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DECEMBER 2020

Technology Opportunities for the ACA Marketplaces

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This policy paper was made possible through generous support from the Robert Wood Johnson Foundation.

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The authors are indebted to Katherine Hempstead, senior policy adviser to the Robert Wood Johnson Foundation, for invaluable suggestions, big and small, at every step of the process. Mr. Ario also wishes to acknowledge that he has represented multiple clients with various interests in the future of ACA technology, including states (e.g., the Commonwealth of Pennsylvania and the State of New Jersey) and technology providers (e.g., Health Sherpa and Stride Health).

Technology Opportunities for the ACA Marketplaces

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Executive Summary

Technological innovation has always been at the center of the Affordable Care Act (ACA) Marketplaces and has never been more important than it is now. Changes brought on by the coronavirus pandemic have clearly illustrated a critical need to expand outreach and provide coverage to millions of people who have lost their employer-based insurance and may be best served by Medicaid or Marketplace coverage. Technology is one part of meeting this challenge, and the ACA Marketplaces have made important technological gains that can help to do so.

This policy brief explores the evolution of the Marketplaces from a technology perspective, drawing from interviews conducted with state Marketplace leaders, technology companies, and consumer advocates. Much of what happened in the ACA's first decade was driven by technology, including the development of two separate but interrelated tracks: the Federally Facilitated Marketplace (FFM) track and the State-based Marketplace (SBM) track, each of which has continued to evolve and improve in different ways. As we begin the ACA's second decade, it is a good time to consider what the FFM and the SBMs can learn from each other to expand enrollment and improve the ACA coverage system.

> Now is a good time to consider what the Marketplaces can learn from each other to expand ACA enrollment.

The brief is intended for states that are considering a transition to SBM status as well as a broader audience interested in the role of Marketplaces in expanding and enhancing coverage. While there has been a resurgence in states transitioning to SBM status over the past two years, the Biden Administration could change the calculus for some states by pursuing a stronger role for Healthcare.gov in driving coverage improvements. For some states, the best option might be an SBM on the federal platform (SBM-FP), a hybrid option that combines the local control elements of an SBM with reliance on Healthcare.gov as a technology platform.

> While there has been a resurgence in states transitioning to SBM status, the Biden Administration could change the calculus for some states.

The paper is divided into three sections covering the history of the FFM and SBM tracks, the technology opportunities available today, and the choices states have, given the current state of technology. The paper also includes a series of recommendations and considerations. Recommendations focus on what the Biden Administration could do to make the FFM a better partner for the states through expanded sharing of data and technology, as well as more targeted support to address the differing needs of FFM and SBM states. Considerations focus on how states can best navigate their options within the FFM and SBM tracks as those tracks evolve, and perhaps make use of hybrid options such as the SBM-FP track. Finally, the paper includes four appendices: a compilation of the recommendations and considerations, a list of interviewees, a recap of state Marketplace transitions over time, and case studies on SBM accomplishments.

Section 1: The First Ten Years

Section 1 details how the federal and state tracks developed over the first decade of the ACA to reach their current status. The FFM track includes 30 FFM states today plus six SBM-FPs, which have their own local governance and financing structures but rely on the FFM's technology. The SBM track includes 20 SBM states plus the District of Columbia, 15 of which rely on their own state-based technology.

For FFM states, Healthcare.gov has quietly leveraged economies of scale to continuously upgrade the website and make it far easier for consumers to search for and enroll in coverage today than in 2014, including enhanced direct enrollment (EDE) partnerships that expand the enrollment channels available to consumers and make it more cost-effective for insurers and brokers to promote ACA coverage over alternative products. However, FFM limitations include minimal data sharing for states that want to do their own consumer outreach, virtually no customization for states interested in policy innovations and limited integration with Medicaid. Current user fees for the federal platform are also higher than the cost of using second-generation technology solutions, especially for larger states.

The SBMs have generally outperformed Healthcare.gov in key areas by committing state resources and using targeted approaches to achieving their goals. While FFM enrollment grew faster than SBM enrollment from 2014 to 2015, SBM states have done better on average than FFM states in maintaining enrollment since 2016, in part because of the larger investment they make in consumer outreach. The SBMs' greater commitment to finding and enrolling the uninsured has also helped offset the high attrition rates that are a constant challenge in the individual market. Despite their best efforts, however, the SBMs have fallen short in reaching the many consumers who are eligible for ACA subsidies but not aware of their eligibility. More broadly, resource constraints have been a challenge in many SBMs, often related to legacy technology platforms, which tend to be less flexible and carry higher maintenance costs than do the more flexible options available to states considering an SBM transition today.

The SBMs have generally outperformed Healthcare.gov in key areas.

Section 2: The Case for Shared Technology

Section 2 focuses on six areas in which Healthcare.gov and the SBMs could share technology to improve the ACA Marketplaces. In each area, we discuss what has been accomplished with technology at the federal and state level, and offer recommendations for how the Biden Administration could build on those accomplishments by leveraging technology to make Healthcare.gov a more versatile resource for both SBM and FFM states.

The Biden Administration could make Healthcare.gov a more versatile resource for all states.

Recommendations for the Biden Administration


Invest in consumer tools


Enhance direct enrollment


Share data with states


Establish a national eligibility service


Improve Medicaid integration


Encourage public policy innovation

More specifically, the Biden Administration could take the following actions:

- **Consumer Decision-making Tools.** Invest the resources necessary to continually improve Healthcare.gov as a world-class consumer-facing website, including a systematic effort to identify and share the most promising innovations of the SBMs and commercial websites. The Centers for Medicaid & Medicare Services (CMS) should support a shared services model that makes new innovations readily available to the SBMs, especially those with more limited resources.
- **Targeted Enrollment Strategies.** Support FFM and SBM-FP states by offering comprehensive data-sharing agreements to any state interested in using consumer data to target consumer outreach and build enrollment. This would encourage more state involvement in building enrollment without having to establish an SBM, though the federal government may want states to show a requisite level of state commitment by establishing an SBM-FP.
- **Coordination Across Medicaid and Other State Agencies.** Facilitate state efforts to improve Marketplace–Medicaid integration, as well as coordination across other state agencies, including unemployment insurance (UI) agencies. As the FFM improves, more FFM states may choose to become Medicaid determination states and may also consider whether EDE and other technologies can be leveraged to improve interagency coordination by, for example, incorporating ACA enrollment into a common process flow when applying for other state benefits.
- **Direct Enrollment Partnerships.** Make it easier for SBMs to diversify their outreach strategies by sharing EDE technologies with states. This would encourage SBMs to utilize an enrollment strategy that has proven successful for the FFM, while still allowing SBM states to make their own decisions about whether to partner with some or all federally certified EDE entities. States could leverage federal oversight standards and/or set stricter state standards.
- **National Eligibility Service.** Establish a national eligibility service that is stringently regulated by the federal government for Marketplace premium tax credits (PTCs), with a hand-off to either Healthcare.gov or an SBM for enrollment. This would simplify the job of the SBMs, allowing them to focus on enrollment rather than continually adjusting to changes in federal eligibility rules and procedures.

- **Public Policy Innovation.** Revisit the question of how much policy flexibility is feasible for FFM and SBM-FP states by engaging with the states to determine what, if any, new policy innovations are both feasible and desirable to be accommodated on Healthcare.gov; then be as clear as possible about what additional flexibility is available to SBMs under Section 1332 or other innovation authorities. This would give all states a more predictable landscape for evaluating their public policy options.

Section 3: The Future of the SBM Track

Section 3 discusses how states with their own healthcare reform goals will have more flexibility as an SBM and could approach this as a two-step process by first becoming an SBM-FP and then assessing how much more flexibility they would gain as a full SBM depending on how the SBM-FP track evolves over time. The collective SBM experience suggests that establishing an SBM is a heavy lift and should not be undertaken lightly. However, the current SBMs have found the effort to be worthwhile, suggesting that current FFM states could benefit from becoming SBMs if they are committed to state-specific goals.

> Establishing an SBM is a heavy lift and should not be undertaken lightly.

The most common state goals in establishing an SBM have included consumer outreach to expand enrollment, Medicaid integration and public policy innovation. Section 3 presents examples of SBM accomplishments in these areas and highlights the second-generation technology options available to transitioning states today. States no longer have to build their own technology platforms from scratch; instead, states can contract with vendors offering "off the shelf" technology platforms that have proven successful in first-generation SBM states. States that have contracted with second-generation vendors have been able to customize their platforms as desired and amortize the costs over long-term contracts. These contracts have resulted in significant cost savings to date, though the relative costs of the FFM track versus the SBM track could change depending on what happens with federal user fees, which have been slightly reduced in recent years and are subject to further changes.

> States that have contracted with second-generation vendors have been able to customize their platforms as desired and amortize the costs over long-term contracts.

Section 3 includes three considerations for states examining their Marketplace options:

- **Marketplace Integration With Medicaid and Other State Programs.** All states should consider their opportunities to better align their Marketplace with Medicaid and other state programs. While integration opportunities are generally better for SBMs, there also are opportunities for FFM states to use federal EDE partners to incorporate ACA enrollment into the workflow of other state agency application processes, such as allowing those applying for unemployment benefits to enroll in ACA coverage as part of one seamless application process.

- **FFM and SBM-FP States.** The 30 remaining FFM states should reconsider the decision to remain an FFM to the extent they have healthcare reform goals that would benefit from more state flexibility. If so, establishing an SBM-FP creates a state entity with accountability to relevant stakeholders that can serve as a forum for debating future state reform proposals. FFM states, particularly smaller ones, should consider becoming an SBM-FP even if they remain uncertain about becoming a full SBM. States that pursue SBM-FP status will find a continuum of options enabled by the transition, from an incremental expansion of local control over consumer assistance and insurer oversight as an SBM-FP to broader control by transitioning at a future time to a full SBM. While cost savings may be an important consideration, states should consider that the economics could change and that full SBM status requires a high level of state engagement.

  Establishing an SBM creates a state entity with accountability to relevant stakeholders.

- **Becoming an SBM.** The six SBM-FP states, most of which view their SBM-FP status as a way station on the road to full SBM status, should watch how the FFM develops and carefully consider the pros and cons of SBM status versus SBM-FP status. The 15 full SBMs show no signs of rethinking their status regardless of how much the FFM improves. There are, however, lessons to be learned by all states from the FFM about technological upgrades. SBM states should continue to watch the FFM closely and be ready to embrace any helpful FFM innovations.

Section 1: The ACA's First Ten Years

The centerpiece of the ACA's vision for a vibrant individual market was an "Exchange" (now called a Marketplace) in every state where qualified insurers would compete to offer benefit plans to consumers without regard for the consumer's health status, and consumers would receive income-based subsidies to purchase comprehensive health benefit plans that are competitively priced. The ACA Marketplaces were to be integrated with Medicaid expansion through a single eligibility and enrollment (E&E) system, offering a seamless coverage continuum for consumers, with either Medicaid or ACA subsidies available to consumers with incomes up to 400% of the federal poverty level (FPL).

One of the most contentious ACA debates was between those who advocated for a single federal Marketplace to deliver a uniform program nationwide and those who supported state Marketplaces to allow for state flexibility. The debate was resolved by allowing states to establish independent state Marketplaces, with the federal government required to provide a federal Marketplace for states that preferred a more passive role. While virtually every state considered the SBM path, only 16 states and D.C. elected to become SBMs for the 2014 launch of the Marketplaces, and five of those quickly encountered technological challenges that forced them to fall back to the federal technology platform in 2014 or 2015. By 2016, Healthcare.gov served as the technology platform for 39 states.[1]

A. Healthcare.gov's Evolution

Healthcare.gov got off to a rocky start in 2013, but the federal technology platform has steadily improved over the years, leveraging the economies of scale that come from serving a majority of the states to continuously upgrade the website and making it increasingly easier for consumers to search for and enroll in coverage. Today, Healthcare.gov enrolls more than eight million people each year in individual coverage, often in real time, and does so with unprecedented transparency about sellers, buyers and products. With millions losing health insurance coverage during the current recession, Healthcare.gov has been a particularly valuable resource in providing a platform for purchasing health insurance coverage this year. Although that value was diminished by the decision not to open a special enrollment period (SEP) for the uninsured during COVID-19, Healthcare.gov has seen an increase in special enrollments from individuals who experienced a loss of minimum essential coverage (qualifying them for a traditional SEP).[2]

Healthcare.gov enrolls more than eight million people each year in individual coverage, often in real time, and does so with unprecedented transparency about sellers, buyers and products.

Strengths of Healthcare.gov. While there has been a resurgence of state interest in transitioning to SBM status in recent years, this trend should not obscure the fact that Healthcare.gov is still the technology platform for 36 states today and has much to offer; and, with the improvements discussed in Section 2, it could continue to be the best option for many of these current FFM states. Strengths of the federal platform include increasingly user-friendly consumer search tools for sorting plans; retention strategies including automatic re-enrollment and regular online reminders about plan choices; and enhanced direct enrollment (EDE) partnerships that expand the enrollment channels available to consumers and make it more cost-effective for insurers and brokers to promote ACA coverage over alternative products.

Direct enrollment makes it more cost-effective for insurers and brokers to promote ACA coverage over alternative products.

The federal commitment to partnering with "web brokers" interested in supporting ACA enrollment through their own websites is a key strength of Healthcare.gov. CMS established the web broker program by regulation in 2012[3] as a way to reach and serve prospective enrollees who may not be aware of Healthcare.gov or would simply be easier to reach through alternative enrollment channels. This form of enrollment became known as "direct enrollment." The initial regulations set out key consumer protection standards for web brokers, similar to the standards used by states to regulate several million agents and brokers who have traditionally helped insurers reach their customers, with some enhancements such as a requirement to show all available plans to each consumer. While the program quickly attracted more than 50 web broker registrations, the "double-redirect" technology offered to web brokers in the first open enrollment period (OEP) was clunky and not very effective at attracting consumers for Healthcare.gov enrollment.[4] As one web broker commented: "From the consumer experience, there was failure to complete and low conversion rates because of the double-redirect. Passing off from one site to another is an opportunity to fail. And getting someone back to that prime site is another opportunity to fail. It wasn't set up well in the initial setup."

Despite these setbacks, however, important groundwork was laid to ensure that web brokers complied with Healthcare.gov standards for displaying all available plans, met rigorous privacy and security standards, and retained electronic records for audit purposes for ten years. A notable feature of direct enrollment from the start has been that electronic systems can be audited for compliance purposes more easily than trying to adjudicate the traditional "he said, she said" disputes between consumers and agents where there is no record to review.

In recent years, the direct enrollment channel has evolved, leveraging emerging technologies to create a seamless enrollment experience for consumers relying on direct enrollment partners. In 2018, CMS released the EDE certification pathway, which significantly expanded the opportunities (and corresponding obligations) for EDE entities to provide end-to-end direct enrollment services on their platforms. EDE partners offer a range of capabilities that augment the effectiveness of Healthcare.gov in reaching and enrolling diverse populations. Among the leading EDE partners is a company that focuses on integrating ACA enrollment into the business models and websites of as many insurers, agents and employers as possible; a second company that focuses on reaching younger gig economy workers through their multiple employers; and a third that works with one large insurer and its agent workforce to streamline the enrollment process.

Drawbacks of Healthcare.gov. Healthcare.gov's technology advantages are counterbalanced by the fact that in having to serve 36 states, it cannot tailor itself to local variations in the same way that an individual state can. As one state official put it: "The FFM is serving a lot of different states with generic messaging that's not specific to a region or group; when it's the state serving the state, and we have access to the data, we can be tailored and specific with the way we communicate with people to convince them to actively shop." This weakness could be addressed by having the federal government share more data with states that are interested in targeted outreach and messaging, but to date, states have had to become SBMs to gain access to detailed data.

> Healthcare.gov cannot tailor itself to local variations in the same way that an individual state can.

In addition to limited data sharing, the FFM did not achieve a seamless integration with state Medicaid programs as originally envisioned. Though federal E&E services have improved and the FFM has provided better information to the states when handing off the Medicaid-eligible, there will generally be more potential for a state to coordinate among state agencies, rather than negotiate better coordination between the FFM and its state Medicaid agency.

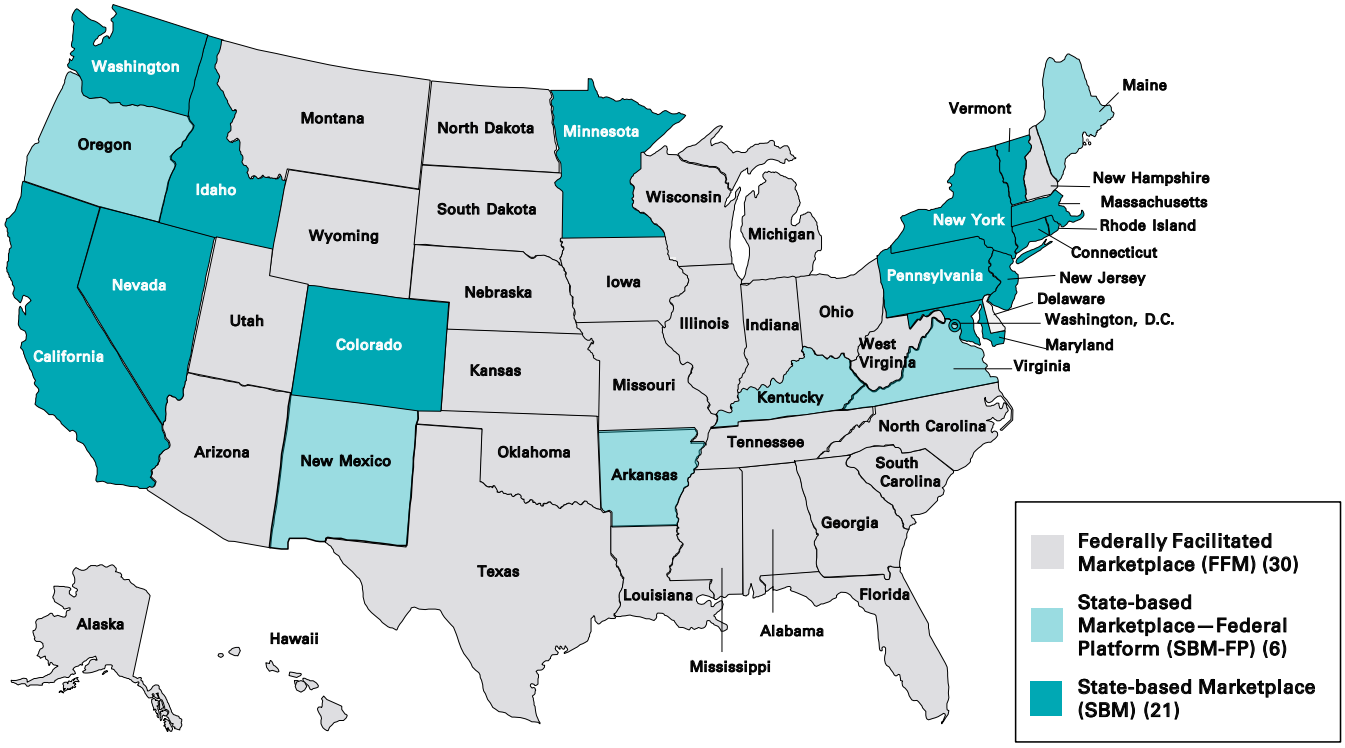
Starting in 2017, technological concerns over Healthcare.gov were eclipsed by the Trump Administration's unpredictable mix of support for certain technology initiatives and overall political hostility to the ACA. For example, the Administration has leveraged new technology to expand enrollment through alternative channels, has used electronic communication to boost re-enrollment rates, and has enhanced consumer shopping tools to improve the user experience and boost price transparency. At the same time, however, it has cut the consumer assistance budget for enrollment by almost 90% since 2016, terminated cost sharing reduction (CSR) reimbursements in 2017 and failed to hold an SEP for the uninsured this past spring.[5]

B. The SBM Path

The 12 SBMs that launched in 2014 and have remained full SBMs since that time have generally performed better than has the FFM on metrics ranging from higher enrollment to lower premiums.[6] That superior track record, combined with the unpredictability of Healthcare.gov under the Trump Administration, helps explain why there will be 15 full SBMs in 2021, as well as six more states that occupy a hybrid status, known as an SBM on the federal platform (SBM-FP). The SBM-FP status today functions primarily as a way station between full SBM status and full FFM status, with most SBM-FP states planning to transition from Healthcare.gov to their own technology platforms in the next couple of years.[7] See Figure 1 below and also Appendix C for a complete picture of state Marketplace decisions leading up to the present day.

> SBMs have performed better than Healthcare.gov on metrics ranging from higher enrollment to lower premiums.

Figure 1. State Health Insurance Marketplaces, 2020



The SBM-FP status emerged in 2014 and 2015 when five SBMs defaulted to Healthcare.gov after their state-based technology platforms failed. In the face of these technological challenges, states with SBMs drew a distinction between technology and local governance. Except for Hawaii, which dissolved its SBM and became an FFM state, the other SBMs that fell back to the federal platform for E&E retained their SBM governance structure and continued to operate as SBMs in their close partnerships with insurers and in their consumer outreach.

These states maintain their own websites and outreach programs, though they are constrained in their ability to use micro-targeting strategies to focus on underserved populations due to limited data sharing from the FFM. More broadly, these states retained their SBMs because these locally governed entities had become the focal point for government officials and stakeholders to develop and refine healthcare reform priorities for the state within the contours of the ACA's federal–state framework.

In addition, the changing technology landscape has led many SBM-FPs to see new advantages in returning to a state-based technology platform or in establishing one for the first time. Some of the technology companies most involved in supporting the original SBMs have leveraged their experience to offer second-generation technology platforms to aspiring SBMs at a lower price point than Healthcare.gov.

Technology companies that supported the original SBMs have leveraged their experience to offer second-generation technology platforms to aspiring SBMs at a lower price point than Healthcare.gov.

Nevada was the first SBM-FP to return to full SBM status in 2020, partly to save money, but also to have more control over its own data for targeting enrollment efforts and better serving its enrollees. Nevada's positive experience has sparked other SBM-FPs and four FFM states to initiate similar transitions, seeking to leverage the lessons learned by the original SBMs to establish a second generation of full SBMs. Three of the six current SBM-FPs—Kentucky, New Mexico and Virginia—have announced plans to transition to full SBM status for 2023. As one state official leading such a transition says, "The current SBM vendor community has the benefit of all that experience and time."

DC Health Link's Tech Renovation

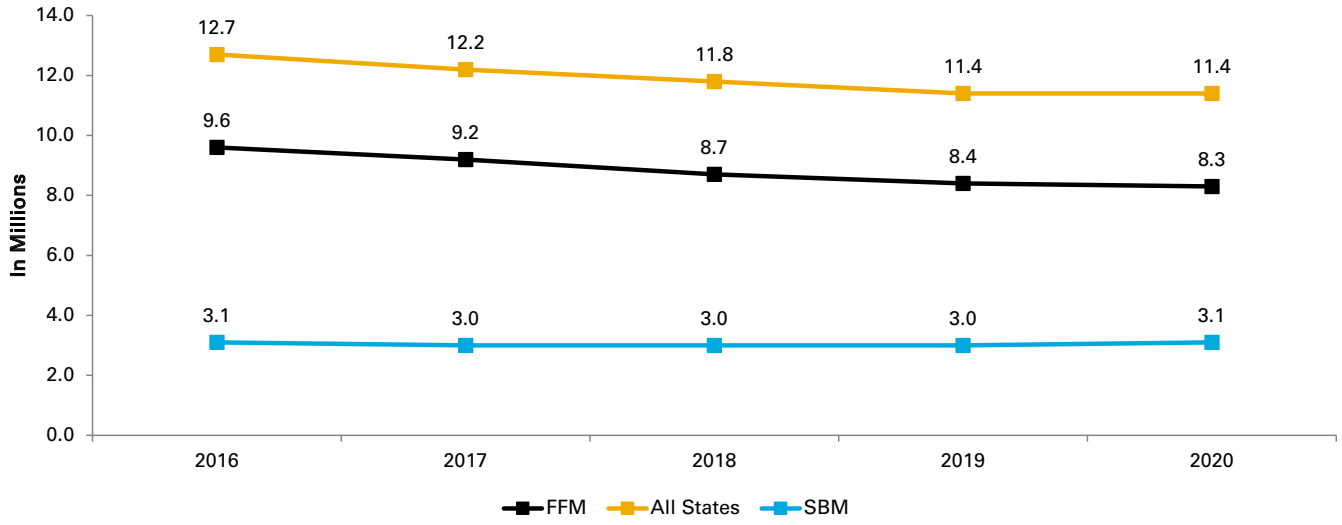
Many of the original technology platforms for state-based marketplaces were somewhat clunky and not very flexible in adapting to regulatory changes that were common in the early days of ACA implementation. DC Health Link faced a particularly challenging situation when it was suddenly required to provide health insurance coverage to members of Congress and their staff in November 2013 while simultaneously preparing for its first OEP for other individuals and small businesses.

DC Health Link made it through two OEPs with its original set of technology vendors, but performance during the second OEP was poor enough that the DC Health Link team tapped a startup company, which was promoting an open source eligibility system, to develop and deploy its unique model for incoming members of Congress and staff following the 2014 midterm elections. The transition was successful enough that the new model was used to replace DC Health Link's original technology platform for all individuals and small businesses. The new model was deployed in October 2015 in advance of D.C.'s third OEP, and it has been used since that point. DC Health Link has offered to share its open source model with other states, an offer that was taken up by Massachusetts for its small business exchange.

Strengths of SBMs. All the SBMs enjoy broad political support in their states and have invested substantial resources to leverage technology advances to improve the shopping experience and to build strong alliances with insurers and community groups, including local agents and brokers, to maximize enrollment. Though SBMs have a mixed record on Medicaid integration, SBMs have generally achieved better results than have the FFM states in minimizing the number of individuals who fall through the cracks as they cycle between Medicaid and the Marketplace.

As Figure 2 illustrates, the FFM grew its enrollment faster than the SBMs in 2014–2016, but the SBMs have generally outperformed the FFM since 2016. The differences are relatively modest overall but are more significant with key subgroups, such as young adults[8] and those not eligible for subsidies.[9]

Figure 2. Health Insurance Marketplace Enrollment (Plan Selections), 2016–2020



Source: State-based Marketplace enrollment has remained steady over the years, while overall Marketplace enrollment has shown modest declines since 2016. CMS Health Insurance Exchange Open Enrollment Report, April 1, 2020. https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf.

The two largest SBMs, Covered California and the New York State of Health, have been leaders in doubling down on their consumer outreach activities, while federal cutbacks have curtailed such outreach in FFM states (see Appendix D for more detail on these states' marketing and outreach strategies). Covered California's annual marketing and outreach budget has been $120 million since 2014 and was increased to $157 million for 2020. Working closely with health plans, brokers and agents, Covered California has achieved a take-up rate among subsidy-eligible adults nearly 25% higher than the average for FFM states, a healthier risk pool and a lower rate of churn—all of which have paid off in more affordable premiums.

The same theme is echoed by SBMs of all sizes: One compelling reason to have an SBM is to work closely with local carriers and agent workforces—supplemented by Navigators to focus on hard-to-enroll populations—to boost enrollment.

Given the SBMs' commitment to growing enrollment, it is interesting that the differences between FFM and SBM states are relatively minor in the aggregate and vary markedly from state to state. Part of this is due to state-by-state variations in Medicaid expansion, which assigns to Medicaid a significant portion of those who would otherwise be eligible for large tax credits and cost-sharing reductions. While this benefits that population and the overall goal of expanding coverage, it also means states that have expanded Medicaid have a smaller target population for ACA subsidies. For example, Maine projected a loss of 19% from its Marketplace population when it expanded Medicaid.[10]

SBM Drawbacks. SBM drawbacks start with the fact that even the largest states lack the economies of scale available to Healthcare.gov. SBM leaders have discussed various shared services models, but progress has been limited. Resource constraints are particularly pronounced in the smaller SBMs, making it hard to keep up with Healthcare.gov in technology investments.

Not every SBM state has been successful in achieving Medicaid integration; in fact, coordination between two state agencies can be as challenging as coordination between the FFM and a state Medicaid agency. While the SBM states may have more authority and ability to create governance structures to improve these processes at the local level, establishing an SBM is not sufficient for achieving Medicaid integration without a commitment to ensuring its success.

Establishing an SBM is not sufficient for achieving Medicaid integration without a commitment to ensuring its success.

In addition, many of the original SBMs are saddled with legacy technology platforms that were expensive to build and operate and offer less flexibility than do the second-generation technology platforms available to states considering a transition to their own technology platforms today. Though DC Health Link replaced its first-generation technology back in 2015, no other SBM to date has followed suit, given the challenges of doing so. Finally, the SBMs must deal with ever-changing federal rules, especially on eligibility, that undermine business planning and create challenges in ensuring Marketplace stability and enrollment.

Section 2: Shared Technology

As the ACA enters its second decade, there are many opportunities at both the federal and state levels to leverage rapidly improving technologies to expand enrollment, facilitate Medicaid integration and support cross-agency coordination, and encourage policy innovation. We make a series of recommendations in this section, primarily focused on what the Biden Administration could do to upgrade Healthcare.gov and related assets to be a better partner to the states. The federal government is generally in a better position to commit resources to upgrade technology and other Healthcare.gov assets than the states are, especially during the current recession.

A. Consumer Decision-making Tools

A number of organizations have published studies documenting the evolution of consumer decision-making tools within the Marketplaces.[11,12,13] These studies show steady improvement in both Healthcare.gov and SBMs, particularly in the areas of cost transparency, readily accessible provider and prescription drug information, availability of quality rating information, and integrated assistance. By 2016, a majority of Marketplace websites, including Healthcare.gov and several (but not all) SBMs, offered cost transparency tools that allowed consumers to see total annual cost estimates that combined premiums and cost sharing given expected healthcare utilization, as well as integrated provider directories and, in a few cases, integrated prescription drug directories to support shopping of plans based on network providers and covered drugs.[14] These features have only continued to improve over time.

The Marketplaces have shown steady improvement in consumer decision-making tools.

Today, the FFM allows consumers to filter and sort plan results by premium, metal level, deductible, quality rating and plan type; the site is able to provide yearly cost estimates, and it also allows consumers to filter plans based on whether specific physicians are in-network or whether specific drugs are covered by the plan.

SBMs have also made their own improvements to consumer decision-making tools, serving as laboratories of experimentation that enrich the menu of options to support plan shopping and comparison as well as shopping assistance. For example, several SBMs, including those in California, Colorado and New York, offer live chat features to ensure timely and accessible assistance to consumers as they shop. Healthcare.gov has not offered this feature and has reduced its consumer outreach budget, which limits the utility of the site's search feature for identifying available partners to offer assistance as consumers shop for coverage.[15]

Recommendation: Healthcare.gov should invest the resources necessary to continually improve Healthcare.gov as a world-class consumer-facing website, including a systematic effort to identify and share the most promising innovations of the SBMs and commercial websites. CMS should support a shared services model that makes new innovations readily available to the SBMs, especially those with more limited resources.

B. Targeted Enrollment Strategies

A critical asset of the Marketplaces is the ability to derive detailed, timely and high-quality insights from gathered consumer data, which empowers Marketplaces to make decisions based on what they understand of their consumer base and to tailor outreach and enrollment to appropriate groups. The ability of the SBMs to understand unique local dynamics of enrollment and non-enrollment and then address those dynamics in real time is key.

SBMs understand local enrollment dynamics and are able to address them in real time.

The specific ability of a state to control more aspects of that data collection, processing and analysis is an essential benefit that SBMs find invaluable for a multitude of reasons. For example, obtaining member data requires member consent, which many individuals decline to provide, limiting the available data points to examine when shared through the FFM; when collected through an SBM, even non-consent can become useful data. In that context, SBMs have advantages that are not currently available to the 36 states that rely on Healthcare.gov.

In New Mexico, when nearly 30% of their eligible members did not give consent to the FFM requests in 2019, the FFM provided the data to New Mexico with those who declined to provide consent as excluded values, hindering the state's ability to develop marketing and outreach efforts targeting individuals in their state for enrollment. Though the challenge of obtaining consent would still remain for New Mexico once it becomes a full SBM, the state would at least be able to identify the volume and attributes of those who declined to share their data.

Having a consistent flow of data also enables states to identify detailed variations in enrollment and non-enrollment by geography within a state, attributes of those non-enrollees, eligibility for tax credits, and churn between Medicaid and the Marketplace (see Appendix D for specific case studies).

If Healthcare.gov could provide improved data sharing with states relying on the federal platform to enable more targeted state consumer assistance, some states may find that remaining on the federal platform is sufficient for achieving their outreach goals.

Recommendation: The federal government should support FFM and SBM-FP states by offering comprehensive data-sharing agreements to any state interested in using consumer data to target consumer outreach and build enrollment. This would encourage more state involvement in building enrollment without having to establish an SBM, though the federal government may want states to show a requisite level of state commitment by establishing an SBM-FP.

C. Coordination Across Medicaid and Other State Agencies

The ACA requires a seamless coverage continuum between Medicaid and Marketplace coverage, and an integrated E&E system between Medicaid and the Marketplace is a key part of ensuring coverage for individuals. Integration across a broad range of social service programs is also valuable, such as Marketplace connections to Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program, or UI agencies (see callout box below).

An integrated E&E system between Medicaid and the Marketplace is key to ensuring coverage for individuals.

Coordinating the Marketplaces With Unemployment Offices

In the current recession, connection to state unemployment insurance (UI) agencies would be especially valuable. With net employment losses in excess of 10 million people, there are new opportunities to reach people who may be eligible for Medicaid or Marketplace subsidies. A Brookings Institution analysis proposed a range of coordination opportunities, from messaging on the UI agency website about ACA coverage opportunities with a link to the relevant Marketplace to an integrated application provided by an SBM or EDE provider that would allow an applicant for UI to apply for and be enrolled in ACA coverage as part of the UI application or recertification process. By incorporating questions about health coverage directly into the consumers' online workflow as they are applying and recertifying their benefits, the process could allow consumers to share their financial data with the SBM or EDE provider and receive eligibility determination for Medicaid or a specific level of tax credits without having to enter much, if any, new data.

For Medicaid integration, SBM states have used a variety of strategies to achieve a high level of integration between their SBMs and their Medicaid agencies and ensure a coordinated effort to cover a larger pool of eligible enrollees:

- Some states have housed their SBM in the same state agency as their Medicaid agency. In New York, both are housed in the New York State Department of Health and managed as a common enterprise.
- Other states have relied on their Medicaid agency to determine eligibility for both Medicaid and Marketplace subsidies. Idaho uses this approach, with the Medicaid agency handing off those individuals eligible for tax credits to a quasi-independent SBM, which handles Marketplace enrollments.
- In Rhode Island, the state Medicaid agency works in close coordination with the SBM, conducting a near-to-real-time eligibility determination for Medicaid; should that application be ineligible, the process is followed by an automatic evaluation of the application for Marketplace coverage, handing off those individuals eligible for tax credits to the SBM.

Beyond Medicaid integration, Idaho and Colorado are examples of SBM states that have achieved a broader "horizontal integration" between their Marketplace and other state agencies.[16] In Idaho, the state uses a single integrated eligibility system (the Idaho Benefits Eligibility System) for Medicaid, CHIP and Marketplace coverage. This makes Your Health Idaho, the state's Marketplace, easier to manage because it receives enrollees from Medicaid after eligibility is already determined.

New Mexico benefits from state agency coordination in a different way, leveraging state relationships to target specific groups within its enrollment population. Much of the state's workforce is made up of gig economy/seasonal jobs, creating a group of individuals who find themselves in the Marketplace during employment transitions or when they've lost Medicaid eligibility as seasonal income shifts.

While FFM states cannot coordinate Healthcare.gov and their state Medicaid agencies in the same way as SBMs can, FFM states have the choice of treating the FFM's eligibility decision as a "determination" of Medicaid eligibility or as an "assessment" to be validated by the state Medicaid agency. To date, a majority of FFM states have chosen not to accept FFM eligibility decisions as determinative for Medicaid.[17] This creates an opportunity for the federal government to be a stronger partner in streamlining the E&E system by encouraging more states to become determination states. The FFM has come a long way since its establishment in 2014, and states that have become determination states in recent years have expressed satisfaction with the performance of the federal platform in coordinating with state Medicaid agencies for E&E. If the FFM could continue to provide avenues for improved state compatibility with a federal eligibility service, states may continue to find the FFM an attractive partner in facilitating Medicaid enrollment.

Recommendation: All states should facilitate state efforts to improve Marketplace–Medicaid integration, as well as coordination across other state agencies, including unemployment offices. As the FFM improves, more FFM states may choose to become Medicaid determination states and may also consider whether technology such as EDE can be leveraged to improve interagency coordination by, for example, incorporating ACA enrollment into the same process flow as applying for unemployment benefits.[18]

D. Direct Enrollment Partnerships

The FFM has invested in direct enrollment technologies that give consumers multiple ways to access ACA coverage, a critical asset in a world where limited awareness of ACA coverage options is a significant impediment to expanded enrollment.[19] EDE partners use exactly the same web-based application that Healthcare.gov uses but are able to reach potential enrollees by embedding links to that application in the workflows of their business partners, which can include insurers, web brokers, traditional agents and brokers, gig economy platforms, employers, and nonprofits.

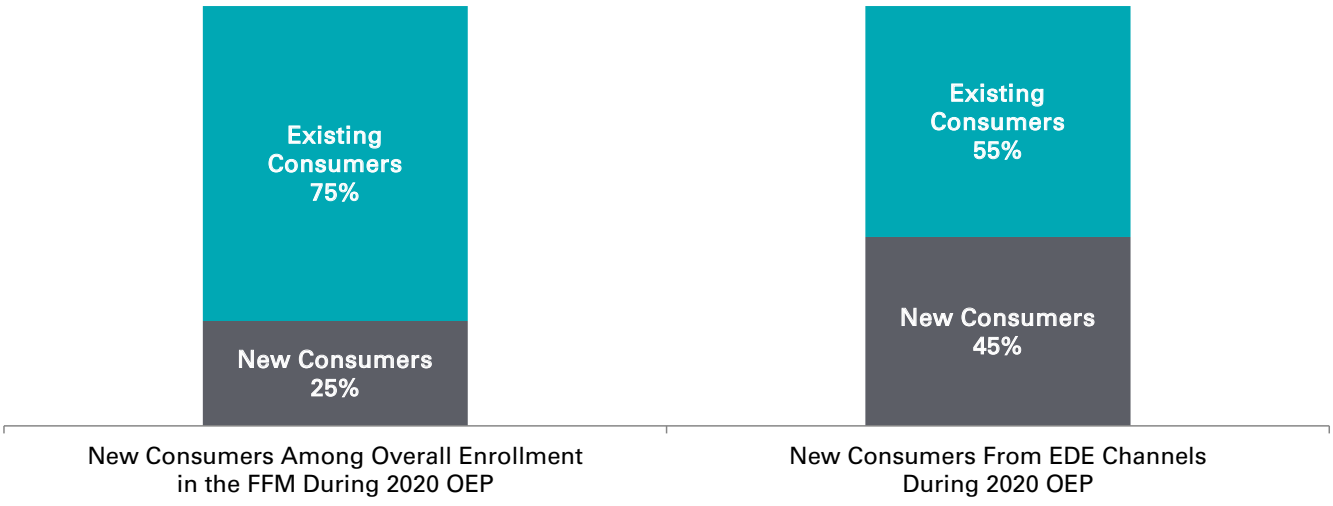
So, for example, an employer website that is gathering financial information online from departing employees would ask them whether they are interested in ACA-subsidized coverage as an alternative to COBRA. If the answer is yes, the site would use technology provided by the employer's EDE partner to give departing

employees a real-time estimate of their ACA subsidy amount or eligibility for Medicaid. If that piqued the employees' interest, they could then be seamlessly processed through the ACA enrollment process as if they had engaged as a new customer on Healthcare.gov, without having to re-enter any information already provided as part of the employer's off-boarding process. The efficiency of this process vastly reduces the drop-off rates that occur when prospective enrollees have to click through to a new website and re-enter information. In addition, prospective enrollees will have added incentive to finish the process if, as is often the case, they find out they are eligible for a larger subsidy than they expected.

EDE enrollment channels have proved particularly beneficial in attracting new enrollees for Marketplace coverage. During the 2020 OEP, for example, all forms of direct enrollment accounted for nearly 30% of total enrollment in Healthcare.gov, and EDE—the highest level of CMS-certified direct enrollment technology—proved especially effective at bringing in new enrollees, an essential component of maintaining a balanced risk pool that keeps premiums affordable. For 2020, over 45% of the individuals enrolled through EDE were new consumers, compared with only 25% of overall enrollment through the federal platform being new consumers.[20]

EDE enrollment channels have proven effective in attracting new enrollees.

Figure 3. EDE Brings in More New Enrollees



Source: Among all enrollees in the FFM, only 25% were new enrollees. In the EDE channel, 45% were new enrollees. CMS Annual Report.[21]

EDE has been especially attractive to insurers and large brokers who process a high volume of people looking for some type of insurance coverage. To the extent that EDE makes it easier and cheaper to enroll people in ACA coverage, it creates strong incentives for insurers to invest in the marketing and sale of ACA-compliant products. Large insurers invest heavily in marketing, and an EDE connection that dramatically reduces insurer costs per acquisition and facilitates year-round investments in member retention could spur insurer marketing. There are trade-offs, of course, with insurers, unlike web brokers, not required to show their competitors' plans.

While the SBMs continue to place a high priority on consumers being able to view all plans and enroll in their preferred plan on the SBM website, the federal government's decision to allow enrollment on third-party insurer and web broker sites is taken one step further with the Medicare program. In the case of Medicare, the federal government has chosen to give insurers the lead role in marketing Medicare Advantage (MA) plans through an online enrollment system that directs all MA enrollment through insurers. The MA approach has been quite successful in steadily building MA enrollment over the past decade, though there are many factors at work; Medicare is a much larger market with higher retention rates, and there is ongoing debate about the merits of MA as an alternative to traditional Medicare. Without weighing in on that debate, it is worth noting that EDE is part of a hybrid solution to the extent it complements rather than replaces the ACA Marketplaces.

Medicare Advantage Enrollment and the Evolution of the Medicare Plan Finder

Medicare Advantage (MA) has 24 million enrollees in private insurance coverage, with an annual open enrollment process similar to the ACA process, though the program is federally run and regulated, and the rules of competition among insurers offering MA products differ from the ACA rules for the individual market.

Another notable difference between MA and the Marketplaces is the central role that insurers play in the shopping and enrollment process. While the federal government maintains the Medicare Plan Finder, the site is only intended to provide information on plans, not enable users of the site to enroll in MA plans. Once users compare plans using the tool, the website redirects them to the website of the carrier offering the plan of interest. Brokers also play a key role, but they must work through insurers since the only way to enroll in coverage is through an insurer.

Like agents and other intermediaries in the sale of health insurance, EDE providers must be effectively regulated to ensure they operate to the benefit of consumers. EDE providers are subject to the same state regulations as other agents and brokers when they sell insurance, and also are accountable to federal regulations to minimize the consumer protection problems that states have with traditional agents and brokers. The federal regulations are generally more stringent than traditional state regulations in several areas, including privacy, security, duties to disclose all plan options to consumers[i] and maintenance of electronic records for audit purposes for at least ten years. SBMs interested in EDE could adopt these regulations and benefit from federal enforcement of the privacy and security regulations, with state enforcement of the transactional regulations and any additional regulations that the state chooses to add to the federal ones. For example, a state may choose to partner only with EDE providers that sell exclusively ACA-compliant plans.

EDE providers must be effectively regulated to ensure they operate to the benefit of consumers.

[i] The duty to show all plans does not apply to direct enrollment by insurers, who are only obligated to show their own plans.

The federal government has made an enormous investment in EDE and should find the most effective way to share EDE and other technology initiatives with SBMs. As several EDE vendors noted, "CMS could offer up EDE because they have it already.... it's been built, there's great models for using it, and they've already built a framework for regulating and auditing us."

Over the long term, the benefits of sharing EDE technology could be enormous. For example, the Internal Revenue Service (IRS) has found partnerships with private vendors to be the most effective route to expanding its e-file system, though it has had to carefully regulate those vendors to ensure that the vendors' e-file systems serve public purposes. As one EDE vendor explained, "What I would love to get states to get is that EDE is analogous to the e-file system for the IRS. They shifted from a paper-based system to allow people to e-file taxes—which can be done wherever they are. The IRS can regulate the data structure, and ensure consumer rights, and then they set a goal of having 80% of people file electronically, but didn't expect to do it themselves—they allowed Intuit and Credit Karma and H&R Block, and all those others to fill out the tax form, and this is just like a tax form. It's a single federated system. The way they organized at a federal level, with a private sector working group—it's a huge change, and there's consistent support for it."

IRS Supports Private E-file Options

The IRS has been highly successful in working with private entities to largely replace a paper-based system with electronic filing. The first Electronic Filing System was developed in 1986 and was rapidly adopted by the public. By 1990, the IRS e-file system was nationally operational, with 4.2 million returns e-filed in total. By 2007, 57% of all tax returns were e-filed.

As the IRS' own technology quickly advanced, the IRS also encouraged the proliferation of private entities that sought to improve on the IRS' services while delivering exactly the same bottom-line answers to tax questions as the IRS. Companies such as H&R Block, Intuit (parent company of TurboTax) and others quickly developed their own proprietary software programs capable of filing income taxes on behalf of their customers in a more user-friendly, easy-to-use format, which proved popular with the general public. By 2019, 89% of filings were e-filed, with over 57 million taxpayers preparing and e-filing their federal tax returns.

As with EDE and CMS, the IRS has had to ensure that private companies adhere to consumer protection standards. In the case of e-filing, the private companies are required to offer a free version of their tax-filing software to low- and moderate-income individuals. To address transparency of the Free File offerings in the 2020 tax filing season, the IRS created the Free File landing page, which allows individuals to find the list of companies that offer Free File services for individuals earning less than $69,000 in 2019. For individuals earning over $69,000, the IRS continues to offer a Free File Fillable Form for those who are comfortable filing their taxes with little assistance.

Recommendation: Healthcare.gov should make it easier for SBMs to diversify their outreach strategies by sharing federal EDE technologies with states. This would allow SBM take-up of an enrollment strategy that has proven successful for the FFM, while still allowing SBM states to make their own decisions about partnering with some or all federally certified EDE entities under federal standards and/or stricter state standards.

E. National Eligibility Service

The federal government could leverage the investment it has made in building common eligibility services for the FFM to establish a high-profile national eligibility service for Marketplace PTCs, with a hand-off to either Healthcare.gov or an SBM for enrollment. Indeed, the language of the ACA seems to favor that approach over delegating eligibility determinations to each individual state Marketplace. The national approach was not adopted in the first phase of ACA implementation because of a broader commitment to state deference and because Medicaid eligibility determinations were a state-by-state matter. However, the ACA does not give states any meaningful flexibility on federal tax credits, which are controlled by federal law and could be most efficiently determined by a federal service operating under a single set of uniform procedures. Such a federal authority would have to accommodate state Medicaid programs, with their varying eligibility rules, but there is no reason a national eligibility service could not incorporate state Medicaid eligibility rules with respect to income eligibility, as the FFM's eligibility services do today.

The ACA does not give states any meaningful flexibility on federal tax credits.

Should the federal government pursue a national eligibility service, the service should be run by a world-class, customer-service-oriented technology company capable of incorporating the Medicaid eligibility rules for each state and establishing a seamless hand-off of Medicaid cases to the states. The system should operate under strict federal oversight given the federal subsidy dollars at stake. Such a system would simplify the job of the Marketplaces; enrollees would start the shopping process with a predetermined subsidy similar to an employee with a predetermined employer contribution using an employer website to shop for and enroll in coverage. Such a system would also enhance direct enrollment partnerships by allowing EDE partners to leverage the national eligibility service.

Recommendation: HHS should establish a national eligibility service that is stringently regulated by the federal government for Marketplace PTCs, with a hand-off to either Healthcare.gov or an SBM for enrollment. This would simplify the job of the Marketplaces and may encourage states to become Medicaid determination states, though states have differing incentives with Medicaid where they share the cost with the federal government as opposed to the federal government bearing the full cost of PTCs.

F. Public Policy Innovation

Public policy innovation has been a hallmark of the SBMs (see Appendix D for some examples). Similar innovation in FFM states has generally been precluded by the inflexibility of Healthcare.gov, but that could change. While it is hard to envision Healthcare.gov becoming flexible enough to enable significant policy innovation at the state level, it is likely that the Biden Administration will look for ways to encourage state experimentation on proposals it favors, such as the public option, especially if the Senate remains in Republican hands and the potential for a federal public option is limited.

The Biden Administration may follow the example of the Trump Administration, which rescinded Section 1332 guidance promulgated by the Obama Administration and released its own updated Section 1332 guidance[22] reinterpreting Section 1332 statutory guardrails to offer states considerably more flexibility in redesigning benefits and subsidies and meeting other statutory requirements. CMS subsequently released a discussion paper[23] outlining four new waiver concepts that permitted states to redirect PTC funding to limited-benefit plans or defined contribution arrangements, restructure subsidies to be flat dollar amounts that are not tied to income, and establish high-risk pools as another way, in addition to reinsurance waivers, to stabilize risk pools. The discussion paper acknowledged that concepts were better suited to SBMs, but offered FFM states the potential to leverage Healthcare.gov to perform eligibility, plan display, plan selection and enrollment functions. The paper also noted that waivers requiring changes to the information technology system or operating procedures would require additional time to implement and require the state to contribute to the cost of development.

In spite of these efforts, the Trump Administration found it difficult to identify state partners interested in pursuing its favored Section 1332 approaches and ended up approving only Section 1332 reinsurance waivers with one notable exception: On November 1, 2020, CMS approved the "Georgia Access Model," a Section 1332 waiver to replace Healthcare.gov with a state-based E&E that relies on insurers, agents and brokers, and other private entities to market health benefit plans, including both ACA-compliant plans and other non-ACA-compliant plans. The Georgia waiver is not scheduled for implementation until 2023 and is likely to be challenged in court for its potential to undermine access to comprehensive and affordable coverage.[24] However, there may well be other states interested in emulating the Georgia waiver and similar approaches that replace Healthcare.gov with decentralized distribution systems, though it remains to be seen whether any other state will propose to do so without creating an SBM, especially since creating an entirely new alternative to the current Marketplace models may end up being considerably more disruptive and expensive than improvising on either an FFM or an SBM technology platform.

> Eliminating the public Marketplaces is likely to be more disruptive and expensive than building on the existing Marketplace model.

More broadly, the Biden Administration may well reverse the Trump Administration's stated preference for "private sector" Section 1332 innovations with a preference for "public options" that seek to use government leverage in one form or another to make coverage more affordable. The Biden Administration would be wise to fully engage with state leaders to ensure that any new guidance or regulations will generate state proposals.

There does appear to be interest in more flexibility. Washington is implementing a public option for 2021 through its SBM,[25] and a number of other SBM states are considering various forms of a public option. While some forms of a public option may be feasible on the federal platform, it is not accidental that most states considering a public option are SBM states. Establishing an SBM has proven to be an effective way to create a state entity with accountability to relevant stakeholders for debating public options and other healthcare goals, and SBMs offer states more diverse pathways for tailoring a public option to state priorities.

Recommendation: The Biden Administration should revisit the question of how much policy flexibility is feasible for FFM and SBM-FP states by engaging with the states to determine what, if any, new policy innovations are both feasible and desirable; then be as clear as possible about what additional flexibility is available to SBMs under Section 1332 or other innovation authorities. This would give all states a more predictable landscape for evaluating their public policy options.

Section 3: The Future of the SBM Track

There has been a resurgence of state interest in SBMs in the past few years, with four FFM states establishing SBMs for the first time and three SBM-FP states planning to become full SBMs by 2023. If all these transitions are completed, there could be as many as 20 full SBMs within the next two years (see Appendix C for the current status of 21 SBMs and SBM-FPs). There also are several additional FFM states considering similar transitions.

Part of this resurgence is driven by the cost savings that are available to states by contracting with a second-generation technology vendor to provide a state-based technology platform for roughly half the cost of Healthcare.gov, with significant variations depending on the number of Marketplace enrollees and the degree of state platform customization.

More important than cost savings is what a state hopes to accomplish in better serving its consumers and pursuing its own brand of healthcare reform innovation. If there is a single lesson to be drawn from the recent spate of SBM transitions, the lesson would be that establishing and operating an SBM is hard work and should not be pursued without a strong vision of what the state hopes to achieve and careful consideration of the costs.[26] While many supporters of the ACA expected most states to pursue local control over ACA implementation, it has not worked out that way for a variety of reasons, ranging from political opposition to the ACA to competing priorities to dissatisfaction with Healthcare.gov.

> Establishing an SBM should not be pursued without a strong vision of what the state hopes to achieve.

Improvements in technology sharing between FFM and SBM states may give current FFM states more reasons to stay with Healthcare.gov. Indeed, if the Biden Administration pursues a healthcare agenda that aims to bolster the provisions of Healthcare.gov, it's possible such a change could even reverse the current migration away from Healthcare.gov and potentially entice some current SBM states to settle in the middle as SBM-FPs, combining local control over many issues with reliance on a technologically strong federal platform.

Unless the ACA is amended or supplanted, however, states will retain the choice to transition to full SBM status with their own state-based technology platform that maximizes local control within the parameters of the ACA as defined by federal statute and regulation. In this section, we highlight the key areas in which SBMs have advantages over Healthcare.gov, describe other reasons why states may want to chart their own path with an SBM, and detail the transition process from FFM to SBM-FP or SBM status.[27]

A. Health Policy Rationales for Becoming an SBM

The collective SBM experience suggests that current FFM states may benefit from becoming SBMs if they want to invest in specific goals tailored to state circumstances in three areas:

Targeted Enrollment Efforts. The current SBMs have advantages with SBM budgets that are state-managed and can be micro-targeted by local leaders who know their communities' unique dynamics and can use real-time data to continuously refresh their outreach efforts. In theory, this could be accomplished by a state–federal partnership with daily data feeds from Healthcare.gov, but the current group of SBM-FP states believe they can still do better in targeted enrollment through the capabilities afforded by an SBM.

SBMs also have more flexibility to extend the annual OEP and add targeted SEPs. For example, 12 of the 13 SBMs held pandemic-related SEPs for the uninsured population, while Healthcare.gov did not. Though recent CMS data revealed that approximately 892,000 individuals did use an existing SEP to gain coverage in 2020,[ii] the FFM's outreach during the pandemic was limited. While SBMs have control over their own outreach efforts and call centers as well as manage their own E&E platforms, FFM states were highly limited in their options to pursue outreach and enrollment during the pandemic without better support from Healthcare.gov.

> FFM states have had more limited options to pursue outreach and enrollment during the pandemic.

Medicaid Integration and Multi-Agency Coordination. Though Healthcare.gov has improved its E&E services for a more streamlined coordination with state Medicaid agencies, SBM states have home-field advantages in being able to build fully integrated E&E systems between two state agencies (e.g., an SBM and the Medicaid agency), which can be housed in the same cabinet level if the state chooses that option. More importantly, states with the requisite commitment to a seamless E&E service should be able to achieve a more integrated approach than a state–federal operation could, including the potential to extend that integrated approach to other social service agencies.

The current recession provides a key example of the importance of a state's ability to coordinate across state agencies. With recent surges in unemployment, making it easy for consumers to apply for ACA coverage at the same time they apply for unemployment benefits would likely boost enrollment among a group that may not otherwise find its way to the Marketplace website. States have provided referrals between the two programs, but no state has yet incorporated the two eligibility systems into a single workflow.

> Making it easy for consumers to apply for ACA coverage at the same time they apply for unemployment benefits would likely boost enrollment.

Establishing an SBM is also found to have positive economic impacts across the health insurance ecosystem. A study by The Commonwealth Fund[28] found that SBM states offer lower premiums to consumers, which may be attributable to the closer relationships SBMs have with their stakeholders compared with the federal Marketplace; many of our interviewees also emphasized the benefits of being "closer" to local organizations

[ii] Over half of these new enrollees (487,000) were eligible for an SEP because they lost minimum essential coverage.

and agencies. As one state Marketplace director said about the SBM transition, "The plan community is incredibly supportive; getting this done was a combination of having everything that comes with a state Exchange, and the affordability of bringing down premiums in the individual market—that's exciting to plans."

Policy Flexibility. The Center for Consumer Information and Insurance Oversight (CCIIO) already offers more complex and nuanced partnership options than most people realize,[29] but there are limits to how flexible Healthcare.gov can be. States that want to stretch the boundaries of Section 1332 waivers and other forms of state innovation will be better off with an SBM. As one SBM director stated, "Policy people who want to change the world are going to see if they can use the Exchange to test their ideas."

In general, many Marketplace leaders expressed that having an SBM empowers a state to be more responsive and provides a vehicle for testing new ideas. For example, states that are interested in offering state-specific subsidies, modifying their tax structure or offering public options are better positioned to do so with the flexibilities afforded by the local infrastructure and space for innovation provided by an SBM. The two states that have made the most progress toward implementing a public option—Washington and Colorado—are SBMs. While being an SBM is not required in order to implement a public option and other SBM-FP states, such as Oregon, have expressed interest in a public option, more control over the Marketplace gives the state increased flexibility in the program design.

Having an SBM empowers a state to be more responsive and provides a vehicle for testing new ideas.

More specifically, the state also can dictate how the plan is branded in the technology platform, design outreach efforts, waive certain ACA design elements, mandate new benefit designs and institute new enrollment pathways (e.g., potential automatic re-enrollment for the churn populations, or SEPs), and will have access to detailed consumer data to help the state target the program. Additionally, state-based user fees can provide additional financial support for agency staff overseeing a public option. If a state would like to include additional state subsidies to improve the affordability of a public option, that is also better facilitated in an SBM. Further, states interested in a Medicaid buy-in-style state-sponsored insurance product may offer the plan on an SBM to facilitate better enrollment, even if the design does not meet Qualified Health Plan (QHP) requirements.

Consideration for States: All states should consider their opportunities to better align their Marketplace with Medicaid and other state programs. While integration opportunities are generally better for SBMs, there also are opportunities for FFM states to use federal EDE partners to incorporate ACA enrollment into the workflow of other state agency application processes, such as allowing applicants for unemployment benefits to enroll in ACA coverage as part of one seamless application process.

B. Other Considerations for Becoming an SBM

The ACA continues to be politically controversial and therefore is, from a state perspective, more volatile than a typical federal program when there is a change of administration. It is possible, for instance, that at least some of the recent SBM transitions may not have occurred if the Trump Administration had not been as adversarial toward the ACA. Indeed, it is noteworthy that under a Republican Administration, the four transitions from FFM to SBM status were proposed and implemented by Democratic governors. Similarly, it would not be surprising to see Republican governors show more interest in SBM transitions under a Biden Administration, though many Republican-led states may remain too adversarial to the ACA to consider an SBM. The long-term stability of the ACA depends on a gradual lessening of partisanship, but it will take time, and pursuing an SBM may provide an opportunity to ensure stability of the Marketplace at the state level in the midst of changing administrations.

> Pursuing an SBM may provide an opportunity to enhance stability at the state level in the midst of changing federal policies.

Cost Considerations. Another consideration is the relative cost of using Healthcare.gov compared with the cost of using a state-based technology platform, as changes to federal user fees will affect how economical it is for states to make the transition. Given the current federal user fee of 3.0% of premiums, states with more than 200,000 Marketplace enrollees, such as New Jersey and Pennsylvania, can reap substantial savings by transitioning to an SBM. Conversely, states with fewer than 100,000 enrollees still have an opportunity to save money through an SBM but will have to be very frugal in their operations, as Nevada was, to achieve savings.

The 2019 reduction in Healthcare.gov user fees from 3.5% to 3.0% made the calculus for pursuing an SBM transition harder for many states, given the slimmer margin for savings between establishing an SBM versus continuing to use the federal platform. However, it will still take a larger revamping of user fees to significantly dampen the financial incentive for larger states to transition to an SBM. A critical caveat to the financial incentive is that transitioning to an SBM represents a substantial investment of political capital and, even with an opportunity to generate savings, does not make sense if the state does not have commensurate healthcare reform goals. States may also want to wait until the financial ramifications of the current economic recession on state budgets are resolved before assessing their longer-term interests.

Alternatively, the calculus is different for states considering a transition from FFM status to SBM-FP status, where the state is able to pay a lower federal user fee than full FFM states pay.[iii] Even though this move still requires the establishment of an SBM with a state-based governance structure, the state can limit its investment in the SBM to consumer outreach and insurer oversight (i.e., plan management), areas where most FFM states have already made substantial commitments, including handling the rate review process.

[iii] SBM-FP states are able to retain 0.5% of the 3.0% federal user fee for Healthcare.gov in 2020.

C. SBM-FP Path

The original SBMs of 2014 did not have the option of relying on the federal platform while preserving an SBM governance structure, as SBM-FPs can do today; that status was "invented" when three of the original SBMs (Nevada, New Mexico and Oregon) suffered severe enough technology failures that they were forced to fall back on Healthcare.gov.[iv] Today, however, any state can transition from FFM to SBM-FP status by establishing an SBM by statute or executive order, creating an SBM governance structure, and demonstrating through a blueprint filing that the SBM has the requisite financial and operational wherewithal to implement the consumer assistance and plan management functions of an SBM. States that want to proceed incrementally can become an SBM-FP and gain an increased level of local control over consumer outreach and plan management, while also paying less in federal user fees under current rules.[v]

States that want to proceed incrementally can first become an SBM on the federal platform.

Each of the four states that have recently transitioned from FFM to SBM status has taken this approach. Two of those states—Pennsylvania and New Jersey—became SBM-FPs for 2020 and full SBMs for 2021. Virginia became an SBM-FP for 2021 and currently plans to become a full SBM for 2023. Maine is unique in that while the state also decided to become an SBM-FP for 2021, it plans to remain in that status unless and until state officials determine that becoming a full SBM is advantageous and cost-effective in light of state goals. Thus, becoming an SBM-FP could be an ideal approach for other states, regardless of whether they decide to take the next step and become full SBMs.

Consideration for States: The 30 remaining FFM states should reconsider the decision to remain an FFM to the extent they have healthcare reform goals that would benefit from more state flexibility. If so, establishing an SBM-FP creates a state entity with accountability to relevant stakeholders that can serve as a forum for debating future state reform proposals. FFM states, particularly smaller ones, should consider becoming an SBM-FP even if they remain uncertain about becoming a full SBM. States that pursue SBM-FP status will find a continuum of options enabled by the transition, from an incremental expansion of local control over consumer assistance and insurer oversight as an SBM-FP to broader control by transitioning at a future time to a full SBM. While cost savings may be an important consideration, states should consider that the economics could change and that full SBM status requires a high level of state engagement.

[iv] Hawaii is the only state to fully abolish its original SBM and revert to FFM status.

[v] User fees for FFM states are collected from insurers and were originally set at 3.5% of premium for 2014 and then reduced to 3.0% for PY 2020. SBMs collect their own user fees, which vary by state, and do not pay any federal user fees for accessing the federal data hub. The first wave of SBM-FPs, which transitioned from SBM status, continued collecting their own user fees and did not have to pay any federal user fees. In recent years, however, SBM-FPs have been assessed federal user fees that have gradually ramped up to 2.5%. The newest SBM-FPs, which have transitioned from FFM status, typically collect the same 3.0% user fees from insurers, pay 2.5% to the federal government, and use the 0.5% difference to fund consumer outreach and other activities. SBMs can have higher user fees than the FFM. For example, New Jersey started its SBM with a 3.5% user fee and has statutory authority to raise it to 4.0%.

D. Full SBM Path

From a technology perspective, the transition to full SBM status is easier than it was in the pre-2014 period, though the process remains an arduous one that can take 18–24 months from legislative authorization to full operational status. The advantages of transitioning today include second-generation technology options that do not require states to build their own technology platforms from scratch. Instead, states have the option to contract with vendors offering "off the shelf" technology platforms that have proven successful in first-generation SBM states. States that have contracted with second-generation vendors have been able to customize their platforms as desired and amortize the costs over long-term contracts. These contracts have resulted in significant cost savings to date, though the relative costs of the FFM track versus the SBM track could change depending on what happens with federal user fees, which have been slightly reduced in recent years and are subject to further changes.[vi] States may also want to wait until the financial ramifications of the current economic recession on state budgets are resolved before assessing their longer-term interests.

Relative costs of the FFM versus an SBM could change depending on what happens with federal user fees.

Consideration for States: The six SBM-FP states, most of which view their SBM-FP status as a way station on the road to full SBM status, should watch how the FFM develops and carefully consider the pros and cons of SBM status versus SBM-FP status. The 15 SBMs show no signs of rethinking their status regardless of how much the FFM improves. There are, however, lessons to be learned by all states from the FFM about technological upgrades. SBM states should continue to watch the FFM closely and be ready to embrace any helpful FFM innovations.

[vi] As this policy brief was about to be published, the Trump Administration proposed to reduce user fees and create a new "direct enrollment" option for states in the proposed NBPP for 2021. While these proposals may or may not be finalized, they illustrate the continued volatility of ACA Marketplace policies.

Appendices

Appendix A. Recommendations and Considerations

Recommendations for the Biden Administration

1. **Consumer Decision-making Tools.** Invest the resources necessary to continually improve Healthcare.gov as a world-class consumer-facing website, including a systematic effort to identify and share the most promising innovations of the State-Based Marketplaces (SBMs) and commercial websites. CMS should support a shared services model that makes new innovations readily available to the SBMs, especially those with more limited resources.
2. **Targeted Enrollment Strategies.** Support Federally Facilitated Marketplaces (FFMs) and State-Based Marketplaces on the Federal Platform (SBM-FPs) by offering comprehensive data-sharing agreements to any state interested in using consumer data to target consumer outreach and build enrollment. This would encourage more state involvement in building enrollment without having to establish an SBM, though the federal government may want states to show a requisite level of state commitment by establishing an SBM-FP.
3. **Coordination Across Medicaid and Other State Agencies.** Facilitate state efforts to improve Marketplace–Medicaid integration, as well as coordination across other state agencies, including unemployment offices. As the FFM improves, more FFM states may choose to become Medicaid determination states and may also consider whether enhanced direct enrollment (EDE) can be leveraged to improve interagency coordination by, for example, incorporating ACA enrollment into a common process flow when applying for other state benefits.
4. **Direct Enrollment Partnerships.** Make it easier for SBMs to diversify their outreach strategies by sharing federal EDE technologies with states. This would allow SBM take-up of an enrollment strategy that has proven successful for the FFM, while still allowing SBM states to make their own decisions about partnering with some or all federally certified EDE entities under federal standards and/or stricter state standards.
5. **National Eligibility Service.** Establish a national eligibility service that is stringently regulated by the federal government for Marketplace premium tax credits (PTCs), with a hand-off to either Healthcare.gov or an SBM for enrollment. This would simplify the job of the Marketplaces and may encourage states to become Medicaid determination states, though states have differing incentives with Medicaid where they share the cost with the federal government as opposed to the federal government bearing the full cost of PTCs.
6. **Public Policy Innovation.** Revisit the question of how much policy flexibility is feasible for FFM and SBM-FP states by engaging with the states to determine what, if any, new policy innovations are both feasible and desirable; then be as clear as possible about what additional flexibility is available to SBMs under Section 1332 or other innovation authorities. This would give all states a more predictable landscape for evaluating their public policy options.

Considerations for States Examining Their Marketplace Options

1. **Marketplace Integration With Medicaid and Other State Programs.** All states should consider their opportunities to better align their Marketplace with Medicaid and other state programs. While integration opportunities are generally better for SBMs, there also are opportunities for FFM states to use federal EDE and other technologies to incorporate ACA enrollment into the workflow of other state agency application processes.
2. **FFM and SBM-FP States.** The 30 remaining FFM states should reconsider the decision to remain an FFM to the extent they have healthcare reform goals that would benefit from more state flexibility. If so, establishing an SBM-FP creates a state entity with accountability to relevant stakeholders that can serve as a forum for debating future state reform proposals. FFM states, particularly smaller ones, should consider becoming an SBM-FP even if they remain uncertain about becoming a full SBM. States that pursue SBM-FP status will find a continuum of options enabled by the transition, from an incremental expansion of local control over consumer assistance and insurer oversight as an SBM-FP to broader control by transitioning at a future time to a full SBM. While cost savings may be an important consideration, states should consider that the economics could change and that full SBM status requires a high level of state engagement.
3. **Becoming an SBM.** The six SBM-FP states, most of which view their SBM-FP status as a way station on the road to full SBM status, should watch how the FFM develops and carefully consider the pros and cons of SBM status versus SBM-FP status. The 15 SBMs show no signs of rethinking their status regardless of how much the FFM improves. There are, however, lessons to be learned by all states from the FFM about technological upgrades. SBM states should continue to watch the FFM closely and be ready to embrace any helpful FFM innovations.

Appendix B. Interviewee Names and Affiliations

Interviews		
Name	**Title**	**Interview Date**
Heather Korbulic	Executive Director of the Silver State Health Insurance Exchange (Nevada State Exchange)	January 24, 2020
George Kalogeropoulos	CEO of HealthSherpa	February 3, 2020
Chini Krishnan	Co-founder and CEO of GetInsured	February 4, 2020
Noah Lang	CEO and Co-founder of Stride Health	February 25, 2020
Zach Sherman	Executive Director of Pennsylvania Health Insurance Exchange Authority	February 26, 2020
Sarah Lueck Tara Straw	Center for Budget and Policy Priorities	March 10, 2020
Jeff Bustamante	CEO of New Mexico Health Insurance Exchange	March 11, 2020
Rob Shriver	VP of Business Development for Idea Crew	March 13, 2020
Nick Tant	Vice President of GuideWell's Individual and Small Group Market Segment	March 18, 2020

Appendix C. History of the SBMs

State	Operated as a State-based Marketplace (SBM)	SBM-Federal Platform Years in which the SBM relied on the federal platform	Federally Facilitated Marketplace
Massachusetts[1]	2014–present		
California[2]	2014–present		
Colorado	2014–present		
Connecticut	2014–present		
District of Columbia[3]	2014–present		
Hawaii[4]	2014–2015		2016–present
Idaho[5]	2014–present	2014	
Kentucky[6]	2014–present	2017–present	
Maryland	2014–present		
Minnesota	2014–present		
Nevada[7]	2014–present	2015–2019	
New Mexico[8]	2014–present	2014–present	
New York	2014–present		
Oregon	2014–present	2015–present	
Rhode Island	2014–present		
Vermont	2014–present		
Washington	2014–present		
Arkansas[9]	2017–present (SHOP only)	2017–present (SHOP only)	2014–2016
Pennsylvania[10]	2020–present	2020	2014–2019
New Jersey[11]	2020–present	2020	2014–2019
Virginia[12]	2021	2021	2014–2020
Maine[13]	2021	2021	2014–2020
21 Total SBM States in 2021	**15 Full SBM States in 2021**	**6 SBM-FP States in 2021**	—

Appendix C Notes

1. Massachusetts established the Commonwealth Health Insurance Connector Authority (The Connector) as part of a comprehensive healthcare reform package that was passed in 2006 under Governor Mitt Romney and later became the model for the ACA Marketplaces.
2. California was the first state to establish an SBM under the ACA in September 2010 and has been a leading advocate for an "active purchaser" Marketplace.
3. The District of Columbia established an SBM for 2014 and then became the first jurisdiction to replace its first-generation legacy system with a second-generation system in 2015.

4. Hawaii is the only state that launched an SBM in 2014 and subsequently abolished its SBM to become an FFM state. The transition back to FFM status was done in 2016, primarily due to massive technology challenges.
5. The Idaho Legislature authorized an SBM in 2013, but the state did not establish its own technology platform until 2015, given the short time frame between establishing an SBM and the first OEP in November 2013.
6. Kentucky established an SBM for 2014 and used its own technology platform for 2014–2016. In 2016, newly elected Governor Matt Bevin vowed to dismantle the SBM in favor of the FFM, but later decided to revert the state to SBM-FP status for 2017 instead. In June 2020, Governor Andy Beshear notified CMS of the state's intent to transition back to a full SBM by 2022.
7. Nevada established an SBM for 2014 but defaulted back to the federal platform when its own technology platform failed. In February 2018, the Nevada Legislature provided funding to restore the state's own technology platform. Nevada was the first second-generation SBM to convert from an SBM-FP to a full SBM for 2020.
8. New Mexico established an SBM for 2014 but never secured CMS approval for its own technology platform. New Mexico remained an SBM-FP and plans to transition to its own technology platform for 2023.
9. Arkansas established an SBM-FP for Small Business Health Options Program (SHOP) purposes only in 2017 and remains an FFM state for individual market purposes.
10. Pennsylvania transitioned from FFM status to an SBM-FP for 2020 and to a full SBM for 2021.
11. New Jersey transitioned from FFM status to an SBM-FP for 2020 and to a full SBM for 2021.
12. Virginia transitioned from FFM status to an SBM-FP for 2021 and plans to become a full SBM for 2023.
13. Maine transitioned from FFM status to an SBM-FP for 2021 and may become a full SBM in the future if that proves feasible and cost-effective.

Appendix D. SBM Case Studies

Material in Appendix D draws on interviews conducted with SBM leaders, technology vendors, consumer advocates and additional research to provide more detailed information about the policy innovations that SBMs have undertaken.

1. Marketing and Outreach Strategies

Since 2016, the federal government has cut the ACA consumer assistance budget for enrollment by almost 90% and has terminated federal CSR reimbursements for Marketplace enrollees, creating significant challenges for the Marketplaces in maintaining enrollees and ensuring a smooth enrollment process.[30] SBMs have been better able to navigate these changes by bolstering and tailoring their marketing efforts through state-level initiatives to support continued and steady enrollment within their Marketplaces.

California. California's SBM (Covered California) has consistently recognized the need for extensive marketing and outreach campaigns to ensure maximum coverage and enrollment. With a $440 million total operating budget for 2020, Covered California dedicates $157 million to the state's annual marketing and outreach efforts (an increase of $30 million for marketing and outreach from previous years). The state's strategy has proven highly effective: Covered California has achieved a take-up rate among those who are subsidy eligible nearly 25% higher than the average for FFM states,[31] and it has achieved a healthier risk pool in its mix of enrollees, which has had a positive impact on premiums.

New York. In 2019, New York's SBM (New York State of Health) focused its advertising and outreach efforts on educating consumers, renewing existing enrollees, reaching new consumers and dispelling consumer confusion around the changes encircling the ACA. By the end of 2019's OEP, New York State of Health enrolled over 4.7 million New Yorkers in health coverage across Marketplace programs and increased enrollment in QHPs and Essential Plans by 7% compared with 2018; notably, all 62 counties demonstrated enrollment increases during the 2019 OEP.

The state surveyed consumer segments to develop its marketing strategy and found that most respondents trusted the New York State of Health website for healthcare information more than any other source, and 90% of current enrollees who were surveyed wanted to renew their Marketplace coverage. And while 60% of the uninsured who were surveyed noted they desired insurance, cost was top of mind, making information about financial assistance and enrollment support important for this population. New York then developed a message that focused on "affordability" of coverage and "ease of use" as critical components of the state Marketplace's campaign.

Through the 2019 OEP, New York State of Health sponsored over 300 events across the entire state, with a heavy focus on the Bronx and Queens, regions with particularly high uninsured rates. New York State of Health also emphasized the need to reach non-English-speaking communities, partnering with community organizations and coalitions representing populations of various ethnic background as well as offering free promotional materials in 27 languages for public use. Nearly 2.7 million educational items were distributed during the OEP in 2019, in addition to over 70,000 items in Spanish and 8,500 in Chinese. Four million personalized emails were also distributed by the Marketplace to provide information and reminders on enrollment and renewals.

2. Targeted Enrollment Efforts

California. Nearly 40% of Covered California's enrollees leave the Marketplace each year as part of the standard insurance churn in the individual market. Marketing and outreach, paired with effective data and information-sharing, are critical components of Covered California's strategy to maintain enrollment and continue new enrollments for those who lose employer-based insurance, parental coverage or coverage from public programs. The state has found that customers who leave the FFM are more than three times as likely to become uninsured as those leaving Covered California. Customers that leave Covered California often move on to another form of insurance coverage, such as employer-based coverage or aging into Medicare—only 16% of customers who leave Covered California become uninsured.

New Mexico. New Mexico's SBM (beWellnm) has a unique population in that New Mexico sees more SEP enrollments than does any other state; as a result, the state requires a more consistent flow of data than the FFM currently provides in order to track members who are moving in and out of coverage throughout the year. In addition, New Mexico's Native American population is a historically challenging group to reach in terms of enrollment; it's hoped that the improved data quality achieved through beWellnm will enable the state to strategize how to better reach those individuals and improve awareness of valuable cost-sharing reductions to facilitate greater rates of enrollment among targeted populations.

Pennsylvania. Pennsylvania's SBM (Pennie) similarly emphasized the value of high-quality data and the importance of being able to draw insights from shared data, given the regional differences within its own state. In the past year, the state was able to identify where a majority of its uninsured population resided regionally and found that a majority of those individuals were eligible for subsidies through Pennie. The ability to understand the unique characteristics of the uninsured population will allow Pennie to focus its efforts on ensuring that those particular individuals are aware of and have access to coverage. The ability for any Marketplace to derive and provide high-quality and timely data can empower Marketplaces to tailor their operations and enrollment efforts to these unique dynamics in a way that ensures strong enrollment and maintenance of coverage.

3. Working With Agents, Brokers and Other State Agencies

California. While 40% of all enrollment in Covered California is from consumers who enroll directly through the CoveredCA.com website, most customers expressed a desire for personal assistance with enrolling in healthcare coverage. Covered California's biggest single channel for enrollment is through Certified Insurance Agents (including licensed professionals and web-based entities) who are paid on commission by health plans, and 47% of Covered California's total consumers are enrolled through this channel. Comparatively, in 2017, Covered California's Service Center enrolled 9% of total consumers and Navigators generated 3% of enrollment. Covered California emphasizes that achieving these high rates of enrollment in any channel depends on active partnership and collaboration with participating health plans and healthcare brokers and agents.

Nevada. Nevada's SBM (Silver State Exchange) found that relationships developed between the SBM and the state Medicaid agency early on were advantageous during the launch of its second-generation SBM. Nevada leveraged opportunities for closer alignment on account transfers with the Medicaid agency in the first year, which the FFM was historically unable to accommodate. Nevada received over 21,000 applications

directly from Medicaid during the 2020 OEP for individuals identified as being over the allotted income threshold in the state; the state's total enrollment was 77,000 people. Not only was the influx of applications an opportunity to increase enrollment during the OEP, but it was also an opportunity for the state to leverage the targeted outreach enabled by the SBM to facilitate that enrollment.

4. Public Policy Innovations

State Subsidies. Several SBMs have supplemented ACA subsidies with state-financed subsidies to make coverage more affordable.

- **New Jersey.** In 2021, New Jersey residents receiving federal subsidies through the new SBM can receive an additional premium subsidy. The subsidy will be a flat amount subject to certain caps and is funded by a new health insurer fee.
- **California.** In 2019, California implemented a new premium subsidy funded by a state mandate penalty and general fund dollars. The subsidy covers very-low-income Californians and those between 400% and 600% of FPL. It caps individual premium contributions on a sliding income scale.
- **Massachusetts.** Since 2007, Massachusetts has offered state-subsidized plans to residents under 300% FPL, with premiums and cost sharing set on a sliding scale based on income. These subsidies are funded through the state's Section 1115 Medicaid demonstration waiver.
- Other states that have enacted state subsidies include Vermont and Colorado.

Public Options. The only state to implement a public option to date is Washington, and the state relied on its SBM to launch Cascade Care for 2021. Cascade Care is a three-tiered program that includes a standardized plan, a public option and a state subsidy study. Under the public option, the state is contracting with insurers to provide state-sponsored standard plans with provider reimbursement caps. Five carriers are offering the public option in 19 of 39 counties for the first year. On average, the 2021 public option premiums are 4% higher than 2020 averages, likely due to offering higher-value standardized plans with lower out-of-pocket costs.

Other states that have proposed public options include two more SBM states: Colorado has proposed a public option through its SBM, and New Mexico considered but did not adopt an off-Marketplace Medicaid buy-in. Two more SBM states, Oregon and Nevada, are currently studying potential public options, with reports anticipated in December 2020.

Standardized Plans. Many of the SBMs have adopted some form of standardized plans both to simplify shopping and to promote value-based benefit designs.

- **New York.** New York requires health insurers to offer at least one standardized plan at each metal level on its SBM; insurers are also allowed to offer up to three nonstandardized plans.
- **California.** California allows only standardized plans to be sold on its SBM. Standardized plans exempt physician visits from the deductible, limit out-of-pocket costs for high-cost prescription drugs, minimize use of coinsurance, and have low copays for primary care visits and generic drugs.
- Other SBM states with standardized plans include Vermont, Connecticut and Massachusetts, as well as the District of Columbia.

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