidies are at stake. He further asserted that precedent suggested the Court should only defer to the IRS on the question of deductions when the law was "very, very clear," and that the IRS should have pointed out this ambiguity to Congress.

Plaintiffs' Rebuttal

As Mr. Carvin began his brief rebuttal, Justice Sotomayor asked Mr. Carvin if his argument for limiting Chevron deference when tax subsidies were involved did not cut both ways, since had the IRS limited premium tax credits to state-operated exchanges it would be expanding tax relief for employers and individuals in federally facilitated exchange states who would be freed from mandate penalties. Mr. Carvin responded by stating that the fact that the employer mandate did not apply in federally facilitated exchange states was unambiguous and that the government was trying unconstitutionally to enforce it against states as a form of coercion. He concluded by saying that section 1311 only applies to state-operated and not federally facilitated exchanges, a curious position since the ACA clearly defines all exchanges as 1311 exchanges, a fact accepted by Judge Griffith in his ruling for Carvin in the *Halbig* case.



REALIZING HEALTH REFORM'S POTENTIAL

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Innovation Waivers: An Opportunity for States to Pursue Their Own Brand of Health Reform

Deborah Bachrach, Joel Ario, and Hailey Davis

Abstract States have long been the testing ground for new models of health care and coverage. Section 1332 of the Affordable Care Act, which takes effect in less than two years, throws open the door to innovation by authorizing states to rethink the law's coverage designs. Under State Innovation Waivers, states can modify the rules regarding covered benefits, subsidies, insurance marketplaces, and individual and employer mandates. States may propose broad alternatives or targeted fixes, but all waivers must demonstrate that coverage will remain as accessible, comprehensive, and affordable as before the waiver and that the changes will not add to the federal deficit. This issue brief describes how states may use State Innovation Waivers to reallocate subsidies, expand or streamline their marketplaces, replace or modify the mandates, and otherwise pursue their own brand of reform tailored to local market conditions and political preferences.

OVERVIEW

The Affordable Care Act (ACA) establishes a new national paradigm for health coverage while leaving room for considerable experimentation by states. Indeed, building on a long history of state innovation with coverage, payment, and delivery models, the ACA is fueling far-reaching campaigns by governors to reform state health care systems across payers and providers. The door to innovation will be thrown open even further in 2017, when section 1332 of the ACA invites states to find alternative ways to meet the coverage goals of the law while staying within its fiscal constraints.

Developed with bipartisan support that continues to this day, section 1332, known as State Innovation Waivers, authorizes states to request five-year renewable waivers from the U.S. Departments of Health and Human Services (HHS) and the Treasury of the ACA's key coverage provisions, including those related to benefits and subsidies, the exchanges (also known as marketplaces), and the individual and employer mandates.¹

Depending on their policy and political priorities, states may propose waivers to pursue broad alternative approaches to expand coverage or targeted fixes intended to smooth the rough edges of the ACA. Some ACA provisions, such as guaranteed issue, may not be waived and all applications must demonstrate that coverage remains as accessible, comprehensive, and affordable as before the waiver and that the proposed changes will not contribute to the federal deficit.

In this brief, we examine the requirements of section 1332 and explore how states might utilize the waivers. We do so with limited guidance from HHS, whose only regulations to date relate almost entirely to the application process.² Thus, our exploration is based on the statutory language, considerable experience with exchanges and Medicaid waivers, and interviews with policy experts and state officials (Appendix A).

THE BASICS

What May Be Waived?

States may propose alternatives to four pillars of the ACA:

- **Benefits and Subsidies.** States may modify the rules governing covered benefits, as well as the subsidies that are available through the marketplaces. States seeking to reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies to implement their alternative approaches.
- **Marketplaces and Qualified Health Plans.** States may replace their marketplaces or supplant the plan certification process with alternative ways to provide health plan choice, determine eligibility for subsidies, and enroll consumers in coverage.
- **The Individual Mandate.** States may modify or eliminate the requirement that individuals maintain minimum essential coverage.
- **The Employer Mandate.** States may modify or eliminate the requirement that large employers offer affordable coverage to their full-time employees.

FAIR PLAY RULES MAY NOT BE WAIVED

States may not waive the ACA's nondiscrimination provisions, which prohibit carriers from denying coverage or increasing premiums based on medical history. States are also precluded from waiving related "fair play" rules that guarantee equal access at fair prices for all enrollees.

Waiver Guardrails

State Innovation Waivers must satisfy four criteria:

- **Comprehensive Coverage.** States must provide coverage that is "at least as comprehensive" as coverage absent the waiver.
- **Affordable Coverage.** States must provide "coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable" as coverage absent the waiver.
- **Scope of Coverage.** States must provide coverage to "at least a comparable number of residents" as would have been covered without the waiver.
- **Federal Deficit.** The waiver must not increase the federal deficit.

Coordination with Other Waivers

HHS is required to coordinate and consolidate the 1332 waiver process with waiver processes for Medicaid, Medicare, the Children's Health Insurance Program, and other federal laws relating to the provision of health care services. Such consolidation of waivers allows for better alignment of coverage programs and may create some flexibility in how waiver packages are assessed.

Taken together, these provisions confirm the ACA's central policy goal—ensuring that every American has access to affordable and meaningful coverage—while giving states considerable flexibility to decide how best to achieve this within their borders. Ultimately, the extent of that flexibility will be defined by statute, regulation, and most notably, through the lens of the administration reviewing the 1332 waiver requests.

POSSIBLE WAIVER STRATEGIES

State Innovation Waivers create a fresh opportunity for states to pursue their own brand of reform tailored to local market conditions and political preferences. As one commentator noted, "Without even changing the law, 1332 could change the ACA almost beyond recognition."³ The possibilities are far ranging, but all are subject to the coverage and fiscal guardrails discussed above. There is considerable interest in the waivers across the political spectrum, although few state officials have identified a particular path forward. The most compelling ideas may emerge after state officials and key stakeholders come together and—through the public and transparent process required under section 1332—forge consensus. Interviews with policy experts and state officials suggest the following areas of interest.

Rethinking Subsidies for Marketplace Plans

The ACA seeks to make coverage affordable for those above Medicaid income-eligibility levels through a combination of subsidies that includes premium tax credits and cost-sharing reductions. State officials at both ends of the political spectrum question whether the law's subsidy rules strike the right balance. Some are concerned that cost-sharing levels are too high and will impede access to care. Others would welcome health plans with greater cost-sharing and lower premiums to attract younger and healthier populations. Both approaches seek to minimize "subsidy cliffs" (dramatic drops in subsidy amount as income rises) and establish more graduated subsidies.

For example, a state may pursue a consolidated 1332 and Medicaid waiver to smooth the subsidy cliff faced by individuals moving from Medicaid to the marketplace. It could align premiums for higher-income Medicaid enrollees with those of lower-income marketplace enrollees and, in doing so, could redeploy the aggregate value of tax credits and cost-sharing reductions to increase subsidies for those with more modest incomes and develop more graduated subsidies.

CONSOLIDATING 1332 AND 1115 WAIVERS: ARKANSAS

Arkansas' section 1115 expansion waiver, also known as the private option, authorizes the state to use Medicaid funds to purchase qualified health plan (QHP) coverage on the marketplace. While the Government Accountability Office challenged the program's budget neutrality, the expansion has been enormously successful. Nearly 200,000 newly eligible adults enrolled in coverage through QHPs in the Arkansas marketplace, which substantially increased its size and helped drive down premium costs. As premiums go down, federal costs related to tax credits likewise decrease. Such savings do not count toward budget neutrality, however, because they are not savings to the Medicaid program. Under a consolidated 1115 and 1332 waiver, one could envision HHS permitting states to demonstrate budget neutrality across waivers. Arkansas Governor Asa Hutchinson recently alluded to a 1332 waiver as playing a role in the future of the private option.

Alternately, some states may pursue the addition of high-deductible, lower-premium plans with greater cost-sharing than is currently allowed in the marketplaces and use the savings to offer health savings accounts to ease cost burdens on low-income individuals—similar to what Indiana has implemented for its Medicaid enrollees. While this may increase the number of individuals covered and decrease premiums if the overall risk pool is improved, the waiver application would need to meet the requirement that coverage be at least as affordable as coverage absent the waiver. The same concerns would apply to states interested in allowing value-based purchasing models that increase cost-sharing for lower-value services or lower-quality plans. Such waiver approaches would have to address how the benefits to some consumers would be balanced against the increased costs to others. States also must be mindful that current spending on subsidies will influence the amount available through a 1332 waiver.

Reforming the Marketplaces

The marketplaces play a central role in the ACA, though some states have done little to support them (ceding control to the federal government) while others are broadening their role. Section 1332 allows for either approach, although states currently using the federal marketplace may be limited in their ability to modify its provisions unless and until the federal marketplace can accommodate more state-specific policies. These states may eliminate the federal marketplace entirely, however, as long as their waiver applications address the law's coverage and fiscal goals.

Eliminating the marketplaces may be an especially attractive option in smaller states where only limited numbers use them. States may choose to replace them with a system that offers vouchers for eligible individuals to purchase coverage from any lawful seller of ACA-compliant coverage. Alternately, states may leverage the rapid growth of Web brokers and private exchanges to outsource marketplace functions to one or more competing Web-based sellers. The federal marketplace already allows a version of this approach, but states may want to move beyond what is currently allowed by the statute.

Other states may want to enhance their marketplaces' scale and leverage by using a 1332 waiver to offer coverage options for additional populations or even to serve as the sole provider of

PRECEDENT FOR REDEPLOYING FEDERAL SUBSIDIES: THE BASIC HEALTH PROGRAM

Under the Basic Health Program (section 1331 of the ACA), states may receive 95 percent of the aggregate value of subsidies that otherwise would have gone to individuals with incomes up to 200 percent of the federal poverty level who are eligible to purchase marketplace coverage and use those funds to offer more affordable coverage. The method for calculating the aggregate federal funding available under this approach suggests how HHS might calculate the funding available to states under State Innovation Waivers. Under Basic Health Program (BHP) regulations, HHS develops rate cells, breaking down the potentially eligible population by age range, geographic area, coverage category, household size, and income level. The payment rate is calculated by taking the sum of 95 percent of the tax credits and cost-sharing reductions—adjusted for risk and other factors—multiplied by the projected number of enrollees within each rate cell. The aggregate amount the state receives is equal to the sum of the payment amounts for each rate cell, reconciled retrospectively based on actual enrollment, coverage category, household size, and income level.

Notably, come 2017, section 1332 will allow states to accomplish the goals of the BHP with 100 percent of the aggregate subsidy amount, rather than 95 percent as authorized for the BHP.

coverage. (Vermont state officials contemplated but ultimately did not pursue this approach, citing fiscal constraints.) States may take incremental steps in this direction by, for instance, adding state employees or other large purchasing pools to their marketplaces.

Waivers focused on reforming the marketplaces are likely to have little impact on the coverage guardrails, though states should be mindful of how changes affect access to coverage across different populations.

Replacing or Modifying the Individual and Employer Mandates

With some exceptions, the ACA penalizes individuals who do not have minimum essential coverage or employers that do not offer such coverage. Arguably the least popular provisions in the law, the individual and employer mandates may be prominently featured in states' 1332 waiver applications. Possible alternatives to the individual mandate include implementing penalties for late enrollment (similar to Medicare), reducing opportunities for enrollment (e.g., multiyear waiting periods if open enrollment is missed), or establishing automatic enrollment. On their own, waivers of the individual mandate would not impact the comprehensiveness of coverage, though they could reduce the number of individuals covered, decrease affordability, and increase federal costs (if premiums rise as a result). Much would depend on how effective the mandate alternative is at maintaining scope of coverage and a balanced risk pool.

As an alternative to the employer mandate, states may implement a "play or pay" requirement in which employers must pay a flat percentage of payroll in benefits or taxes. With the relatively low enrollment in the Small Business Health Options Program (SHOP), many states may welcome the flexibility to experiment with new approaches to serving the small business community. While waivers of the employer mandate might have little impact on coverage, they might have a significant fiscal impact: such a waiver would reduce the penalty revenue to the federal government and therefore raise the federal deficit, absent some other waiver component to offset it.

Targeted Fixes

In the earlier sections, we reflect on some of the more expansive ideas that have emerged around 1332 waivers. In this final section, we look at more targeted approaches. By targeted, we do not mean small or unimportant, but rather approaches that focus on a narrow slice of the law, such as undoing the ACA requirement that small-group rating rules apply to businesses with 51 to 100 employees. Other targeted reforms that were suggested in our interviews include:

- **Filling Coverage Gaps.** States might address coverage gaps, such as the "family glitch," which makes dependents ineligible for tax credits if they are offered employer coverage, regardless of whether that coverage is affordable.

CONTEMPLATING THE OPTIONS POSED BY 1332

In Hawaii, a longstanding and popular employer mandate, the Prepaid Health Care Act, has led to a high coverage rate (92%) among state residents. Efforts to reconcile Prepaid Health Care Act and ACA provisions have created challenges for Hawaii and motivated the legislature to establish a task force focused on 1332 waiver possibilities. The task force has not yet made any substantive recommendations but has engaged stakeholders in a review of options—a process that could be a model for other states wanting to ensure that all options are considered in a public and transparent way.

- **Advancing State Reform Priorities.** States might provide incentives for health care quality improvement by reallocating subsidies to favor plans with higher quality ratings, as is currently done in Medicare Advantage.
- **Grace Periods.** States might replace the ACA's three-month grace periods for non-payment with the one-month grace periods that are common in states for plans outside the marketplace.
- **Aligning Rules.** States might alter the rules on issues such as the definition and verification of income to align exchange, Medicaid, and other program rules.
- **Simplifying Regulations.** States might want to preserve federal reforms, such as cost-sharing reductions, but replace complex federal recordkeeping rules.

SMOOTHING THE LAW'S ROUGH EDGES

The Minnesota Department of Human Services has identified several opportunities for better aligning coverage rules across subsidy programs, including:

- *Income counting.* Income is counted differently under Medicaid, the state's BHP, and the marketplaces.
- *Eligibility verification.* Verification rules are not entirely consistent across Medicaid and the marketplaces.
- *Implementation of a consistent enrollment effective date.* The ACA and the Social Security Act use different enrollment start dates for Medicaid, QHPs, and the BHP.
- *Definition of American Indian.* The definition of American Indians differs for purposes of Medicaid and marketplace coverage.

CONCLUSION

State Innovation Waivers involve a delicate balancing act: providing states with considerable latitude to experiment with alternative coverage mechanisms while also requiring that they continue to meet the coverage and affordability goals of the Affordable Care Act. Combined with Medicaid waivers, they may provide states with the opportunity to move beyond the politics of the ACA and pursue their own reforms. Indeed, if state policymakers agree on the value of having accessible, affordable, and meaningful health care coverage for all, then 1332 waivers offer a way to achieve these goals while reinforcing states' leadership role in regulating their insurance markets and serving as the laboratories of health reform.

APPENDIX A. LIST OF INTERVIEWEES

Stuart Butler, Ph.D., Senior Fellow, Economic Studies, Brookings Institution

Devon Green, Special Counsel for Health Care Reform, Vermont Agency of Administration

Gordon Ito, Insurance Commissioner, Hawaii Department of Commerce and Consumer Affairs, and Vice Chair, Hawaii State Innovation Waiver Task Force

Scott Leitz, Chief Executive Officer, MNsure (Minnesota Health Insurance Marketplace)

Robin Lunge, Director of Health Care Reform, Vermont Agency of Administration

John McDonough, Dr.P.H., Professor, Department of Health Policy and Management, and Director, Center for Executive and Continuing Professional Education, Harvard University School of Public Health

Len Nichols, Ph.D., Director, Center for Health Policy Research and Ethics, and Professor of Health Policy, College of Health and Human Services, George Mason University

Marie Zimmerman, Medicaid Director, Minnesota Department of Human Services

NOTES

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

² U.S. Department of the Treasury and U.S. Department of Health and Human Services. Final Rule. "Application, Review, and Reporting Process for Waivers for State Innovation." *Federal Register* 77, no. 38 (Feb. 27, 2012):11700, <http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf>.

³ S. M. Butler, "Why the GOP Needs an Alternative to the Obamacare Repeal Strategy," *Health360* (blog), Brookings Institution, Jan. 28, 2015, <http://www.brookings.edu/blogs/health360/posts/2015/01/28-gop-obamacare-repeal-strategy-alternative-butler>.

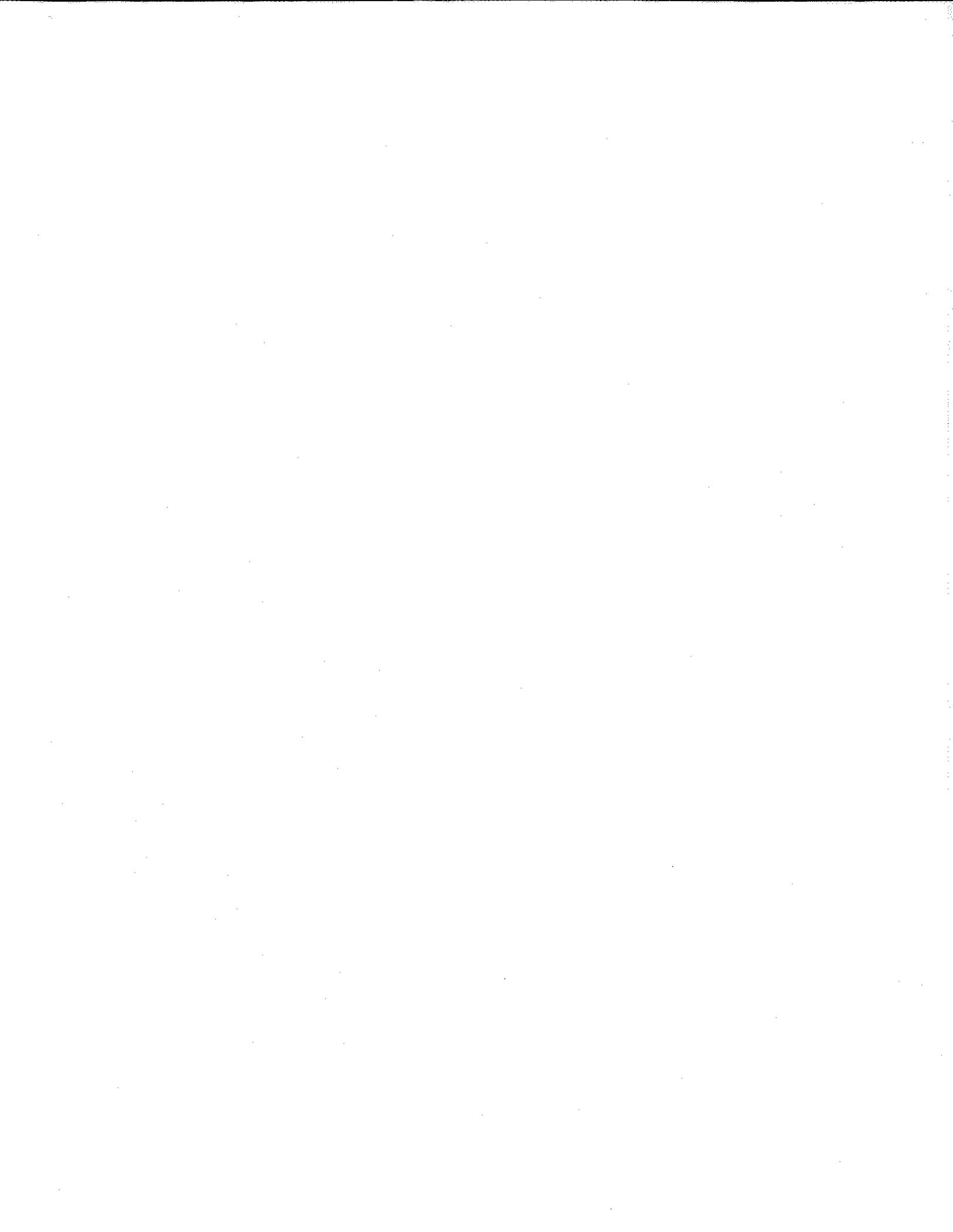
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Hailey Davis, M.P.H., a manager at Manatt Health Solutions, provides policy analysis, project implementation support, and other strategic business services to foundations, health care providers, payers, and other health care stakeholders. Her services focus primarily on the implementation of the Affordable Care Act, state marketplaces, and Medicaid managed care. Prior to joining Manatt, she served as a program analyst in the HHS Office of the Inspector General Office of Evaluation and Inspections. In this position she conducted national and statewide evaluations of HHS programs and served as a member of the Healthcare Reform Strategy Work Group. Ms. Davis received her B.A. from the University of Texas and her M.P.H. from Columbia University.

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