ACA Implementation—Monitoring and Tracking

The Launch of the Affordable Care Act in Selected States:

State Flexibility is Leading to Very Different Outcomes

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. Cross-cutting reports and state-specific reports on case study states can be found at **www.rwjf.org** and **www.healthpolicycenter.org.** The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) constitutes substantial reform of the US health insurance system. It includes an expansion of Medicaid eligibility to all those with incomes of up to 138 percent of the federal poverty level (FPL), regulatory reforms of private health insurance markets (particularly in the small group and nongroup markets), and financial assistance for the purchase of private insurance plans through newly established Health Insurance Marketplaces (HIMs, or Marketplaces, sometimes also referred to as Exchanges). In addition, the law requires most individuals to enroll in health insurance coverage or pay a penalty (the so-called individual mandate). It also institutes requirements for employers (recently delayed), most notably establishing financial penalties for large employers[1] with workers who obtain subsidized coverage through the HIMs.

While the law established federal minimum standards, the ACA left considerable room for state participation and design flexibility in implementation of its insurance market reforms and the establishment of the Marketplaces. For example, states could establish their own Marketplaces using federal funds (creating State-Based Marketplaces, or SBMs), could leave the entire responsibility for establishing the HIM to the federal government (Federally Facilitated Marketplaces, or FFMs), or could take on particular HIM responsibilities while leaving the lion's share of their establishment to the federal government (FFM-Partnerships [FFM-Ps] or FFM-Marketplace Plan Management arrangements [FFM-MPMs]). States were expected to implement and enforce the new insurance market rules included in the law, but if they could not or would not do so, the rules would be enforced by the federal government. And, while not the original intent of the law as written, a 2012 Supreme Court decision made the ACA's Medicaid expansion an option for states. Many other options were left to states choosing to participate within the rubric of HIM design, insurance reforms, and Medicaid implementation.

As such, the design and effects of the ACA will differ across the states as a function of different policy choices made. Some states demonstrated a strong and consistent commitment to the law's implementation, quickly pursuing options to expand coverage and improve insurance markets as much as possible. Other states—often as a result of powerful political opposition to the law in either the governor's office, the state legislature, or both—chose to play only a limited role in implementation or no role at all. Assessment of the ACA and its potential to reduce the uninsured and to increase access and affordability to adequate insurance coverage will require drawing distinctions between outcomes in states putting maximum effort into the law's implementation and those whose involvement is limited, reluctant, or even obstructionist. The different design and implementation decisions will inevitably result in different outcomes for states, consumers, and other stakeholders.

Researchers at the Urban Institute along with colleagues at the Georgetown University's Center on Health Insurance Reforms assessed the state of health reform implementation in eight states that exhibit varying levels of support for the law. The findings are contained in a series of papers. These include eight briefs or papers that summarize findings for different kinds of states on a particular topic, including: coverage expansion potential, federal funding flows, information technology (IT) system development, eligibility determination and enrollment outreach, insurance plan participation, competition and premiums, insurance market reforms, Small Business Health Options Program (SHOP) development, and provider capacity. In this paper, we summarize the key findings and discuss the broad implications.

The study states were chosen from among those participating in a multiyear project funded by the Robert Wood Johnson Foundation (RWJF). The project provides in-kind technical support to states to assist them with implementing the reform components each has chosen to pursue; the project also provides funds for qualitative and quantitative research to monitor and track ACA implementation at the state and national levels. The participating states were chosen from among those whose governors expressed interest in participating; governors in all 50 states and the mayor of the District of Columbia were invited to apply. States did not need to have committed to SBM development to participate, but they had to express interest in exploring potential roles for their state in the implementation of the ACA.

The states ultimately chosen for the larger project from among those expressing interest included Alabama, Colorado, Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia. Seven of these states (Colorado, Maryland, Minnesota, New Mexico, New York, Oregon, and Rhode Island) developed their own SBMs. Illinois and Michigan entered into formal partnership arrangements (FFM-Ps, both taking on responsibility for insurance plan management and Illinois also taking responsibility for outreach and enrollment activities) with the federal government, and Virginia developed an FFM-MPM arrangement (taking responsibility for insurance plan management tasks but avoiding the Partnership moniker).

For the current analysis, we chose five states that were actively pro-reform—Colorado, Maryland, Minnesota, New York, and Oregon. These states have demonstrated policy leadership and a strong commitment to effective implementation of the ACA. Each has adopted the Medicaid expansion and developed SBMs. They have engaged with a broad array of stakeholders in designing their state approaches and have pursued significant outreach and enrollment activities in order to increase coverage through their new HIMs and through Medicaid. Each has conducted extensive quantitative analyses of the effects of the law on their states and were quick to engage IT vendors. Each has taken responsibility for implementing insurance market reforms and has moved beyond federal requirements in order to improve stability and sustainability of their insurance markets. Not all of these states have had the same experience—for example, Oregon and Maryland had particularly challenging rollouts of their IT systems and were well behind in enrolling applicants during the initial months of the open enrollment period.

We chose Alabama, Michigan, and Virginia as examples of states taking on a more limited role in the implementation of reform. While all three states explored the possibility of developing their own SBMs early on, none decided to do so. As such, all rely on the federal IT system associated with healthcare.gov for eligibility determination and enrollment. But even as problems with the federal website are resolved, these states will face difficulties. None of them participate in consumer outreach and enrollment activities related to their state HIM, and far fewer resources will be devoted to those activities compared with the other five states. Again, the three are not all the same. For example, Michigan and Virginia have taken a responsibility for plan management, but Alabama left that responsibility to the federal government. Michigan chose to expand Medicaid for 2014; Alabama and Virginia may ultimately do so, but at present, they have not. While some factions in each state support the goals of the ACA, in these states there has not been a unified commitment to full participation, and the political leadership has chosen to take a more limited role as a result. These states are not likely to fare as well in expanding coverage and achieving the ACA goals for the foreseeable future.

Findings from this series of papers suggest the following:

- All states will benefit from the establishment of HIMs and income-related subsidies. Employer coverage is not expected to change significantly. States that are expanding Medicaid will ultimately experience larger relative gains in insurance coverage than those states that do not. These states will also see greater reductions in the number of uninsured, in the range of 40 to 50 percent. States not expanding Medicaid will

have smaller reductions. Because most of the non-expanding states had fewer uninsured to begin with, the ACA will result in increased disparities in coverage, at least in the early years.

- Because of greater increases in Medicaid coverage, expanding states will receive significantly larger relative inflows of federal dollars than those not expanding. The Medicaid expansion, with the very high federal matching rate, will bring in large amounts of federal dollars that will offset the ACA cuts in Medicare provider payment rates and Medicaid and Medicare disproportionate share hospital (DSH) payments. Non-expanding states will still have the ACA cuts with much less in new revenue. New state spending is relatively small, and much of it can be offset by savings in other parts of state budgets.
- SBM states have substantially more federal resources per uninsured person for outreach, education, and enrollment assistance than FFM states have. For public education, our five SBM states are spending, on average, $20.97 per uninsured person versus $5.90 in FFM states. Funding for application assistance per uninsured person is $30.66, on average, in our SBM states versus $8.79 in our FFM states.
- Performance of the IT systems supporting eligibility and enrollment in the five SBM states has been mixed and is reflected in state-specific enrollment numbers. The systems launched by the New York and Colorado Marketplaces are off to a relatively successful start, providing consumer-friendly plan comparison information and a streamlined, automated enrollment experience for a majority of applicants. In Maryland, Oregon, and (to a lesser degree) Minnesota, however, Marketplace IT systems have struggled to overcome technical glitches, defective software, and design flaws. Though these SBMs are committed to improving system functionality, full repairs could take several months (or longer if major software components are replaced) and enrollment numbers are further behind projections. The federal IT system on which the FFM states rely also stumbled badly in its first two months; but, following a large-scale repair effort, functionality of the healthcare.gov site has improved considerably, facilitating a December surge in enrollment that has continued into 2014. The SBM states will continue to benefit from having close coordination between their HIM and Medicaid IT systems, facilitating smooth transitions across programs and greater continuity of coverage for beneficiaries. In contrast, the lack of close coordination between healthcare.gov and FFM states' Medicaid IT systems is a disadvantage for these states, relative to the fully participating ones.
- Plan participation and the level of competition is less a function of whether states are SBMs or FFMs and more a function of the pre-ACA insurance market as well as the managed competition framework in the ACA—for example, standardized rules, more information on premiums and benefits, and subsidies that are linked to the second-lowest-cost plan. In both SBM and FFM states, there are a large number of participants in most markets, including large and small commercial insurers and some new entrants, such as Medicaid plans and co-ops. Premiums have been lower-than-expected, reflecting cost-sharing requirements and limited or tiered networks but also intense competition for market share. In essentially monopolistic markets, however, the ACA lacks tools to create competition and premiums are higher (e.g., some rural markets in Alabama, Michigan, and New York).
- Significant reforms to regulations governing the operation of insurance markets, particularly in the small-employer and nongroup markets, went into effect on January 1, 2014. Although only five of our states—Colorado, Maryland, Minnesota, New York and Oregon—chose to operate their own HIMs, both Michigan and Virginia are playing significant roles in managing the new plans in the HIMs. And, with the exception of Alabama, all the states have been actively involved in developing and implementing processes to review, approve, and monitor insurer compliance with the new rules. However, to date, the SBM states appear to be more proactive in efforts to mitigate potential premium increases during the transition to a reformed market; they have also been more inclined to implement long-term strategies to stabilize health insurance rates and to ensure the sustainability of their HIMs.
- Overall, the SHOP Marketplaces in the SBMs as well as in the FFMs have been slow to make progress, compared with their nongroup Marketplace counterparts. The SBM states with fully functional SHOP websites, however, have committed to providing choice of plan options in 2014 for workers of participating small employers; employee choice will not be available to the FFM states until 2015. There have been delays in two of the five SBM states studied, Maryland and Oregon, so employer choice will be unavailable until their websites are repaired. SHOP enrollment for the FFM states has been delayed until 2015 due to constraints with healthcare.gov. As a result of these delays, SHOP participation for the FFM states is expected to fall below that in many of the SBM

states, at least for the first year of operation.

- Likewise, provider supply is a problem in some geographic areas in all states. States that are expected to experience the largest relative increases in insurance coverage—for example, Colorado and Oregon—will see the greatest increase in pressure on this system. States with broad coverage already and those not adopting the Medicaid expansion will see less increase in demand for services. There are several systematic changes taking place to alleviate these demand pressures: increases in Medicaid physician fees, increased funding of community health centers, and increases in hospital ambulatory care capacity.

The remainder of this paper presents an overview of the findings from our analyses of the eight states.

COVERAGE GAINS[2]

The ACA includes many provisions likely to lead to expanded health insurance coverage. These include the significant expansion of Medicaid eligibility, although this is an option for states following the 2012 Supreme Court decision. Two of the states discussed in this brief—Alabama and Virginia—have thus far decided against expansion. All states will benefit from the provision of income-related tax subsidies for the purchase of private plans offered in new Marketplaces and the individual mandate that provides financial incentives for the currently uninsured to enroll in coverage. The combination of the tax exclusion for employer-based insurance—which continues under the ACA—the individual mandate, nondiscrimination rules, and other factors[3] means that employer coverage will stay at roughly the same levels as would be the case without the ACA, if not increase slightly.

We used the Health Insurance Policy Simulation Model (HIPSM)[4] to estimate coverage changes and the impact on the uninsured when the ACA is fully implemented in the eight study states. The states that

Table 1: Change in Medicaid/CHIP Coverage Among the Nonelderly With the ACA, 2016 Estimates

State	Without ACA		With ACA		Change	Percentage Change in Medicaid Enrollment
	Number of People	% of Nonelderly Population	Number of People	% of Nonelderly Population		
States Expanding Medicaid						
Colorado Medicaid/CHIP	498,000	10.7%	746,000	16.0%	248,000	49.7%
Maryland Medicaid/CHIP	643,000	12.3%	914,000	17.5%	271,000	42.2%
Michigan Medicaid/CHIP	1,612,000	18.7%	2,139,000	24.8%	527,000	32.7%
Minnesota Medicaid/CHIP	724,000	16.1%	844,000	18.7%	120,000	16.5%
New York Medicaid/CHIP	4,265,000	24.9%	4,777,000	27.9%	512,000	12.0%
Oregon Medicaid/CHIP	509,000	15.2%	834,000	24.9%	325,000	63.8%
States Not Expanding Medicaid						
Alabama Medicaid/CHIP	743,000	18.3%	835,000	20.6%	92,000	12.4%
Virginia Medicaid/CHIP	681,000	9.6%	815,000	11.5%	134,000	19.7%

Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.
Notes: ACA was simulated as if fully implemented in 2016. CHIP = Children's Health Insurance Program.

Table 2: Change in the Uninsured Nonelderly With the ACA, 2016 Estimates

State	Without ACA		With ACA		Change	Percentage Change in Uninsured
	Number of People	% of Nonelderly Population	Number of People	% of Nonelderly Population		
States Expanding Medicaid						
Colorado Uninsured	848,000	18.2%	456,000	9.8%	-392,000	-46.2%
Maryland Uninsured	762,000	14.6%	442,000	8.5%	-320,000	-42.0%
Michigan Uninsured	1,339,000	15.5%	722,000	8.4%	-617,000	-46.1%
Minnesota Uninsured	456,000	10.1%	283,000	6.3%	-173,000	-37.9%
New York Uninsured	2,724,000	15.9%	1,700,000	9.9%	-1,024,000	-37.6%
Oregon Uninsured	674,000	20.1%	329,000	9.8%	-345,000	-51.2%
States Not Expanding Medicaid						
Alabama Uninsured	694,000	17.1%	486,000	12.0%	-208,000	-29.9%
Virginia Uninsured	1,045,000	14.8%	714,000	10.1%	-331,000	-31.7%

Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.
Note: ACA was simulated as if fully implemented in 2016.

chose to adopt the Medicaid expansions will see larger coverage gains. We project that Medicaid enrollment will increase by 49.7 percent in Colorado, 42.2 percent in Maryland, 32.7 percent in Michigan, and 63.8 percent in Oregon (Table1). Coverage changes are smaller in Minnesota and New York—16.5 percent and 12.0 percent, respectively—because both states had already considerably expanded coverage prior to the ACA.[5] With the Medicaid expansion, the percentage of the nonelderly population on Medicaid ranges from 16.0 percent in Colorado to 24.9 percent in Oregon and 27.9 percent in New York.

In contrast, Alabama and Virginia will have smaller increases in Medicaid coverage under the ACA: 12.4 percent and 19.7 percent, respectively (Table1). These enrollment increases occur because of greater enrollment among those eligible under pre-ACA rules; increased outreach efforts and various strategies to simplify eligibility determination and enrollment under the ACA will have the side effect of drawing more previously eligible individuals into the program. If Alabama and Virginia had adopted the Medicaid expansion, they would have had Medicaid enrollment increases of 353,000 and 338,000, respectively (rather than 92,000 and 134,000); these would have amounted to increases relative to enrollment projections absent the ACA (also referred to as the baseline) of 47.5 percent and 49.7 percent, respectively. By not adopting the Medicaid expansion, these states will leave a major coverage gap between current eligibility levels and the poverty level, at which point individuals without affordable access to employer-sponsored insurance will be eligible for subsidies for Marketplace-based plans.

Marketplace coverage in all states should be significant because of the individual mandate and the availability of premium and cost-sharing subsidies, but coverage may vary because of outreach and enrollment efforts and IT system development. In the SBM states, between 3.6 percent (New York) and 7.5 percent (Colorado) of the state nonelderly population will enroll in plans offered through Marketplaces by 2016. In the FFM states, the percent of the nonelderly population in HIMs could range from 3.4 percent in Alabama to 5.8 percent in Virginia, though realizing these levels may prove difficult given the limited resources devoted to outreach and enrollment activities in FFMs.

Uninsurance rates will fall by about 38 percent in

Minnesota and New York, by about 40 percent in Colorado and Maryland, and by more than 50 percent in Oregon. As shown in Table 2, a sizable percentage of the nonelderly population remains uninsured even after full implementation of the ACA. This ranges from 6.3 percent in Minnesota to 9.9 percent in New York. Alabama and Virginia will see reductions in the number of uninsured of 29.9 percent and 31.7 percent, respectively. Alabama will reduce its uninsurance rate from 17.1 percent to 12.0 percent and Virginia from 14.8 percent to 10.1 percent. If Alabama and Virginia had adopted the Medicaid expansion, then the number of uninsured would have fallen by 64.2 percent and 51.8 percent, respectively. The remaining uninsured include some undocumented immigrants who are prohibited from enrolling in Marketplace coverage, with or without subsidies, and who are excluded from the Medicaid program. Some of the remaining uninsured are exempt from the mandate (e.g., due to low income or still not having access to affordable coverage), while others are bound by it but choose to pay the penalty rather than comply.

FINANCIAL IMPACTS[6]

States that have chosen to expand Medicaid under the ACA will benefit from a large influx of new federal revenues. States that expand Medicaid will receive a 100-percent federal match for newly eligible individuals enrolled (eventually phasing down to a 90-percent federal match in 2020). All states—even those that did not expand Medicaid—will receive pre-ACA federal matching dollars for those eligible under previous rules and an increase of 23 percentage points in the Children's Health Insurance Program (CHIP) federal matching rate.

The states that have not adopted the Medicaid expansion will see an increase of federal dollars coming in two ways: the increased enrollment among those eligible under pre-ACA rules (e.g., "woodwork effect") and the increase in the CHIP matching rate, which applies to all states under the ACA. The amount of federal dollars that will flow into these states will be far less than what it would have been had the states adopted the Medicaid expansion, however.

State expenditures on Medicaid will increase as the federal contribution to Medicaid declines for new eligibles, but there are many ways that the states can offset future increases in state spending. For example, states will be able to reduce their support of uncompensated care provided by hospitals and clinics as the number of uninsured in the state falls.

We find that states expanding Medicaid will see significant increases in federal payments because of the Medicaid expansion (Table 3) and subsidies (Table 4). Colorado and Oregon will see increases in federal payments for Medicaid of 41.5 percent and 43.3 percent, respectively, relative to what they would have had in 2016 in the absence of the ACA (i.e., their 2016 baseline). These large percentage increases reflect the fairly large coverage expansions in these states. Maryland will have increases in federal payments of $1.4 billion, or 27.9 percent, over its baseline in 2016 and Michigan will have a $2.5 billion increase, or 27.1 percent. These percentage increases are lower than in Colorado and Oregon because the latter two had broader pre-ACA Medicaid programs.

Minnesota has even broader current public coverage due to its pre-ACA Medicaid expansions. Because the state now receives federal matching payments for many of these individuals, Minnesota's expected increase in federal payments is only $710 million, or 10.8 percent, in 2016. New York will see an increase in federal payments of $3.9 billion in 2016, or 13.1 percent. Again, the coverage expansion in New York is relatively small due to previous public coverage expansions. But the state will receive substantial new revenue from the enhanced match on their expenditures for previously covered childless adults.

In addition to new federal funds for Medicaid, federal subsidy dollars are available in Medicaid expansion states for eligible individuals with incomes in the 138–400 percent of FPL income range who enroll in Marketplace coverage. In states not expanding Medicaid, Marketplace-based subsidies are available to eligible individuals in the 100–400 percent of FPL income range.[7] Aggregate premium and cost-sharing subsidies flowing to state residents are shown in Table 4. They range from $615 million in Minnesota to $2.4 billion in New York in 2016. The amount of the subsidies depends on the size of state populations, the number of individuals in the subsidy income range, the distribution of their incomes, and premium levels. They do not depend on whether states are SBMs or FFMs, though the latter could be affected by outreach efforts—if fewer

Table 3: Increase in Federal and State Medicaid Expenditures Due to the Affordable Care Act, 2016 (dollars in millions)

	Baseline	ACA		Change		% Change	
State	Without ACA	Without Expansion	With Expansion	Without Expansion	With Expansion	Without Expansion	With Expansion
States Expanding Medicaid							
Colorado							
Federal	$2,821		$3,991		$1,170		41.5%
State	$2,654		$2,724		$70		2.6%
Maryland							
Federal	$4,948		$6,328		$1,380		27.9%
State	$4,779		$4,629		-$150		-3.1%
Michigan							
Federal	$9,371		$11,911		$2,540		27.1%
State	$4,597		$4,837		$240		5.2%
Minnesota							
Federal	$6,557		$7,267		$710		10.8%
State	$6,345		$6,495		$150		2.4%
New York							
Federal	$30,071		$34,011		$3,940		13.1%
State	$29,195		$26,677		-$2,518		-8.6%
Oregon							
Federal	$3,421		$4,901		$1,480		43.3%
State	$1,897		$1,877		-$20		-1.1%
States Not Expanding Medicaid							
Alabama							
Federal	$4,687	$4,787	$6,237	$100	$1,550	2.1%	33.1%
State	$2,043	$2,063	$2,073	$20	$30	1.0%	1.5%
Virginia							
Federal	$4,652	$4,821	$6,302	$169	$1,650	3.6%	35.5%
State	$4,456	$4,574	$4,606	$118	$150	2.6%	3.4%

Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.[8]
Note: ACA simulated as if fully implemented in 2016.

eligible individuals enroll in Marketplace plans, total subsidies paid will be lower as well.

All these states will see relatively small increases in their own expenditures. State Medicaid expenditures will increase because of increased enrollment of current eligibles due to broader outreach and enrollment efforts, and because states will eventually contribute 10 percent to the cost of Medicaid enrollees made newly eligible under the ACA. Maryland and New York, however, will experience a decrease in state spending on these programs. Maryland will see savings of $504 million over the 2013–22 period because of the high federal matching rate for those currently enrolled in its limited benefits program for adults. The higher matching rate paid by the federal government for this group under the ACA leads to a reduction in state spending. New York will see savings of $23.0 billion over this period, a 7.7 percent reduction over pre-reform Medicaid expenditures.

The states that expand Medicaid will also have reductions in spending on other items in the state budget, including reductions in the state's share of DSH payments and reductions in current budget allocations for mental health, substance abuse, and public health programs because these items will become covered benefits in the Medicaid expansion. States like Alabama and Virginia that did not expand Medicaid will not be able to reduce current state expenditures for uncompensated care as much as they otherwise would have, nor will they be able to save state dollars spent on medical services that would have been covered as Medicaid benefits for an expanded population of enrollees.

Table 4: Federal Subsidies Per Nonelderly in Selected States, 2016 (in millions)

State	Premium Subsidies	Cost-Sharing Subsidies	Total Subsidies
SBM States			
Colorado	$971	$42	$1,013
Maryland	$594	$62	$656
Minnesota	$548	$67	$615
New York	$2,160	$263	$2,423
Oregon	$777	$88	$865
FFM States			
Alabama	$638	$65	$703
Michigan	$1,591	$120	$1,711
Virginia	$1,044	$121	$1,165

Source: Urban Institute estimates, HIPSM 2013; The Urban Institute has developed a New York specific model which is used for all New York estimates in this paper. Estimates for all other states are from the national HIPSM model.

There are also significant economic consequences of not expanding Medicaid. Alabama and Virginia will not experience the same economic impacts as the states that are expanding Medicaid coverage. Although, like all other states, Alabama and Virginia will have reductions in Medicare provider payment rates and Medicaid and Medicare DSH payments under the law, they will not have the sizable influx of federal dollars from the Medicaid expansion to offset these reductions that Medicaid expansion states will receive. Thus, Alabama and Virginia will not enjoy the positive economic effects on state gross domestic product, employment, and tax revenues that would have occurred with the expansion.

ELIGIBILITY AND ENROLLMENT SYSTEMS[9]

Arguably the biggest task facing HIMs has been to create an ACA-compliant IT system that determines an individual's eligibility for and facilitates enrollment in a qualified health plan, income-based federal subsidies, or Medicaid/CHIP. Reaching the ACA's goals for coverage is dependent on a functional IT system, with a key component being a self-service website where consumers can shop, apply for, and enroll in health insurance coverage.

The five states studied here that chose to operate a SBM—Colorado, Maryland, Minnesota, New York, and Oregon—were responsible for developing the IT system to support their Marketplaces. The states prioritized system development during ACA implementation, and many were recognized as early leaders in this area. In the final months leading up to October 1, 2013, officials in these states were generally optimistic about how their Marketplaces would perform, though they shared common concerns about what might go wrong.

The initial website launch was rocky for each of these five SBM states, as consumers encountered error messages and were unable to create accounts or move forward with the application process. But states' experiences since that early point have been very different. Some sites have been operating successfully for months; others are still struggling to overcome technical glitches more than midway through the initial open enrollment period. For instance:

- After making a series of upgrades in the first week of open enrollment—including a significant increase in server capacity—New York's HIM has been running smoothly and has been recognized as a "top performer" among all Marketplaces (state-based and federally facilitated). Like most states, New York's Marketplace experienced a surge in applications in December 2013 that contributed to some minor delays in processing time; New York plans to add more than 300 trained representatives to its Marketplace call center in preparation for the March 31, 2014, end of open enrollment.[10]
- Despite some early stumbles, Colorado's

Marketplace system is now functioning well for most users. Initially, many online applicants were experiencing long waits for an eligibility determination from the state's Medicaid/CHIP system, a necessary first step before determining eligibility for Colorado's Marketplace-based subsidies. Colorado made improvements and by the end of December 2013 reported that application backlogs had been cleared and that Medicaid/CHIP eligibility determinations were immediate for as many as 80 percent of applicants.[11] A major fix is expected sometime in 2014, when the state integrates the two steps into a single process.

- The problems facing Minnesota's IT system are significant enough that officials are considering (among other options) fundamental changes to its software architecture. A recent consultant's report identified more than 200 software defects in the system and suggested two possible remediation strategies or a third, more drastic option of replacing software components to implement a new solution that would be launched by 2016. Minnesota Marketplace officials will decide on a repair strategy in early 2014; meanwhile, the state is making improvements to its call center and implementing manual workarounds to the technical glitches that continue to hamper the enrollment process.[12] In early February 2014, officials reported that 98 percent of website users are now able to complete their transaction without help, compared to 70 percent at the end of 2013.[13]
- Maryland's website has also been fraught with technical issues since it went live, including frozen screens, lost information, error messages, and mistaken identities. Officials announced in early November that the Marketplace was increasing staff and other resources devoted to improving the website,[14] and more recently claimed that the site—while still glitchy—was working smoothly for most users.[15] Though the pace of enrollment has picked up over the past two months, it is still far below the state's projections. Some lawmakers have suggested that the state abandon the website and begin using the federal healthcare.gov portal, but Governor Martin O'Malley's administration publicly announced that Maryland would "stay the course" and continue repairs to its own site through the end of the open enrollment period. After that, the state's options for implementing a long-term solution include rebuilding large segments of its system or replacing parts of it with superior technology from other SBMs, partnering with the FFM, or joining a state consortium.[16] Meanwhile, the governor has signed into law a measure that allows residents who attempted but were unable to access Marketplace coverage to enroll in the state's high-risk insurance pool.[17]
- Oregon's is the only Marketplace website in the study with technical problems serious enough to prevent any online enrollment. After a failed launch, the state implemented a contingency plan requiring three steps: 1) an individual submits a paper or PDF application, which is manually entered into the system by an eligibility worker; (2) the individual is notified about his or her eligibility by mail, email, or phone; and 3) eligible individuals select a plan through the website. Hundreds of new workers have been hired to process paper applications manually under this temporary approach. Though the primary vendor responsible for building Oregon's IT system continues to work on repairs, some question whether it will ever be functional, and state officials are considering backup options if the site is not working by the end of March. These options include replacing software with components designed by other states or the federal government.[18] State lawmakers have also proposed a number of legislative measures that would help more residents obtain coverage (e.g., directing Oregon's Marketplace to extend the open enrollment deadline by a month) and increase oversight of Marketplace operations.[19] Most recently (and just before this brief was published) Oregon's

ACA Requirements for Eligibility and Enrollment Systems

The ACA envisions a streamlined, simplified, and coordinated system that determines eligibility for and enrolls individuals in all health subsidy programs (including Medicaid, CHIP, and Marketplace-based premium and cost-sharing subsidies) and that facilitates seamless transitions across programs. The ACA also calls for the system to allow for self-service enrollment and renewal and to rely on electronic rather than paper-based processes. To meet these goals, the ACA requires health insurance Marketplaces to:

- Create a "no wrong door" system that includes a website and screens people seeking coverage for all health subsidy programs and enrolls them in the correct program.
- Use a single, streamlined enrollment application that allows individuals to apply for all health subsidy programs and that can be submitted online, by mail or telephone, or in person.
- To the maximum extent possible, develop and use secure electronic interfaces to share available data to establish, verify, and update eligibility for all health subsidy programs.

Table 5: Health Insurance Marketplace-Based Eligibility and Enrollment and Urban Institute Enrollment Projections in Selected States During the First Four Months of the Open Enrollment Period[1]

State/ Marketplace	Number of Individuals Determined Eligible and/or Enrolled Through Marketplaces			Urban Institute Projections for Private Plan Enrollment Through CY2014	
	Medicaid/CHIP (Determined or Assessed Eligible)[2]	Marketplace (Private) Plan		Projected Enrollment (Number of Individuals)	Enrolled in Private Plan as a Percentage of Projection
		Determined Eligible	Enrolled in a Plan[3]		
Colorado	n/a	123,820	68,454	133,361	51%
Maryland	81,040	38,375	29,059	94,133	31%
Minnesota[4]	61,784	94,789	28,611	88,785	32%
New York	178,145	476,385	211,290	313,232	67%
Oregon	76,578	59,242	33,808	91,991	37%
All State-Based Marketplaces (14 states + DC[5])	2,013,145	2,488,288	1,359,904	2,160,381	63%
Alabama	16,270	111,951	43,863	108,642	40%
Michigan	34,032	255,055	112,013	201,642	56%
Virginia	27,860	200,865	74,199	188,553	39%
Federally Facilitated Marketplace (36 states[5])	1,168,010	4,778,942	1,939,588	4,936,254	39%

Sources: DHHS Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Marketplace: February Enrollment Report, 2/12/14, http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf; Urban Institute projections using the Health Insurance Policy Simulation Model (HIPSM), February 2014. See endnotes 20 and 21 for additional information about HIPSM and methodology for the Urban Institute's projections.

Notes:

(1) Data are for period between 10/1/13 and 2/1/14.

(2) States have the option of having Marketplaces either (a) assess Medicaid/CHIP eligibility before transferring applicant information to the state Medicaid/CHIP for a final determination, or (b) conduct a final determination for Medicaid/CHIP. Colorado's Marketplace does not currently have an integrated eligibility system, and data for individuals determined or assessed eligible for Medicaid/CHIP is not available.

(3) Private plan enrollment totals include individuals that have selected a plan, with or without the first premium payment having been received directly by the Marketplace or the insurance carrier. This is sometimes called pre-effectuated enrollment.

(4) Minnesota's cumulative data for individuals who have been determined eligible for or enrolled in a private Marketplace plan do not include adults with incomes between 133 percent and 200 percent of the FPL, because those individuals are enrolled in the MinnesotaCare program. Between 10/1/13 and 1/4/14, the Minnesota Marketplace determined that 17,570 individuals were eligible for MinnesotaCare. (See: MNsure, the MNsure Metrics October 1, 2013 through January 4, 2014, https://www.mnsure.org/images/Bd-2013-01-08-MNsureMetrics.pdf.)

(5) Idaho and New Mexico have established a State-Based Marketplace but are using the FFM eligibility and enrollment system (accessed through healthcare.gov) for 2014; accordingly, enrollment in these two states has been included in the FFM total.

> Marketplace launched a password-protected version of the website that can be accessed by insurance agents and other application assistors. Officials have not provided a date for when the web portal will be open to the public but have indicated they hope to have this done by the end of March 2014.[20]

The three FFM study states—Alabama, Michigan, and Virginia—are relying on the IT system developed by the federal government (primarily known through its online application portal, healthcare.gov) to determine eligibility for qualified health plans and Marketplace-based subsidies. Healthcare.gov stumbled badly in its first weeks of operation. Major issues included difficulty logging in and creating accounts, long waits in application verification and eligibility processing, wrong or missing data submitted to health plans regarding individual enrollment, and delays in transferring data to states regarding individuals who may be eligible for Medicaid coverage. As the story unfolded in the days following the site's launch, several factors were identified as contributing to the rocky start. Chief among them was that a full, "end-to-end" testing of the site did not take place until two weeks before its October 1 debut. Following the launch, the administration publically implemented several changes to both the website itself and the management of the effort. The administration publicly announced a goal to have a completely

functioning system that worked for 80 percent of consumers by the end of November 2013 and has indicated that it met these goals after more than 400 technical fixes and a significant upgrade in server capacity. Still, much work remains to make the FFM's IT system truly "state of the art," as envisioned by the ACA and—as in many of the SBMs—officials expect continued improvements and enhancements to the system in the months and years to come.

Marketplace-based enrollment numbers for the first four months of open enrollment (October 1, 2013 through February 1, 2014) reflect the early successes and stumbles of the web-based eligibility and enrollment systems at work in the study states. As shown in Table 5, enrollment figures for the SBM states range from 211,290 individuals enrolled in private plans in New York to 28,611 individuals enrolled in a private plan in Minnesota. (Note that private plan enrollment totals include individuals that have selected a plan, with or without the first premium payment having been received directly by the Marketplace or the insurance carrier.) To assess the success of Marketplace systems in determining eligibility for and enrolling applicants in health plans, Table 5 shows actual private plan enrollment as a percentage of Urban Institute (UI) projections for private plan enrollment through December 2014. To allow for cross-state comparisons of early enrollment success, UI projections (based on HIPSM,[21] which has been described elsewhere) are used rather than estimates developed in September 2013 by the Department of Health and Human Services (the latter can reflect different methodologies used by different states).[22] When assessed against UI projections, the relative success of New York and Colorado's Marketplaces is evident: these two states have already enrolled, respectively, 67 and 51 percent of December 2014 projected enrollment, at the start of February 2014. On the other hand, the Maryland and Oregon SBMs have each enrolled approximately one third of projected enrollees. Minnesota's SBM has performed similarly (at 32 percent of projected enrollment). Unlike in other study states, however, low-income SBM applicants in Minnesota are not enrolled in private plans but are instead enrolled in the public MinnesotaCare program. Compared to other study states, therefore, Minnesota's private plan enrollment total is artificially low by an amount that is difficult to calculate.

During the first four months of open enrollment, more than 1.9 million individuals enrolled in a private plan through the FFM, including 43,863 in Alabama, 112,013 in Michigan, and 74,199 in Virginia. Michigan enrollment represents more than fifty percent of UI projections, and enrollment in Alabama and Virginia is lagging in comparison. Even so, relative to projections, the FFM has been more successful in enrolling individuals in private plans than some of the SBM states. As a whole, however, Table 5 shows that the 15 SBMs have experienced more success (in terms of meeting projections) than the FFM.

The Marketplaces have also determined (or assessed) eligibility for Medicaid or CHIP for millions of individuals during the first four months of open enrollment, ranging from 16,270 individuals in Alabama to 178,145 individuals in New York. All totaled, more than 3 million individuals have been determined eligible for Medicaid through the Marketplaces (state-based and federal) since October 1, a sometimes overlooked success of these systems.

For all the study states (and across the Marketplaces more generally), the pace of enrollment has increased as the open enrollment period has progressed and as technical issues have been addressed. Enrollment surged in December as the deadline for coverage beginning January 1, 2014, approached; in that month alone, enrollment increased more than threefold among the SBMs and more than sevenfold across FFM states. Significant growth has continued into 2014, with federal officials reporting a 53 percent increase in plan selection in January.[23] Federal and state officials have also predicted a significant uptick in enrollment in March 2014, as the close of open enrollment approaches, including among individuals determined eligible for a private plan but who have yet to enroll in one. A comparison of the third and fourth columns in Table 5 shows that across the study states, many individuals have been determined eligible but have not selected a plan to complete the enrollment process.

OUTREACH AND ENROLLMENT[24]

A major determinant of whether ACA implementation succeeds will be how federal and state governments face the challenge of reaching and enrolling new eligibles. Overcoming the sheer complexity, public confusion, and lack of awareness of the law requires public marketing campaigns that raise eligible populations' awareness of the availability of new coverage options and of how to access that coverage. In addition, enrollment assistance programs are required to provide diverse populations with various ways to get

Table 6: Funding for ACA-Related Public Education Relative to the Number of Uninsured Who Will Qualify for Medicaid and Marketplace Subsidies Under the ACA

State	Marketing Funding	Number of Eligible Uninsured	Marketing Funding per Eligible Uninsured Individual
Colorado	$10,000,000	567,141	$17.63
Maryland	$2,500,000	428,587	$5.83
Minnesota	$9,000,000	350,427	$25.68
New York	$40,000,000	1,566,875	$25.53
Oregon	$10,000,000	497,380	$20.11
Total of above states	**$71,500,000**	**3,410,410**	**$20.97**
FFM and FFM-P states	**$86,000,000**	**14,565,297**	**$5.90**

Sources: State estimates of public education spending; Urban Institute estimates of eligible uninsured.

Table 7: Funding for Application Assistance Compared to the Number of Uninsured Who Will Qualify for Medicaid and Marketplace Subsidies Under the ACA

State	Application Assistance Resources			Total Number of Eligible but Uninsured	Funding per Eligible but Uninsured Individual
	Funding for Navigators and In Person Assistors	Community Health Centers	Total		
Colorado	$17,000,000	$3,077,201	$20,077,201	567,141	$35.40
Maryland	$24,000,000	$1,620,449	$25,620,449	428,587	$59.78
Minnesota	$16,294,000	$1,684,340	$17,978,340	350,427	$51.30
New York	$27,000,000	$7,243,004	$34,243,004	1,566,875	$21.85
Oregon	$3,760,000	$2,884,396	$6,644,396	497,380	$13.36
Total of above states	**$88,054,000**	**$16,509,390**	**$104,563,390**	**3,410,410**	**$30.66**
Alabama	$1,443,985	$2,424,896	$3,868,881	266,791	$14.50
Michigan	$2,541,887	$3,782,688	$6,324,575	1,011,958	$6.25
Virginia	$1,762,025	$2,501,028	$4,263,053	365,841	$11.65
Total of above states	**$5,747,897**	**$8,708,612**	**$14,456,509**	**1,644,590**	**$8.79**

Sources: Study states: State estimates of application assistance spending; FFM states: Centers for Medicare and Medicaid Services (CMS) estimates of application assistance spending; FFM-P IPA funding: CMS and state estimates of application assistance spending; Urban Institute estimates of eligible uninsured.[25]

help with the application process. The five states that have aggressively implemented the ACA have launched ambitious outreach and marketing campaigns and have developed multifaceted enrollment assistance programs. Meanwhile, the three states with FFMs or FFM-Ps—two of which have also chosen not to expand Medicaid—have deferred these responsibilities to the federal government; as such, they are receiving a substantially reduced level of federal funding for marketing and enrollment assistance.

To develop a strong marketing campaign, the five SBM states convened workgroups of numerous stakeholders to develop programs for outreach, public education, and awareness. By late 2012 and early 2013, all five states were well engaged in planning efforts and were working with private-sector marketing and advertising firms to conduct market research. Subsequently, they began developing websites; by October 1, 2013, they had aired television commercials reflecting their states' unique characteristics. (Some SBM states delayed their marketing campaigns because of website problems.) On the other hand, little is known about the details of

the federal marketing campaign in the three FFM or FFM-P study states. Since the passage of the ACA, the Department of Health and Human Services (DHHS) has awarded $86 million to two public relations firms to develop the outreach campaign that would target 14.6 million uninsured individuals. While the federal campaign is spending $5.90 per uninsured person eligible for coverage, the five SBM states are spending more than three times that amount—$71.5 million or about $21 per targeted consumer (Table 6).

Similarly, the five SBM study states have established application assistance programs using navigators, in-person assistors, and certified application counselors. By October 1, 2013, all five states had made awards to various groups that were trained to provide consumers assistance with the application process. These efforts differ among states. Meanwhile, in the three FFM and FFM-P states studied, the federal government funded and selected navigator entities. Every state, however, will benefit from additional federal funding and efforts by federally qualified health centers (FQHCs) to assist with enrollment.

As with the marketing and public outreach efforts, states taking on enrollment assistance have substantially more resources available to establish an application assistance infrastructure. Between navigators and community health centers' outreach funding, Alabama, Michigan, and Virginia will have a total of $14.5 million to support application assistance, or $8.70 per each uninsured resident. This is less than the $88 million, or $30.66 per uninsured person, supporting application assistance in the five SBM states discussed here (see Table 7).

Although the ACA also allows states to use targeted enrollment strategies to provide Medicaid to people based on data matches from other public programs, only one of the study states—Oregon—has developed a program to use the receipt of SNAP benefits (food stamps) in order to determine eligibility.

Although it is unclear how effective the federally run ACA marketing campaign will be, it is clear that public education and enrollment assistance in federally managed outreach states—including three of the study states—have significantly less funding than states that are operating their own Marketplaces. This lower level of funding is likely to translate into lower enrollment levels in HIMs, particularly among young and healthy consumers who will tend to be harder to reach.

INSURER COMPETITION AND PREMIUMS IN THE NONGROUP MARKETPLACES[26]

A significant number of insurers are participating in the Marketplaces in both SBM and FFM states. The level of competition is less a function of whether states have SBMs or FFMs than of the managed care completion framework—for example, transparency, standardized rules, and the link of subsidies to the second-lowest-cost plans.

Insurers participating in SBMs include many of the largest existing carriers in those states. There has been a significant presence of local commercial plans in Colorado, Minnesota, and Oregon, and these were often the most competitive insurers in those states. In most of the states, new nonprofit co-ops and Medicaid managed care organizations are entering the Marketplaces. The previously Medicaid-only plans are particularly strong competitors in several regions in New York, but in other states, the premiums of Medicaid plans are well above the lowest-cost option. Co-op plans have generally been among the highest-priced plans in Colorado and Oregon, with New York as an exception.

In the FFM states, Alabama has only two insurers participating: Blue Cross Blue Shield throughout the state and Humana in the Birmingham area. Michigan has a large number of insurers participating in the HIM, particularly in the larger urban markets. Blue Cross Blue Shield Michigan has a very large market share in the state, but several smaller commercial carriers as well as Molina, a Medicaid HMO, and a co-op also participate. Virginia has a large number of participants, too. Anthem, participating throughout the state (except Northern Virginia), and CareFirst, operating in Northern Virginia, are the largest carriers. Aetna is a presence in several markets in the state, including a partnership with the Inova hospital system in northern Virginia and the

Table 8: Lowest Cost Silver Plan for the Three Lowest Cost Insurers in the Largest Metropolitan Areas

State	Location	Insurer	Premium: 27-year-old	Premium: 50-year-old
CO	*Statewide*	*Pre-ACA Small Group Statewide Average*	*$440.50*	
	Denver	Kaiser Permanente	$208.52	$357.77
		Humana	$212.96	$365.36
		Colorado HealthOP	$232.10	$398.23
MD	*Statewide*	*Pre-ACA Statewide Small Group Average*	*$456.75*	
	Baltimore	CareFirst Blue Choice*	$187.00	$319.00
		CareFirst BCBS (MSP)	$197.00	$335.00
		Kaiser Permanente	$221.27	$377.11
MN	*Statewide*	*Pre-ACA Statewide Small Group Average*	*$445.83*	
	Minneapolis	PreferredOne*	$126.21	$215.09
		Health Partners	$135.99	$231.75
		Blue Cross Blue Shield of Minnesota	$150.72	$285.95
NY	*Statewide*	*Pre-ACA Statewide Small Group Average*	*$525.33*	
	New York County (contains Manhattan)	MetroPlus Health Plan	$359.26	$359.26
		Health Republic	$365.28	$365.28
		Oscar	$384.72	$384.72
OR	*Statewide*	*Pre-ACA Statewide Small Group Average*	*$430.83*	
	Portland	Moda Health*	$159.00	$270.00
		HealthNet	$176.00	$300.00
		Providence	$192.00	$327.00

** Issuer offered the two lowest-cost plans in the area noted*
***New York has full community rating and thus rates do not vary by age*
Source for Pre-ACA averages: MEPS (2012) Table II.C.1 Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: Less than 50 employees, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2012/tiic1.pdf.

Carilion system in southern Virginia.

In general, we find that the nongroup Marketplace plans available to people in these states were moderately priced. We focus on the lowest-cost silver plans; premiums can reflect the expected costs of enrollees as well as the deductibles in these plans (about $2,500 for single coverage) and limited or tiered networks. We use average premiums available to employees in today's small group markets as a comparison in assessing the level of premiums in the Marketplaces because pre-ACA individual plan premiums varied tremendously in the vast majority of states, depending on underwriting, benefits, and other factors. Small group premiums reflect many of the same issues seen in the individual market but to a somewhat lesser degree: high administrative costs, limited benefits, and high cost-sharing. Further, most states chose their most enrolled small group plans as the essential health benefits benchmark for the ACA-compliant nongroup and small group markets. These small group premiums are shown in Tables 8 and 9 as the "Pre-ACA statewide average."

The managed competition structure of HIMs provides strong incentives for insurers to bid aggressively. Subsidies are tied to the second-lowest-cost silver plan in the individual's area of residence. Individuals who want a more expensive silver plan, or a gold or a platinum plan, have to pay the full difference in cost from the second-lowest-cost silver option. Choosing a plan with a lower premium results in savings for consumers. Thus, consumers have a strong incentive to select a plan

Table 9: Lowest Cost Silver Plan for the Three Lowest Cost Insurers in the Largest Metropolitan Areas

State	Location	Insurer	Premium: 27-year-old	Premium: 50-year-old
AL	*Statewide*	*Pre-ACA Statewide Average*	*$439.08*	
	Jefferson County (contains Birmingham)	Humana	$209.16	$356.46
		Blue Cross and Blue Shield of Alabama	$211.24	$360.00
		-	-	-
MI	*Statewide*	*Pre-ACA Statewide Average*	*$464.17*	
	Wayne County (contains Detroit)	Humana Medical Plan of Michigan, Inc.	$156.16	$266.14
		Total Health Care USA, Inc.	$183.75	$313.14
		Blue Care Network of Michigan	$198.76	$338.73
VA	*Statewide*	*Pre-ACA Statewide Average*	*$449.92*	
	Fairfax City (Washington, DC, area)	Innovation Health Insurance Company	$213.00	$362.00
		CareFirst Blue Choice	$222.97	$379.99
		Kaiser Permanente	$225.54	$383.55

** Issuer offered the two lowest-cost plans in the area noted.*
Source for Pre-ACA averages: MEPS (2012) Table II.C.1 Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: Less than 50 employees, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2012/tiic1.pdf.

equal to or less expensive than the second-lowest-cost silver plan. This dynamic led many insurers to set their premiums aggressively in order to attract a large share of consumers. The types of plans emerging as the most competitive varied across states.

Table 8 provides premium data for the largest market in each of the SBM states studied. The lowest premiums are found in Minnesota, followed closely by Maryland and Oregon. The lowest-cost monthly premiums for silver plans for 27-year-olds are $126.21 in Minneapolis, $187.00 in Baltimore, and $270.00 in Portland. Comparable monthly premiums for 50-year-olds are $215.09 in Minneapolis, $319.00 in Baltimore, and $270.00 in Portland. New York's rates are difficult to compare to the other states' premiums because of New York's community rating policy, which prohibits premium variation based on the age of enrollees; the premiums for the lowest-cost plan in Manhattan are $359.06, with young and old paying the same amount. In general, there is no real pattern in the level of premiums across regions within states; however, the rural counties we examined in Colorado and New York have higher premiums than those states' urban markets.

There was little discernible pattern across the states in the types of insurers offering the lowest premiums. The lowest-cost plans in Colorado are generally offered by the Rocky Mountain Health Plan and Anthem. In Denver, however, Kaiser Permanente is the lowest-cost plan, followed by Humana. In Maryland, Blue Cross Blue Shield generally has the lowest premiums in each market, followed by Kaiser Permanente.

In Minnesota, local commercial plans, particularly Preferred One and Health Partners, are the lowest-cost participating plans in each market. Blue Cross Blue Shield of Minnesota is often the third-highest-cost plan or higher. In Oregon, several local or regional commercial plans are the lowest-cost bidders. These included Moda Health, Pacific Source, Lifewise, and Health Net.
In New York, the entrance of Medicaid plans has affected the market, forcing active insurers to develop lower-cost plans to compete for market share. Fidelis Care, a large Medicaid plan, is extremely competitive throughout the state; other Medicaid plans, such as Metro Plus, are very competitive in New York City. The state's co-op, Health Republic, is also generally one of the lower-cost plans. Blue Cross Blue Shield plans, Empire and Excellus, generally have higher premiums, but their broad name

recognition is expected to somewhat counterbalance costs. In Allegany County in western New York, the premium of the second-lowest-cost plan—Blue Cross Blue Shield—is well above that of the second-lowest-cost plans in Nassau County, Manhattan, and Syracuse.

Among the FFM states, there seems to be little insurer competition in Alabama, with Blue Cross dominating in most of the state, just as they had pre-ACA. Nonetheless, as shown in Table 9, Blue Cross Blue Shield of Alabama (BCBSAL) charges relatively moderate Marketplace premiums—$211.24 per month for a 27-year-old and $360.00 for a 50-year-old in Birmingham—which are slightly higher than Humana's premiums. Given BCBSAL's market power and dearth of competitors, it is surprising that its premiums are so low. The low premiums likely result from higher deductibles, limited provider networks, and the carrier's strong market power vis-à-vis providers.

In Michigan, Marketplace premiums are also well below those in the pre-ACA small group market. The lowest-cost plans in Detroit were offered by Humana: $156.16 per month for a 27-year-old and $266.14 for a 50-year-old. Although Blue Cross Blue Shield was a strong competitor in most markets, it was not one of the lowest-cost plans in Detroit. In rural areas of Michigan, premiums were substantially above those in Detroit and Ann Arbor. The threat of competition in several markets in Michigan seemed to have kept rates low, though premiums in rural areas are quite high, reflecting the fact the Blue Cross Blue Shield has no competition there.

In Virginia, Anthem or CareFirst was the lowest-cost carrier in most parts of the state, although Optima Health provided competition to Anthem in many regions. In Northern Virginia, there is considerably more competition between Innovation Health Insurance Company (the joint partnership of Aetna and the Inova hospital system), Kaiser Permanente, CareFirst, and Anthem (the latter two compete in different markets in the Northern Virginia area). In all cases, premiums seem to be fairly low. In Fairfax City, premiums for the lowest-cost plan are $213.00 per month for a 27-year-old and $362.00 for a 50-year-old.

INSURANCE REFORMS[27]

The ACA includes a number of insurance market reforms to improve the availability, affordability, and adequacy of individual and small group market health insurance coverage, and many of them went into effect January 1, 2014. These include guaranteed issue, prohibitions on waiting periods exceeding 90 days, new premium rating rules, prohibition of preexisting condition exclusions, actuarial value (AV) standards, and out-of-pocket cost limits. As a result, our eight study states are experiencing a rapidly changing health insurance environment where new plans are sold both inside and outside the new Marketplaces.

With the exception of Alabama, insurance regulators in all our states are reviewing and approving new plans for sale, monitoring insurers' marketing practices, and working with insurers to help bring their policies into compliance with the new reforms. These seven states have enacted new legislation and developed additional insurer guidance to assist with implementing the ACA's reforms. The new legislation has provided state insurance regulators with a more comprehensive range of tools to monitor insurers' behavior and protect consumers. Additionally, all seven states have engaged in efforts to shape a package of minimum essential health benefits that balances both comprehensiveness and cost.

Differences between the five SBM states and the three FFM states begin to emerge with their varying efforts to mitigate possible temporary spikes in premiums, address consumer concerns about changing coverage options, and ensure the long-term affordability of premiums for HIM plans. There was considerable consensus among our SBM study states in their rejection of a late federal 2013 proposal to allow consumers to renew noncompliant policies into 2014, while among the FFM study states, only Virginia declined to adopt it—and then primarily because of restrictions in underlying state law. And all five of the SBM study states adopted at least one strategy to mitigate premium-rate shock and adverse selection against the HIM; among our FFM study states, only Michigan took any action. While it is not yet clear what implications such variation in state action will have, it appears that states that have built and are operating their own HIMs have, to date, been the most proactive in managing the transition in their markets and ensuring the HIM's long-term sustainability.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) MARKETPLACE[28]

The ACA introduces SHOP Marketplaces as a tool to provide structure and oversight to the small group insurance market. Small employers have historically faced higher premium rates and fewer health insurance options compared with large groups, largely because they lack the purchasing power of large employers, have fewer employees over whom to spread health care risk, and face higher per-enrollee administrative costs. The SHOP Marketplace is intended to decrease administrative burdens and costs as well as increase affordable coverage options to small businesses across the country.

Five of the study states—Colorado, Maryland, Minnesota, New York, and Oregon—have SBMs; thus, they administer their own SHOP Marketplaces. The other three states—Alabama, Michigan, and Virginia—use the healthcare.gov SHOP portal. Overall, due to a combination of federal delays, compressed timelines, and prioritization of the nongroup portion of the Marketplace, the SHOP Marketplaces have been much slower to evolve, compared with their nongroup counterparts in both groups of states.

The ACA contemplates that the SHOPs will provide employees with options among a range of plans in the SHOP (often referred to as "employee choice"), a change from current practice in the small group market, where most employers have been unable to provide a choice of health insurance plans to their employees. In general, we have found employee choice to hold significant value for employers looking to provide coverage through the SHOP Marketplace.[29] Colorado, New York, and Minnesota have implemented some variation of employee choice. The design variations range from full *employee* choice, wherein an employee can select any plan offered at any AV level, to full *employer* choice, wherein an employer offers a single plan at a designated AV level; different levels of constrained employee choice, with limits set by employers, are also available. Due to setbacks with the federal system, FFM states will not have employee choice as an option until the 2015 plan year.

While online SHOP enrollment is available in the New York, Colorado, and Minnesota SBMs, the federal government has delayed online enrollment in the FFM SHOPs until November 2014. Maryland has delayed SHOP enrollment of any kind until April 2014 and has delayed online SHOP enrollment until January 2015. Oregon currently provides small employers with Qualified Health Plan coverage directly through carriers and brokers due to their own online SHOP functionality problems. The healthcare.gov setback will challenge the success of the FFM SHOPs, as interested applicants must either mail in a completed application or use a broker to enroll in SHOP coverage. Regardless, despite initial criticism, healthcare.gov displays the plans available and premium prices in the SHOP, facilitating "window shopping" for small employers in the FFM states. New York is the only SBM state to show premium prices and plan options to employers without asking them to first register as official users. Aside from some glitches, all of the other SBMs' websites as well as healthcare.gov are a consumer-friendly resource, informing interested parties about the details of the SHOP exchange.

Brokers and agents, known as "assistors," are crucial in connecting small employers to health coverage. Although the study states, including the FFMs, anticipate developing a separate portal for all the assistors so they can easily view information on their clients, the websites do not currently have this function. In addition, healthcare.gov does not yet include a "broker search engine" like most of the SBM counterparts and could improve its utility to consumers by adding one. Given the delay of online enrollment, the brokers' role in the FFM and Oregon SHOPs is crucial to successful enrollment.

Plan competition and offerings vary by state, but, the SHOP Marketplaces generally offer consumers a number of plans to choose from at all AV levels. The level of competition among insurers within the SHOPs varies from state to state. Michigan's SHOP market is highly competitive, with eight carriers offering silver plans in Wayne County. In comparison, New York's SHOP market has only three carriers offering silver plans in Manhattan.

Overall, the SHOP Marketplaces, both the SBMs and FFMs, have been slower to make progress compared to their nongroup Marketplace counterparts. However, federal and state officials continue to make technical improvements to the online experience for the SHOPs. They appear on their way to providing consumers with online portals that, at the very least, is a resource for information on the SHOP Marketplace and the availability of federal tax credits to reduce the cost of coverage for some employers.

PROVIDER CAPACITY[30]

Much of the success of the ACA will ultimately hinge on providing access to care. The ACA will expand coverage significantly and potentially stretch the capacity of the existing system. Capacity problems are likely to be greatest in states with the largest coverage expansions, such as Colorado and Oregon. New York and Minnesota, in contrast, will have much smaller coverage expansions; as a result, they will see only minor additional strain on existing capacity. Such states as Alabama and Virginia would have had greater capacity issues had they expanded Medicaid. All states faced an uneven distribution of capacity prior to the ACA, with problems most frequently in inner cities and rural areas. Places with pre-ACA supply shortages will see those shortages exacerbated.

Several provisions in the law are designed to increase primary care capacity. One is the ACA provision to raise Medicaid primary care reimbursement to Medicare levels. Many observers question whether this increase will be sufficient, largely because of its temporary nature. But the expansion is sizable, amounting to increases in payment rates that range from 32 percent in Colorado and 36 percent in Minnesota to 125 percent in Michigan and 156 percent in New York (some of the increase in New York was implemented by the state independent of the ACA). States may find it politically difficult to reverse these increases, potentially leading to a more permanent change in reimbursement (see Table 10).

The expansion of community health centers under the ACA, building upon efforts in the previous decade, will also expand primary care capacity in all states. Given their history of serving low-income populations, FQHCs are well positioned to meet the increased demand for primary care by the newly insured. Recent studies suggest that expanding primary care medical homes and nurse-managed health centers could mitigate shortages of primary care providers. These reforms are taking place in each of the study states.

There are several other efforts to expand the primary care workforce, including new resources to fund medical education and expand the National Health Service Corps. There were few initiatives in SBM states, however, to expand the scope of practice for nurse practitioners and physician assistants. One state—Virginia—enacted legislation liberalizing scope-of-practice laws to allow nurse practitioners to practice in separate locations from their team physicians, such as in clinics, community health centers, and nursing homes.

Hospital systems are expanding primary care capacity through mergers with larger systems and via purchases of

Table 10: Average Primary Care Fee Increase, by State, 2013–14

State	Average Primary Care Fee Increase
SBM States	
Colorado	32%
Maryland	45%
Minnesota	36%
New York	156%
Oregon	39%
FFM States	
Alabama	47%
Michigan	125%
Virginia	36%
United States	**73%**

Source: Zuckerman, S., and D. Goin. How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? *Washington, DC: The Urban Institute. 2012.*

physician practices. Hospital employment is attractive to physicians because of the pressure to adopt electronic health records, and physician incomes can be sustained because of hospitals' greater market strength in negotiating reimbursement rates with insurers. Hospitals also see the opportunity to expand their primary care capacity as providing a base for future referrals.

Many delivery-system reform efforts can expand capacity. Much of this is related to accountable care organizations, but many hospital systems are launching private efforts to improve efficiency, largely through electronic health records and telemedicine. Such states as Colorado, Minnesota, and Oregon have made significant efforts to improve the efficiency of major hospital systems. Oregon has developed 15 coordinated care organizations, which include health plans, physician groups, hospitals, and county health departments. In Colorado, similar efforts built around primary care medical home providers are expanding rapidly in Medicaid. In Virginia, large hospital systems like Sentara and Virginia Commonwealth University hospital are developing telemedicine and transport services to compensate for provider shortages and to increase their capacity to serve rural areas. Though these efforts are in their infancies, they offer promise.

CONCLUSIONS

The overarching conclusion of this paper (and background supporting papers) is that the ACA, as implemented, will vary significantly among states—it is very definitely not "one size fits all." The law provides for considerable state flexibility; as a result, states differ widely in their commitment to implementation of the law and in the policy choices made in reform design. As a result, the law will work differently for residents in different states around the country and will have different outcomes, both in terms of coverage and economic impacts. All of this could, of course, change over time. States that have not adopted the Medicaid expansion could do so, and the federal Marketplaces could work as well as the best state-run HIMs, or there could be transitions to more state-based Marketplaces. Congress could appropriate more funds to FFM states to increase outreach, education, and enrollment assistance. But that, of course, is uncertain. At this point, all we know is that there are considerable disparities in effort and investment across the states. These disparities are likely to lead to further differences between high and low uninsurance rate states.

States that have been actively pro-reform are generally off to a strong start in implementing the ACA. They have all expanded Medicaid and set up SBMs. The fact that each has adopted the Medicaid expansion will mean that they will all experience large coverage gains and significant reductions in the number of uninsured. The expanded coverage will also ensure a significant flow of federal dollars into these states, which will help offset the reductions in Medicare provider payment rates and Medicaid and Medicare DSH payments that are also part of the ACA. In addition, the SBM states received substantial resources to support outreach and enrollment assistance. The rollout of the IT systems in Colorado and New York had early problems but are now working well. Bigger IT system problems persist in Maryland, Minnesota, and Oregon, but these states continue to make progress in fixing their problems and using contingency plans to assure enrollment.

All the SBM states plus Virginia and Michigan have adopted the 2014 insurance market reforms. The SBM states have also taken at least some steps to mitigate the effects of adverse selection and rate shock.

There are a fairly large number of competing insurers in most markets in each SBM study state plus Virginia. In Alabama and Michigan, there is less competition outside of the larger urban markets. Premiums for silver plans are lower than expected, primarily because of the managed competition structure in the law—that is, subsidies are tied to the second-lowest-cost silver plans in each market. The aggressiveness of insurer bids for market share have proven that the competitive model can be successful, although there is potential for unintended adverse effects. For example, many insurers have made use of limited provider networks, which could affect access.

On the other hand, states that have not made a commitment to implement the ACA or to aggressively develop and oversee policies directed at ensuring that the law's objectives are fulfilled will have different experiences. States that have not adopted the Medicaid expansion—for example, Alabama and Virginia—will have coverage gains, but they will be significantly below

what could have been achieved, leaving larger numbers of uninsured state residents than otherwise would have been the case. As a result of not expanding Medicaid and leaving outreach and enrollment responsibilities to the federal government (the latter is true for Michigan as well), these states will also receive a smaller influx of federal payments than they could have had. The economies of the states not expanding Medicaid will be adversely affected, in particular, because the cuts in Medicare rates and Medicare and Medicaid DSH payments that are also part of the ACA will occur without any counterbalancing from additional federal Medicaid dollars. Michigan has adopted the Medicaid expansion and, unlike Alabama and Virginia, will have greater coverage gains and receive more federal funds.

The states that are relying in whole or in large part on the federal government for running their Marketplaces will face other problems. The healthcare.gov website had serious problems in the beginning of open enrollment, although it has improved greatly since the launch. Even with improvements, the initial IT problems slowed enrollment in FFM states, similar to the experiences of the Maryland, Minnesota, and Oregon SBMs.The FFM states also have substantially fewer resources for outreach and enrollment efforts than their SBM counterparts, which may lead to lower relative enrollment. These same states are also experiencing a delayed rollout of online enrollment in the SHOP Marketplaces.

These states have not had the same commitment to achieving the ACA's objectives as other states have, and their outcomes in terms of insurance coverage, state economic impacts, and consumer protections are likely to lag behind their more active counterparts for years to come. Ironically, these states are among those with the most to gain from the ACA, and the effects of their opposition to the law will exacerbate the disparities in coverage and access to care that exist across states today.

These findings demonstrate that the ACA will have very different effects across the country—some a direct reflection of the policy decisions made by the states themselves under the flexibility afforded under the federal law. We used the example of eight states in this paper. The five states that have been actively pro-reform are somewhat representative of others—such as California, Connecticut, Kentucky, and Washington—that have been similarly aggressive in implementing the law. The experiences of states like Michigan are likely to be similar to states such as New Jersey and Ohio, which have opted for the Medicaid expansion but not developed SBMs. The experiences of non-Medicaid expansion and non-SBM states, Alabama and Virginia, are likely to be played out in other states throughout the South as well as states like Missouri and Wisconsin.

ENDNOTES

1. Defined as firms with more than 50 workers (100 workers, beginning in 2016).
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3. Blumberg, L.J., Buettgens, M., Feder, J. and Holahan J. "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act." Inquiry: Summer 2012, Vol. 49, No. 2, pp. 116-126.
4. A description of the HIPSM model can be found at http://www.urban.org/publications/412154.html.
5. The Urban Institute is in the process of updating its New York specific version of the HIPSM model, and new estimates for New York will be available early in 2014. The estimates in this series reflect the output of the national HIPSM model and may be somewhat different than those coming out of the New York state specific model later this year.
6. Information in this section is drawn from Holahan, J. *The Launch of the Affordable Care Act in Selected States: The Financial Impact on States from the Affordable Care Act*. Washington, DC: The Urban Institute, February 2014.
7. Individuals and families are subsidy eligible if they are not Medicaid eligible and they do not have access to employer-based insurance coverage deemed adequately affordable, according to the law.
8. These estimates could understate or overstate the effects by state because they were based on a model first employed in 2011. At that time we used the most recent Medicaid Statistical Information System (MSIS) data available on Medicaid enrollment and expenditures – 2007. We inflated 2007 data to hit estimates of Medicaid expenditures by eligibility group for 2013 that we derived from published Congressional Budget Office (CBO) results. For subsequent years, we project all states to increase to be consistent with CBO projections; this method yields baseline enrollment and expenditures for each state. We then used HIPSM to simulate new enrollment both among current and new eligibles and used HIPSM estimates to calculate spending per person. The baseline projections in Tables 1 and 2 can be somewhat high or low in individual states, depending on whether the states have grown faster or slower than projections between 2007 and 2013. This does not affect the estimates of increases or decreases in spending because of the ACA which depend largely on coverage changes.
9. Information in this section is drawn from Courtot, B., T. A. Coughlin, and D. Upadhyay. *The Launch of the Affordable Care Act in Eight States: Building ACA-Compliant Eligibility and Enrollment Systems.* Washington, DC: The Urban Institute, February 2014.
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21. HIPSM relies on three years of the American Community Survey and thus is representative at the state level. For our purposes, the model estimates in a consistent manner the population with income between 138 percent and 400 percent of the federal poverty level (FPL) that does not have an affordable employer offer of health insurance coverage and uses model parameters to estimate HIM enrollment. We then scale the HIPSM estimates of enrollment at full implementation down to agree with the Congressional Budget Office (CBO)'s original estimates of enrollment – 7.0 million – in December 2014. CBO's more recent projection of 6.0 million enrollees (released on February 5, 2014) through December 2014 reflects reduced enrollment due to the problematic IT system rollout; we do not use the more recent projections because our analysis attempts to assess IT system performance independently. For more information about HIPSM see "The Urban Institute's Health Microsimulation Capabilities." Washington, DC: The Urban Institute. 2010.
22. In some (though not all) cases, the DHHS estimates included in a publicly-available September 2013 memorandum to HHS Secretary Kathleen Sebelius are based on states' own projections, and because of different methodologies there is considerable variation among states in DHHS-projected enrollment. The resulting estimates of enrollment relative to projections can produce misleading conclusions about success.
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