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At Deadline, 18 States, D.C. Intend To Operate State-Based Exchanges

By: Sara Hansard - December 19, 2012

With the passing of the Dec. 14 deadline for states to declare whether they intend to run state-based insurance exchanges, a total of 18 states and the District of Columbia appeared poised to run SBEs.

Department of Health and Human Services Secretary Kathleen Sebelius said in a Dec. 17 blog entry that 10 states had filed blueprint applications with HHS to set up SBEs under the Affordable Care Act. Applications were filed by California, Hawaii, Idaho, Minnesota, Mississippi, Nevada, New Mexico, Rhode Island, Vermont, and Utah. HHS is to act on the applications by Jan. 1, Sebelius said.

In addition to those applications, HHS, the week of Dec. 10, gave conditional approval to create state-based exchanges to Colorado, Connecticut, the District of Columbia, Kentucky, Massachusetts, Maryland, New York, Oregon, and Washington. Conditional approval means HHS has found that the eight states and the District of Columbia have made enough progress in setting up their own exchanges for individuals and small group plans that they are likely to be ready to take applications when open enrollment begins Oct. 1, 2013. Plans sold in the online markets will take effect in 2014.

"We know that some states will need more time before being ready to run their own marketplace or want to run part, but not all of the exchange in 2014," Sebelius said. States can choose to enter into partnership exchanges with the federal government, in which states conduct plan management and/or consumer assistance functions, she said. The deadline for states to apply to be in partnership exchanges is Feb. 15, 2013. The deadline for filing blueprint applications to operate SBEs was Dec. 14.

Federally Facilitated Exchanges.

Under ACA, HHS will operate federally facilitated exchanges (FFEs) in states that do not set up their own SBEs or enter into state partnership exchanges (SPEs).

On Nov. 20 the administration released proposed rules regarding essential health benefits and health insurance markets (*see previous article*). On Nov. 30 it released a proposed rule on payment parameters for risk adjustment programs (*see previous article*).

Sebelius said the proposed rules will “ensure states have more information to continue their work.”

HHS is “not taking an 'all or nothing' approach to exchanges,” she said. “Many states are making impressive progress and we are committed to working with all states as we approach open enrollment in October 2013.”

Sebelius also noted in her blog entry that many states have received planning and establishment grant awards to develop information technology systems and perform other tasks to create exchanges. Testifying before the House Energy and Commerce Health Subcommittee Dec. 13, Gary Cohen, director of the Centers for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight, said that $2.1 billion in exchange grants have been awarded to states *(see related article)*.

Many States Have Balked.

Many states, especially those led by Republicans, have balked at creating exchanges to implement the controversial health care reform law. “The story here is that 32 states have refused to help the government implement this law in the way that its authors envisioned,” Michael Cannon, director of health policy studies at the libertarian Cato Institute, told BNA.

“That was unthinkable two years ago,” when ACA was enacted, he said. “It speaks to how unpopular this law remains, how complex and costly the law is, and how state officials expect that this law is not going to work,” he said.

Cato has argued against ACA, and Cannon has called for states to refuse to set up the exchanges.

However, not all ACA opponents agree that states should avoid creating SBEs.

Douglas Holtz-Eakin, president of the American Action Forum and a critic of ACA, told BNA it would be preferable for states to create state-based exchanges.

“It seems to me the silver lining in what's going on is that states who would agree to do the exchanges are also in a good bargaining position with the administration,” notably concerning the terms of expanding Medicaid, he said.

In frequently-asked-questions guidance issued Dec. 10, CMS told states they will not receive enhanced federal funding if they decide to only expand Medicaid partially, rather than up to 133 percent of the federal poverty level as called for under ACA (*see previous article*).

Holtz-Eakin suggested states could bargain with HHS to “run their own-style exchanges,” in exchange for fully expanding Medicaid. Otherwise, he said, “they can say no, and the administration doesn't get their Medicaid expansion.”

Exchanges: Conservative Idea.

A free market exchange is a conservative idea that should be embraced by conservative states, Holtz-Eakin said. “If they don't seize this opportunity, it goes past,” he said, and “a very conservative idea, exchanges, ends up being lost in the regulatory overkill of the Affordable Care Act.”

Sarah Dash, research faculty and project director at Georgetown University's Health Policy Institute, told BNA that many states may set up state-based exchanges after 2014. “It takes a while to do the planning and preparation to set up a state-based exchange,” she said.

Some states “were going to do it right from the get-go and really started their planning,” she said. Other states, such as Illinois and Kansas, had administrations or insurance commissioners that wanted to set up SBEs or partnership exchanges, but they were unable to win approval from their legislatures or governors, she said.

Other states waited for the U.S. Supreme Court to rule on the law in June or for the result of the presidential election in November, and now it is too late to create an SBE in time for plans to take effect in 2014, Dash said.

Many states complained that HHS took too long to release regulatory information, especially on the FFEs, Dash noted. “There's probably a decent amount of leeway there” for states that have moved to create SBEs in terms of regulatory flexibility from HHS, she said.

Partnerships, FFEs.

The number of states likely to operate SPEs or have FFEs is not yet clear. On its exchange progress map, as of Dec. 17, health care consulting firm Avalere Health LLC estimated that 12 states would be likely to form SPEs: New Hampshire, New Jersey, Delaware, North Carolina, Michigan, Ohio, West Virginia, Tennessee, Illinois, Iowa, Arkansas, and South Dakota.

Twenty states are likely to have FFEs, according to Avalere: Maine, Pennsylvania, Virginia, South Carolina, Georgia, Florida, Alabama, Indiana, Wisconsin, Missouri, Louisiana, Texas, Oklahoma, Kansas, Nebraska, North Dakota, Montana, Wyoming, Arizona, and Alaska.

Avalere estimated that 18 states and the District of Columbia would be likely to have SBEs. Avalere included Utah, which already has an exchange, as likely to operate a SBE. Utah has asked HHS to approve its exchange as an SBE.

On its map on “where states stand so far” on exchanges, dated Dec. 17, the National Academy for State Health Policy's “State Refor(u)m” health reform project lists 18 states and the district having declared their intent to establish an SBE, seven states that are considering or have declared partnerships, and 25 states that have rejected state-run exchanges.

NASHP lists Delaware, North Carolina, West Virginia, Michigan, Illinois, Arkansas, and Iowa as likely partnership states. States rejecting state-operated exchanges are Maine, New Hampshire, Pennsylvania, New Jersey, Virginia, South Carolina, Georgia, Florida,

Alabama, Tennessee, Ohio, Indiana, Wisconsin, Missouri, Louisiana, Texas, Oklahoma, Kansas, Nebraska, South Dakota, North Dakota, Montana, Wyoming, Arizona, and Alaska, it said.