

State Health Reform Assistance Network

Charting the Road to Coverage

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A Look at Different Marketplace Models: How Can They Help States Achieve Their Goals?

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Introduction

Now that the failure of legal challenges to the Affordable Care Act (ACA) have left the role of Marketplaces undiminished, and the wind-down of federal grants is putting pressure on Marketplace budgets, some states may reconsider their choices about whether to sponsor and assume responsibility for operating their Marketplaces. This brief is intended to serve as a resource for state decision-makers by describing the potential to achieve policy objectives associated with various ways to organize a Marketplace. It describes four models for sponsoring Marketplaces, seven policy objectives that states typically pursue, and assesses the suitability of each Marketplace model for pursuing these seven objectives. The brief is written for the benefit, and from the perspective, of state policymakers considering whether and, if so, how to participate in Marketplace sponsorship.

These four models of Marketplace sponsorship have evolved and developed a “track record” over the past few years (see Appendix for list of states using each model):

- 1. State-Based Marketplace (SBM):** Conceived by Senate drafters of the ACA as the predominant form of a Marketplace, each SBM is operated by an agency of its state government or a quasi-independent, public corporation chartered by the state. It must undertake all the functions necessary to operate a Marketplace (listed in Table 2), generally within constraints described in federal regulation, and it must be financially self-sustaining (no ongoing federal funding for operations).
- 2. State-Based Marketplace on the Federal Platform (SBM-FP)*:** This model is evolving in four states and has yet to be finalized in federal regulation. It is expected to be an SBM, with its own state governance and policy determination, that nevertheless relies upon the federal IT platform and customer call center to operate its eligibility determination, enrollment, and much of its customer service functions. In effect, the SBM “leases” functionality from the Centers for Medicare & Medicaid Services (CMS); CMS has proposed for 2017 a user fee of 3.0 percent of premiums for enrollment through the SBM-FP to defray the cost of operating the federal platform.
- 3. State Partnership Marketplace (SPM):** This model is operated by the FFM for the standard FFM user fee of 3.5 percent, but one or two important functions

*Referred to as State-Based Exchange on the Federal Platform (SBE-FP) in the NPRM of 12.2.2015 in the Federal Register; for consistency with other references to Marketplaces, we use SBM-FP.

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State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org.

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are assumed by the state, at its own cost: (a) outreach and education, and/or (b) plan management, including Qualified Health Plan (QHP) certification and de-certification. The full 3.5 percent user fee is retained by CMS.

4. **Federally-Facilitated Marketplace (FFM):** This Marketplace is operated entirely by CMS, except that (like any Marketplace) it does require some coordination with a state's division of insurance and its Medicaid and CHIP programs. Issuers of QHPs pay CMS a user fee of 3.5 percent of premiums for enrollment through the FFM to defray the cost of operating the FFM.

As enrollment under the ACA continues to grow and its reforms take root, some of the 27 states that currently rely on the FFM may evaluate moving to a different format that enhances state control. Some of the 13 states (including Washington, D.C.) that currently bear full responsibility for operating their own SBMs may re-evaluate the relative costs and benefits of this model. And some of the 11 “in-between” states that share risk and responsibility with the FFM could move to full state control or exit the field altogether. Before doing so, policymakers should understand the potential reasons for operating a Marketplace, under any model. This policy brief describes seven Marketplace goals that states typically pursue. On the assumption that some or all of these goals may be of interest to state policymakers, we assess the potential of the four models to achieve each goal.

In doing so, we make no judgment about the relevance of these goals for any particular state—only that they represent commonly articulated state policies. We rank the *potential* for each Marketplace model to give the state either a reasonable chance of achieving that goal, or at least some certainty about the outcome.

SEVEN COMMON MARKETPLACE GOALS

1. **Maximize outreach & enrollment of potential customers:** Perhaps the most fundamental policy goal is to cover as many of the uninsured as possible, which means maximizing enrollment. The process of doing so requires Marketplaces to reach and inform potential enrollees about the need for coverage, eligibility for premium subsidies, and how and why to enroll through the Marketplace. Bringing down the cost of coverage is the peculiar province of the public Marketplace as a channel of distribution for commercial insurance.
2. **Enable seamless eligibility determination across the coverage continuum:** More than eight in ten Marketplace enrollees receive tax credits to help make coverage affordable, and eligibility determination can represent a daunting hurdle even before enrollment. Many applicants will need to transition between Marketplace and Medicaid and CHIP coverage as their income fluctuates over time; some households are even split between Marketplace and CHIP coverage. Enabling consumers to move seamlessly across the coverage continuum at application, renewal, and when reporting changes in circumstances will improve the customer experience, maximize coverage, and reduce the chances that eligible individuals fall through the cracks.
3. **Improve customer service & the shopping experience:** As service entities for millions of customers attempting to make complex purchasing decisions, another basic goal of Marketplaces is to provide the tools that consumers need to make informed choices and enroll efficiently. Of course, improving customer service is highly desirable for its own sake and it would also support the first goal by removing obstacles to enrollment.
4. **Increase health plan competition:** As the name suggests, Marketplaces facilitate competition among private health plans, which is expected to serve customers. The ability of a Marketplace to recruit issuers and stimulate competition of the kind that consumers value is an important policy goal and is key to the ACA's reform of individual commercial insurance.
5. **Control administrative costs of the Marketplace:** As an incremental cost of distributing private health insurance, Marketplaces should manage their own administrative costs. Enrollees ultimately pay these administrative expenses in the form of higher premiums, although some SBMs may also charge other insureds and/or taxpayers. Whoever bears the costs, they should be managed at a reasonable and predictable level.
6. **Contribute to health delivery reform & systems transformation:** Some states have a broad reform agenda that includes changing how care is reimbursed and/or delivered. For example, a number of states have posited the transformation from fee-for-service to global budgeting and/or the development of patient-centered medical homes as a desirable reform. States expect their Marketplaces to support their broader health care reform goals.
7. **Develop a robust SHOP program that attracts customers:** Marketplaces have struggled to achieve robust programs for small employers. We list this goal last, since various states seem to regard it quite differently. Some states have expressed considerable interest in this goal, while others simply do not emphasize SHOP. We leave it in the analysis below for consideration by policymakers with different foci.

Our rating in Table 1 of the achievability of these seven goals is primarily a subjective judgment, based on a close reading of the regulations, including the recently released Notice of Proposed Rulemaking (NPRM) published in the Federal Register dated

December 2, 2015, and years of experience working with many states under each model. However, our rating in Table 1 also gives some weight to the flexibility that a model offers the state to influence or pursue the policy goal. Ratings are explained in the text and summarized in Table 1 as “Achievable,” “Challenging,” or “Very Difficult.” For example, the SBM model gives states full control over administrative spending on the Marketplace (“Achievable”), but it denotes control only, *not* assurance of the state’s ability to meet a certain expense target. By comparison, we rank the FFM “Challenging” because CMS sets the assessment (3.5 percent), so there is no state liability, but neither is there any state control over the assessment, and therefore no opportunity to modify it.

Table 1 – Marketplace Ability to Achieve Goals

Ability to Achieve Goals				
	Structure of Marketplace			
	SBM	SBM-FP	Partnership	FFM
Marketplace Goals				
Maximize outreach & enrollment	✓	●	●	●
Seamless eligibility determination	✓	✘	✘	✘
Improve customer service	✓	●	●	✓
Increase health plan competition	✓	●	●	●
Administrative cost control	●	✘	●	●
Support payment & system reform	●	●	✘	✘
Robust SHOP offering & sales	●	●	✘	✘

Key: ✓ = Achievable ● = Challenging ✘ = Very Difficult

To pursue some of the goals requires local knowledge, relationships, and coordination among a number of state-based stakeholders and constituents. As a result, the national FFM is especially challenged to pursue such goals, no matter how well it is managed. These challenges are reflected in some of our rankings of the FFM. However, as Marketplaces continue to evolve, technology improves, start-up challenges are overcome, and policy aims are reprioritized, the FFM may be able to overcome this significant obstacle and enhance its local relationships and flexibility.

In Table 2, we list a far larger number of Marketplace functions which can contribute to achieving the seven goals noted above. For each function, we indicate *whether or not the state is primarily responsible* for developing and administering that function (in every model, federal regulations constrain state control). The value of this table is to provide state policymakers with a more granular understanding of the type of functions that they would need to develop in order to operate the Marketplace model effectively. In turn, effective management of these functions is required to pursue the policy goals.

Table 2 – Does the State Largely Control These Functions Under Each Marketplace Model?

State Control Over Key Marketplace Functions				
	Structure of Marketplace			
	SBM	SBM-FP	Partnership	FFM
Key Functions of a Marketplace				
Administrative Assessment Amount/Sources	Yes	Mixed	No	No
Medicaid Integration/No Wrong Door	Yes	No	No	No
IT Functionality/Operations	Yes	No	No	No
QHP Plan Management	Yes	Yes	Yes	No
Navigator/Assister/Broker Programs	Yes	Yes	Yes	No
Decision Support & Calculator Tools	Yes	No	No	No
Customer Service/Self Service	Yes	No	No	No
Provider Lists/Formulary Lists	Yes	No	No	No
Financial Management	Yes	Mixed	No	No
Call Center Integration	Yes	No	No	No
Marketing (Outreach & Education)	Yes	Yes	Yes	No
Inter-Agency Coordination	Yes	Yes	No	No
Outsourcing Decisions & Vendor Management	Yes	Mixed	No	No
Public Reporting/Transparency	Yes	Yes	No	No

State-Based Marketplace (SBM)

As indicated in Table 1, the SBM model allows states to control the various functions associated with Marketplaces, and therefore the highest potential to achieve their goals. For example, an SBM should be able to increase enrollment by dialing up its outreach spending. Conversely, it controls its own administrative costs. Of course, how to balance these sometimes conflicting goals is challenging, but these goals are generally more within an SBM's grasp than if the state were to depend on the FFM. For example, states that want to take advantage of the flexibility allowed by a Section 1332 waiver of ACA requirements to revise the functioning of their Marketplaces will need to establish their own SBMs.

Even with its own Marketplace, a state may find it extremely challenging to develop a robust SHOP or to reform payment and delivery systems. In the case of system-wide reforms, SBMs generally must align with larger coverage programs, such as Medicaid, Medicare, and/or public employee groups in order to effect change.

Of course, control also confers accountability, and operating an SBM carries its own risks of poor service and administrative cost overruns. Presumably, some disappointments or dislocations associated with the ACA (fairly or not) would also "taint" a state administration that runs its own SBM.

We assess the SBM model's potential to achieve each of seven goals as follows:

1. **Maximize outreach & enrollment:** Compared with other models, the SBM offers the greatest opportunity to pursue enrollment. Based on enrollment projections calculated by the Urban Institute, the 13 SBMs together enrolled 85.2 percent of their target projections in OE2, versus only 78.7 percent for the other states that also expanded Medicaid eligibility.¹

By contrast with relatively modest (per enrollee) federal spending on outreach, SBMs can decide to fund extensive outreach. They also can achieve synergies and economies of scale by coordinating these efforts with outreach for Medicaid and CHIP. (Of course, a state could spend on outreach even when using the FFM, but it would not be able to coordinate specific promotional efforts with the FFM's call center, nor would it share the resulting increase in the FFM's user fee.) Indeed, one of the unique features of a user fee is that it can fund outreach efforts that increase revenues (from increased enrollment) more than the variable costs for handling that growth. This "self-funding" business model provides the kind of incentive to grow that is typical of private business.

Because of federal start-up grants, SBMs (and SBM-FPs) have had far more to spend (per capita) on outreach than CMS. Enroll America and other outreach groups have partially compensated for this shortfall in the FFM states, but how robust their future efforts will be is not known. SBMs, too, have exhausted federal grants for outreach and are likely to reduce spending, but they still enjoy the ability to coordinate local assisters (navigators, agents, and application counselors) and opportunities to partner with or solicit funding from local foundations, issuers, brokers, etc.

Within any level of funding, the SBM can also target its outreach and coordinate with its own customer service, navigators, and other local parties. For example, an SBM could coordinate a special effort to reach Hispanics with the launch of a Spanish-language version of its website, certifying more Spanish-speaking assisters, developing sponsorship opportunities for Spanish-language media, and requiring QHPs to increase their ability to serve Hispanics. For the FFM to do this nationally or for a state to coordinate such an initiative with CMS is far more daunting.

Finally, only under the SBM format can a state subsidize premiums, beyond the tax credits available from the IRS, in order to make coverage more affordable and thereby likely boost enrollment. In Massachusetts, for example, additional state premium subsidies reduce net premiums for most enrollees below 300 percent of the federal poverty level (FPL). Minnesota has a Basic Health Program designed to reduce premiums and cost-sharing for enrollees under 200 percent of FPL, and New York has done the same for 2016. As explained in the next section, this requires the state to control and integrate eligibility determination across coverage programs.

2. **Seamless eligibility determination:** The often laborious front-end process of determining eligibility for Medicaid, CHIP, or advance premium tax credits (APTCs) in the Marketplace should be handled in one step under an integrated state process. Since eligibility determination can take as much or more time than plan shopping and enrollment, this is a critical advantage for most Marketplace clients (those under 400 percent FPL and therefore eligible for subsidies). By contrast, Marketplace formats which depend on the FFM generally rely on CMS to determine eligibility for APTCs and, if a client (or part of his/her household) appears to be eligible for Medicaid or CHIP, then refers that client to a state agency for final eligibility determination. (A state may delegate eligibility determination to the FFM for all three coverage programs and thereby achieve integration, but states are generally reluctant to forego such control over eligibility determination for their own Medicaid and CHIP programs.)

For a few states (three as of December 2015), reducing the net cost of coverage beyond the subsidies available as APTCs is an important policy, which contributes to maximizing coverage. This can be done by adding state subsidies to federal APTCs—as Massachusetts does—or by bidding out coverage (from 138 percent to 200 percent of FPL) to one or more Medicaid Managed Care Organizations in order to reduce premiums and/or cost-sharing, as Minnesota and New York have decided to do. Because the FFM cannot (currently) determine eligibility for additional state premium subsidies, nor for the Basic Health Program (BHP), either approach requires that eligibility determination be performed by an SBM.

- 3. Improve customer service & shopping experience:** The quality of customer experience is a function of many factors, not all of which are controlled by any Marketplace. Key variables include: selection, management, and performance of the call center vendor or, for example, Covered California’s management of its own call center; the reliability, speed, and ease of using its website and back-office systems; the number and diversity of QHPs offered; availability of decision-support tools; and training of assisters. With an SBM, many more of these variables are under the state’s control.

Marketplaces are entering their third year, and with the stabilization of operations in most states has come an increased focus on customer service. Likely due to initial contract terms expiring, several SBMs are going out to resolicit call center vendors. For example, HealthSource Rhode Island (HSRI) issued a Request for Proposal (RFP) in September 2015 and, with two years of experience on which to draw, is better informed about how to improve customer service. In the areas of recruiting and training assisters, developing new decision-support tools, and managing vendors, they are learning how to be more effective. The “industry” as well is developing capabilities that will give SBMs more options and control.

However, as SBMs are transitioning off federal grant funding they are also pairing down their budgets. Gaining control over call center expenses has emerged as another priority, and doing so could actually threaten to undermine customer service levels. For example, SBMs may pursue customer service strategies designed to drive users to self-service, as a way to limit their own costs. Meanwhile, the FFM is piloting new decision-support tools and improving its customer service. How much SBMs will actually improve their customer service, or whether they will do a better job than the FFM remains to be seen.

- 4. Increase health plan competition:** Offering more issuers on an exchange may be especially desirable if only one or a few of them dominate the market. By contrast, reliance on a few carriers may reduce the pressure to compete on price and service; and any one of them dropping out of the Marketplace would probably jeopardize coverage for many enrollees, and further reduce competition.

An SBM working in conjunction with the state’s insurance commissioner can actively encourage new competitors, and has the flexibility to customize operations, if necessary to accommodate and retain existing issuers. For example, the Massachusetts Health Connector actively recruited a new issuer in its third year, and made special accommodations in operations to retain a major health plan for small employers. Most SBMs work closely with their issuers to accommodate them where they can, and to make their Marketplace as appealing as possible. While the FFM shares this goal, it often lacks the local relationships and the operational flexibility to accommodate local circumstances or a few critical issuers.

- 5. Control administrative costs of the Marketplace:** The advantage of an SBM in this regard is control; the disadvantages are accountability and scale. The large IT spend for development and for ongoing operations and management ought to allow scale economies in the FFM. While there are ways other than having a big Marketplace to achieve scale, such as group purchasing, these are awkward and uncertain compared with the FFM’s national scale. And yet, the disadvantages of smaller scale have not proven insurmountable, as a handful of SBMs continue to operate effectively with modest enrollment.

The FFM’s user fee of 3.5 percent of premiums has become a baseline or standard for SBMs, and it appears that many are close to that percentage, although some are also struggling to reduce their operating budgets to that level.

On the other hand, with experience and data-sharing, the SBMs should be able to control administrative costs as well. Unless the FFM realizes scale economies and reduces its user fee, most SBMs should be able to control costs as well, if not better than, the FFM.

- 6. Contribute to health delivery reform & systems transformation:** While an ambitious goal, some states have a health care reform agenda to which an efficient, effective Marketplace for health insurance can contribute. Whether that agenda favors more public activism in directing competition, protecting consumers, and shaping provider incentives, or the extension of competition and markets to other state programs, an SBM can support other state efforts. For example, Covered California has adopted contracting and reporting specifications for QHPs which align with multi-payer, value-based purchasing criteria; Arkansas plans to deploy its SBM in support of a premium support program for Medicaid; and the Massachusetts Health Connector administers both a student health insurance program for public colleges and temporary insurance coverage for the unemployed. Such efforts require customizing both plan management and Marketplace operations to achieve the state’s policy objectives.

- 7. Develop a robust SHOP program that attracts customers:** Doing so is tough enough for the most adept Marketplace. It requires strong broker support, building trust between the Marketplace and local employers, and a differentiated value proposition for small-group customers (employer and employees). For example, HSRI has put considerable emphasis on growing SHOP, and despite doing a very good job with it, has only about 4,000 members through SHOP, or less than five percent of the state’s small-group market. Whether developing a robust SHOP program is achievable, even with the local market knowledge, contacts, and relationships that are generally associated with SBMs, remains to be seen. We rank this goal as “Challenging,” even for SBMs. It would be even more difficult for a Marketplace to build a robust SHOP program without these *local* resources and tools.

State-Based Marketplace-Federal Platform (SBM-FP)

The SBM-FP is a model that began to emerge in 2014 and applies to four states as of 2015: Hawaii, Nevada, New Mexico, and Oregon.

Recently, CMS released a Notice of Proposed Rulemaking (NPRM), published on December 2, 2015, in the Federal Register, which describes the division of function: SBM-FPs retain responsibility to ensure that all Marketplace requirements are met, but may do so by relying on the FFM for eligibility determination, enrollment processing activities, and most consumer call center activities.ⁱⁱ The SBM-FP retains primary responsibility for performing all other Marketplace functions, including plan management, consumer outreach and assistance, and ongoing program oversight and integrity. In performing plan management, however, the state must require issuers to meet standards that are no less strict than the standards on the FFM with respect to data submission, network adequacy, essential community providers, etc. CMS reserves the right to enforce such standards, should the state not do so.

For the moment, the FFM is not offering states an “a la carte” menu of services but suggests that it may be able to do so in the future. For example, the NPRM proposes that eligibility determination as well as enrollment be done on the FFM: a state cannot conduct its own eligibility determination for all subsidized programs and then refer APTC-eligible applicants to the FFM for enrollment. The one area of flexibility specified in the NPRM is that states may operate either their own SHOP or individual program, and use the FFM platform for the other program, or states may use the FFM for both programs. (This could turn out to be an important option for SBMs that do not care to bear the cost of supporting miniscule SHOP enrollment or for FFM states that have a clear policy agenda for one, but not both, Marketplace programs.) More details are expected to be set forth in the model contract between CMS and the SBM-FP, which should be published in 2016.

SBM-FPs are authorized and governed by the state. The state has the responsibility to support the SBM-FP, and issuers will be charged for the SBM-FP’s use of the federal platform starting in 2017. The NPRM states that CMS will charge a user fee of 3.0 percent on QHP premiums, although it also suggests that it might reduce this fee temporarily, as a transitional accommodation for the four existing SBM-FPs which currently receive federal platform services for free. Under these proposed regulations, the FFM would collect and keep its 3.0 percent user fee, and also, on behalf of the state, collect and remit any incremental user fees (above the 3.0 percent) that the SBM-FP establishes in order to offset the cost of its administrative functions. As the FFM charges a 3.5 percent user fee, it seems highly likely that states would minimally want to have an additional 0.5 percent collected by CMS and remitted to the states, thereby keeping the user fee in SBM-FP states at least as much as in FFM states.

Assuming that CMS’ proposed financial arrangement is confirmed in final regulations—and ignoring for the moment any transitional accommodation—we assess the SBM-FP model’s potential to achieve seven goals as follows:

- 1. Maximize outreach & enrollment:** This format provides states with some of the flexibility and control that the SBM model confers on outreach and assister activities, but not all of it. For example, the limited extent to which CMS can share with states identifiable data on enrollees is a point of some sensitivity within CMS. Clearly, there are obstacles to doing so, and even if CMS finds a way around them, it will probably not customize data and reporting for each state. CMS may clarify the extent and conditions for data-sharing in the model contract that is forthcoming.

Also, a state’s ability to coordinate its own activities with CMS’ call center may be limited or more difficult than coordinating with its own call center. On the other hand, the SBM-FP would develop its brand, control advertising, be able to target outreach activities, coordinate with the issuers that the SBM-FP certifies, and so forth. Presumably, an SBM-FP can notify the federal call center of special outreach activities, to which its customer service representatives should be ready to respond, but whether it can count on CMS’ vendor to handle special marketing initiatives is unclear. The nature of that response as well as upholding the SBM-FP’s brand through the call center will depend on a vendor selected and managed by CMS, not the SBM-FP. Because of this constraint, we rate this model as “Challenging” to the SBM-FP’s priorities for outreach and enrollment.

2. **Seamless eligibility determination:** Again, one of the biggest challenges to good customer service is integrating eligibility determination for the Marketplace, Medicaid, and CHIP. To date, only states with SBMs have developed fully-integrated eligibility determination systems, which can assign APTCs, Medicaid, or CHIP eligibility in one process, and manage renewals and change reporting across programs over time. The NPRM explicitly states that the FFM will perform both eligibility determination and enrollment, although it also alludes to future flexibility, so the current dynamic might not be permanent. Because SBM-FP states rely on federal eligibility determination, customers will experience significantly more barriers to accessing the right program quickly and easily than their counterparts in SBMs, which integrate and streamline eligibility determination for all subsidized coverage programs.
3. **Improve customer service & shopping experience:** This goal can only be achieved via functions that are shared between the FFM and the SBM-FP. Specifically, the call center, website, and decision-support tools of the FFM, determined by CMS, play a major role in the customer experience. Doubtless, CMS and SBM-FPs share the goal of improving customer service, but they may well differ on priorities, especially since each bears the cost of different functions related to customer service. For example, the SBM-FP might feel intense pressure from customers to reduce call waiting times, but CMS may be under financial pressure to increase web-based self-service—a priority which can conflict with reducing call wait times. Even when they are aligned, coordination between two different agencies reporting up two entirely separate chains of command can be challenging. The SBM-FP might not even be aware of much of the customer feedback received by CMS’ call center.

Nevertheless, SBM-FPs do control more functions and resources related to customer service and the shopping experience than they would under either Partnership or FFM models. The SBM-FPs must have their own call center and web portal—if only for referring consumers to the FFM call center and website—and the SBM-FPs will control assister training, certification, and contracting (including brokers), as well as QHP management (including standardization of cost-sharing). They can better integrate with other state agencies, such as Medicaid and insurance departments, which also interact with consumers and potential enrollees.
4. **Increase health plan competition:** On its own or working in concert with the insurance commissioner, an SBM-FP can manage QHPs, flex certification criteria, and promote Marketplace enrollment in such a way as to attract and retain issuers. It can also establish QHP certification criteria and even negotiate rates to enhance competition. In this regard, it is similar to the SBM (and Partnership) models. Unlike the SBM, however, an SBM-FP cannot control the back-office functions that directly impact issuers; nor does it operate the call center, which also impacts the issuers’ own customer service. To the extent that these differences matter to issuers, we rate the goal as “Challenging” for SBM-FPs, rather than “Achievable.”
5. **Control administrative costs of the Marketplace:** Under this model, costs and functions are shared between CMS and the state, and CMS proposes to retain a 3.0 percent user fee to defray its own costs. Were a state to oversee a robust outreach, marketing, and sales effort, plus active plan management and other legal responsibilities, it is very likely that the total cost (federal + state) would exceed what it should cost for a free-standing SBM, or the 3.5 percent of premium being charged to support the FFM. Therefore, we rate this goal as “Very Difficult” for the SBM-FP model. Once the FFM’s charge for supporting SBM-FPs has been finalized, this rating may merit revision.
6. **Contribute to health delivery reform & systems transformation:** As is the case for SBMs (and Partnership states), an SBM-FP can spur payment and delivery system reforms via the criteria it sets for QHP certification, how selective it is in applying these criteria, and how effective it is in marketing QHPs. However, to the extent that such operational functions as customer service, decision support, and rules for enrollment and renewal might play a role in Marketplace strategies to influence payment reform, these simply are not under the SBM-FP’s control. Like an SBM, for example, an SBM-FP could decertify or rank lower on quality those QHPs which do not deploy Pay-for-Performance incentives tied to quality improvements, but it cannot structure its own decision-support tools to tie specific quality incentives to patient conditions (e.g., to use re-admission rates for cardiology discharges to rank QHPs on quality for enrollees with heart conditions). Therefore, we rate this goal as “Challenging” for SBM-FPs, rather than “Achievable.”
7. **Develop a robust SHOP program that attracts customers:** An SBM-FP can deploy most of the tools available to an SBM to make SHOP attractive. It can also develop and run its own SHOP, while using the federal platform for individual coverage. Nevertheless, it is still a tough challenge. We rate SBM-FPs, like the SBM model, “Challenging” in its potential to develop a robust SHOP program.

State Partnership Marketplace (SPM)

An SPM model allows states that do not develop their own Marketplace the opportunity to take primary responsibility for one or both of two functions otherwise reserved to the FFM: plan management and/or consumer assistance and outreach. For all other Marketplace functions, an SPM must rely on the FFM. In concept, the distinction between SPM and SBM-FP is clear: the SPM is a federal exchange with the state managing (and funding) one or two functions; the SBM-FP is a state Marketplace that “leases” its IT platform and call center from CMS. In reality, the two concepts may overlap considerably.

Similar to an SBM or SBM-FP, states that elect to retain the plan management function may develop QHP certification standards, maintain issuer management activities, ensure compliance with QHP certification standards, and coordinate with CMS on key elements of quality standards and reporting. For the consumer assistance and outreach function, states are allowed to develop a comprehensive communication and outreach plan that incorporates local assisters, navigators, and other enrollment-based entities, and to coordinate with other state health and human services programs.

While requiring close coordination with CMS, SPM states may customize these two key functions for local circumstances. These two functions can significantly influence the implementation of health care reform and the state's Marketplace goals.

One of the challenges with this model is how to fund such activities once federal grants are eliminated. Issuers in an SPM are assessed the same fee as in the FFM: 3.5 percent of QHP premiums for enrollment through the Marketplace, but none of that revenue is available to the SPM to support its own activities. Any state assessment to fund this activity would be incremental to the FFM assessment.

Taking each of the seven goals individually, we assess the SPM model's potential to achieve them as follows:

- 1. Maximize outreach & enrollment:** An SPM relies on the FFM technology for key functions, such as eligibility determination and enrollment, customer call center, and a consumer-facing web portal. However, one of the key functions that may be retained by a state operating an SPM is outreach and marketing to eligible residents.

Importantly, retention of this function allows a state to target outreach and education to particular populations and develop partnerships with other interested stakeholders, such as consumer advocacy groups, faith-based organizations, Medicaid, and other state-subsidized programs—opportunities not possible under an FFM. This local touch can be extremely important in identifying hard-to-reach populations and customizing information and education materials. Another advantage of a locally-developed outreach and marketing strategy is access to state-specific data, including past enrollment trends, to identify opportunities for increasing enrollment.

However, with federal grant funding winding down after calendar year 2015, there is no dedicated revenue stream to fund the added cost of outreach. A state must fund its own campaign, broad or targeted, out of general revenues. For example, responding to budget pressures, the administration in Illinois (one of seven SPMs), reduced its outreach and enrollment effort for Fiscal Year 2016. While a state-specific marketing strategy can be more effective than a broad-based national campaign, without the requisite funding to develop the analysis, engage local stakeholders, maximize geographic knowledge, and execute an implementation plan, the value of an SPM in this regard will be diminished. So, the administrative cost and level of effort required to be designated an SPM may not be worthwhile without adequate state support for marketing.

Moreover, an SPM also needs individually identifiable data from the enrollment process to improve its consumer outreach planning, and to date, little of these have been shared with SPMs. Due to the lack of federal funding and data-sharing, we rank the ability of the Partnership model to improve outreach and enrollment as “Challenging.”

- 2. Seamless eligibility determination:** Again, one of the biggest challenges to good customer service is integrating eligibility determination among the Marketplace, Medicaid, and CHIP. To date, only SBMs have developed fully-integrated eligibility determination systems, which can assign APTCs, Medicaid, or CHIP eligibility in one process and manage renewals and change reporting across programs over time. Because SPM states rely on federal eligibility determination for APTCs, customers will experience significantly more barriers to accessing the right program quickly and easily than their SBM counterparts.
- 3. Improve customer service & shopping experience:** The SPM has little ability to modify the federal web portal or call center, functions critical to an improved consumer shopping experience and responsive customer service. (SPMs may customize their own landing page and link to decision-support tools there, but the real shopping activity takes place on the FFM.) As a result, the SPM is hampered in advancing state-specific policy goals or incorporating feedback from interested stakeholders regarding opportunities for improvement. For example, SPMs (like SBM-FPs) do not control their Marketplace's primary customer call center.

On the other hand, we note that the FFM delivered a far better consumer experience in 2015 than in 2014 and continues to improve its decision-support tools. For example, the FFM is testing a total cost estimator and centralized provider directory—tools which many SBMs lack for OE3.

- 4. Increase health plan competition:** An SPM can increase health plan competition through the QHP certification process. The opportunity to apply the state's knowledge of the local health plan market, familiarity with payer and provider dynamics, and a relationship with the state's division of insurance could be an important reason for developing an SPM.

An important element of increasing health plan competition is a nuanced understanding of the local market, which is difficult under an FFM model. An SPM has ongoing relationships with health insurance carriers in the market, can assist them in working through issues with the FFM, and would be able to facilitate and coordinate the often competing perspectives of health plans, providers, and related state agencies, such as Medicaid and the division of insurance. Under this model, a state can use both QHP certification and rate regulation as policy levers to enhance competition or directly control rates.

One drawback of an SPM relative to an SBM is that certain incentives for increasing health plan competition might require refinements or enhancements to the underlying technology, such as the web portal, decision-support tools, or plan comparison features. The SPM does not control what type of functions or modifications are offered on the FFM technology platform and may be stymied in its efforts as a result.

5. **Control administrative costs of the Marketplace:** An SPM exerts no control over the user fee assessed by the FFM, which is currently 3.5 percent of Marketplace premiums. Of course, the SPM does control its own expenses in two ways: (a) what functions it decides to operate (plan management and/or consumer assistance and outreach) and (b) the resources it devotes to perform these functions.

However, robust consumer assistance and outreach does require substantial spending. The ability to reach targeted populations, inform, educate, and drive consumers to the web portal or call center will be directly commensurate with the level of resources allocated to the function. In order to maximize outreach and enrollment, the state would need to adequately fund these functions without access to any portion of the user fee that is built into premiums, and is available in part to an SBM-FP and entirely to an SBM.

Because many elements of plan management are partly administered by a state's division of insurance, this function could be fully developed with a modest increase in expenses. Given its potential to help control premiums and improve other features of the market, plan management could generate a significant "policy return" for a modest investment.

6. **Contribute to health delivery reform & systems transformation:** Again, an SPM can contribute to this policy goal via plan management. In doing so, the SPM could use the QHP certification process as a lever to assist in advancing broad health care reform goals. While modest enrollment may limit the SPM's influence, as it would the SBM's and SBM-FP's, exercising control over how QHP certification is developed and implemented can still be an effective policy lever.
7. **Develop a robust SHOP program that attracts customers:** As currently articulated in statute and regulatory guidance, an SPM is wholly dependent on the FFM for its SHOP and does not have an option to retain or pull-back from the FFM any SHOP-specific functions. Therefore, we rate this goal as "Very Difficult" for an SPM to pursue.

Federally-Facilitated Marketplace (FFM)

The FFM provides eligible residents and small businesses with access to tax subsidies, a public exchange, and information on the ACA in states that have decided against playing any role in implementing a Marketplace.

The primary vehicles for communicating to the public about QHPs, subsidies, and related information are the HealthCare.gov website and the FFM's consumer call center. As might be expected, the FFM provides little state-specific information other than the comparison of available QHPs for consumers to evaluate when shopping. (It recently rolled out centralized provider and prescription drug directories for QHPs.) The FFM organizes all of the statutory functions required of a Marketplace, including eligibility determination for tax credits, outreach and marketing, the QHP certification process, and a consumer web portal. (At the state's discretion, the FFM can also determine eligibility for Medicaid and CHIP, but most states are reluctant to delegate this important function of their own programs to CMS.)

Taking each of the seven goals individually, we assess a state's ability to achieve them via the FFM as follows:

1. **Maximize outreach & enrollment:** The FFM relies primarily on the web portal HealthCare.gov, a modest national advertising budget (per enrollee), and a relatively unstructured broker program to inform individuals and small businesses of the availability of subsidies to purchase health insurance. The FFM is able to use digital targeting much like an SBM, to develop *national* partnerships (e.g., CVS, Walmart) that are beyond the reach of most SBMs, and to work on retention (direct contact with enrollees) as effectively as any SBM. The FFM site provides a lot of informative facts, figures and key dates, and even includes a link to real-life personal stories in which individuals discuss the importance of health insurance generally, and the benefits of the Marketplace specifically. While the website is functional and the stories compelling, the ability of the FFM to actively target and engage prospective enrollees within a given state is limited.

The FFM serves 34 states across the country with a wide range in the level of uninsured and unemployed and with varied population demographics. With significant differences across the states, it is unrealistic to expect the FFM will target a given population within any state. Successful outreach to a low-income, uninsured population requires a targeted outreach and communication plan informed by small-area data, and the identification and mobilization of local resources working in specific communities across the state; even with this approach, engaging the targeted population can be challenging.

By design, the FFM is a national web portal and contact center for information, eligibility determination for APTCs, comparison shopping for QHPs, and enrollment in the chosen QHP. As currently constructed and resourced, the FFM is hard-pressed to target a specific state or population, relying instead on broad-based marketing and advertising, and national partnerships (e.g., Walmart) to drive a targeted population to its web portal. Therefore, we rate the ability of the FFM to maximize outreach and enrollment as “Challenging.”

2. **Seamless eligibility determination:** Importantly, the FFM is not seamlessly integrated with state Medicaid and CHIP programs, thus slowing the eligibility and enrollment process for individuals who qualify for Medicaid or other state social services programs. While states could delegate eligibility determination for Medicaid, CHIP, and APTCs to the FFM, none have done so to-date. They are loath to give up control of Medicaid and CHIP costs driven by enrollment. Without such delegation, the FFM will not be able to provide a seamless, efficient application and enrollment process, and therefore we rate the FFM’s ability to achieve this goal as “Challenging.”
3. **Improve customer service & shopping experience:** Over the past few years, the FFM web portal has become stable and highly functional; it includes basic consumer assistance tools to help inform consumer choice of health and dental plans. The FFM augments the web portal with a consumer call center to assist individuals in understanding their health and dental plan options, and to respond to inquiries about eligibility and how to access health care services.

In the recent NPRM, there is a proposal to allow the FFM to standardize plan options. A number of SBMs have recently moved in this direction to improve the consumer shopping experience when evaluating plan options. (Issuers would also be allowed to offer non-standardized plans as long as they are meaningfully different from the standard offerings.) This could facilitate comparison shopping on the FFM, but it does not give a state the authority to customize these standard plan designs for its own market circumstances.

In addition, the FFM has been testing decision-support tools for consumers to determine the availability of select physicians, hospitals, and medications when comparing QHPs. There is also a total-cost calculator that estimates out-of-pocket spending plus monthly premiums. As a result, the FFM will have decision-support tools that many SBMs lack. Moreover, as these tools improve over time, the FFM should be able to realize scale economies in adopting them.

4. **Increase health plan competition:** To increase health plan competition, the FFM relies primarily on the pricing structure of Marketplaces, which emphasizes for consumers the difference in QHP premiums, and on enrollment volume to interest health insurance plans in offering competitively priced QHPs on the FFM. The FFM has attracted several national issuers, which entered the new Marketplaces slowly in 2014. For states that prefer a “light touch” from government, this may be their preferred approach to enhancing plan competition.*

Moreover, any state that wants to regulate health insurance premiums aggressively can do so through the Insurance Commissioner’s authority to review rates. The December 2015 NPRM proposes that the FFM have the ability to become more of an “active purchaser” of QHPs by providing the FFM the right to deny certification as not in the best interest of consumers despite meeting all other minimum certification requirements. On the other hand, to pursue this goal as an “active purchaser” generally requires an empirical assessment of the competitiveness of a given market, the potential for new enrollment, and the likelihood of providers working with new market entrants by, for example, offering price concessions. Such work requires coordination and collaboration with state agencies, and developing relationships with health plans that is different than generally adopted by federal agencies. The FFM lacks significant local knowledge and resources, as well as ongoing working relationships with state agencies and Insurance Commissioners of the sort required for planning, strategizing, goal-setting, and coordination to effectively implement an “active purchaser” type of Marketplace.

Recent evidence suggests that “active purchaser” Marketplaces, such as California and Massachusetts, can increase health plan competition, but the FFM is remote from the local markets and challenged in developing health plan relationships without subjecting itself to calls of unfairness.

*Having hesitated for 2014, United Healthcare jumped into some 25 Marketplaces for 2015, but recently announced its intention to retrench in 2017. While it is hard to see how the FFM can exert pressure on United to stay on, an SBM using an active purchasing model could put pressure on UHC to remain actively engaged.

Despite these obstacles, having the regulatory ability to withhold certification of QHPs as not in the best interest of consumers, despite meeting minimum requirements, does provide a powerful lever for the FFM, and observing how the FFM utilizes this new lever may require revisiting its current rank of “Challenging” for this goal.

- 5. Control administrative costs of the Marketplace:** The FFM spent a lot of money in the last few years remediating a number of well-publicized technology problems, so assessing its ability to control operating costs may be premature. It should be able to achieve scale economies, at least for the IT platform and sophisticated decision-support tools.

To date, however, neither the FFM nor the larger SBMs have demonstrated scale economies. Moreover, there is a growing demand from non-SBM states to remediate the FFM technology with some elements of customization; they also want to receive more detailed data extracts on enrollment, premiums, web portal activity, and consumer shopping patterns so states can better understand who is enrolling in the Marketplace, what are the needs and issues of the enrolled population, and what policies can be developed and implemented to advance a state’s health care agenda. Therefore, due to competing priorities, it might be difficult for the FFM to lower its 3.5 percent user fee.

On the other hand, the FFM states and issuers enjoy the certainty of this 3.5 percent surcharge, without the near-term risk of costs exceeding that. So we rate this goal as “Challenging” for the present, but if the FFM realizes scale economies in the future it should be “Achievable.”

- 6. Contribute to health delivery reform & systems transformation:** The ability of the FFM to achieve some goals discussed above suffers from a lack of local resources, difficulty developing long-term relationships with key state agencies and stakeholders, and the variability of needs across the 34 states currently serviced. Transforming a state’s health care is no different: most states have their own reform agendas, preferred approaches, local challenges, politics, and stakeholder perspectives, which the FFM is not in a position to address.

An additional challenge is that transformational change requires a long runway for planning and public vetting of various policy and business options, according to each state’s particular time horizon. This variability and multiple stakeholder process is not easily managed by an organizational structure such as the FFM, and CMS’ goals in operating the FFM do not encompass state-specific health care reform agendas.

- 7. Develop a robust SHOP program that attracts customers:** To-date, SHOP has not been a focus of the FFM. There does not appear to be much investment by CMS in attempting to develop a competitive advantage or marketing the availability of SHOP. Presumably in an effort to develop some competitive advantage, the recently-released NPRM proposes the FFM offer employers “vertical choice” of benefit plans, in which employees can select benefit plans across all levels from a single carrier. While this does present a potential opportunity for the FFM, a strategy regarding the engagement and development of brokers and agents, critical to the success of any SHOP effort has not been communicated. As a result, we assess the capability of the FFM to develop a robust SHOP program as “Very Difficult.”

Conclusion

Now that the country has had some experience working with various Marketplace models, the states have some interesting options to consider in pursuit of their particular policy goals. For example, states that are primarily focused on enhancing health plan competition may be able to do so with any of the Marketplace models, but the SBM, SBM-FP, and SPM models offer additional tools for pursuing this goal. States that want to integrate eligibility determination into one streamlined process, or that want to “go their own way” under a section 1332 waiver, must use (or develop) their own SBMs. States that prefer to engage as little as possible with the ACA, or worry about ballooning administrative costs, can simply rely on the FFM.

In addition, as information technology continues to improve, cost efficiencies receive more attention, and policy evolves, it is likely that the Marketplace options for states also will evolve. States that are considering a change should continue to evaluate the Marketplace models against their policy goals, and also might consider ways to continue modifying these models in order to best meet their needs.

Appendix – List of States by Marketplace Model, as of December 2015

State-Based Marketplace (SBM)	Supported State-Based Marketplace (SBM-FP)	State Partnership Marketplace (SPM)	Federally-Facilitated Marketplace (FFM)
California	Hawaii	Arkansas	Alabama
Colorado	New Mexico	Delaware	Alaska
Connecticut	Nevada	Illinois	Arizona
District of Columbia	Oregon	Iowa	Florida
Idaho		Michigan	Georgia
Kentucky		New Hampshire	Indiana
Maryland		West Virginia	Kansas
Massachusetts			Louisiana
Minnesota			Maine
New York			Mississippi
Rhode Island			Missouri
Vermont			Montana
Washington			Nebraska
			New Jersey
			North Carolina
			North Dakota
			Ohio
			Oklahoma
			Pennsylvania
			South Carolina
			South Dakota
			Tennessee
			Texas
			Utah
			Virginia
			Wisconsin
			Wyoming

ⁱ Jane Wishner et al, “Factors that Contributed to High Marketplace Enrollment in Five States in 2015.” (Urban Institute, October 2015). Calculated from the Table I, after removing Hawaii from the 14 states listed as “Not Using Healthcare.gov in 2015.”

ⁱⁱ CMS Notice of Proposed Rulemaking, Proposed Benefit and Payment Rules for 2017, at <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-29884.pdf>, pp. 11-115, and 39-320.