

**STATEMENT OF**

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**ON**

**STATE-BASED HEALTH INSURANCE MARKETPLACES**

**BEFORE THE**

**UNITED STATES HOUSE COMMITTEE ON ENERGY & COMMERCE**

**SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS**

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**State-Based Health Insurance Marketplaces**  
**U.S. House Committee on Energy & Commerce,**  
**Subcommittee on Oversight & Investigations**  
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Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation to discuss the Affordable Care Act's State-based Health Insurance Marketplaces (SBMs). The Centers for Medicare & Medicaid Services (CMS) serves both Marketplace consumers and the American taxpayers by providing oversight of and access to high-quality, affordable health insurance coverage.

Because of the Affordable Care Act, pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. Consumers now have the comfort of knowing that if their employment changes or they lose coverage, they can purchase affordable coverage through the Marketplaces—regardless of their personal health histories. As the Affordable Care Act has taken effect, we've covered 17.6 million Americans. Since 2010, the uninsured rate (for those aged 18-64) has decreased by 45 percent. And for the first time, more than 90 percent of Americans are covered.<sup>1</sup> The reduction in the uninsured benefits Americans no matter how they get their health insurance, as reductions in the uninsured rate generally mean that doctors and hospitals provide less uncompensated care, the costs of which are often passed along to consumers and employers who pay premiums for health coverage.<sup>2</sup>

The Health Insurance Marketplaces bring private-sector health plans together to compete to meet consumer needs and help people shop for and afford health care coverage. In the past, when consumers shopped for health insurance, they had to read a patchwork of non-uniform and intricate disclosures about important matters, such as what benefits are covered under what conditions and the cost sharing associated with those benefits. The process was inefficient, difficult, and time-consuming. Because of the difficulty in obtaining comparable information across and within health insurance markets, consumers had trouble finding and choosing the coverage that best met their health and financial needs, as well as the needs of their families or their employees. Along with employer-sponsored coverage, Medicare, and Medicaid, private

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<sup>1</sup> <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf>

<sup>2</sup> [http://aspe.hhs.gov/sites/default/files/pdf/83961/ib\\_UncompensatedCare.pdf](http://aspe.hhs.gov/sites/default/files/pdf/83961/ib_UncompensatedCare.pdf)

insurance purchased through Health Insurance Marketplaces is now a reliable option for consumers to get the care they need at essential times in their lives. To help consumers shop for coverage, the Marketplaces allow consumers to compare health insurance plans based on key factors, such as covered services, providers, and importantly, price.

CMS's goal with the Health Insurance Marketplaces is to provide people in every state access to quality, affordable health care coverage and a fully functional Marketplace in which to purchase such coverage—whether their state chooses to have a Federally-facilitated Marketplace (FFM) or a SBM. SBMs have played a critical role in the success of the Affordable Care Act by enrolling consumers across the country into affordable, high-quality, private health insurance plans, while allowing states the option to offer local control over key Marketplace functions. Since the ACA was enacted in 2010, CMS has provided states with the information, guidance, and tools needed to make informed decisions about which type of Marketplace would meet the needs of their citizens.

### **SBMs are Tailoring their Work to Meet the Needs of their States**

Across the country, a diverse set of states have chosen to implement an SBM to provide coverage to their residents, educate consumers about the importance of health insurance, and enroll them in high-quality, affordable health insurance coverage.

States that choose to establish and operate their own Marketplace must meet certain requirements and responsibilities set by the Affordable Care Act. Section 1311 of the Affordable Care Act outlines Federal requirements for establishing SBMs and makes available grant funding to states to meet those responsibilities. These requirements include, but are not limited to, establishing a governance structure, developing and implementing consumer assistance functions and resources (including a Navigator program and call center), and certifying qualified health plans (QHPs).

The Affordable Care Act provides significant flexibility to states to design and operate Marketplaces to meet the unique needs of their citizens. SBMs have taken different innovative approaches to their Marketplace consistent with their local needs. In California, Covered California employs an active purchasing strategy related to QHP certification and rigorously

reviews health insurance companies to determine whether they meet specific standards of quality, affordability, and accountability. These efforts helped improve consumers' options and contributed to a significant decrease in the uninsured rate in California. Approximately 1.7 million more Californians had insurance coverage in 2014 than in 2013.<sup>3</sup> During this Open Enrollment, residents in California will have at least two carriers to choose from, and 99.6 percent will have three carriers to choose from.<sup>4</sup> Covered California is working with 68 community-based Navigators and over 30,000 Certified Insurance Agents, Certified Application Counselors and other representatives across the state to enroll consumers in health insurance coverage during Open Enrollment this year.<sup>5</sup>

Massachusetts' Marketplace, the Health Connector, has significantly expanded its customer service for this year's Open Enrollment period, by providing additional customer service hours, creating four new walk-in centers, and expanding on-line capabilities which allow consumers to update their applications and make changes without calling a call center.<sup>6</sup> Kentucky and Connecticut use a retail store format to educate and enroll consumers in coverage and have implemented on-line decision support tools for consumers and a mobile application and as of June 30, 2015, over 88,000 residents of Kentucky and over 92,000 residents of Connecticut were enrolled in high-quality, affordable health insurance coverage through their State-based Marketplaces.<sup>7</sup>

CMS facilitates and encourages the sharing of best practices between states, including the replication of successful models. For example, for the second year of Open Enrollment Maryland adopted Connecticut's Marketplace system for eligibility and enrollment functions.<sup>8</sup>

### **CMS Provides Oversight and Technical Assistance to the SBMs**

CMS is responsible for the financial integrity and cost-effectiveness of the award and administration of grants to states to establish SBMs. CMS used HHS' established grant oversight

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<sup>3</sup> <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf>

<sup>4</sup> <http://docs.house.gov/meetings/IF/IF02/20150929/103791/HHRG-114-IF02-Wstate-LeeP-20150929.pdf>

<sup>5</sup> <http://news.coveredca.com/2015/10/covered-california-is-launching-its.html>

<sup>6</sup> <http://docs.house.gov/meetings/IF/IF02/20150929/103791/HHRG-114-IF02-Wstate-GutierrezL-20150929.pdf>

<sup>7</sup> <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html>

<sup>8</sup> <http://www.baltimoresun.com/health/health-care/bs-hs-exchange-board-vote-20140401-story.html>

process to safeguard taxpayer funds, which includes a competitive grant award process, budget negotiations, ongoing monitoring and oversight, funding release restrictions, and corrective actions for grantees that are in non-compliance with the terms and conditions of the grant, including the repayment of grant funds.

All funds for the establishment of SBMs have been allocated following HHS Grants Policy and applicable Federal statutes and regulation. States applied for funding through a competitive grant opportunity, and were required to meet the criteria established in the Funding Opportunity Announcement.<sup>9</sup> Proposals were reviewed by an objective review panel, made up of non-Federal staff with content expertise in such areas as information technology (IT), operations, Medicaid, provider issues, and health care financing. Simultaneously, CMS conducted a thorough review of the applications and engaged the grant applicants in a thorough budget negotiation process, which several times resulted in a reduction of the requested award amount.

Each state that received a section 1311 grant is subject to a post-award, ongoing monitoring process to enforce the grant's terms and conditions and to identify issues to be corrected or mitigated. SBMs are required to submit semi-annual progress reports, quarterly financial reports, and monthly budget reports. CMS also restricts the release of the states' grant funding for IT development. Prior to having access to IT funding for any deliverable, states are required to submit information justifying their requests, including details on the proposed spending. CMS reviews and assesses the requests to release funds submitted by grantees for reasonableness of the request and soundness of the technical approach. CMS often requires states to submit revised requests with more detail before granting a release of IT funds. If a state's request is determined to be unreasonable, unsound, or duplicative of previously-funded activities, CMS denies the SBMs' request for the release of grant funds.

The grant recipients were subject to establishment reviews where CMS and state grantees met face-to-face to assess progress or identify risks and issues during the planning, design, development, and implementation phases of their projects. If issues were identified during this review, CMS required states to implement mitigation strategies or workarounds in order to be

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<sup>9</sup> [https://www.cms.gov/ccio/resources/Funding-Opportunities/index.html#Health Insurance Marketplaces](https://www.cms.gov/ccio/resources/Funding-Opportunities/index.html#Health%20Insurance%20Marketplaces)

able to meet functional requirements by the time of open enrollment. CMS also required a state to develop and submit a Corrective Action Plan (CAP) when significant issues were identified. For example, in December 2013, CMS required Massachusetts to develop a CAP to address system deficiencies that impacted the state's ability to enroll consumers through the online Marketplace. The CAP outlined the steps Massachusetts was required to take to achieve compliance with the ACA's online eligibility and enrollment requirements. CMS established a series of milestones and due dates for key areas such as governance, organization and resource management, schedule, business capability, and engineering views. Massachusetts provided CMS with an updated program schedule weekly and regular demonstrations on the IT development. As a result of this oversight, Massachusetts successfully launched a new individual enrollment and eligibility system for the second open enrollment period. As states move from the establishment of the SBMs to the operation of the SBMs, CMS continues to oversee and monitor each SBM's performance through ongoing and regular consultations and Open Enrollment readiness review.

The Affordable Care Act requires that beginning January 1, 2015, SBMs must be financially self-sustaining by having a source of funding - other than section 1311 funds - in place for ongoing operations. After January 1, 2015, section 1311 funds may not be used for ongoing SBM operations. No new section 1311 grants were awarded after January 1, 2015, consistent with the statute. Under established HHS Grant Policy, states may request a time-limited No Cost Extension (NCE) to use existing establishment funding, where the grantee reasonably requires additional time to complete the design, development, and implementation of establishment activities that were part of the SBM's establishment work plan. Requests for an NCE must include a monthly budget and spend plan that identifies non-section 1311 funds that will support ongoing operations and to demonstrate that an SBM has internal controls to ensure that section 1311 funding and other funding sources are properly separated and documented. CMS reviews each request to assure the request is appropriate, meets allocation parameters, and reasonableness of costs based on section 1311 and existing HHS grant rules and policies. NCE requests may be granted after CMS reviews and determines that expenditures associated with the funding request meet previously approved funding proposals. CMS conducts careful oversight of states' compliance with these requirements.

To ensure the appropriate use of section 1311 grants, CMS provides extensive technical assistance to clarify the difference between operational and establishment costs, including through webinars and phone conferences tailored to individual SBMs. CMS posted written guidance on section 1311 grants in March and September 2014.<sup>10</sup> In June 2015, consistent with the recommendation of the HHS Office of the Inspector General (OIG), CMS issued additional guidance on the difference between operational and establishment costs, including specific examples for states to consider.<sup>11</sup> Following this policy, in September 2015, CMS found through our routine oversight of state Marketplaces that the Arkansas SBM spent approximately \$1 million of the state's section 1311 funding for activities that are not allowed under regulations. CMS notified the state, and it is working cooperatively to return the funds to the Federal Government.

Additionally, CMS conducts reviews of the SBMs to enforce the sustainability requirements established in the statute. SBMs are required to submit a five-year budget that includes non-Federal funding sources and amounts. CMS reviews budgets and funding sources, and evaluates the SBMs' reserve funding, projected revenues, and the management structure and organizational stability of the SBM. These reviews enable CMS to identify SBMs that may not comply with sustainability requirements. On May 29, 2015, CMS notified Rhode Island's Marketplace, HealthSourceRI that it must identify and obtain a funding source other than section 1311 grant funds or it would be out of compliance. On July 1, 2015, Rhode Island enacted a new state budget<sup>12</sup>, which included a 3.5 percent assessment on health plans sold through HealthSourceRI, which brought the Marketplace into compliance with the Affordable Care Act.

CMS provides analysis and tools for the SBMs to assess financial self-sustainability and forums for SBMs to share and discuss strategies and best practices regarding their administrative costs and finances. In July 2015, CMS hosted an in-person workshop that was attended by SBM

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<sup>10</sup> <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf>

<sup>11</sup> <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf>

<sup>12</sup> <http://www.ri.gov/press/view/25187>

leadership from across the country, and included discussions regarding strategies and best practices toward achieving sustainability.

## **Conclusion**

The Health Insurance Marketplaces are designed to assist consumers with accessing affordable health care by connecting them to coverage, and making it easier to shop for private-sector health care options. Millions of Americans have taken advantage of the choice, competition, and affordability provided by these Marketplaces – both State-based and Federal – since they first launched in 2014. SBMs have used innovative approaches appropriate to their state-specific needs and conditions. Together, SBMs have provided health care coverage to millions across the country. While there has been a historic decrease in the number of uninsured in the United States, those states that have established and operated their own Marketplace have had on average, a larger decrease in the uninsured.<sup>13</sup> CMS is equally committed to strong ongoing oversight of SBMs that protects taxpayer funds. As part of this work, CMS provides support in the form of technical assistance and oversight to steward the use of Federal dollars and compliance with applicable laws. CMS is committed to protecting the investment made in SBMs through ongoing monitoring and oversight and recovers misspent funds in accordance with HHS' established grants oversight process. As the needs of consumers and states continue to evolve, CMS will continue to support states as they consider their options with support and oversight. We appreciate the Subcommittee's interest and I am happy to answer your questions.

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<sup>13</sup> <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf>