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House Ways and Means Subcommittee on Health
Implementation of Health Insurance Exchanges and Related Provisions
Testimony of Heather Howard
September 12, 2012

Chairman Herger, Ranking Member Stark, Members of the Subcommittee, thank you for the opportunity to address you today on the implementation of health insurance exchanges. My name is Heather Howard and I am the director of the State Health Reform Assistance Network (State Network), a program of the Robert Wood Johnson Foundation that is helping states implement the coverage expansion provisions of the Affordable Care Act (ACA). The program is housed at Princeton University's Woodrow Wilson School of Public and International Affairs, where I am also a lecturer in public affairs teaching about – among other things – health policy and ACA implementation. Before coming to Princeton I was New Jersey's Commissioner of Health and Senior Services. My testimony today calls on my experience working with states on exchange implementation and my previous service as a state health official. My comments are my own and not on behalf of Princeton University or the Robert Wood Johnson Foundation.

Over the past 18 months the State Network has been working with a diverse group of states helping them implement all aspects of ACA's coverage expansion policies, from health insurance exchanges to insurance market reforms to the Medicaid expansion. Through our technical assistance to states, we have seen them work diligently to capitalize on the opportunities created by the ACA to reform their health systems in ways that meet each state's unique needs and interests. We are working with states as they navigate the many challenges that are part and parcel of any change on this scale that relies on a strong state/federal partnership for success. Indeed, the ACA presents an important test of the critical federal-state relationship: it contains a basic framework for reform with broad national standards and significant federal resources to support implementation, but preserves state-control over the details of design and implementation. Consequently, realizing the ACA's promise of expanding access to affordable health insurance coverage will largely depend on the success of state implementation efforts.

While hurdles remain to be overcome, many states are actively working and are on schedule to stand up exchanges that will provide a competitive marketplace for individuals and small businesses to shop for affordable coverage just over a year from now.

Consistent with the goal of this hearing, my testimony today will focus on what is happening on the ground in the states and the lessons we have gleaned from working with them. I will discuss the significant variation in state progress that is the natural result of the different political, demographic, and health care landscapes across the country (e.g. disparities in uninsured rates, insurance market concentration, provider structure, etc.). I will then focus on the progress of states that are actively working toward developing state-based exchanges. These and other states are working closely with federal officials on exchange development in a collaborative way that creates multiple paths for getting to 2014, taking advantage of the substantial flexibility the ACA affords. Finally I will discuss some of the substantive issues and challenges states are facing and how – despite those challenges – states are making considerable strides implementing ACA's health insurance exchanges.

The State of the States – Understanding the Variation in Exchange Implementation

I know from personal experience that a number of states are putting the building blocks in place to have exchanges ready for 2014. Other states are working diligently but may need to rely on the federal government to assume responsibility – at least temporarily – for key exchange functions. Still others have done little beyond basic research in preparing for an exchange in 2014. The primary factor contributing to this variation is the political climate in the states. Despite this variation, there is a clear path forward for all states resulting from the flexibility offered by HHS with three different exchange models: the state-based exchange (SBE); a partnership model; and a federally-facilitated exchange (FFE).

The ACA clearly envisioned that not all states would necessarily want or be able to create a state-based exchange. The federal government is creating an FFE option that is designed to provide consumers access to affordable insurance products in those states that choose not to set up their own exchanges. Most states that are likely to choose the FFE option will do so because of political reasons and underlying concerns about the ACA and its approach. Other considerations leading to an FFE decision might include existing state staff expertise and capacity, or market factors such as the size of the uninsured population eligible for exchange coverage (especially in smaller states). Regardless, these FFE states have similar opportunities as their partnership and SBE counterparts to work with the federal government on implementation. The FFE will need to talk to existing state Medicaid eligibility and enrollment systems, and states will continue their historic role of approving insurance products available for sale in the state. HHS has also offered federal funds through establishment grants to support necessary state work with the federal government on the establishment of an FFE.

The partnership model allows states to retain plan management and consumer assistance functions, two areas where states generally have strong existing programs and capacity. In 2014 many of the partnership states will be those that have been working diligently on exchange development but encountered some obstacles that have slowed the pace of exchange authorization and infrastructure development. The partnership model is being considered by many states as a bridge to an SBE by providing flexibility and allowing states to maintain control of functions traditionally within state regulatory purview.

Some may argue that the mere existence of FFE and the partnership model is evidence that states are either not capable of building exchanges or that they have received insufficient guidance from federal officials to be able to do so. Our experience with a number of states leading the way on exchange development belies that contention. Those states that are committed to reform are making significant strides in developing exchange infrastructure and implementing insurance market reforms. While states always want more guidance, they do not want it at the expense of flexibility. States that are moving forward are working diligently, in close collaboration with federal officials, to effectively operationalize the substantial guidance that has been released to date. It is these states, their approaches, collaboration with federal officials, engagement with stakeholders, and ongoing challenges that will be the focus of the remainder of this testimony.

States are Effectively Implementing Exchanges

Beginning in 2010 nearly all states began to look at their options for developing an exchange. Taking advantage of $1million federal planning grants, 49 states and the District of Columbia commissioned

reports, held public meetings, assessed existing programs, and studied existing markets in an effort to begin to gain an understanding of the impact of an exchange in their state. A number of states did little more beyond this initial step, but 35 states went on to receive exchange establishment grants to facilitate additional planning and implementation.[1] In all, more than $16 billion in federal funding has supported state exchange implementation efforts (see Figure 1 below).[2]

States that are farthest along in implementing exchanges have taken a range of approaches and utilized varying levels of internal and external resources. These states have chosen different paths, taking advantage of the flexibility afforded them in the ACA: some have established non-profit or quasi-governmental agencies to oversee their exchanges, while others have established their exchanges within an executive agency. They have not done it alone (the next section discusses more about collaboration with federal officials), but they have dedicated themselves to building internal and external coalitions necessary to make the exchange a reality, and through legislation or executive orders have established exchange infrastructure, governance, and guiding program principles. This has allowed leading states to hire staff, make policy decisions, develop business and operational plans and processes, and contract with vendors (especially around information technology (IT) systems development), all the while continuing the stakeholder engagement that is key to making sure exchanges best meet the needs of consumers while recognizing the vital role of carriers, providers, and others in this new system of obtaining coverage.

Successful states have also relied on strong interagency implementation processes to achieve quick progress on complicated issues that impact multiple agencies[3]. Techniques for effective interagency collaboration range from regular meetings and clear delineation of roles and responsibilities to high tech document and project management software. As part of the exchange development process required by the establishment grants, states are developing formal memorandums of understanding between agencies to ensure that key exchange functions do not fall through the cracks. Appendix A at the end of this testimony provides a list of how states participating in our State Network program have attacked this issue.

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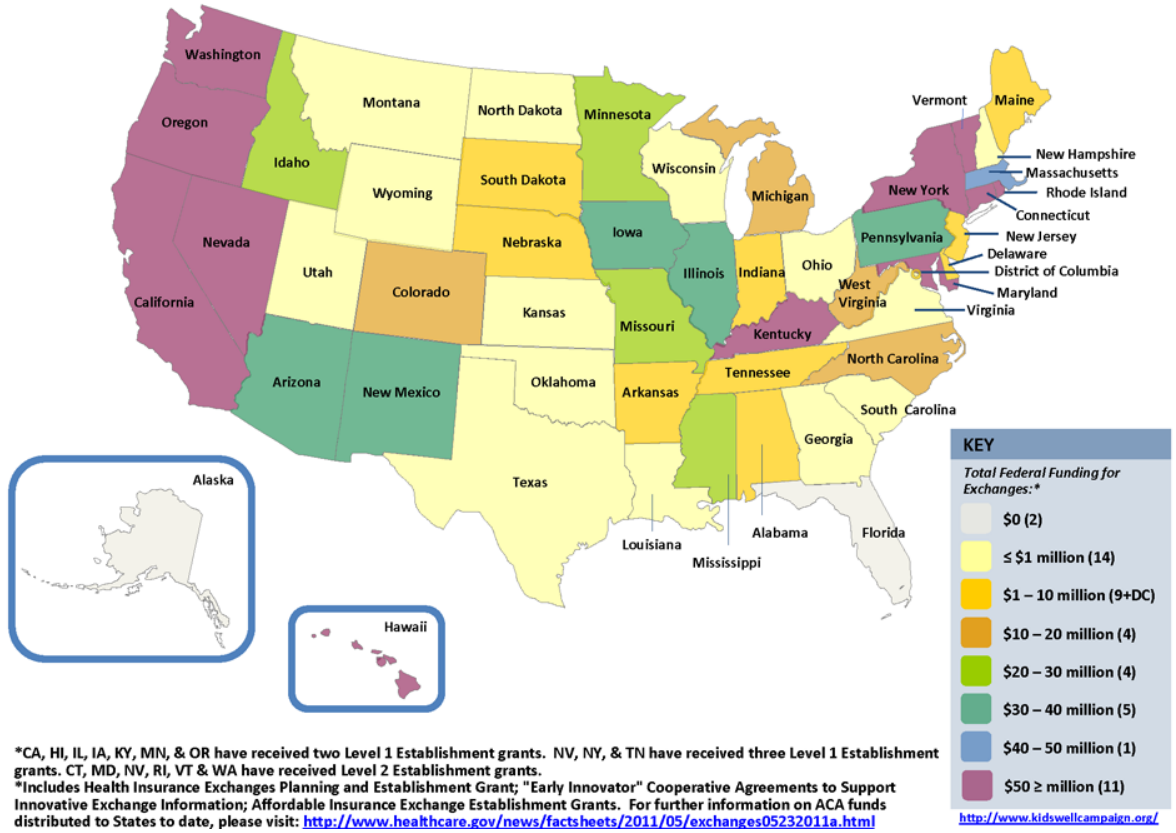
[1] ***Creating a New Competitive Marketplace: Affordable Insurance Exchanges,*** Healthare.gov – U.S. Department of Health and Human services, available at http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html.

[2] ***ACA Federal Funds Tracker,*** Kaiser Family Foundation Health Reform Source, Available at http://healthreform.kff.org/federal-funds-tracker.aspx.

[3] ***Managing State-Level ACA Implementation Through Interagency Collaboration***, Shelly Ten Napel, MSW, MPP, Kyla Hoskins, MPH, Enrique MartinezVidal, M.P.A. and Heather Howard, J.D., July 2012, available at http://www.statenetwork.org/resource/managing-state-level-aca-implementation-through-interagency-collaboration/

Figure 1



Source: Kidswellcampaign.org

Examples of how states are making progress on different aspects of exchange implementation are too numerous to list here. There are, however, some obvious and some less well known state activities that are illustrative of the type and scope of projects states are undertaking that are critical in setting up their exchanges. In each example, states are working to take advantage of opportunities in the ACA to customize implementation to meet their state's needs.

- **IT Systems:** Much of the funding from establishment grants is being used by states to support the development of exchange IT systems designed to create a Travelocity-like web enrollment experience for consumers. States are hiring software vendors and systems integrators to connect existing state systems and new exchange systems. HHS is actively working with a group of states that received early innovator grants to share IT lessons and system elements, and that sharing has carried over into peer-to-peer collaboration as well. For example, Minnesota and Maryland have been coordinating to leverage the work being done for each state by their IT vendor. If one state is prepared to move forward on developing an element of exchange infrastructure, the other can take advantage of the IT solutions that were developed, enabling them to learn from one another and prevent duplication of resources.

- **Stakeholder Engagement:** States are engaging their citizens, small businesses, insurance carriers, brokers and agents, and consumer groups throughout the exchange implementation process by conducting substantial stakeholder meetings and outreach campaigns. Indeed, stakeholder support is critical for successful implementation, and academics have argued that this support remains strong across the country[4]. In order to promote an open process and foster public engagement (and consistent with establishment grant requirements), all advisory group meetings, committee and sub-committee meetings, and meeting materials can be easily found on each state's health reform website. In many cases these efforts are breaking down long standing barriers between state agencies and stakeholder groups. Examples of state advisory committees and related stakeholder engagement efforts include:
    - Colorado convenes multiple public meetings each week between its advisory groups, exchange board and sub-committees of the exchange board. The meetings regularly attract 20-70 members of the general public.[5]
    - Maryland has five exchange advisory committees covering general exchange implementation, continuity of care, financing, navigators, and plan management. Each committee reviews specific policy issues gathering stakeholder insights to help the exchange board and staff make final implementation decisions.[6]
    - The executive order creating the New York Exchange created regional advisory committees, each with a broad array of stakeholders charged with advising and making recommendations on the establishment and operation of the exchange, with a special focus on recommendations regarding relevant regional factors.[7]
    - Oregon's Exchange enabling legislation directed the exchange's governing body to recruit a diverse, 21-member, Individual and Employer Consumer Advisory Committee to provide feedback to staff and the board on various issues. This Committee represents the state's geographic, cultural, individual, consumer advocate, and business interests. Regular meetings have also been established with consumer groups representing both mainstream advocacy groups and community organizations representing communities of color and immigrant populations.[8]

- **Quality Improvement and Cost Control Systems:** Rhode Island is one of several states that have used ACA to improve their health data infrastructure – which will be critical for helping them understand and manage health care cost and quality across their entire public and private health system. Specifically, Rhode Island is developing an All-Payer Claims Database (APCD) which will be used by state officials, researchers, plans, providers and others to monitor the performance of Rhode Island's health care delivery system, map the causes of health care cost

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[4] Joel Ario and Lawrence R. Jacobs, "In The Wake Of The Supreme Court Decision, Many Stakeholders Still Support The Affordable Care Act," *Health Affairs*, 31, no.8 (2012):1855-1865.
[5] ***Events Archive***, Colorado Health Benefit Exchange, available at http://www.getcoveredco.org/News-Events/Events-Archive.
[6] ***Maryland Health Benefit Exchange Committees***, Maryland Department of Health and Mental Hygiene, available at http://dhmh.maryland.gov/exchange/SitePages/Committees.aspx.
[7] ***Governor Cuomo Issues Executive Order Establishing Statewide Health Exchange***, Office of New York Governor Andrew M. Cuomo, April 12, 2012, available at http://www.governor.ny.gov/press/04122012-EO-42.
[8] ***Consumer Advisory Committee***, Oregon Health Insurance Exchange, available at https://orhix.org/cac.html.

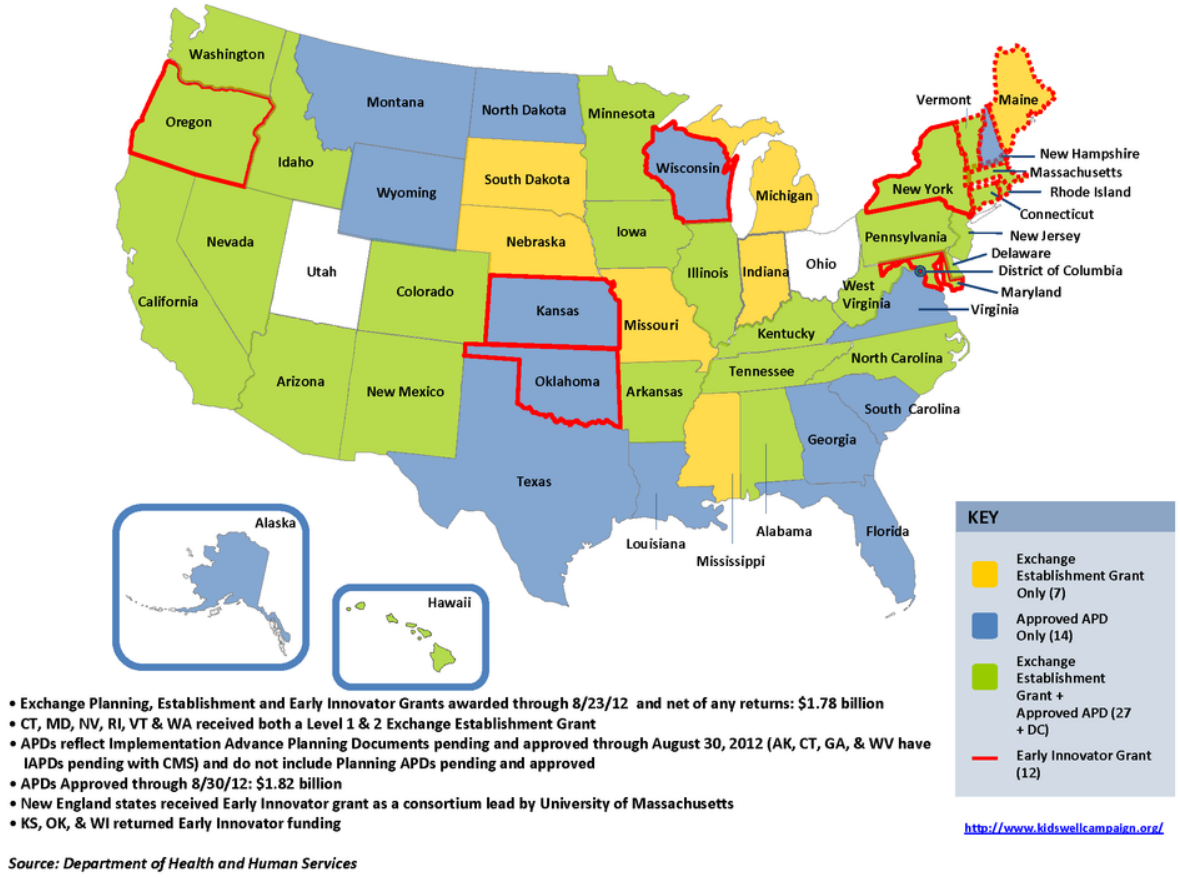
trends, and to assess the impact of delivery system reforms, such as Patient-Centered Medical Home and the Beacon Community Program.

- **Improving Existing Eligibility Systems:** Exchange implementation has opened new doors for states to improve existing systems as well. More than 40 states have received HHS approval of advanced planning documents (APDs), which allow states to upgrade their Medicaid eligibility systems with the help of 90/10 federal match (see Figure 2 below).[9] In addition to providing the impetus to upgrade decades old legacy Medicaid systems for the 21st century, the funding also requires building capacity for interoperability with exchanges to ensure seamless, streamlined, single point of entry eligibility for all who access the exchange, regardless of the program for which they are eventually determined eligible.

- **Thinking beyond Coverage to Health System Transformation:** There are many other aspects of the ACA that states are excited about pursuing, not the least of which are designed to test delivery system reforms that can reduce costs while increasing quality. Accountable Care Organizations, new health insurance co-ops that will be available on the exchanges, and the State Innovation Model multi-payer reform planning and testing grants are just a few of the delivery system improvements that states are excited about and actively pursuing. Oregon recently reformed its Medicaid delivery system through the creation of Coordinated Care Organizations, which may eventually pave the way for a whole new way of delivering care in the state across payers. The availability of State Innovation Waivers (ACA Section 1332) beginning in 2017 also provide a vehicle for states to build on these delivery system reforms and apply identified high quality and low cost solutions to ACA coverage expansion populations more broadly.

[9] ***Exchanges and Upgrading Medicaid Eligibility Systems***, Kidswell, National Snapshots, available at http://www.kidswellcampaign.org/National-Snapshots.

Figure 2



Source: Kidswellcampaign.org

This progress in implementing exchanges has all happened at a time when states are facing substantial fiscal challenges. Only now in fiscal year 2013 are total state revenues reaching pre-recession 2008 levels, and in 23 states revenues still have not returned to those levels.[10] States face hiring freezes, early retirements and furloughs, and program budgets have decreased substantially, all during a time when demand for state-funded services is at an all-time high. The fact that states have been able to weather the fiscal storm, do more with less in managing existing programs, and take on new duties in setting up exchanges is a remarkable feat. As previously mentioned, they have not done it alone. Constant collaboration with in-state stakeholders and with federal officials has been a key to state success in tight budgetary times.

Flexibility and Collaboration between Federal and State Officials

In my experience, the relationship between federal officials and the states has been characterized by flexibility, responsiveness, and collaboration. That, of course, was the vision conceived in the ACA, and it is proving to work that way. This is appropriate given that the task of ACA implementation requires complex and innovative thinking. I have watched federal officials seek out conversations with states in which they are truly interested in the ideas coming from the state level. Rather than setting an exacting set

[10] ***Fiscal Survey of the States Spring 2012***, National Association of State Budget Officers, available at http://www.nasbo.org/publications-data/fiscal-survey-states/fiscal-survey-states-spring-2012.

of standards with which states must comply, federal officials are asking states for their best ideas and working with states to help them achieve their goals within the context of the law.

The options for the federal government's role could be seen along a continuum. On one end, federal officials could provide meticulous, exacting standards, providing states very clear direction. At the other end of the continuum, states could be invited into a collaborative process that encourages them to innovate. Certainly, this is a balancing act. Some standards and guidance must be provided, though my observation is that federal officials (inclusive of HHS, Labor, and Treasury) have come down on the side of flexibility and innovation. I think this is appropriate given the enormity of the task at hand, as well as the variations across the states.

Federal officials have used various tools and techniques to work with states, share information, and educate states about various policy options and flexibilities. For example, I have had the fortune to attend a number of meetings CCIIO has held for the states. The states we work with have found these meetings to be extremely valuable. At the most recent national meeting last May, I participated in a panel with two of our states, facilitating a conversation amongst a number of states about their unique successes and challenges. I have found that this type of in-person, peer-to-peer interaction is one of the most efficient ways for states to learn from each other, discuss best practices, and share functional elements that improve exchange development across states. It is also an opportunity to discuss obstacles and forecast problems early in the process. In addition to the large national meetings, CCIIO has hosted regional convenings and nearly weekly conference calls with states, which provide additional opportunities for collaboration between federal officials and states on exchange implementation.

Group-based assistance is extremely important for explaining guidance and level-setting around establishment grant and general exchange requirements, but the complexity of implementation also requires one-on-one support. We have found in our program that the rubber meets the road in moving from a high-level understanding of what an exchange must do to the more granular tasks, such as operationalizing the business rules and IT systems requirements that will actually make an exchange work. States receive assistance from vendors, consultants, and programs like ours, but each state also has a designated state officer at CCIIO who works with them to provide technical guidance on federal requirements and to help provide them with maximum flexibility to implement. In addition, the federal government has set up a collaborative process of "establishment reviews." Rather than the usual approach of rigid rules and a highly formalized process of application and approval, establishment reviews are more like an ongoing conversation in which states can demonstrate their early accomplishments and receive feedback on implementation models and ideas. This approach of individualized attention takes substantial time and effort on the part of both state and federal officials, but it ensures exchange implementation can happen in a way that remains state-specific while conforming with federal guidance and the statute.

Much of the collaboration between state and federal officials has been around the substantial amount of guidance that has been released to date. A mix of final rules, proposed rules, bulletins, and other guidance has given states and stakeholders the tools they need to continue making progress in establishing exchanges.[11] The mere fact that more than a dozen states are well down the path of setting up their

[11] ***Regulations and Guidance***, Center for Consumer Information & Insurance Oversight, available at http://cciio.cms.gov/resources/regulations/index.html.

exchanges suggests there is sufficient guidance for states to meet the 2014 effective date. Final rules on exchange establishment and qualified health plans (QHPs), in conjunction with the exchange blueprint, have given states a clear path forward for building their exchanges and getting them approved by HHS. Even where final rules have not been promulgated, federal officials have provided substantial guidance that has allowed states to move forward.

Let me provide a concrete example. One of the most difficult and contentious issues in health reform implementation has been the selection of an essential health benefit (EHB) benchmark, the package of benefits that each exchange plan must officer. Federal officials sought input from the states and stakeholders and took advantage of the advice of an expert panel convened by the Institute of Medicine. On December 16, 2011, HHS issued a bulletin indicating their proposed approach, which allowed states significant flexibility to choose an EHB based on health plans that already were popular in each state's market. In January 2012, HHS issued additional information on the three largest small group health plans in each state. That was followed by a set of Frequently Asked Questions that specifically addressed many of the questions states and stakeholders had posed in the interim.

Leading states took that guidance and developed a plan for selecting an EHB. They collected information about the benefit packages and coverage rules of the leading plans in their market. They compared those benefit sets with the ten required benefit categories outlined in the ACA. They assessed the potential impact of each benefit set on premium cost. Leading states took that information to their stakeholders and asked them to help decide how their state should balance the desire for a comprehensive benefit set with the desire to keep premiums low. In addition, states weighed other values like limiting disruption to the existing markets or promoting a high level of carrier participation in the exchange. For states that are unable to make a proactive choice due to political challenges or other concerns, a reasonable fallback (the largest plan in the small group market) has been identified.

In the absence of more formal rules, states are beginning to select their EHB plans. For example, the Oregon Exchange Board issued a preliminary recommendation to select the third largest small group plan as its EHB benchmark.[12] In Colorado, the governor's office – in collaboration with the Health Benefit Exchange and the Division of Insurance at the Department of Regulatory Affairs – released a draft EHB benchmark plan recommendation for public comment following substantial analysis and a stakeholder input process.[13] This final round of public comments will inform the state's final decision to be made by the end of the month. While highly specific guidance could have made the choice easy for states, the deliberate and open process of selecting an EHB in several leading states has helped to ensure broad acceptance from the stakeholder community and a clear understanding of why and how the EHB was chosen.

Are more formal rules on EHB and other difficult topics still needed? Absolutely. Do implementation efforts need to come to a halt in the absence of formal rules on every open issue? State Network states and

[12] ***Board Packet***, Oregon Health Insurance Exchange Corporation Board of Directors, joint meeting with Oregon Health Policy Board, August 14, 2012, available at https://orhix.org/meetings.html.
[13] ***Draft Recommendation for Stakeholder Input***, Office of the Governor, Colorado Health Benefit Exchange and Department of Regulatory Affairs – Division of Insurance, August 31, 2012, available at http://www.getcoveredco.org/COHBE/media/COHBE/public%20meetings/EHB-selection-8-31-12-recommendation.pdf.

other states across the country that want to implement reform are proving that is not the case. We know that states and those helping states will continue to work with federal officials to ensure forthcoming guidance and rules support and reflect the emerging reality in innovative and leading states.

Conclusion

There have been and will continue to be many challenges for state and federal officials working diligently to launch exchanges by this time next year. Politics will continue to be a factor even after the election, as many states still need authority from the Governor or legislature to move forward with exchanges. State budget and staffing pressures will continue to be a pressure point, even with the availability of substantial federal funds for exchange development. Likewise, as states assess the long-term fiscal impacts of the Medicaid expansion and financial sustainability models for ongoing operations of the exchanges, the budgetary implications will drive many decisions. However, despite these challenges, we believe states that want to implement reform have and will continue to make great strides in developing and implementing exchanges. States will continue to learn from each other and draw on the expertise and support of federal officials to move quickly once political barriers are ameliorated. Moving forward, states will continue to take innovative yet pragmatic approaches that take advantage of flexibility in the ACA and give them the best opportunity to develop exchange solutions that meet their unique needs.

Appendix A
Coordinating and Governing Structures in State Network States Following the Passage of the ACA

State Network State	Executive Order	Description
Alabama	Yes	Governor Robert Bentley created the Health Insurance Exchange Study Commission by Executive Order on June 2, 2011 which included the Commissioners of Medicaid and Insurance and the Director of Finance. The Study Commission is an advisory group to the Governor that made recommendations to the governor and legislature in late 2011. Governor Bentley also appointed an Executive Director in June 2011 to coordinate Alabama's efforts to establish and implement a state-based exchange in accordance with the provisions of the ACA.
Colorado	Yes	Former Governor Bill Ritter issued an Executive Order to designate a Director of Health Reform Implementation and an Interagency Health Reform Implementing Board to develop a strategic plan for implementation of the ACA. When Governor John Hickenlooper was elected in 2011, he established an internal health care team and worked with the legislature to establish a non-profit Health Benefits Exchange with its own governing board. A legislative oversight committee was also established to oversee Executive Director selection, certain financial decisions, and the initial work plan of the board.
Maryland	Yes	Governor Martin O'Malley signed an Executive Order on March 24, 2010 creating the MD Health Care Reform Coordinating Council, consisting of the Executive Director of the Office of Health Care Reform; and the Secretaries of Health and Mental Hygiene; Budget and Management; Human Resources; and Labor, Licensing and Regulation. The legislature then established a quasi-governmental Health Benefits Exchange with its own governing board.
Michigan	No	Michigan has established a Health Reform Steering Committee that includes the Department of Community Health, the Department of Technology, Management and Budget, the Department of Licensing and Regulatory Affairs, the Office of Financial and Insurance Regulation, the Department of Human Services and others that meet regularly to discuss and coordinate on health care related issues, including health reform. This mechanism helps keep agencies informed and involved in multiple aspects of the reforms taking place in Michigan.
Minnesota	Yes	Governor Mark Dayton signed an Executive Order on October 31, 2011 creating the Minnesota Health Care Reform Task Force (charged with broadly studying health reform) and directing the Minnesota Department of Commerce to design and develop a Minnesota Health Insurance Exchange.
New Mexico	No	Governor Susana Martinez established an Office of Health Reform that is located in the Human Services Department and is charged with coordinating health reform efforts across agencies.
New York	Yes	New York's reform efforts are coordinated by an inter-agency team directed by the Governor's office, including staff from the Department of Health, the Department of Financial Services (Insurance Division), and staff charged with initial planning for the exchange. Governor Andrew Cuomo also established an exchange for New York within the state's health department through Executive Order.

Oregon	No	Prior to passage of the ACA and as a part of the state's own health reform efforts, Oregon integrated several health-related agencies and functions into one agency: the Oregon Health Authority. The legislature then established a quasi-governmental Health Benefits Exchange with its own governing board.
Rhode Island	Yes	Governor Lincoln Chafee signed an Executive Order creating the Rhode Island Healthcare Reform Commission on January 11, 2011. The Executive Committee of the Commission includes the Lt. Governor, Secretary of the Executive Office of Health and Human Services, Health Insurance Commissioner, Director of Administration, and the Governor's Policy Director. The full commission, comprised of over 200 stakeholders, is charged with the coordination and management of all healthcare reform efforts, and maximizing stakeholder engagement. Governor Chafee also established the Rhode Island Health Benefits Exchange through Executive Order.
Virginia	No	Virginia utilizes the Virginia Health Reform Initiative (VHRI), which was established by Governor McDonnell. VHRI has an Advisory Council of 24 members and is chaired by the Secretary of Health and Human Resources. The group met from August 2010 to September, 2011 and generated recommendations related to exchange development, Medicaid reform, insurance reform, purchasing, technology, capacity and delivery/payment reform. The group remains active.

Source: Managing State-Level ACA Implementation Through Interagency Collaboration, State Health Reform Assistance Network, July 2012. Available at: http://www.statenetwork.org/resource/managing-state-level-aca-implementation-through-interagency-collaboration/