State-Based Marketplace Policy Brief for New Hampshire

A New Hampshire Insurance Department analysis of recent trends and results for states moving from the Federally Facilitated Marketplace to a state-based operation.

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The New Hampshire Insurance Department, in response to legislative activity, asked Freedman HealthCare to describe recent trends and results for states considering moving from the federal health insurance exchange, HealthCare.gov, to a state operation. This report examines the major benefits and risks of such a change, describes case studies of individual states, examines financial and non-financial implications, identifies leading vendors, and provides links to sources of further information, for use by NH officials before the 2021 legislative session ends.

I. EXECUTIVE SUMMARY

1. Recent advances in technology operations may allow states to develop and implement a State-Based Marketplace (SBM) platform for less than the fees paid to use the Federally Facilitated Marketplace (FFM) platform (HealthCare.gov).
2. All-in costs for SBMs in states recently converting range from $100-200/enrollee/year, including required functions and state personnel. At 2020 enrollment, this would be $4.5-8.9M annually for NH. Whether the switch will lead to long-term cost savings depends on the vendor contract negotiated by the state, the projected FFM user fee schedule, potential ACA regulatory and policy changes, and state management.
3. Converting to an SBM gives states real-time access to enrollment data, plus the flexibility to pursue state-specific exchange goals (such as targeting certain populations for enrollment or performing integrated eligibility across benefit programs).
4. Regardless of potential cost saving opportunities, transitioning to an SBM is a complex undertaking that is best pursued as part of a broader vision for what the state hopes to achieve (e.g., increased enrollment or improved consumer experience).
5. States that are uncertain about transitioning to a full SBM—or that want to proceed incrementally to reduce risk—may pursue SBM-FP status (SBMs that utilize the federal platform).
6. New Hampshire officials should carefully weigh the advantages and disadvantages of an SBM in making their decision.

II. BACKGROUND

Under the Patient Protection and Affordable Care Act (ACA), there are three essential functions for a health insurance marketplace:

1. Eligibility and enrollment
    i. Provide a platform for consumers to receive an eligibility determination for income-based premium tax credits and cost-sharing subsidies
    ii. Allow consumers to enroll in a qualified health plan (QHP) or connect them to Medicaid or CHIP, if eligible
2. Consumer assistance
    i. Establish a web portal, call center, and Navigator program[1] to help consumers find and enroll in public or private coverage
    ii. Assist consumers with changes in circumstance (e.g., in income, employment status, or household composition), which are more frequent compared to populations covered by employer insurance[2]
3. Plan management (*Note: Some states, including NH, already perform this task*)
    i. Review insurers' justifications for premium rates
    ii. Certify that participating health plans meet all requirements, including licensure
    iii. Provide oversight of plans, including de-certifying non-compliant ones

States may elect to design and run their own State-Based Marketplace (SBM) as long as it meets minimum requirements—including performing the functions above—and it is financially self-sustaining. States that choose not to implement their own marketplace rely on the Federally-Facilitated Marketplace (FFM), including its

[1] "Data Note: Limited Navigator Funding for Federal Marketplace States." Kaiser Family Foundation. October 13, 2020.
[2] "Revisiting churn: An early understanding of state-level health coverage transitions under the ACA." August 2016.

HealthCare.gov technology platform. Initially, political opposition to the ACA, as well as early operational and technological hurdles, led to most states using the FFM.

Currently, some FFM states conduct limited aspects of marketplace functions, like plan management or consumer assistance, but have not codified SBM through legislation. Other states operate as a "hybrid" or State-Based Marketplace-Federal Platform (SBM-FP). These states have legislative authority to run a state-based marketplace, and are responsible for all functions, but use HealthCare.gov as their eligibility and enrollment platform.

Table 1. State Functions and Authority Under the Three Types of ACA Exchanges

Function and Authority[3]	FFM	SBM-FP	SBM
State runs eligibility & enrollment platform	N	N	Y
State conducts plan management	N*	Y	Y
State administers consumer assistance	N*	Y	Y
State has legal authority to run SBM	N	Y	Y

*FFM states, including NH, may choose to conduct plan management and/or consumer assistance functions, although the federal government retains primary responsibility. Some sources refer to these as State Partnership Marketplaces (SPM)[4]

III. COMPARISON OF FFM AND SBM

Table 2. Key Aspects of Exchanges Under Federal vs. State Marketplace

Category	FFM	SBM
Legislation & Buy-In	Not needed	Requires legislation and early/extensive stakeholder engagement (including payers and brokers)
Cost & Platform	*Cost* - Federal 3% user fees (paid by health plans) or $240 to $360 per enrollee. - Fees have decreased over the last three years and will drop to 2.25% in 2022. (*Note: See Table 4. History of CMS fees 2014-2022 for more information*). *Platform* - FFM platform (HealthCare.gov) running since 2014 and already integrates with payment site and data services hub - Current and future enhancements limited to features applicable to all FFM states	*Cost* - Savings from user fees may be used to fund SBM. (In 2018, NH paid $10.6M in fees[5]). - In 2018 analysis of six SBMs, annual budgets ranged from $32.5M to $340M, with median of $63.2M.[6] More recent states to transition estimate annual budgets of between $11M-$30M (or $100-$200 per enrollee)[7] - CMS provides $2M grant funding to assist states with transition work *Platform* - Commercially available, stable SBM platforms - State-specific customization is available - State must migrate enrollee data from HealthCare.gov, reroute insurance data, and connect data services hub (to verify identity and eligibility) to state platform. May happen within about 18 months after legislation is passed.
Data Access	FFM sends limited individual enrollment data, often a month or more after the enrollment is effectuated	Real-time access to enrollee and potential enrollee data allows for: - Timely analysis (e.g., Medicaid/QHP churn) - Monitoring (e.g., website and call center interaction) - Targeted outreach (see below) - Live connection to integrated eligibility platform for other services (e.g., SNAP, housing)

[3] "State Health Insurance Marketplace Types, 2021" Kaiser Family Foundation. 2021.
[4] "States seek greater control, cost-savings by converting to state-based marketplaces" Urban Institute. October 2019.
[5] "Should your state consider building a state-based exchange?" GetInsured. April 11, 2019.
[6] "The Your Health Idaho Marketplace: A model for state-based adoption." Leavitt Partners Study. July 2018.
[7] "Adopting a state-based health insurance marketplace poses risks and challenges." Center on Budget and Policy Priorities. February 6, 2020

Autonomy	*Enrollment* - Must adhere to FFM enrollment period (historically a fixed six-week open period, currently expanded), but determined at federal level with no flexibility - FFM has increasingly limited criteria for Special Enrollment Periods (SEPs) *State Oversight* - Allows short-term/non-ACA compliant plans	*Enrollment* - Flexible/expanded open enrollment period (SBMs have not experienced adverse selection issues)[8] - Special Enrollment Periods can have flexible, state-specific rules *State Oversight* - State control over plan quality, including rates, and plan design.
Consumer Support	*Targeted outreach* - Not available, due to delayed and limited nature of the data provided by the federal government. *Plan Compare* - Generic plan comparison tool for all states *Call centers* - 150 languages - Operators must adhere to general scripts[9] - No escalation path for complex issues; referred to state for resolution *Additional Support* - Federal funding for Navigators eliminated, though may change with COVID relief bill.	*Targeted outreach* Since all data resides on the state platform, states may reach to: o Consumers with late payments o Eligible, but unenrolled, consumers o Specific groups by age, language, geography, etc. *Plan Compare* - Customized consumer decision support tools *Call centers* - Insourced or outsourced - State-based to address state-specific needs *Additional Support* - Can train and deploy Assisters/Navigators to target specific areas of need

IV. COMPARISON TO HYBRID MODEL (SBM-FP)

SBM-FPs are often used as a transition step between FFM and full SBM (as Nevada, New Jersey, and Pennsylvania did prior to converting to their SBMs; Virginia is currently using SBM-FP in planned transition to SBM). These states gain an increased level of local control over consumer outreach and plan management. In return, federal government remits 0.5% of the state's FFM user fees to help fund these efforts.

Table 3. Characteristics of State-Based Marketplaces on Federal Platform, AKA "Hybrid" Exchanges

Category	Similar To	Notes
Legislation & Buy-In	SBM	May be possible to establish by executive order, with eventual legislation and stakeholder support needed.
Cost & Platform	FFM	*Cost* - Same 3% user fee as FFM states, but 2.5% goes to the FFM and 0.5% remitted to the state to offset cost of exchange - For 2022, CMS plans to reduce fees to 2.25% for SBM-FB states,[10] of which 0.5% will be remitted to state *Development* - Uses FFM platform (HealthCare.gov) for eligibility and enrollment functionality
Data Access	FFM	Limited data, with lag of a month or more

[8] "State marketplaces outperform the federal marketplace: enrollment and premium comparisons across state and federal marketplaces." National Academy for State Health Policy. April 1, 2019.

[9] "How assisters can help consumers apply for coverage through the marketplace call center." CMS. November 8, 2017.

[10] "Notice of benefit and payment parameters for 2022 final rule fact sheet." Centers for Medicare & Medicaid Services. January 14, 2021

Autonomy	Both	*Enrollment* (Like FFM) - Must adhere to FFM enrollment period; determined at federal level with no flexibility *State Oversight* (Like SBM) - State control over plan quality, including rates, and plan design
Consumer Support	Both	*Targeted Outreach* (Like FFM) - State responsible for outreach and marketing, but only receives limited data *Plan Compare* (Like FFM) - Uses generic plan comparison tool for all states *Call Centers* (Like SBM) - State-based and can address state-specific issues *Additional Support* (Like SBM) - Can train and deploy Assisters and Navigators to target specific areas of need

Table 4. History of CMS Fees 2014-2022

Year	FFM	SBM-FP
2014	3.5%	0.0%
2015	3.5%	0.0%
2016	3.5%	1.5%
2017	3.5%	1.5%
2018	3.5%	2.0%
2019	3.5%	3.0%
2020	3.0%	2.5%
2021	3.0%	2.5%
2022	2.25%	1.75%

V. BENEFITS OF TRANSITIONING TO SBM

1. *Increased enrollment and retention*[11] - Enrollment growth is one indicator of market health and is a consistent benefit observed in states that transitioned to SBMs. In the 2019 open enrollment period, FFM states saw enrollment decline nearly 4%, continuing a trend that started in 2017. During the same time period, SBM enrollment remained steady and, for some states, increased. SBM states have also been more successful at containing premium growth and maintaining affordable prices. These factors are related to:
    i. Open enrollment flexibility – States operating their own platform have the option to extend or shift their annual enrollment period. Longer sign-up periods are associated with an increase in plan selections.[12] A state may also choose to allow individuals with low or moderate incomes to enroll in plans at any time, which can contribute to enrollment increases throughout the year.[13]
    ii. Special Enrollment Periods (SEP) – Outside of the federal open enrollment window, consumers in FFM states can only purchase marketplace coverage if they experience a qualifying life event (e.g., losing health insurance, moving, getting married, etc.). SBMs have the autonomy to implement additional SEPs in response to local needs, including natural disasters.[14] Several SBMs allow users to self-attest to qualifying SEP events, rather than requiring them submit documentation like the FFM does. The following are examples of state-specific SEPs:
        a. COVID-19 – In 2020, twelve of thirteen SBMs implemented a broad SEP the early stages of the pandemic, an option that FFM states did not have due to the federal government's concern that it would lead to adverse selection and, in turn, higher premiums. However,

[11] "State marketplaces outperform the federal marketplace: enrollment and premium comparisons across state and federal marketplaces." National Academy for State Health Policy. April 1, 2019.
[12] "ACA Marketplace Open Enrollment Numbers Reveal the Impact of State-Level Policy and Operational Choices on Performance." The Commonwealth Fund. April 16, 2019.
[13] "Proposed change to ACA enrollment policies would boost insured rate, improve continuity of coverage." Center on Budget and Policy
[14] "During the COVID-19 crisis, state health insurance marketplaces are working to enroll the uninsured." The Commonwealth Fund. May 19, 2020.

evidence suggests that the SEP had the opposite impact: SBMs saw a relative increase among younger, healthier enrollees compared to the year before.[15]

b. Reduced Income – For people enrolled in off-marketplace minimum essential coverage (MEC) plans who experience income reduction that makes them newly eligible for marketplace subsidies.
c. State Premium Subsidy Awareness – For enrollees not aware of state-level premium subsidies.
d. Easy Enrollment Program – Maryland allows residents to initiate an SEP for an uninsured person in their household while completing a state tax return. (Note: recognizing that NH does not have an income tax makes this specific intervention moot, though it illustrates the flexible outreach a state may use.)

2. *Real-time access to consumer data*[16] – Consumer-level data is immediately available, allowing the state to analyze new and renewing customers—as well as who is not enrolling in marketplace coverage—by gender, age, race, ethnicity, geography, etc. The platform can also collect data to monitor users' interaction with the website and call center. This gives state officials the ability to:
   iii. Conduct timely analyses – Access to individual enrollment data would allow the state to proactively address common issues, such as simultaneous enrollment in multiple QHPs. Individual enrollment data also facilitates a more accurate churn analysis between Medicaid and the SBM. When paired with improved integration with the state Medicaid agency, this could lead to fewer lapses in coverage.
   iv. Improve consumer experience – The state may monitor what pages a user spends significant time on or leaves from and use that data to identify and revise confusing language or site navigation. Call center staff can have access to where a user is in the application process and what previous SBM communication they have received, allowing for faster resolution of issues.
   v. Tailor marketing and outreach efforts – States can launch a data-driven approach to increase the effectiveness and efficiency of campaigns. For example, Rhode Island saw increased plan selections after providing enrollment assistance at local community centers, and Colorado increased enrollment with targeted advertising (e.g., on Spanish-language radio stations) to reach specific populations.[17] SBMs have also been more successful engaging younger enrollees.[18]
3. *Potential for integrated eligibility systems* – Medicaid and other state benefit programs; potential to develop "no wrong door" eligibility and enrollment system.

VI. RISKS OF TRANISTIONING TO SBM

1. *Platform development and data migration*[19,20] – Though initially the HealthCare.gov platform was plagued with technological problems, in recent years it performs several complex functions relatively well, including extensive email outreach to consumers, resolving income-related data matching issues, and leveraging new technologies to create a streamlined enrollment process for consumers who rely on direct enrollment partners. To successfully transition to an SBM platform, the state must migrate consumer data from HealthCare.gov; limit data-matching issues and simplify the process for addressing them; and ensure that identity-proofing systems protect consumer information without presenting undo challenges. Second-generation technology vendors have demonstrated the ability to migrate consumer data and provide a state-based platform at approximately half the cost of the FFM, but there is significant price variation depending on the desired level of customization and other details. States must also coordinate outreach with CMS during the transition, which can provide bureaucratic challenges. Finally, a high level of oversight

[15] "Many states with COVID-19 Special Enrollment Periods see increase in younger enrollees." The Commonwealth Fund. January 28, 2021.
[16] "States seek greater control, cost-savings by converting to state-based marketplaces." Urban Institute. October 2019.
[17] "ACA marketplace open enrollment numbers reveal the impact of state-level policy and operational choices on performance." The Commonwealth Fund. April 16, 2019.
[18] "State-based health insurance market performance." National Academy for State Health Policy. September 2019.
[19] "Adopting a state-based health insurance marketplace poses risks and challenges." Center on Budget and Policy Priorities. February 6, 2020
[20] "Technology opportunities for the ACA marketplace." Manatt Health. December 2020.

and clear accountability are necessary for the development and implantation process to remain on time and on budget.

2. *Call Center and Navigator/Assistant Programs* – States relying on the FFM use the federal call center. FFM operators must adhere to general scripts that require complex issues to be transferred to state officials. States considering the switch to SBM should ensure that their new call center has adequately trained and supervised employees who are well-equipped to address the state-specific needs of residents. Some platform development vendors (e.g., GetInsured) offer all core exchange functions, including call centers, which minimizes the risks associated with multivendor coordination. Other vendors (e.g., MAXIMUS) specialize in operating Consumer Assistance Centers (CACs). Vendor staffing and training time estimates vary widely.[21] However, at least one state (Idaho) found that running its own call center was the most cost-effective option.[22]
3. *Limitations of Medicaid integration* – Although a well-integrated platform is a significant potential benefit of operating an SBM, it requires a strong interagency commitment to achieve. The process is also dependent of existing Medicaid technology and staff availability to coordinate the change.[23]
4. *Accurate cost projection* – Changing federal rules can undermine business planning and make it difficult to ensure marketplace stability and enrollment.

VII. ESTIMATED COSTS FOR NH SBM[24,25]

1. *Technology platform and call center* – These are the largest items in an SBM budget.
2. *Advertising* - States vary in the amount they spend on SBM advertising and outreach, but a larger investment is related to increased enrollment and improved risk pools. A 2018 survey of SBMs found that the advertising spending per uninsured resident vary widely depending on the media market, from less than $3 (Colorado) to over $65 in an expensive media market (District of Columbia) with an average of $13.23 per uninsured person. In 2019, NH had an uninsured population of about 84,600, so estimated advertising costs may be approximately $1M/year.
3. *Outreach* – State funded Navigator spending per uninsured person ranged from $2.20 (California) to $27.40 (Maryland) with an average of $13.37 per uninsured person. NH's estimated Navigator costs may be about $1M/year.
4. *State personnel* – to oversee operations and in some cases perform certain operations
5. All-in costs for SBMs in states recently converting range from $100-200/enrollee/year, including required functions and state personnel. At 2020 enrollment, this would be $4.5-8.9M annually for NH.

VIII. FUNDING OPPORTUNITIES

1. *User Fees* - All exchanges charge user fees or assessments that are calculated as a percentage of the premiums, though states have made different decisions about which insurers pay the fees and at what percentage. In 2018, NH health plans paid $10.6M in FFM user fees, at a rate of 3.5% of premiums for its 49,600 marketplace enrollees. If NH adopts the same fee as the FFM (states may elect to charge higher fees, as does Rhode Island), for 2022 or after, 2.25% of premium would yield about $7.0-8.0M annually (~$150-160/enrollee/year).
2. *Federal Medicaid Match* – CMS will match the costs for Medicaid-related work to support those enrollees (Minnesota, Pennsylvania[26], and Washington). The match may be at enhanced rates.

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[21] "Summary analysis of Nevada and New Mexico marketplace technology platform RFIs." DCBS Consumer and Business Services. January 7, 2019.

[22] "The Your Health Idaho Marketplace: A model for state-based adoption." Leavitt Partners Study. July 2018.

[23] "Technology opportunities for the ACA marketplace." Manatt Health. December 2020.

[24] "Adopting a state-based health insurance marketplace poses risks and challenges." Center on Budget and Policy Priorities. February 6, 2020

[25] "States lean in as the federal government cuts back on navigator and advertising funding for the ACA's sixth open enrollment." The Commonwealth Fund. October 26, 2018.

[26] Pennie Board of Directors Meeting Slide deck. July 17, 2020.

3. *1332 waiver* – SBMs are eligible for federal funding to support a reinsurance program or premium subsidies.[27] NH's current 1332 waiver supports reinsurance and thereby reduces premiums. We did not examine whether NH could revise its waiver to secure additional support.
4. *CMS Transition Funding* – CMS makes one-time grants of $2M to states to assist in an SBM transition. For NH, this amounts to about $40/enrollee (non-recurring).

IX. CONCLUSIONS

The ACA permits states to operate and control their own SBM, following federal rules and supported by several funding streams. This paper has outlined financial and non-financial aspects of conversion from FFP to SBM, the possible risks and benefits, and lessons learned from around the country. Converting to a hybrid SBM-FP may allow NH some added flexibility (including the ability to target specific groups for enrollment), while leaving platform and customer service operations to HealthCare.gov. Recent state conversions to SBM have been generally successful operationally and financially. If converting to an SBM, NH could potentially derive benefits of increased enrollment, integration with other programs, and lower costs. However, these benefits will be dependent upon the level of enrollment, changing federal policy, successful vendor procurement, and skilled state oversight.

[27] "What is a 1332 waiver?" HealthInsurance.Org. n.d.

X. APPENDIX

A. STATE CASE STUDIES

Table 5. Features of Recent State Transitions to State-Based Marketplaces

Notable SBM States				
State (Year Implemented) *Vendor(s)*	**2020 Enrollees**[28]	**Stated Transition Goals**	**Timeline**	**Cost Considerations and Notes**
Idaho[29] (2014) *GetInsured* *Accenture LLP*	78,431	"Maintain maximum control of the insurance market at minimum cost to consumers"	2013 – Adopted legislation 2014 – Launched SBM	In 2014, state awarded 5-year contract with two vendors totaling $41M ($104/enrollee/year, includes DDI, Project Management, and M&O)[30] Low-cost, capable vendors offering commercial off-the-shelf (COTS) solutions rather than building from scratch. One of the first *successfully* launched SBMs with lessons learned from other states, like not attempting to upgrade Medicaid systems while developing SBM platform. Prioritized operation/minimal essential functionality of marketplace. Incorporated marketplace into existing state infrastructure. SBM reimburses the Dept. of Health & Welfare for eligibility determination and call center functions; DOI handles plan management/rate review. In-house model is major source of cost saving; the only contracted services are system M&O and marketing activities.
Nevada[31] (2019) *GetInsured*	77,410	Cost savings, improve consumer experience, autonomy, access to data	2014 – Launched SBM 2015 – Switched to SBM-FP after IT failures 3/19/2018 – RFP Issued 11/1/2019 – SBM launch (19 months from RFP to SBM)	In 2018, state awarded five-year, $24.4M contract with GetInsured ($63/enrollee/year). Once the SBM reaches a steady state, platform operation is expected to cost $6M/year ($78/enrollee/year) vs. $12M/year FFM fee. NV anticipates over 42% cost savings each year through FY2024 compared to using HealthCare.gov.[32] NV's all-in cost to operate its SBM is estimated as $172/enrollee/year. [33] NV met budget/schedule targets; call center was effective. Some technical issues arose at launch but were resolved quickly by vendor.

[28] "Total Marketplace Enrollment." Kaiser Family Foundation.
[29] "The Your Health Idaho Marketplace: A model for state-based adoption." Leavitt Partners Study. July 2018.
[30] "Your Health Idaho Announces Selection of Technology Vendors." GetInsured. February 21, 2014.
[31] "Nevada State Based Exchange Transition Talking Points." Nevada Health Link. February 25, 2019.
[32] "Fiscal and Operational Report." Silver State Health Insurance Exchange. December 31, 2020.
[33] "Adopting a state-based health insurance marketplace poses risks and challenges." Center on Budget and Policy Priorities. February 6, 2020

New Jersey[34,35] (2020) *GetInsured (DDI, M&O)* *MAXIMUS (call center)*	246,426	Stabilize market against ACA roll-backs, improve access	6/28/2019 – Adopted legislation 8/1/2019 – Submitted application 8/15/2019 – RFP issued 11/1/2019 – SBM-FP launch 11/1/2020 – SBM launch (14 months from RFP to SBM)	In 2019, state awarded five-year contract to GetInsured for $39.8M, and a 3-year contract to MAXIMUS for $17.8M. After initial set up, combined vendor cost for FY2021 estimated at $14.7M ($60/enrollee/year). Starting in 2021, NJ expects to generate over $200M in revenue from new 2.5% assessment of insurance premiums (replacing federal assessment that ended with 2020; NJ elected to charge a different rate than the federal platform).[36] Approximately $77M of this was dedicated to reinsurance program to address high-cost claims and lower premium costs, which made, the net premium for 2021 the lowest since HealthCare.gov implementation.[37] During first year as SBM, NJ enrolled over 9.4% more consumers than in 2020 and 5.6% more than 2019. In 2021 state also invested $3.5M in trained Navigators, up from $1.1 million in 2020 and $400,000 under the federal government in 2019. This expanded outreach allowed 16 local New Jersey organizations in the state to help residents enroll.[38]
Pennsylvania[39,40] (2020) *GetInsured*	331,825	Cost savings, operational efficiency, comprehensive, user-friendly consumer tool, access to data	2019 – Adopted legislation 4/19/2019 – RFP Issued 11/1/2020 – SBM launch (18 months from RFP to SBM)	In 2019, state awarded seven-year contract to GetInsured. Once the SBM reaches a steady state, PA expects platform operation to cost $33.3M ($100/enrollee/year), and total costs of $49.9M ($150/enrollee/year) vs. a FFM user fee of $98M/year. PA expects federal enhanced Medicaid match funding of $17.7M for 2022 to help reduce state costs by about a third.[41] First SBM open enrollment – 9.7% year-over-year increase. - Retained 97% of customers from Healthcare.com[42] - Sent over 7.5M emails to targeted customers - No major system, eligibility or enrolment blocking issues identified. - "Other issues resolved in timely fashion by GetInsured and KPMG"

[34] "Governor Murphy Announces New Jersey to Transition to State-Based Exchange." March 22, 2019.
[35] "NJ Department of Banking and Insurance announces selection of GetInsured to develop, operate tech platform & MAXIMUS to operate CAC for state-based HIX." NJ Dept. of Banking and Insurance. January 6, 2020
[36] "Governor Murphy signs legislation to restore a key provision of the Affordable Care Act and lower the cost of health care in New Jersey." Office of the Governor. July 31, 2020
[37] "Governor Murphy announces health insurance signups in NJ surpass previous two years." Office of the Governor. February 8, 2021
[38] "Governor Murphy announces launch of new state-based-health insurance marketplace, Get Covered New Jersey." Office of the Governor. October 14, 2020
[39] Pennsylvania RFP (Word Doc). Issued April 19, 2019
[40] "Pennsylvania moves to take over health insurance exchange." Associated Press. June 4, 2019.
[41] Pennie Board of Directors slide deck. November 18, 2020.
[42] Pennie Board of Directors Strategic Planning Session Feb 25, 2021.

Table 6. Features of States Considering SBM Transition

States Transitioning to SBM				
State (Model)	**Enrollees**[43] (2020)	**Transition Goals**	**Timeline**	**Cost Considerations and Notes**
Virginia[44,45,46] (FFM)	269,474	Cost savings, flexibility and autonomy, increased enrollment and affordability	7/1/2020 – Adopted legislation 12/15/2020 – Launched SBM-FP 2/10/2021 – RFP issued (5/1/21 scheduled award date) 1/1/2023 – Expected launch of full SBM	Estimated cost of SBM is $45M/year ($167/enrollee/year) vs. FFM user fee of $86M/year In August 2020, state awarded two Navigator programs $1.5M in grant funds. Reinsurance program currently under consideration
New Mexico[47,48] (SBM-FP)	42,714	Cost savings, greater flexibility, access to data	2013 – Adopted SBM legislation 2015 – Switched to SBM-FP 11/2021 – Expected launch full of SBM (originally planned for 11/2020)	Using the savings from switching to the hybrid model (SBM-FP), NM conducts outreach and education, operates a call center, contracts for plan management, and runs the SHOP program Awarded contract to Optum and NFP Health to build, deploy, and operate SBM for policy year 2022. According to board meeting minutes from 11/2020, project is on track overall.

Table 7. Features of States Using State-Based Marketplace on Federal Platform

Notable SBM-FP States		
State	**Enrollees**	**Notes**
Maine[49]	62,031	Initially planned to become full SBM due to wanting greater flexibility to improve user experience and to invest current FFM user fees into state efforts to increase enrollment. Final decision to adopt, pending determination that SBM is cost-effective and aligned with state goals. 2019 – Gov. notified CMS of intention to implement SBM-FP for plan year 2021, SBM for plan year 2022 2020 – Adopted legislation and submitted SBM application 8/4/2020 – RFP for Navigator Services issued 11/1/2020 – Launched SBM-FP 1/1/2022 – SBM launch date (pending final decision to adopt)

[43] "Total Marketplace Enrollment." Kaiser Family Foundation.
[44] HB 1428 Virginia Health Benefit Exchange Summary
[45] "Virginia receives approval to expand access to health care through state-based exchange." Office of the Governor. August 21, 2020.
[46] "Virginia working to transition from federal insurance exchange to state-based marketplace." The Roanoke Times. February 8, 2020
[47] New Mexico Request for Proposals (Word Doc)
[48] beWellnm Board Meeting slide deck. November 20, 2020.
[49] "Maine progresses toward a state-based health insurance marketplace." Department of Health and Human Services. August 6, 2020.

		- During SBM-FP phase, Maine DHHS will assume more responsibility for outreach, marketing, and consumer assistance - Received $2M from federal government to pay for outreach efforts.[50] However, as an SBM-FP, Maine is no longer eligible to receive Navigator grants from the federal government.[51]
Oregon[52]	145,264	2011 – Adopted SBM legislation 2015 – Due to IT issues, switched to SBM-FP 2016 – Considered transitioning back to SBM, tabled for 3-5 years (was slightly more expensive to run their own exchange platform, but would have enabled the state to have a more finely-tuned enrollment platform, specific to Oregon's needs). 2018 – Reinsurance program began 2019 – RFI issued for vendors interested in developing SBM platform and customer service center. OR state's Marketplace Advisory Committee reports • Dissatisfaction with Healthcare.gov call center, lack of OR-specific regulations/plans • Desire for greater flexibility for enrollment dates ○ Looking to establish lower-cost, more efficient platform

[50] "Maine plans state-based marketplace for Affordable Care Act insurance." Consumers for Affordable Health Care. September 3, 2019.
[51] "2020 CMS Navigator Cooperative Agreement Recipients." CMS. N.D.
[52] Oregon Request for Information (PDF).

B. BUDGET DATA FROM OTHER STATES

Table 8. BUDGET DATA FROM SBMs

State	Total Expenditures & Per Enrollee Cost (2020 enrollment)	State Personnel Costs	Selected Operational/Contracted Costs	
Idaho[53] (FY2020) Enrollees: 78,431	$9,342,066 $119/enrollee/year	$3,437,367	*Professional Services* *Marketing/Advertising* *Call Center Services*	$1,754,631 $792,032 $2,143,701
Nevada[54] (FY2021 approved) Enrollees: 77,410	$21,076,085 (includes $6.6M cash reserve) $186/enrollee/year (excluding cash reserve)	$2,304,145 (22 FTEs)	*Exchange platform* *Marketing/Outreach* *Navigators*	$5,669,055 $3,249,004 $1,480,622
New Jersey[55] (FY2021 projected) Enrollees: 246,426	$43,774,355 $178/enrollee/year	$2,700,000	*Development* *Marketing/Outreach* *Navigator/Enrollment Assistance Grants* *Exchange Improvements*	$19,573,503 $10,000,000 $4,000,000 $7,500,00
Pennsylvania[56] (CY2021 proposed) Enrollees: 331,825	$49,958,630 $151/enrollee/year	$6,231,524 (30 FTEs)	Total: *External Affairs* *IT/Customer Service* *General Operations*	$43,727,106 $8,583,356 $33,274,350 $1,869,400
Rhode Island[57] (FY2020) Enrollees: 34,634	$10,821,172 $312/enrollee/year (RI is a 1st generation SBM)	$1,815,022 (12 State FTEs)	Total: *IT* *Legal Services* *Management/Consultant* *Other Contracts*	$7,749,311 $3,684,243 $4,433 $3,834,748 $225,887

C. VENDORS

Table 9. Prominent DDI Vendors in the SBM Landscape

Vendor (Founded)	**Experience**	**Growth/Stability**
CSG[58] (1997)	- In IA: Project management Office (PMO) and Independent Verification & Validation (IV&V) services - In RI – IV&V on Unified Health Infrastructure Project (UHIP), risk mitigation, and User Acceptance Testing (UAT) - In MA, IV&V oversight, risk management, validation testing and attestation for federal compliance	Less prominent in platform development
Deloitte[59] (1890)	- Responsible for RI's UHIP, which experienced major failures after 9/2016 launch and several years after. ACLU filed federal class action lawsuit over how platform's poor performance impacted	Losing customers. Uneven performance

[53] "Financial Statement." Idaho Health Insurance Exchange. June 30,2020
[54] "Fiscal and Operational Report." Silver State Health Insurance Exchange. December 31, 2020.
[55] "Fiscal Year 2021 Revised Budget Proposal." New Jersey Department of Banking and Insurance. November 1, 2020.
[56] "Pennie Board of Directors Slide Deck." December 17, 2020.
[57] Rhode Island Health Insurance Exchange Budget (page 74)
[58] CSG Delivers website: https://csgdelivers.com/program-expertise/healthcare/health-insurance-marketplace/
[59] Deloitte's website: https://www2.deloitte.com/us/en/pages/public-sector/solutions/health-insurance-exchange-life-sciences-and-health-care-services.html

	low-income, elderly, and disabled residents. In 2019, Deloitte paid RI/federal government settlement, agreed to discount rates.[60] - In 2020, was sued over security vulnerabilities found in OH pandemic unemployment website data.[61] - In 2021, FL Chief Inspector General released findings that the unemployment system Deloitte built had several fatal defects prior to 2013 launch that caused system failure during pandemic.[62]	
GetInsured[63] (2005)	- CA, ID using platform for six years. - Recently transitioned NV, NJ, and PA from FFM platform. - Can manage and operate call center; tightly integrated into platform[64] - For PA, lowest cost proposal among Qualified Offerors	Growing exponentially; consistently used since 2014. Provides full individual SBMS (end-end)
Optum[65] (formally hCentive; 2009)	- Served as a general contractor to HealthCare.gov in 2013 - Used by CO, NY, and NM. - Brought in by MD after they terminated original vendor (Noridian Healthcare Solutions).[66]	Provides full individual SBMS (end-end)

[60] "R.I. still unsure how much it will get from $50-million Deloitte settlement." Providence Journal. May 21, 2019.
[61] "Deloitte sued over pandemic unemployment website data breaches." Bloomberg Law. May 22, 2020.
[62] "Review of the Department of Economic Opportunity Florida Connect System." Office of the Chief Inspector General. March 4, 2021.
[63] GetInsured's website: https://company.getinsured.com/
[64] PA Health Insurance Exchange Authority Board of Directors Special Session Slide Deck. PHIEA. November 13, 2019
[65] Optum's Website: https://www.optum.com/business/solutions/government/state/health-insurance-exchange.html
[66] "Maryland fires contractor that built troubled health insurance exchange." Washington Post. February 24, 2014.

D. KEY CONSIDERATIONS AND LESSONS LEARNED

Certifi - Transitioning to a State-Based Exchange: A Complete Guide (10/20/2020)	NASHP – Advice from Marketplace leaders (5/20/2019) [slide deck]	Urban Institute Health Policy Center – States Seek Greater Control, Cost-Savings by Converting to SBM	Center on Budget & Policy Priorities - Adopting a SBM Poses Risks and Challenges (2/6/2020)
Steps to Transitioning: 1. Get buy-in a. Legislative stakeholders b. Payers 2. Select Vendors a. Technology b. Call center c. Security d. Marketing/ Communications 3. Migrate data 4. Create marketing plan 5. Maintain enrollment 6. Ongoing innovation	1. Focus on the basics 2. Prioritize consumer experiences 3. Set clear expectations and timelines 4. Build Stakeholder relationships a. State policy makers b. State agencies c. Governor's office d. Federal officials e. Insurance carriers f. Navigators/Brokers g. Consumers 5. Establish clear leadership that can take action 6. Use SBM as health reform "hub" across agencies 7. Adapt over time	1. Know and articulate state goals 2. Set realistic expectations 3. Allow for sufficient lead time 4. Engage stakeholders early and often **Primary driving factors transition** - Prospect of cost savings - Improved consumer experience - Autonomy over insurance markets	1. Set targets for increased enrollment across programs. 2. Determine immediate, concrete ways that SBM can match/exceed FFM user experience 3. Prioritize significant investments in marketing, outreach, and enrollment assistance. 4. Commit to—and make immediate strides towards--a "no wrong door" eligibility and enrollment system 5. Ensure that SBM spending will be sufficient to provide high-quality services to residents and achieve the state's other goals for the transition. 6. Protect consumers from subpar health plans and problematic web-broker/insurer marketing practices. 7. Leverage the establishment of SBM to advance broader policy changes.

Stakeholder engagement tips - See Implementation of ACA in Kentucky: Lessons Learned to Date and the Potential Effects of Future Changes