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Emerging Opportunities for State-Based Marketplaces (SBMs)

Joel Ario, National Advisor
Amy Zhan, Manager

Manatt Health

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Joel Ario
National Advisor
Manatt Health
518.431.6719
jario@manatt.com

Amy Zhan
Manager
Manatt Health
212.790.4573
azhan@manatt.com

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Executive Summary

The Affordable Care Act (ACA) Marketplaces have nearly tripled their enrollment in their first decade of operation, from eight million people in 2014 to 21.4 million in 2024. At the national level, the ACA has helped cut the uninsured rate nearly in half through a combination of Medicaid expansion, Marketplace enrollment and other initiatives. However, this national success masks wide variation among the states, from a 2.4% uninsured rate in Massachusetts to a 16.6% uninsured rate in Texas.

This white paper focuses on the role that State-Based Marketplaces (SBMs) have played in helping reduce the uninsured rate in the SBM states and discusses how the 32 states currently using the Federally-Facilitated Marketplace (FFM) could achieve similar coverage gains by establishing an SBM. The paper relies on insights garnered from interviews with SBM leaders in ten states to explain how SBM states can better target consumer outreach to reach the uninsured, improve coordination between their SBM and state Medicaid agency, and enhance affordability by adopting state subsidies and other policy initiatives not possible as an FFM state.

SBM states can better target consumer outreach, improve Marketplace-Medicaid coordination and supplement federal subsidies with state subsidies.

The paper begins with an introductory section that identifies Medicaid expansion as the single most important way to expand coverage, with establishment of an SBM as a complementary strategy to make further coverage gains. The 12 FFM states that had not expanded Medicaid as of 2022 had an average uninsured rate of 10.3%. The average rate dropped to 7.0% for the 21 FFM states that had expanded Medicaid. Most significant for this paper on SBMs, the average rate dropped again to 5.8% for the 17 states plus D.C., which had both expanded Medicaid and established an SBM as of 2022.

States that both expanded Medicaid and established an SBM had an average uninsured rate of 5.8% in 2022. States that had done neither had an average uninsured rate of 10.3%.

The introduction also highlights the importance of future SBMs meeting the high bar established by current SBMs and discusses steps the Biden Administration is taking to raise the minimum SBM standards, which the current SBMs typically exceed. The paper makes recommendations for how the Administration could continue raising the bar for SBMs to ensure that states have clear plans for using their SBM to improve their health care markets in ways not possible on the FFM, which has become a high performing IT platform for states that prefer a more passive approach to health reform.

The Biden Administration has taken steps to raise the minimum standards for SBMs and could do more.

The next two sections provide historical context:

- **SBM/FFM landscape.** A short history of SBMs, including the 12 first generation SBMs and the near doubling of SBMs since 2020, with seven second generation SBMs operative as of 2024, three more on schedule to become operational by 2027 and a half dozen other states actively considering SBMs.
- **Technological innovation.** An overview of technology advancements in two areas: consumer-facing websites that are continuously updated to offer consumers a high-quality online shopping experience and back-end

systems that support improved Marketplace/Medicaid coordination, as well as supporting other data management and compliance issues.

These historical sections are followed by three sections on SBM accomplishments in consumer outreach, Marketplace-Medicaid collaboration and policy innovation. Each section concludes with recommendations on how the Center for Consumer Information and Insurer Oversight (CCIIO) could strengthen standards for future SBMs:

- **Consumer outreach.** SBMs are able to collect and analyze granular data to expand and target consumer outreach on uninsured and churning populations, and SBMs generally devote more resources to consumer outreach than the FFM does. CCIIO has proposed a more robust SBM Blueprint process and could also enhance transparency about SBM spending on consumer outreach, and consider performance metrics for key consumer outreach responsibilities.

  CCIIO has proposed a more robust SBM Blueprint process.

- **Marketplace-Medicaid collaboration.** SBM states have achieved better coordination between their SBMs and state Medicaid agencies. All SBMs to date have expanded Medicaid, and state leadership in SBM states generally prioritizes close working relationships between sister state programs. Most FFM states have chosen to treat FFM decisions about Medicaid eligibility as "assessments" of Medicaid eligibility, meaning the state Medicaid agency has to reassess the FFM's decision. CCIIO could require SBM states to treat SBM eligibility decisions as binding determinations for Medicaid, tighten the operational requirements for a common Marketplace-Medicaid application and improve the account transfer process. CCIIO could also incent states that have not yet expanded Medicaid to do so in conjunction with establishing an SBM.

  CCIIO could incent states that have not yet expanded Medicaid to do so in conjunction with establishing an SBM.

- **Policy innovation.** A majority of SBM states have supplemented federal tax credits with state subsidies, adopted easy enrollment programs, or implemented other policy initiatives to enhance access and affordability. All Marketplaces have had access to enhanced federal subsidies since 2020, but those subsidies are scheduled to lapse in 2026, and if Congress fails to renew them, SBM states will be in a better position to maintain ACA affordability gains. CCIIO cannot mandate innovation, but it could develop checklists that make it easier for other states to replicate successful innovations and develop templates for new types of innovation that advance the goals of the ACA.

  CCIIO could develop checklists and templates to make it easier for states to replicate successful innovations, such as the Colorado Option.

Introduction

The Marketplaces are a central pillar of the Affordable Care Act (ACA), which, together with Medicaid expansion and other ACA programs, have expanded coverage to more than 40 million people and cut the uninsured rate to 6% or less (often substantially less) in states that have embraced the coverage goals of the ACA the most. The Marketplaces have come a long way in their first decade, from eight million enrollees in 2014 to 21.4 million enrollees in 2024.[1,2,3]

This white paper focuses on how these enrollment gains can be taken to the next level by states interested in further reducing their uninsured rates and moving closer to universal coverage. State decisions on expanding Medicaid and establishing a State-Based Marketplace (SBM) have made a critical difference in the first ten years, and as uninsured rates are reduced and further gains become more challenging, state decisions could be even more pivotal in the ACA's second decade.

Uninsured rates vary among states from 2.4% in Massachusetts to 16.6% in Texas.

At the national level, the ACA has helped cut the uninsured rate nearly in half, from 14.9% in 2013 to 7.9% in 2022, but this national success masks wide variations among the states, from a 2.4% uninsured rate in Massachusetts to 16.6% in Texas.[4] The most important reason for this wide variation is Medicaid expansion. 40 states and D.C. have chosen to expand Medicaid to date, and 78% of them have uninsured rates below the national average. The remaining ten states have had a decidedly different experience. Nine of the ten non-expansion states had uninsured rates well above the national average (8.6% to 16.6% in 2022); the only exception was Wisconsin, which financed its own partial expansion.[i]

Medicaid expansion is the single best way to reduce the uninsured rate.

For a state interested in reducing its uninsured rate, the case is overwhelming that Medicaid expansion is the single best step toward that goal. The case is not as open and shut for establishing an SBM, since the choice is not SBM or no Marketplace. In fact, the ACA requires a Federally-Facilitated Marketplace (FFM) in any state that does not establish an SBM. As discussed in this paper, the FFM has also been a success story in the ACA's first decade, providing a vibrant Marketplace for 32 states.

SBMs are well positioned to expand consumer outreach, collaborate with state Medicaid agencies and supplement federal subsidies with state ones.

There are, however, a growing number of states that have expanded Medicaid and want to do more at the state level to expand coverage. This white paper looks at three areas where the SBM states have pursued coverage initiatives that are easier to accomplish as an SBM state than as an FFM state—more targeted consumer outreach, better Marketplace-Medicaid collaboration and state subsidies to supplement federal ones. We describe the recent upsurge in SBMs—from 12 in 2017 to 19 today, with three more in the pipeline—and then focus on what has made the SBMs successful and how that success could be multiplied if more states adopt SBMs, especially those that have already expanded Medicaid or choose to pursue Medicaid expansion and an SBM as a package.

[i] See Exhibit 4 for a summary of uninsured rates by state.

It is, of course, far from certain that future SBMs will follow the path of the current SBMs. Indeed, the nation is at a crossroads in the evolution of the ACA, with most SBM states led by Democratic governors supportive of the ACA and most remaining FFM states led by Republican governors with mixed or even adversarial views of the ACA, though more than half of these Republican-led states have expanded Medicaid. The Biden Administration has begun to address this situation by proposing higher SBM standards.

The proposed Marketplace rules for 2025 focus on higher standards for network adequacy and consumer outreach, where most current SBMs have exceeded minimum standards. The Administration has not proposed Medicaid expansion as a precondition for new SBMs, even though all SBMs to date have expanded Medicaid, nor has the Administration proposed other forms of Marketplace-Medicaid collaboration or state financial commitments beyond relatively minimal consumer outreach spending. It may be challenging to develop workable standards across all three areas discussed in this white paper, yet SBM success is a product of progress in all three areas. We make recommendations in all three areas for what the federal government could do, with more emphasis on incenting innovation than enforcing standardization.

Most current SBMS have exceeded minimum federal standards.

Of course, the partisanship that has plagued the ACA since its passage could continue to impede the establishment of additional SBMs if standards are tightened to align with the ACA's coverage goals. In that case, the status quo for states that rely on the FFM might have coverage results more in keeping with the intent of the ACA than would new SBMs with more limited objectives. But that result would also be less than optimal if it means that the majority of states do not feel ownership over their markets, leaving the FFM to drive the kinds of changes that SBMs are much better positioned to achieve, as detailed in this white paper.

The first decade of ACA implementation demonstrates that the ACA will be more stable and successful in states where the federal government and the state are active partners in achieving the coverage goals of the ACA. Establishing an SBM does not guarantee productive state-federal collaboration, but SBMs have been a critical factor for the most engaged states, and there are reasons for optimism about new SBMs bridging rather than exacerbating partisan tensions.

The ACA will be more stable and successful where the federal and state governments are active partners in reducing the uninsured rate.

Overview of White Paper

This white paper frames the opportunities for growth in the number of SBMs into a broader context, including insights gained from interviews with the SBM leaders in ten states. The paper begins with two historical sections:

- **SBM/FFM landscape.** A short history of SBMs, including the emergence of SBM-FPs, a new hybrid Marketplace model that has become an important waystation for states moving to a full SBM and may become a long-term option for some states wanting a limited partnership with the federal government.
- **Technological innovation.** An overview of technology advancements in two areas: consumer-facing websites that are continuously updated to offer consumers a high-quality online shopping experience and back-end systems that support improved Marketplace/Medicaid coordination, as well as supporting other data management and compliance issues.

The historical context is followed by three sections that focus on SBM accomplishments in three areas:

- **Consumer outreach.** SBMs are able to collect and analyze granular data to expand and target consumer outreach on uninsured and churning populations, and SBMs generally devote more resources to consumer outreach than the FFM does. The FFM's commitment to Navigator funding and other consumer outreach efforts has fluctuated by Administration, and the FFM has not made its more detailed data available to FFM or SBM-FP states.

The federal commitment to Navigator funding has fluctuated by Administration.

- **Marketplace-Medicaid collaboration.** SBM states have achieved better coordination between their SBMs and state Medicaid agencies, partly because state leadership in SBM states generally prioritizes close working relationships between sister state programs. Most FFM states have chosen to treat FFM decisions about Medicaid eligibility as "assessments" of Medicaid eligibility, meaning the state Medicaid agency has to reassess the FFM's decision. States could improve coordination by treating FFM decisions as determinative, which a handful of FFM states have done. In addition, first generation SBMs benefited from large federal grants to build customized legacy technology systems that integrated Marketplace and Medicaid Eligibility and Enrollment (E&E) functionalities. Despite the better record in SBM states, however, an important caveat is that all 50 states still have a long way to go to achieve the seamless coverage continuum envisioned in the ACA, partly because benefits, cost sharing and other regulations continue to differ significantly between Marketplace and Medicaid programs.

SBM states generally prioritize close working relationships between their SBM and their state Medicaid agency.

- **Policy innovation.** A majority of SBM states have supplemented federal tax credits with state subsidies. All Marketplaces have had access to increased federal subsidies since 2020, but those subsidies are scheduled to lapse in 2026, and if Congress fails to renew them, SBM states will be in a better position to maintain those affordability gains.

A majority of SBM states have supplemented federal subsidies with state subsidies.

In each of these three sections, we began with a summary of FFM and SBM progress, then highlight SBM accomplishments and conclude with recommendations for what the Center for Consumer Information and Insurer

Oversight (CCIIO) could do to enhance the SBM Blueprint process and strengthen standards without undercutting the flexibility that has been key to SBM success.

The Marketplaces at a Crossroads

The ACA gives states the option of establishing their own SBM or deferring to the FFM, commonly known as Healthcare.gov, to run their Marketplace. The FFM dominated in the early years, with nearly 80% of states (39) relying on Healthcare.gov in 2017, including four states that were certified as SBMs, but then defaulted back to the FFM because of technology failures. While the 12 "first generation" SBMs (11 states plus D.C.) made significant coverage gains, future growth of SBMs was uncertain at best in 2017.

The landscape has changed dramatically since 2017, with the number of SBMs on pace to nearly double by 2027. One key factor has been technology advancements that have made "second generation" SBMs cheaper, more flexible and as dependable as Healthcare.gov from a technology perspective. Another factor was the Trump Administration's funding cutbacks and relaxed oversight of the FFM, which reminded states that federal policy is subject to change, and that one way for states to have more control over their own destiny is to establish an SBM.

The number of SBMs is on pace to nearly double from 12 to 22 states between 2017 and 2027.

In a 2020 Manatt white paper, *Technology Opportunities for the ACA Marketplaces*, we predicted a wave of new SBMs, and that is exactly what has happened with the seven new SBMs that became fully operational between 2020 and 2024, and three more legislatively authorized SBMs and SBM bills under consideration in several other states. Most significantly, Georgia could become the first Republican-led state to establish an SBM since Idaho in 2015, which could encourage other Republican-led states to establish SBMs and eventually make SBMs as dominant as the FFM was in 2017.

The doubling of the number of SBM states is a good sign for the ACA since there is a strong correlation between states that have established SBMs and states that have most effectively expanded coverage under the ACA. This is not to say that establishing an SBM automatically expands coverage. The historical record indicates that Medicaid expansion is more important, but every SBM state to date has also expanded Medicaid, and most have adopted multiple other strategies to expand coverage opportunities. These strategies include: better funded and/or more targeted data-driven consumer outreach strategies; better collaboration between the Marketplace and Medicaid; state subsidies that supplement federal tax credits; and, other initiatives that enhance affordability.

Despite the track record of SBMs, the expansion of SBMs into Republican states has not been a universally welcome development, as some Republican leaders continue to champion ACA repeal. The Biden Administration has responded by proposing stronger standards for future SBM applicants. The swirl of competing considerations is evident in the history of Georgia's approach to the Marketplaces, which began with a Section 1332 innovation waiver, approved by the Trump Administration in 2020, that would have replaced the FFM with a privatized market rather than with an SBM. Georgia has since abandoned its privatized proposal and is in the process of implementing a 2023 Georgia statute that directs the state insurance commissioner to establish a federally-compliant SBM in 2025. If Georgia does become a full SBM in 2025, it would become the first SBM to not have expanded Medicaid.

The Biden Administration has proposed stronger standards for future SBM applicants.

The SBM/FFM Landscape

The Marketplaces were a central pillar of the ACA, which together with Medicaid expansion and other ACA programs, have expanded coverage to more than 40 million people and cut the uninsured rate to 6% or less (often substantially less) in states that have most fully embraced ACA implementation.[5,6,7]

States that fully embrace the ACA have cut their uninsured rates to 6% or less.

The ACA required a Marketplace in every state to offer subsidized individual market coverage to the 10–15% of consumers who are not eligible for group coverage, Medicare or Medicaid and meet subsidy guidelines. The law charged the Department of Health and Human Services (HHS) with establishing standards for states to have the option of running their own SBM or deferring to the federally-facilitated FFM, commonly known as Healthcare.gov.

The number of states running their own Marketplaces has varied from a low of 11 states plus D.C. in 2017 to 19 SBMs today, with three more states in the process of becoming SBMs, and the potential for a majority of states to run their own Marketplaces over the next decade. This resurgence of state interest in establishing SBMs is motivated by multiple factors, but the underlying driver is more state control over the individual insurance market under the ACA framework, which offers states relatively wide latitude under federal standards that continue to evolve from one presidential administration to the next.

The underlying driver for SBMs is state control over the insurance market under the ACA framework.

The complex blend of state and federal authority under the ACA has proven effective in stabilizing and growing the individual market. In 2024, the Marketplaces achieved their highest enrollment to date with 21.4 million enrollees,[8] and there is now strong bipartisan support for prohibiting discrimination based on pre-existing conditions and other practices that limited market access in pre-ACA days. Insurer competition has increased as well, and states have taken a more active role in enforcing ACA standards. For example, 48 states are currently certified by HHS to review insurer premium rate filings for compliance with ACA requirements.[9]

Since the early days of the ACA, state decisions to establish their own SBMs have been made in response to an evolving technological and political environment. Notably, the partisanship that continues to haunt the ACA has meant that SBMs have been established primarily in Democratic-led states, though once established, SBMs have generally garnered bipartisan support.

SBMs have been established primarily by Democratic governors, though once established, SBMs have generally garnered bipartisan support.

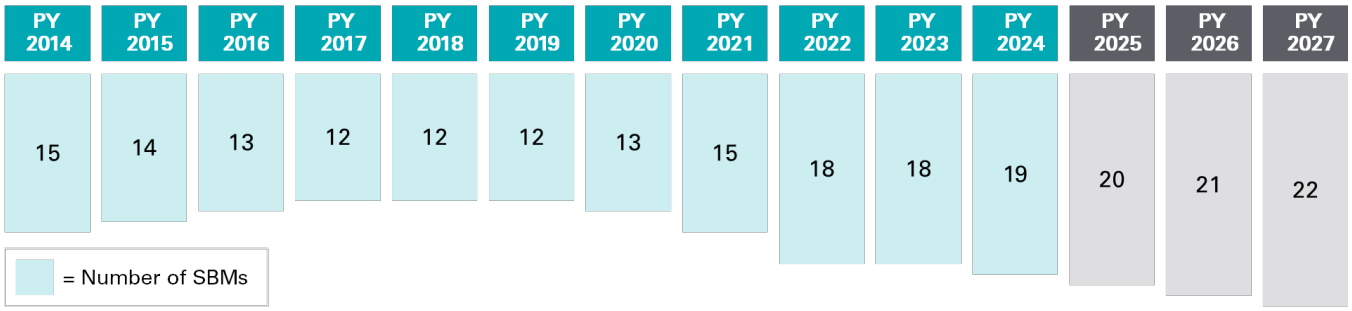
First Generation SBMs

Prior to the November 2013 launch of the Marketplaces, 16 states and D.C. made serious attempts to build their own SBM technology. Three of those states (Hawaii, Nevada and Oregon) defaulted back to reliance on Healthcare.gov when their SBM technology failed. Kentucky, which had one of the earliest successful SBMs, defaulted back to the FFM in 2016 at the direction of a new governor opposed to the ACA. New Mexico operated a small group exchange but was not approved as a full SBM until 2022.

By 2017, the number of "full SBMs" was down to 11 states plus D.C., with 39 states reliant on the FFM. As discussed more fully below, four of the five states that defaulted to the FFM for technology reasons retained their SBM aspirations, which led HHS to create a new hybrid SBM-FP category.[10] SBM-FP states are responsible for consumer assistance and plan management (insurer oversight) but remain dependent on the FFM for eligibility and enrollment.

Exhibit 1 highlights the SBM/FFM landscape over time.

Exhibit 1. State-Based Marketplace Transitions Over Time, 2014–2025[ii,iii,11]



Second Generation SBMs

From 2017–2020, the Trump Administration's cutbacks in FFM support, particularly its dramatic cuts in Navigator spending and advertising, and the emergence of more dependable second-generation SBM technology precipitated a resurgence in full SBMs with seven new full SBMs operative by 2024, and three more states in the process of transitioning to full SBM status. Nine of these ten states had a Democratic governor at the time the SBM transition decision was made, reinforcing the idea that SBMs are a Democratic state phenomenon. Georgia is the exception, with a Republican governor and legislature deciding to pursue an SBM only after the Biden Administration challenged the legality of Georgia's 1332 waiver for a privatized Marketplace that had been approved by the Trump Administration in 2020.

Each of the ten second generation SBMs has taken its own unique path to an SBM, though they generally have followed in the footsteps of the first generation SBMs in their commitments to expand consumer outreach, expand Medicaid and improve Marketplace-Medicaid collaboration, and pursue public policy initiatives not possible on the FFM to make ACA coverage more affordable.

The ten second generation SBMs have each taken their own unique path to an SBM.

- **Nevada (2020).** Nevada, which has an independent Marketplace board, was the first state to adopt a second generation technology platform. While the state was primarily focused on cost savings and a streamlined

[ii] For purposes of this paper, because SBM-FPs rely on the FFM platform, which offers minimal flexibility, this graphic focuses only on full SBMs over time.
[iii] 2014 SBMs included 15 states, including CA, CO, CT, DC, HI, KY, MA, MD, MN, NV, OR, NY, RI, VT, WA. ID became an SBM in 2016, and five original SBMs fell back to reliance on the FFM in the early years. All but one of those states (HI) has returned or is on track to return to full SBM status. By PY 2027, the 22 SBMs will include CA, CO, CT, DC, GA, IL, HI, KY, MA, MD, ME, MN, NJ, NM, NV, NY, OR, NV, RI, VA, VT, WA.

operating model, the state has improved the account transfer process between the Marketplace and Medicaid and passed legislation to create a public option plan through a 1332 waiver.

- **Pennsylvania (2021).** Pennsylvania established an SBM with an independent board and used cost savings from its transition to fund a 1332 reinsurance waiver that reduced Marketplace premiums. Pennsylvania has also forged a close working relationship between its Marketplace and Medicaid, with Medicaid funds now covering more than one-third of the Marketplace budget under federal cost allocation rules.

> Medicaid funds more than one-third of the Pennsylvania SBM under Medicaid cost allocation rules.

- **New Jersey (2021).** New Jersey placed its SBM in the state insurance department to pursue state subsidies and other health reforms. The enabling legislation also required SBM-Medicaid integration for eligibility and enrollment, though that integration has proved challenging.
- **New Mexico (2022).** New Mexico, which has an independent board, pursued an SBM to obtain more granular consumer data unavailable from the FFM to target consumer outreach efforts, as well as to improve coordination with Medicaid.
- **Maine (2022).** Maine placed its SBM in the same agency as Medicaid to facilitate coordination between the SBM and Medicaid. The state also secured federal approval for a 1332 waiver to merge the individual and small group markets and extend the state's reinsurance program to the small group market.
- **Kentucky (2022).** Kentucky was a successful first generation SBM that took a step back to SBM-FP status in 2017 when a Republican governor decided to suspend rather than terminate its SBM. Under a new Democratic Governor, Kentucky was able to simply restore its original SBM model for 2022, under which the SBM and the state Medicaid agency share an integrated E&E system under the same umbrella agency.
- **Virginia (2024).** Virginia became the 19th full SBM in 2024, with the SBM housed in the same regulatory body that oversees the state insurance department. It is the first second generation SBM state to authorize its SBM to make Medicaid determinations and is one of several states where a newly-elected Republican governor has supported the SBM path.

> Virginia is the first second generation state to authorize its SBM to make binding Medicaid determinations.

- **Georgia (2025).** Georgia was approved as an SBM-FP for 2024 and anticipates becoming the 20th SBM in 2025, though its path to an SBM has been unique (see Exhibit 2).
- **Illinois (2026).** Illinois is slated to become the 21st SBM in 2026. The 2023 legislation housed the SBM in the state insurance department and called for close coordination between the SBM and Medicaid, with the state Medicaid agency given the leading role in developing a coordinated E&E system.
- **Oregon (2027).** Oregon has been an SBM-FP since 2015 and is on track to restore its full SBM in 2027. Oregon has pursued several public policy initiatives as an SBM-FP, including a Basic Health Plan (BHP), and intends to pursue broader initiatives not possible on the FFM when it becomes a full SBM in 2027. Oregon also moved its SBM-FP from the umbrella department for the state insurance division to the umbrella department for Medicaid to facilitate Marketplace and Medicaid coordination.

Exhibit 2. Georgia Case Study

Georgia merits special attention, since unlike the other full SBMs, Georgia first proposed a privatized system. In 2020, the Trump Administration approved Georgia's 1332 innovation waiver for a privatized system with no FFM or SBM. However, the Biden Administration subsequently suspended Georgia's approval, and the state enacted a 2023 law authorizing the insurance commissioner to establish an ACA-compliant SBM. Georgia is operating as an SBM-FP in 2024, anticipates becoming a full SBM in 2025 and is pursuing several traditional SBM priorities, including expanding its consumer outreach, increasing the number of participating insurers and conducting a major study of network adequacy.[12] At the same time, Georgia would be the first SBM state to not expand Medicaid, though the state is under pressure to adopt a full expansion after a failed attempt at a partial Medicaid expansion. Finally, the Center for Consumer Information and Insurer Oversight (CCIIO) has recently proposed various changes in what it means to be a federally-compliant SBM that, if finalized, will apply to Georgia and other future SBM applicants. How Georgia navigates these cross-currents may well shape how other Republican-led states will view their SBM options.

Georgia is on track to become the first SBM state to not have expanded Medicaid.

User Fees

One development since Manatt's 2020 paper is that while the FFM continues to improve its services, it also has reduced federal user fees (the fees charged to insurers for using the Healthcare.gov platform). These fees have decreased since 2020 from 3.5% of monthly premium revenue to 2.25%. These fee reductions have changed the cost calculus for states focused on cost savings as the reason to establish an SBM. While the common practice of second generation SBMs was to set their user fees at or below the FFM fee at the time of legislative enactment, none of the second generation SBMs have followed the FFM in reducing their fees. This means that most SBMs have higher fees than the current FFM fee and suggest that some future SBMs may have to propose higher fees than the FFM, especially in smaller states.

Most SBMs have not followed the FFM in reducing their user fees, preferring to continue investing in consumer outreach and state subsidies.

SBMs may be able to bring their fees down if premiums continue to increase faster than inflation and/or technology costs continue to decline. Alternatively, SBMs may redeploy any cost savings they have achieved into new outreach campaigns, state subsidy programs or other efforts to improve affordability and expand enrollment within their individual markets. In short, FFM user fees, which could increase or decrease in the future depending on how many states continue to rely on the FFM platform, are no longer a dependable marker for SBM user fees, which complicates the argument that cost savings is a good reason to establish an SBM.

The changing landscape on user fees only reinforces the fact that the best reason to establish an SBM is a strong state interest in having more control over ACA implementation, given the likelihood that FFM policy will remain volatile and dependent on presidential and congressional prerogatives. For some states with low to modest interest in health reform, federal policy changes will be less of a concern. However, for states with clear policy goals, establishing an SBM can be critically important.

The best reason to establish an SBM is a strong state interest in ACA implementation.

Technological Innovation

Overview

The Affordable Care Act (ACA) Marketplaces were envisioned to include state-of-the-art websites where consumers could go online to shop and pick a health benefit plan in real time with the support of consumer search tools that simplify the shopping experience in the same way that Amazon and other online retailers have streamlined the shopping experience for other consumer goods.

The ACA Marketplaces were envisioned to be state-of-the-art websites for consumer shopping.

At the same time, the ACA Marketplaces face unique technology challenges in the area of eligibility and enrollment (E&E), where integration of Marketplace and Medicaid systems proved challenging.

FFM Overview

For the millions of consumers who readily meet eligibility requirements for ACA individual market coverage, Healthcare.gov has made tremendous progress in developing a consumer-friendly website and a set of enrollment partners, that enable consumers to purchase ACA benefit plans online, often in 15 minutes or less.[iv] The FFM has made huge advances in the consumer tools that were discussed in our prior white paper.[13] Changes include improving assistive tools for estimating income, improving tools to search and filter plans based on prescription drugs or providers, providing more comprehensive information on plan cost-sharing, developing new tools to allow for "window shopping" in advance of the Open Enrollment Period, as well as adaptation to innovations in smart phones, social media advertising and other technological changes.[14,15]

Healthcare.gov has partnered with web brokers that enable consumers to enroll in ACA benefit plans, often in 15 minutes or less.

SBM Overview

Healthcare.gov has scaling advantages over the SBMs in the ongoing challenge of keeping pace with technology improvements, though many FFM innovations are relatively easy for SBMs to replicate. In addition, even the smallest SBMs will have increasing opportunities to partner with technological innovators in the consumer experience space. Both the FFM and SBMs face diverse consumers. Some, such as young invincibles, who are often looking for the lowest premium plan in their zip code, may seek an online experience that is quick and to the point. Others with complicated health needs, such as those that require multiple providers or drugs, or have expensive

Healthcare.gov has scaling advantages over the SBMs, though all Marketplaces have opportunities to partner with technological innovators.

[iv] Healthcare.gov has certified a number of direct enrollment partners with the capacity to replicate the Healthcare.gov website and offer consumers alternative websites for directly enrolling in ACA-qualified health without having to be transferred to Healthcare.gov. See consumer outreach section for more information on how "enhanced direct enrollment" (EDE) accounted for roughly half of all FFM enrollments for 2024.

health needs that make small differences in cost-sharing rules a critical consideration, will expect to spend more time with sophisticated sorting and filtering tools to allow them to compare options in detail. Still others, such as those with complicated households (e.g., a mix of Marketplace, CHIP and Medicaid eligible members) will require even more complex guidance, often including the advice of a Navigator or at least a well-trained call center staffer.

These consumer differences will require all Marketplaces to maintain robust call centers and in-person assistance to supplement their online services, but, like virtually all forms of commerce, online sales will continue to grow as a portion of business, and the pace of technological change will require continuous upgrades in Marketplace technology. Users will increasingly seek website interfaces for enrolling in health insurance that are designed intuitively and easy to navigate, that are compatible with smart phones and a variety of devices and that offer alternative channels for obtaining assistance outside of a call center or in-person office.[16]

All ACA Marketplaces must maintain robust call centers and in-person assistance to supplement their online services.

Eligibility and Enrollment (E&E)

When states were first establishing SBMs, the focus was less on developing a world class shopping experience and more on determining who exactly was eligible for coverage and financial assistance in the first place. The most complex and expensive technology challenge was integrating eligibility for Marketplace financial assistance with Medicaid and CHIP eligibility, and in some cases, further integrating the Marketplaces with other social service programs. As discussed in the later section on Marketplace-Medicaid coordination, first generation SBM states received large federal grants to build customized and highly-integrated technology systems. These customized systems give those states distinct advantages over second generation SBM states that did not have access to federal grants and had to rely on separate and non-customized Marketplace E&E systems that were not integrated with their state Medicaid E&E systems.

First Generation SBMs

First generation SBMs were able to build integrated Marketplace and Medicaid systems with the support of $5 billion in federal "establishment" grants.[17] Examples include:

- **California** received over $1 billion to build an integrated E&E system for Medicaid and the Marketplace. Medicaid enrollment remains relatively decentralized, with strong governance processes over both the Marketplace and Medicaid proving critical to ensuring a smooth customer experience across the agencies.[18]
- **New York** received over $571 million to build a fully integrated "single-door" for Medicaid and Marketplace that includes a single rules engine for both Medicaid and Marketplace eligibility and enrollment for the MAGI population.[19,20] New York's integrated Marketplace includes Qualified Health Plans (QHP) for Marketplace enrollees, Essential Plans (EP) for BHP enrollees, Child Health Plus for CHIP enrollees and Medicaid.[21,22]
- **Washington** received over $302 million to build the state's integrated Marketplace, which includes an integrated application and single rules engine to provide eligibility determination and enrollment for both Marketplace and the MAGI Medicaid and CHIP population.[23,24]

- **Kentucky** received over $289 million to build the state's Health Benefit IT system, which integrated data exchanges with all of Kentucky's HHS programs and provided an end-to-end eligibility and enrollment system to serve both Medicaid and Marketplace enrollees.[25]

These integrated systems were highly customized to adapt to state Medicaid systems, and, while they are still functioning well after a decade, these integrated systems have clear advantages over systems that require hand-offs or "account transfers" between two systems. This is especially true when it comes to challenges such as the unwinding of the Medicaid continuous coverage provisions, where millions of people who are losing Medicaid coverage could benefit from seamless approaches to being screened for and, where eligible, enrolled in Marketplace coverage.

First generation SBMs relied on federal grants to build highly-customized E&E systems that were integrated with state Medicaid systems.

Second Generation SBMs

Without the benefit of federal grants, second generation SBMs have had to rely on technology vendors, most of whom played support roles in helping build first generation Marketplaces and now offer off-the-shelf technology with costs amortized over time. Although the new technologies are not integrated with Medicaid, second generation SBMs have been able to improve on the FFM experience, partly because coordination between two state agencies is generally easier than coordinating between the FFM and state Medicaid agencies.

Furthermore, advances in technology have allowed for more modular approaches to improving SBM technology, by linking separate systems together to create a more nimble solution that is easier to upgrade over time. While these new technology products have been critical to the success of second generation SBMs, modular systems are also increasingly being used by first generation SBMs to update and, in some cases, replace first generation legacy systems, particularly with the consumer-facing aspects of their Marketplaces. As discussed in the Medicaid section, this does not mean that fully integrated systems have been abandoned in first generation SBMs. Indeed, those systems could be proven superior in the Medicaid unwinding and that could lead to new funding sources for fully-integrated systems.

Second generation SBMs have relied on off-the-shelf technology that takes a more modular approach to Marketplace-Medicaid coordination.

At the present time, states are pursuing various strategies, some of which involve a "single door" approach where the E&E system is fully integrated; other strategies involve a "no wrong door" approach where separate E&E systems are coordinated so that the consumer gets to the right program regardless of what door they initially enter. And, of course, many strategies for coordination involve working relationships and protocols that do not depend on any form of complex technology to forge better coordination between the Marketplace and Medicaid. It remains to be seen what the most effective approaches will be in the future given how quickly technology evolves.

Consumer Outreach

Overview

The ACA Marketplaces, working in tandem with Medicaid expansion, have cut the nation's uninsured rate nearly in half (from 14.5% of the total US population in 2013 to 7.9% in 2022).[26] Yet, of the total 25.6 million nonelderly adults who remained uninsured in 2022, more than half (six in ten, or 15.3 million individuals) were eligible for financial assistance either through Medicaid or subsidized Marketplace coverage.[27] There is also considerable churn in coverage, with a 3.4% monthly turnover rate within the ACA Marketplace, compared to 2.1% in the group market.[28] There remain major differences between FFM and SBM states.

Currently, 60% of the remaining uninsured are eligible for Medicaid or Marketplace subsidies.

FFM History

FFM support for reaching the uninsured and other populations that churn in and out of coverage has been mixed, with the Obama Administration putting many programs in place to increase outreach, particularly through a high-profile Navigator program to fund community groups to target populations with lower than average coverage rates.[29] The Trump Administration cut the Navigator funding by 90%, but the Biden Administration has restored and greatly exceeded Obama-era spending on Navigators.[30] The FFM has invested heavily in establishing partnerships with online brokers who offer alternative enrollment channels, which accounted for roughly half of all FFM enrollments for 2024.[31,32]

The Trump Administration cut Navigator funding by 90%.

SBM History

The SBM states have placed a high priority on reducing the uninsured rate, including Medicaid expansion.[33] As a result, SBM states generally have lower uninsured rates than FFM states. As illustrated by Exhibit 3, in 2022, the average uninsured rate was 10.3% for the 12 states that relied on the federal platform (FFM or SBM-FP states) and had not expanded Medicaid. The average drops to 7.0% for the 21 federal platform states that had expanded Medicaid and drops further to 5.8% for the 18 states that had both expanded Medicaid and established an SBM.

As of 2022, the average uninsured rate in the 18 SBM states was 5.8%.

Exhibit 4 displays all states and shows that of the 12 federal platform states that have not expanded Medicaid, only one state (8.3%) has an uninsurance rate below the national average of 7.9%. Among the 21 FFM or SBM-FP states that have expanded Medicaid, 14 states (66%) have uninsurance rates below the national average. Among the 18 states that have both expanded Medicaid and established an SBM, 15 states (83%) have uninsured rates below the national average.[34,35]

Exhibit 3. Average Uninsurance Rates by Category (2022)[36]

Category	Total # of States	Average Uninsurance Rates by Category
FFM/SBM-FP states + No Medicaid Expansion	12	10.3%
FFM/SBM-FP states + Medicaid Expansion	21	7.0%
SBM states + Medicaid Expansion	18	5.8%

Exhibit 4. Individual State Uninsurance Rates Compared to National Average Uninsurance Rate, by Category (2022)

Category	States with Uninsurance Rates Below National Average (7.9%) in Each Category (indicated in grey)	Total
FFM/SBM-FP states + No Medicaid Expansion	WI, 5.4%; AL, 8.6%; SC, 9.0%; TN, 9.4%; WY, 11.6%; GA, 11.7%; SD, 8.0%; KS, 8.7%; NC, 9.4%; MS, 10.8%; FL, 11.2%; TX,, 16.6%	1 of 12 states (8%)
FFM/SBM-FP states + Medicaid Expansion	HI, 3.6%; MI, 4.6%; WV, 5.9%; ND, 6.6%; LA, 6.8%; MT, 8.1%; AZ, 10.3%; IA, 4.1%; DE, 5.5%; OR, 6.0%; VA, 6.6%; NE, 6.8%; MO, 8.4%; AK, 10.7%; NH, 4.5%; OH, 5.8%; IL, 6.6%; IN, 6.8%; UT, 8.1%; AK, 8.5%; OK, 11.9%	14 of 21 states (67%)
SBM states + Medicaid Expansion	MA, 2.4%; RI, 4.1%; CT, 5.2%; MD, 6.0%; ME, 6.5%; ID, 8.2%; DC, 2.9%; MN, 4.3%; KY, 5.4%; WA, 6.0%; NJ, 6.9%; NM, 8.4%; VT, 3.9%; NY, 4.9%; PA, 5.4%; CA, 6.5%; CO, 7.0%; NV, 11.1%	15 of 18 states (83%)

As these two exhibits suggest, for states that want to do everything they can to reduce their uninsured rate, the best approach is to both expand Medicaid and establish an SBM. It also is worth noting that the FFM has helped many of the least insured FFM states grow their enrollment at a faster rate of increase than the most insured SBM states in recent years. Needless to say, enrollment gains become more difficult as the addressable market shrinks with Medicaid expansion, which only heightens the case for Medicaid expansion states to also establish an SBM to maintain and grow enrollment in the high churn individual market.

SBM leaders continue to reiterate that investing in consumer outreach remains one of the most effective ways to facilitate enrollment and coverage in the Marketplace. They also suggest the need for multiple strategies to reach different populations with distinct characteristics. For example:

- **Hard-to-reach populations.** The long-term uninsured may be hard to reach through traditional channels and may require targeted outreach with Navigators and other community partners that can navigate cultural barriers.[37]
- **Medicaid-Marketplace churn.** People whose incomes fluctuate between Medicaid and Marketplace eligibility may require close collaboration between Medicaid agencies and the Marketplace to reduce coverage loss during transitions.
- **Marketplace-Employer Sponsored Insurance (ESI) churn.** People that cycle in and out of ESI, such as gig workers or entrepreneurs, may need Marketplace coverage between jobs; those without ESI may need long-term coverage.

For many SBM states, a strong state interest in reaching targeted populations and the lack of granular data from the FFM to allow the state to engage in more targeted outreach is a top reason for preferring an SBM. Interviews with SBM leaders reveal deep commitments to strengthening and innovating around consumer outreach strategies that are targeted, effective, data-driven, culturally and linguistically competent and coordinated with other health providers and state services. For example:

SBM leaders are deeply committed to consumer outreach strategies that are targeted, data-driven, and culturally and linguistically competent.

- Using state-procured data, **Rhode Island** identified zip codes with a higher likelihood of having uninsured residents and created a “street team” to distribute health insurance enrollment materials, such as door hangers, flyers, brochures and posters, specifically in those areas.[38]
- **Washington** is similarly using state data on the remaining uninsured to target specific geographic areas of the state and provide targeted outreach efforts to encourage enrollment, including education and listening sessions.[39] Especially in light of the state’s 1332 waiver, which provides a new coverage opportunity for many individuals regardless of immigration status, the state is focused on outreach efforts to ensure broad awareness.
- During the pandemic, **New York** targeted outreach toward industries with higher rates of uninsured individuals, including the service industry, small businesses and self-employed individuals.[40]

As these examples illustrate, SBM leaders are often focused on populations with a high rate of uninsurance, who typically face equity barriers, and low-income populations that churn between Medicaid and Marketplace coverage.

SBMs are additionally able to use their own data to develop targeted multi-media outreach campaigns, with the ability to micro-target consumers increasing every year. For example, **Maryland**, which had nearly 50% more new enrollees in 2022 than in 2021, emphasized the impact of partnering with social media influencers to reach hard-to-reach consumers that might be eligible for subsidies under American Rescue Plan Act (ARPA) and young adults eligible for state-funded subsidies.[41]

SBMs also back up their outreach goals with resources. Many SBMs spend a third or more of their budgets on consumer outreach. For example, **California's** 2021 budget for marketing, outreach/sales and related programs was $157.7 million, or 35%, of Covered California's total budget.[42,43] Covered California also requires its carriers to meet key outreach spending metrics (see Exhibit 5 for more detail). Commitment to consumer outreach is a key reason why most SBMs have not reduced their user fees in lockstep with federal user fee reductions.

California spends 35% of its budget on consumer outreach and requires carriers to meet outreach spending metrics.

Exhibit 5. Covered California's Comprehensive Consumer Outreach Strategy

A key example of robust, best-in-class consumer outreach efforts continues to be Covered California, which has pursued nearly all available channels of consumer outreach, established a robust marketing campaign and relied on large numbers of Navigators, agents and brokers to support enrollment.

Covered California also conducts a significant amount of market research to inform and shape its marketing campaigns by understanding its target audiences. As a result, Covered California's statewide ad campaign and media efforts are tailored to several target populations, including previously enrolled members and people formerly enrolled in Medicaid.

Covered California also ensures broad access to its messaging by making campaigns available in multiple languages and across varying platforms (online, mail, text messages, phone calls) to reach people "where they live, learn, work, worship and play."[44,45,46,47]

California also has over 10,000 certified agents and nearly 100 directly funded Navigator partners and subcontractors, which Covered California leverages through its "Assisters Program."[48,49]

Lastly, Covered California also uses its QHP contracting process (active purchasing authority) to establish marketing expectations for carriers' spend on consumer outreach.[50]

Navigators and Assisters

The varying emphases of SBMs and the FFM are perhaps most clear with respect to Navigators and assisters, which are federally defined roles designed to reach populations that carriers and agents may not. Federal funding levels for Navigator programs have varied, with each Administration supporting and prioritizing Navigator programs at different levels over time. For example, for the 2022 coverage year, the Biden Administration allocated nearly $100 million for Navigators, including $12.5 million to support additional direct outreach, education and enrollment activities aimed at helping eligible individuals transition from Medicaid/CHIP to Marketplace coverage.[51,52] In

SBMs typically spend more per capita than the FFM on Navigator and assister programs.

contrast, the Trump Administration allocated only $10 million for the Navigator program in 2018.[53] SBMs have historically heavily invested in supporting Navigator and assister programs above and beyond the levels of support provided by the federal government:

- **Pennsylvania** substantially increased its support for Navigators when it became an SBM in 2022.[v,54]
- **New York** has trained nearly 14,000 assistors, Certified Application Counselors (CACs) and Facilitated Enrollers (FEs) to help with enrollment in hospitals and other places, including job fairs, local libraries, farmer's markets and food pantries.[55,56,57,58,59]
- In **Maine**, referrals from local social services and health departments helped Navigators better target uninsured individuals.[60]

Agents and Brokers

SBMs vary more in how much they rely on agents and brokers and tend to favor local agents and brokers, who are often key partners for local outreach events and can be especially effective in following up with their enrollees at renewal time. For example:

SBMs vary in how much they rely on agents and brokers and tend to favor local agents.

- The **Idaho** Marketplace has a robust agent workforce, with over 800 agents and brokers in the state. The State works closely with local agents, sharing information on local agents with consumers seeking health insurance and sharing information with agents on individuals moving from Medicaid to the Marketplace to promote targeted outreach. As a result, agents account for nearly 75% of Idaho's Marketplace enrollment.[61]
- **Colorado** similarly drives nearly 60% of enrollments through local agents, nurturing relationships with agents in targeted communities (i.e., immigrants, people of color) and providing a "broker academy" to encourage more diverse groups to join the broker/agent workforce in the state.

[v] In 2018, Pennsylvania received $400,000 in annual Navigator funding. In 2022, the state spent over $2 million on Navigator funding after becoming an SBM.

Alternative Channels

SBMs use "broker portals" and similar initiatives to make it easier for carriers and agents to do their own online enrollments, but have shied away from replicating the federal EDE program for various reasons, including branding concerns. Although SBMs have been careful to protect their unique brand as the only entities that can offer premium tax credits for ACA-compliant coverage, SBMs are working with an increasing array of partners to reach their target audiences, and Georgia has included EDE in its outreach strategies.

Exhibit 6. Alternative Enrollment Channels

Recognizing that not all consumers will find their way to Healthcare.gov, CMS has certified a network of Enhanced Direct Enrollment (EDE) partners, whose third-party websites offer the same plan choices as Healthcare.gov and who have been certified to meet federal standards for privacy and security.[62] EDE partners work with insurers, agents and directly with consumers to enroll consumers in Marketplace coverage through their own websites, which some users find to be more user-friendly or intuitive than the FFM. Providing these alternative channels for enrollment enables the FFM to capture enrollees, often through agents, that may not come through traditional outreach channels, such as individuals with fluctuating employment or gig economy jobs where income varies year-to-year, as well as individuals who contact agents who may or may not promote the ACA Marketplaces depending on how easy the enrollment process is for them.[63] CMS has found the EDE program to be helpful in multiple ways, and the program now accounts for a substantial portion of all FFM enrollment.[64]

Enhanced direct enrollment (EDE) now accounts for a substantial portion of Healthcare.gov enrollment.

SBMs have been reluctant to establish similar programs, partly because of oversight concerns. CMS addresses this issue in its 2025 proposed Notice of Benefit and Payment Parameters (NBPP) by requiring SBMs to comply with federal standards for overseeing EDE, which eliminates the challenge of developing a state-specific oversight program, but leaves open the question of how to finance the oversight.[65]

Recommendations: Improving Consumer Assistance and Outreach

CCIIO could help improve consumer outreach for new SBMs by enhancing the SBM Blueprint process and establishing performance standards.

- **Blueprint process.** CCIIO currently requires states to provide information about the state's consumer outreach plan in its SBM Blueprint.[66] In the proposed 2025 NBPP, CCIIO proposes to build out this process in several directions:
  - Requiring FFM states to spend at least one year as SBM-FPs, during which the state takes on consumer outreach responsibilities, including recruiting and training Navigators and managing other consumer outreach responsibilities.
  - Requiring more documentation of consumer outreach plans in the Blueprint. CCIIO has asked detailed questions of Georgia,[67] and the proposed NBPP would codify CCIIO's position that the agency can ask for whatever information is necessary to assess a state's outreach plan.
  - Requiring a robust public engagement process, with both CCIIO posting the Blueprint application for 90 days and the state holding at least one public engagement session.

Performance standards. CCIIO could also consider minimum performance standards.[68] There are good reasons to be cautious with standards that limit state flexibility, but clear and transparent standards would help ensure accountability and fairness across states as long as the standards allowed flexibility for state innovation.

The most ambitious standard would be a global budgetary one, perhaps starting with more transparency about how SBMs compare in consumer outreach spending. California allocates one-third of its user fees to consumer outreach, which may be a high-end marker, but a standardized budget metric calibrated to Marketplace size would provide a useful measure of state commitment to consumer outreach. Other areas to consider include:

- **Stakeholder consultation.** Medicaid unwinding has exposed the need for improved Marketplace-Medicaid consultation, and equity considerations are expanding the list of who should be consulted.[69]
- **Website and call center.** Online activity will continue to increase, but call centers will continue to be important. The 2025 NBPP proposes stronger standards for call centers.
- **Outreach, education and assistance.** Marketplaces should be keeping pace with new technologies (e.g., mobile apps) and new communications (e.g., social media). For assistance, user accounts should include comprehensive information to make it easier to re-apply amid coverage changes.
- **Navigators.** Navigator funding is perhaps the single best measure of commitment to reaching the uninsured.
- **Agents, brokers and web brokers.** Support for these traditional forms of business acquisition is one measure of commitment to reaching people cycling in and out of insurance coverage, especially employer-sponsored insurance.

Medicaid-Marketplace Collaboration

Overview. The ACA established requirements for states to implement a coordinated E&E system across all insurance affordability programs—a "no-wrong-door" approach for health insurance consumers.[70] ACA regulations envisioned seamless coordination between state Medicaid agencies and the Marketplaces, enabling consumers to submit a single application to either the Marketplace or state Medicaid agency, receive an eligibility determination and ultimately, be enrolled in the appropriate program.[71] However, both the FFM and SBMs have fallen short of the ACA's goals of a single seamless coverage continuum, with more work to be done by both the FFM and SBMs to ensure smoother coverage transitions between Medicaid and the Marketplaces.

There is more work to be done by both the FFM and SBMs to achieve seamless transitions between the Marketplaces and Medicaid.

Exhibit 7. Key Terms for Understanding Marketplace Eligibility and Enrollment

- **"Single Door"** refers to an approach to E&E that is "fully integrated," meaning individuals enter a single door to a single E&E system that is able to determine eligibility across multiple programs, such as Medicaid and the Marketplace.
- **"No Wrong Door"** refers to an approach to E&E comprised of multiple entry points, but with each capable of referring an individual to the "correct" program. For example, an individual entering through the Medicaid door who is determined ineligible for Medicaid will then be redirected to the Marketplace door for an eligibility determination. Regardless of which door they entered, they are ultimately referred to the right program. This is required by the ACA.
- **Determination of Eligibility** refers to when a Marketplace "determines" Medicaid eligibility and that determination is transferred to the state Medicaid agency, which accepts the eligibility decision as final and moves the individual directly to program enrollment.
- **Assessment of Eligibility** refers to when a Marketplace "assesses" an individual's eligibility for Medicaid. That assessment is transferred to the state Medicaid agency, which then reviews the application to make its own final eligibility determination before moving the individual to program enrollment.
- **Account Transfer** refers to the secure electronic transfer of an individual's "account," or an individual's application for health insurance coverage and other relevant information for purposes of determining eligibility, between one agency and another (usually Medicaid and the Marketplace).

FFM Overview

While first generation SBMs were held to high standards for integration in exchange for generous establishment grants, the FFM was not able to meet such standards for its states. On the policy side, CMS gave the states flexibility to decide whether the FFM would "determine" Medicaid eligibility for the state's enrollees (a binding decision) or would "assess" Medicaid eligibility (leaving the State to make the final decision); most states chose the assessment option. On the technology side, the FFM experienced a variety of technology setbacks, such that the FFM was only able to provide state Medicaid agencies with "account transfers" containing limited information; the FFM also was limited in how it could process information from state Medicaid agencies on potential Marketplace enrollees.

The FFM relies on account transfers to exchange information with state Medicaid agencies, and most states reassess Medicaid eligibility when receiving an account transfer.

SBM Overview

As discussed in the technology section earlier, the first generation SBMs started out with integrated Marketplace-Medicaid E&E systems, largely paid for by federal grants. The second generation states, however, started out with separate Marketplace systems, largely relying on vendors who offered "off the shelf" E&E systems that generally followed the FFM model of coordinating with Medicaid through account transfers.

In practice, however, the sharp distinction between first and second generation technology has become more blurred as first generation SBMs have made various changes to their systems, ranging from full replacements for failed systems to incremental changes in the direction of modularization. Meanwhile, second generation SBMs have adopted various strategies to coordinate their Marketplace and Medicaid E&E systems, often in preparation for the unwinding of Medicaid's continuous coverage provisions.

First Generation SBMs

The 12 first generation SBMs all started with integrated E&E systems that, with some exceptions, offered a "single door" access point for both Marketplace and Medicaid recipients, eliminating the need for account transfers between two systems. However, these states have evolved their systems in different ways as illustrated by the following examples:

The first generation SBMs relied on federal grants to build integrated E&E systems that eliminated the need for account transfers.

- **New York** continues to rely on its custom-built, back-end system for integrated Medicaid and Marketplace E&E functionalities, while implementing upgrades to its front-end system that seek to improve consumer shopping experience, such as building out a new mobile platform for plan shopping and enrollment.
- **California** also continues to use its integrated Medicaid and Marketplace eligibility system to perform core E&E functions, while also working to modularize its consumer-facing front end to improve the consumer shopping experience.
- The **D.C.** Marketplace initially used an integrated E&E system with hard-coded functionalities that offered minimal flexibility, but later transitioned to a cloud-based, open-source SBM platform. D.C.'s new platform

enabled the Marketplace to make system changes in a more cost-effective and timely manner without taking the entire system temporarily offline. For example, D.C. was able to quickly implement the American Rescue Plan Act of 2021, calculating the enhanced premium subsidies only weeks after passage of the new law.[72]

- **Colorado** was one of the first states to create an SBM,[73] but a number of technical and operational challenges[74] led the state to split Marketplace eligibility from Medicaid eligibility in 2019. The SBM is now replacing and custom-building its Marketplace technology entirely in-house.[75]

Colorado and some other first generation SBMs have transitioned to separate eligibility systems to enhance Marketplace flexibility.

- **Washington** has an integrated platform that performs E&E functions for Medicaid and the Marketplace, as well as for other state benefit programs. The state is thinking through how to transform its legacy system to a more flexible and modular system, without disrupting the various state programs that its legacy system currently supports.[76]
- **Minnesota's** Marketplace also shares an integrated E&E platform with its Medicaid agency. The state is thinking through how it could implement a more modular solution for the future without disrupting the various agencies currently being serviced by that same platform.[77]
- **Idaho** leveraged an off-the-shelf SBM vendor to shift the QHP application and eligibility process away from Idaho's Medicaid agency and into the Marketplace, which was able to provide real-time eligibility determinations and offer new self-service capabilities for enrollees.

Second Generation SBMs

In 2020, **Nevada** became the first state to successfully rely on second generation technology to become a full SBM for the second time, having fallen back to SBM-FP status in 2015 because of technology challenges. Nevada did not attempt an integrated build the second time around, but instead sought to "mirror" the FFM with a separate Marketplace technology platform that was coordinated through "account transfers" rather than integrated with its sister Medicaid agency to provide a smooth consumer experience. In practice, Nevada found that implementing account transfers between two state agencies led to discussions that improved that process and provided a stepping stone to other collaboration, including working together on public option legislation.

Second generation SBMs did not have the resources to build integrated systems and generally followed the FFM model of using account transfers to coordinate two separate E&E systems.

The six other states that have fully operational second generation SBMs all have followed Nevada's lead in building separate SBM platforms that are coordinated rather than integrated with Medicaid, though each of them has taken important steps to forge an effective partnership with its Medicaid counterpart.

- **Pennsylvania** used the same SBM vendor as Nevada and chose to keep its SBM build as simple as possible by not incorporating Medicaid integration goals into its SBM build. In practice, however, the Pennsylvania SBM has developed a close working relationship with its sister Medicaid agency, including development of a cost allocation plan with Medicaid that results in Medicaid covering over 30% of the SBM's budget. Coordination between the two state programs has intensified in the Medicaid unwinding, with the SBM offering prepopulated applications to people losing Medicaid who appear to be eligible for Marketplace coverage.

- **New Jersey** was the first second generation SBM to incorporate Medicaid integration into its enabling legislation. In seeking an SBM vendor, New Jersey requested vendors to propose a two-step process with a separate SBM platform to start, followed by a second step to achieve the integration with Medicaid required by the legislation. The second step is underway, but it has proven challenging, partly because Medicaid and the SBM are housed in different umbrella departments.[78]
- **Maine** explored an integrated approach but decided it was not practical given the status of the Medicaid E&E system and the competing priorities the state had for improving that system. However, Maine did decide to house the SBM in the same umbrella department as Medicaid to maximize coordination between the two programs, which was particularly important since Medicaid expansion and the SBM transition occurred in the same time frame.
- **New Mexico** chose an SBM vendor with Medicaid experience because Medicaid coordination was a high priority in a state with a larger portion of its population in Medicaid than any other state. New Mexico has explored multiple versions of a public option that would extend eligibility for Medicaid-like coverage to some or all of the Marketplace population.
- **Kentucky** was a first generation SBM with an integrated legacy system that it later turned back on when a new governor returned the state to full SBM status. Kentucky houses its SBM in the same umbrella department as Medicaid and manages the two programs together.
- **Virginia** became the first second generation SBM to choose a determination model, which means that eligibility decisions made by the SBM platform are binding on the Medicaid agency, as a way to forge better coordination between the SBM and Medicaid. One reason Virginia chose that model was because the state wanted to avoid having to put Marketplace applicants determined eligible for Medicaid in a queue for the Medicaid agency to then rerun the process.

Virginia's Medicaid program treats SBM eligibility decisions as binding to avoid having to reassess Marketplace applicants determined eligible for Medicaid.

As these examples illustrate, there are multiple ways that first or second generation SBMs with separate E&E systems today can move toward functional coordination and even integration. As the results of the Medicaid unwinding continue to unfold, it is likely that there will be discussion of how to make more progress toward the seamless coverage continuum envisioned by the ACA. There may be some progress in that direction by **Illinois**, which is slated to become a full SBM in 2026. The Illinois SBM will be housed in the state's insurance department, but the enabling legislation called for the state Medicaid agency to conduct the procurement for a Marketplace vendor as a means to explore all options for a more integrated approach to Marketplace and Medicaid E&E.

In sum, a highly coordinated, "no wrong door" approach has now been successfully accomplished in seven second-generation states with four SBM vendors, providing a strong stepping stone for states seeking to implement an SBM while working toward Medicaid integration. However, achieving seamless transitions between the Marketplace and Medicaid with two separate systems requires strong state commitment and alignment in priorities and goals across the two agencies, which varies highly state-by-state. Many states with separate SBM vendors are continuing to work towards better coordination with Medicaid after implementing a separate Marketplace system.

Achieving seamless transitions between the Marketplace and Medicaid with two separate systems requires alignment in priorities and goals across the two agencies.

Exhibit 8. Automatic Enrollment

The public health emergency's (PHE) unwinding provides a graphic illustration of how difficult it remains for enrollees losing Medicaid to transition to Marketplace coverage where eligible. MedPAC found that, in 2019, only 3% of those losing Medicaid ended up with Marketplace coverage. This is a much larger issue than technology, with some people unable to afford Marketplace subsidies, even with minimal cost sharing. On the technology side, California has been a leader in creating an automatic enrollment pathway from Medicaid to Marketplace coverage with a 2019 law that authorizes Covered California to automatically enroll consumers in a QHP when they lose Medi-Cal coverage and gain eligibility for APTCs.[79] Rhode Island has a similar program.[80]

Marketplace-Medicaid coordination strategies. The unwinding of the Medicaid continuous coverage provisions has demonstrated the importance of having close working relationships between Marketplace and Medicaid officials to advance a continuum of coordination strategies designed to minimize coverage gaps for people losing Medicaid and eligible for Marketplace coverage. Examples of strategies to facilitate coordination across Medicaid and the Marketplace include:[81]

Marketplace and Medicaid officials continue to advance a continuum of coordination strategies to minimize coverage gaps.

- Providing longer notice to individuals before their Medicaid coverage ends to minimize gaps in coverage;
- Requiring QHP issuers to permit retroactive Marketplace enrollment to avoid coverage gaps;
- Communicating to individuals about coverage terminations though multiple channels—including electronically—to help ensure prompt receipt;
- Extending the 60-day special enrollment period deadline for Marketplace enrollment after Medicaid coverage ends; and
- Using account transfer and other available information to prepopulate Marketplace applications, among other strategies.

On the federal level, CMS leadership has expressed a commitment to improving coordination between the FFM and Medicaid on issues such as account transfers.

CMS leadership has expressed a commitment to improving coordination between the FFM and Medicaid on account transfers.

Recommendations: Improving Medicaid Collaboration

New SBM states should consider all of the strategies noted in this section for improving coordination between the SBM and the state Medicaid agency, but should also go bigger and consider a couple overarching strategies to improve Marketplace-Medicaid collaboration:

- **Expand Medicaid.** Every SBM state prior to Georgia had fully expanded Medicaid, with dramatic impact on the uninsured rate. Conversely, nearly half of the remaining FFM states have not expanded Medicaid. CCIIO may not have the authority to require Medicaid expansion for future SBM applicants, but willingness to take this step is certainly a measure of how serious a state is about reducing its uninsured rate.
- **Policy alignment.** Marketplace and Medicaid coverages are converging in a number of areas that make it easier for consumers to move back and forth between the two programs. These include benefits, network adequacy standards and care management.[82]

CCIIO's standards for second generation SBMs allow states to have a separate E&E system for the Marketplace, but still require states to fulfill the statutory mandate of using a common application regardless of whether the applicant comes through a Marketplace or Medicaid door (the "no wrong door" approach). This approach requires close coordination between the two state agencies to make the process more or less seamless for the consumer. Performance standards that could be adopted by CCIIO to maximize coordination could start with two issues:

- **Common application.** CCIIO could be more prescriptive as to what exactly it means to have a common application, given that online applications are constantly evolving and dynamic, with multiple pathways possible depending on how the applicant answers each question. As SBMs continue to improve their applications, CCIIO could focus on ensuring that new best practices are quickly adopted by other SBMs in areas like ensuring that applicants only have to answer questions once for purposes of identity proofing, account set-up, income verification and other similar functions.
- **Determination model.** A growing number of states treat eligibility decisions by the FFM as binding or determinative of eligibility for Medicaid. Virginia moved to the "determination" model when it launched its SBM to avoid a backlog in its Medicaid eligibility process. This did not appreciably change the requirements for the Virginia SBM vendor, suggesting that CCIIO would not be imposing any significant new operational burdens were it to require SBM states to treat all SBM MAGI-based income decisions as determinative for both Marketplace and Medicaid income eligibility.

Other areas where best practices could evolve into performance standards include:

- **Account transfers.** Neither Medicaid nor Marketplaces have perfected their account transfer processes. More accurate and comprehensive data mean fewer cases requiring multiple transfers across agencies.
- **Cost allocation.** Many SBMs have both improved coordination with Medicaid and enhanced their budgets by identifying areas where mutually beneficial coordination can be partially paid for by Medicaid under cost allocation rules.

Recommendations: Improving Medicaid Collaboration

- **Common agency.** Many SBMs house their Marketplaces in the same department that houses Medicaid to facilitate closer working relationships between the two programs. A common agency also makes it easier to have coordinated (or combined) notices and combined accounts for the two programs, and to create shopping tools that are tailored to mixed eligibility households (households that may include both Medicaid/CHIP and Marketplace members). Regardless of whether state agencies are working within an intra- or inter-agency context, clear governance remains critical for ensuring alignment across the two programs.
- **Sharing procurement responsibilities.** Illinois has charged its Medicaid agency with procuring a Marketplace vendor to facilitate close coordination between the two E&E systems.

CCIIO also could explore “single door” strategies, but even if there were funds available to build fully-integrated systems as first generation SBM states did, the trend across most SBM states is to transition away from fully-integrated Medicaid and Marketplace E&E legacy systems and toward more flexible, modular E&E systems.

Policy Innovation

Overview

The ACA established critical new consumer protections for the insurance-buying public and provided federal subsidies to make coverage more affordable, but the law also retained the states' role as the primary regulators of individual and small group health insurance in their states, including the authority to enhance affordability through state-based subsidies and pursue other policy initiatives through state innovation waivers under Section 1332. Those waivers were used sparingly by the states in the first decade, with the exception of 19 reinsurance waivers, but SBM states are beginning to pursue broader innovations that are likely to expand in the next decade.

The ACA retained the states' regulatory role and provided for state innovation waivers to allow states to test new ideas.

FFM Overview

Healthcare.gov has successfully implemented several policy innovations in federal law, including enhanced federal subsidies through the Inflation Reduction Act (IRA), but those subsidies are scheduled to end for 2026.[vi] If those subsidies are not renewed, SBM states will have policy options to reduce the harm to consumers. In contrast, FFM states will be much more limited since, at least to date, the FFM has not been able to accommodate state-by-state differences in subsidy policy or in other areas of state innovation. The Trump Administration proposed some 1332 waiver options for FFM states, but the proposals were of limited utility to states, as indicated by the fact that no state attempted to use the offered flexibility. The Trump Administration did approve a Georgia 1332 waiver for a privatized ACA Marketplace, but that waiver was challenged by the Biden Administration and has since been abandoned by Georgia. The Biden Administration has not offered any new flexibility to FFM states but has approved broader 1332 waivers for four SBM states—Colorado, Maine, New York and Washington—in the last two years.

The FFM has not been able to accommodate most forms of state innovation, limiting options in FFM states primarily to reinsurance waivers.

The Biden Administration has approved four broad innovation waivers for SBM states in the last two years.

[vi] In 2020, Congress passed ARPA, which provided enhanced subsidies that improved the amount of financial help available to individuals already eligible for financial assistance to purchase health insurance and also expanded subsidies for new populations as well previously ineligible for financial assistance. These subsidies were intended to last for two years (2021 and 2022) but were later extended for three years (through 2025) as part of the Inflation Reduction Act.

SBM Overview

There are 12 SBMs and SBM-FPs that have reinsurance programs, and a majority of SBMs have also taken steps to improve consumer affordability with state-based subsidy programs and streamlined access with easy enrollment programs. Most states have not benefited from 1332 waiver funding for these programs, but SBMs have taken note of recent approvals for broader waivers, and most SBMs have innovative plans on the drawing board. In the next decade, SBMs are likely to test the flexibility of federal regulators to approve 1332 waiver proposals that have widespread positive impacts on affordability and access for vulnerable populations, but also may involve slightly higher costs for some people. It is also possible that FFM and SBM-FP states will test what innovations are possible on the federal platform, but to date, states with innovative ideas have had to become SBMs to accomplish their goals.

SBMs have developed innovative policy in five areas summarized in Exhibit 10. In each of these areas, SBMs have more flexibility than FFM and SBM-FP states, which are limited by the inflexibility of the federal platform to accommodate state-by-state variation.

SBMs have developed innovative policy ideas in five areas, many of which do not require innovation waivers.

Reinsurance

Of the 19 reinsurance waivers approved by CCIIO, 11 have gone to SBM states. These waivers have helped stabilize the Marketplaces after the federal reinsurance program that initially accompanied the implementation of the health insurance Marketplaces ended in 2016. Reinsurance programs remain critical in some states with volatile market conditions, but their value is generally receding as Marketplaces have increased insurer competition and reduced premium volatility. In addition, reinsurance does not improve consumer affordability for subsidized consumers since the amount they owe toward premiums is based on their income and does not change when premiums increase or decrease.

There are 19 states that have established reinsurance programs but their value is receding as Marketplaces have become more stable in recent years.

For these reasons, the 19 states with reinsurance waivers may wish to reconsider their waivers, especially if the enhanced federal subsidies are renewed for 2026, meaning that the vast majority of Marketplace enrollees remain subsidized and do not directly benefit from reinsurance. This would be totally feasible for SBM states, but the eight FFM states with reinsurance programs would have limited flexibility to redirect the state share of reinsurance waivers to state-based subsidies given the FFM's inflexibility. Indeed, no FFM or SBM-FP state has enacted a direct subsidy program. This limitation will become a significant liability in the next two years as states consider their options in the event that enhanced federal subsidies are terminated for 2026.

State Subsidies

A majority of SBM states have supplemented federal subsidies with state subsidies to improve premium and/or cost-sharing affordability for enrollees. States can target subsidies by income level, by age, or even for certain categories of individuals, such as certain workers, parents or caregivers. See Exhibit 9.

Ten SBM states have supplemented federal subsidies with state ones.

Exhibit 9. State Subsidy Programs

State	Subsidy Type	Income Level for Subsidy Eligibility	Target Population
CT	Premium and Cost-Sharing	Up to 175% FPL	Everyone APTC-eligible, with targeted subsidies for parents and caregivers
CA	Cost-Sharing*	Up to 250% FPL	Everyone APTC-eligible
WA	Premium	Up to 250% FPL	APTC-eligible individuals enrolled in gold and silver standardized plans
VT	Premium and Cost-Sharing	200%–300% (CSRs) Up to 300% of FPL (premium)	Everyone APTC-eligible
CO	Premium and Cost-Sharing	Up to 300% FPL	Everyone APTC-eligible and certain benefits for non-APTC eligible
MD	Premium	Up to 400% FPL	Young adults (age 18–34) APTC-eligible
NM	Premium and Cost-Sharing	Up to 400% FPL	Everyone APTC-eligible
MA	Premium and Cost-Sharing	Up to 500% FPL	Everyone APTC-eligible
NJ	Premium	Up to 600% of FPL	Everyone APTC-eligible
DC	Premiums	No income limit	Employees of OSSE-licensed early childcare learning centers and homes, regardless of immigration status, for silver plans

*California previously had a premium subsidy program from 2020–2021 that was transitioned to a cost-sharing reduction for 2023.

The distinction between premium subsidies and cost sharing reductions is an important one; states vary between the two and some have both. Where feasible, the flexibility to choose one or the other, on an annual basis, may be the best approach. For example, California previously had premium subsidies but switched to cost sharing reductions because of the enhanced federal premium subsidies. If, however, those federal subsidies are not extended beyond 2025, the case for premium subsidies will become stronger. Conversely, if federal premium subsidies are extended, it may be that cost sharing reductions will be the more needed subsidy at the state level given the interplay between premiums and cost sharing in determining affordability for consumers, especially those with more limited incomes and even less wealth to fall back on in the event of an expensive medical bill not covered by their plan.

Exhibit 10. SBM Policy Innovation

SBM/SBM-FP States	Reinsurance 1332 Waiver	State Subsidies	Easy Enrollment	1332 Waiver (Non-Reinsurance)	Basic Health Program
California		✓	✓		
Colorado	✓	✓	✓	✓	
Connecticut		✓			
D.C.		✓			
Idaho	✓				
Kentucky					
Maine	✓		✓	✓	
Maryland	✓	✓	✓		
Massachusetts		✓	✓		
Minnesota	✓				✓
Nevada				✓	
New Jersey	✓	✓	✓		
New Mexico		✓	✓		
New York				✓	
Pennsylvania	✓		✓		
Rhode Island	✓				
Vermont		✓			
Virginia	✓		✓		
Washington		✓		✓	
Arkansas*					
Georgia*	✓				
Oregon*	✓				✓**
Total	11	10	9	5	2

* Arkansas, Georgia, Oregon are SBM-FPs.
** Oregon is implementing a Basic Health Program in July 2024.

Easy Enrollment

Starting with Maryland, SBMs have used their flexibility to work with state tax agencies to expand enrollment through "easy enrollment" programs.[83]

- **Maryland's** program allows residents to choose to share their insurance status, income and other necessary information to receive an eligibility determination for Medicaid and Marketplace plans, and if appropriate, an opportunity to enroll into coverage.[84,85] Other states following suit in implementing similar programs include **Colorado**, **Massachusetts**, **Pennsylvania**, **Virginia**, **New Mexico**, **New Jersey**, **Maine**, **California** and **Illinois**.[86,87]

Ten SBM states have worked with state tax agencies to adopt easy enrollment programs.

- Note that California, Massachusetts and New Jersey also have individual mandates that make easy enrollment programs even more effective.[88] In mandate states, the state has the option of allowing consumers to choose between paying a penalty for not having insurance or redirecting the penalty amount toward enrolling in coverage.

Public Option

After a federal public option was struck from the final version of the ACA, multiple SBM states have explored a state-level version, including **Colorado**, **New Mexico**, **Washington** and **Nevada**. In 2022, **Colorado** won 1332 waiver approval for the first broadly available public option—the "Colorado Option"—with the following features:

Colorado was the first SBM state to win approval for a broad public option approach.

- Carriers that offer individual and small group plans must also offer a standardized Colorado Option plan, both on- and off-Marketplace.
- Colorado Option plans must meet statutory premium reduction targets.
- The State will enforce statutory premium reduction targets in the Colorado Option, with a backstop enforcement mechanism to achieve compliance.
- Beginning in 2024, the law provides the State the authority to hold hearings and require providers to accept the rates necessary for carriers to meet premium reduction targets.
- The standardized Colorado Option plans must meet key health equity requirements, including providing culturally responsive networks and offering first-dollar, predeductible coverage of primary, behavioral and perinatal health services.
- Pass-through savings fund a subsidy program for Coloradans who are ineligible for federal subsidies, without regard to immigration status.

In December 2022, **Washington** received approval for a 1332 waiver authorizing Washington's SBM to expand access to health and dental plans for state residents across all incomes, regardless of their immigration status, beginning January 1, 2024. Washington's waiver also provides $50 million in state subsidies to improve affordability for state residents with incomes at or below 250% FPL.[89] **Nevada** is developing a public option implemented through a 1332 waiver, scheduled for implementation in 2026.[90]

Basic Health Program

New York and Minnesota are the only states that have implemented a Basic Health Program (BHP) under Section 1331 of the ACA, though New York's program was recently suspended under an innovation waiver that expands BHP-like coverage to a broader group than is allowed under BHP rules.[vii] Both state programs provide robust benefits for individuals with incomes between 138–200% FPL and feature low-to-no-premiums and cost sharing for enrollees and have demonstrated strong and consistent enrollment in the years since their establishment. Having an SBM was helpful for the implementation of each of these programs.

New York recently extended BHP-like coverage to enrollees up to 250% of FPL.

Oregon is scheduled to launch the third state BHP in July 2024 to achieve two primary policy goals: preserve the Medicaid coverage gains from the federal COVID-19 PHE continuous coverage requirement and expand the role of coordinated care organizations—Oregon's Medicaid managed care entities—to all Oregonians with incomes up to 200% FPL. Without an SBM in place, Oregon has had to resolve a number of operational and implementation issues associated with relying on the FFM platform while pursuing a state-specific innovation. Oregon is already anticipating potential enhancements to its BHP when it transitions back to a full SBM in 2027.

Oregon is on track to become the third BHP state in July 2024.

Addressing Racial and Ethnic Disparities

While all states can and should implement efforts to advance health equity and address racial and ethnic disparities, having an SBM may provide states with additional opportunities as well as greater flexibility and authority to comprehensively identify and address racial and ethnic disparities in coverage, access to services and even plan/network designs. Many SBMs are pursuing comprehensive and innovative strategies to advance health equity in their state, including:

All states can address racial and ethnic disparities, though SBMs have more flexibility.

- **Designing plans to meet the needs of communities of color and/or underrepresented communities.** The **D.C.** Health Link required adoption of a new condition-specific plan design that eliminates cost-sharing for Type 2 diabetes care, which disproportionately impacts patients of color in DC.[91,92] The **Massachusetts**[93] Health Connector also pursued a similar strategy, offering $0 cost-sharing in the ConnectorCare program for diabetes, asthma, coronary artery disease and hypertension—conditions that disproportionately affect communities of color in Massachusetts, in 2023.[94] **Colorado** revised its Essential Health Benefits benchmark plan to add some $0 care, as well as to affirm and clarify the requirement for coverage of gender-affirming care.[95,96]

[vii] New York's 1332 waiver required suspension of the BHP since the waiver expands coverage to 250% of FPL, and the BHP is limited by statute to those under 200% FPL. In essence, however, the NY plan is an expansion of the BHP plan to a larger group.

- **Developing culturally competent networks.** The **Colorado** Option statutory language includes a requirement that Colorado Option plans "have a network that is culturally responsive and, to the greatest extent possible, reflects the diversity of its enrollees in terms of race, ethnicity, gender identity and sexual orientation in the area that the network exists"[97]

The Colorado Option requires culturally responsive provider networks that reflect the diversity of enrollees.

- **Enhancing race and ethnicity data collection, analysis and use. California**[98] requires its insurers to collect "self-identified race and ethnicity data" for at least 80% of marketplace enrollees,[99] and requires insurers to create goals, based on collected data, to improve quality and increase equity. Financial incentives are tied to insurers' use of data to drive improvements in quality of care.[100]

Recommendations: Improving Policy Innovation

"Required innovation" sounds like an oxymoron, and CCIIO does not have the authority to require new SBMs to be innovative. That said, CCIIO could add a section to the SBM Blueprint that asked questions about SBM plans with respect to reinsurance, state subsidies, easy enrollment or other common innovations. And over time, certain innovations, such as standardized plans, could evolve into requirements to the extent that certain approaches prove most effective for consumers. CCIIO also could extend certain regulations that are only applicable to FFM states today to all Marketplaces.

Approaches to innovation that CCIIO could consider include:

- **Checklists for approved waivers.** For innovations CCIIO has already approved, the agency could provide checklists that streamline the process for other states that may be interested in pursuing similar innovations. For example, CCIIO has published a simple checklist for 1332 reinsurance waivers that has helped streamline the approval process. Similar checklists could be developed for newer waivers, such as the Colorado Option, though it would be a more complicated checklist than the reinsurance one.
- **Templates for new waivers.** CCIIO could take this a step further and propose waiver ideas that it believes would further the goals of the ACA even if no state has yet proposed the idea. The Trump Administration pursued this idea in 2018 and 2019, when CCIIO released guidance that provided checklists for states that might be interested in pursuing various 1332 waiver concepts under the rubric of "State Relief and Empowerment Waivers." That effort failed with no state taking up the proposed concepts and critics questioning whether the concepts met the 1332 waiver statutory guardrails. Nevertheless, the idea of CCIIO helping guide states toward the most promising concepts is one that could be helpful if it were done in a way that met the 1332 guardrails and helped advance the goals of the ACA.[101,102]

Conclusion

As the ACA Marketplaces enter their second decade with a record enrollment of 21.4 million, there are still large disparities in the uninsured rate between states that have expanded Medicaid and established an SBM and those that have not. The small minority of states that have not yet expanded Medicaid continue to have average uninsured rates in the double digits (10.3% in 2022) and could cut that rate by a third were they to join the majority of FFM states that have expanded Medicaid (7.0% average uninsured rate in 2022).

The case for also establishing an SBM is not as open and shut, since the choice is not SBM or no Marketplace. In fact, the ACA requires a Federally-Facilitated Marketplace (FFM) in any state that does not establish an SBM. The FFM has also been a success story in the ACA's first decade, providing a vibrant Marketplace for 32 states. States that do not have a strong state-based health reform agenda should continue to be well-served by the FFM, though there is always the potential for a new presidential administration to change the course of ACA implementation.

States that do not have a strong state-based health reform agenda should continue to be well-served by the FFM.

For states that do have their own health reform agenda and want to better control their own destiny, the SBM states demonstrate that SBMs do offer significant advantages over the FFM, particularly in allowing states to expand and better target consumer outreach, improve collaboration between their Marketplace and their state Medicaid agency, and to enact state subsidies and pursue other policy innovations that require the flexibility of an SBM. As of 2022, the 19 SBM states (all of whom had expanded Medicaid) had an average uninsured rate of 5.8%, and many of them had cut their uninsured rate substantially more.

For states that do have their own reform agenda, SBMs do offer significant advantages over the FFM.

The country is in the middle of a major expansion of SBMs—from 12 SBMs in 2017 to 22 SBMs in 2027, with many other states taking a second look as well. If past is prologue, there will continue to be bumps in the road as the federal government decides on the appropriate level of federal subsidies and countless other issues. States that establish SBMs will not be immune from those federal decisions, but they will have many more tools at their disposal to chart their own health reform path.

Appendix: Interviewee Names and Affiliations

Name	Title (at time of interview)	Interview Date
Zach Sherman	Executive Director. Pennie	June 28, 2022
Mila Kofman	Executive Director, D.C. Health Benefit Exchange Authority	June 28, 2022
Pat Kelly	Executive Director, Your Health Idaho	June 30, 2022
Kevin Patterson	Chief Executive Officer, Connect for Health Colorado	July 1, 2022
Jessica Altman	Chief Executive Officer, Covered California	July 6, 2022
Meg Garratt Reed	Director, Maine's Office of Health Insurance Marketplace	July 12, 2022
Danielle Holahan	Executive Director, New York State of Health	July 18, 2022
Michael Marchand	Chief Marketing Officer, Washington Health Benefit Exchange	July 18, 2022
Michele Eberle	Executive Director, Maryland Health Benefit Exchange	July 19, 2022
Chiqui Flowers	Administrator, Oregon Health Insurance Marketplace	July 19, 2022

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