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Federal Funding for Health Insurance Exchanges

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Summary

Pursuant to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), a health insurance exchange has been established in each state and the District of Columbia (DC). Exchanges are marketplaces where individuals and small businesses can "shop" for health insurance coverage.

The ACA instructed each state to establish its own state-based exchange (SBE). If a state elected not to create an exchange or if the Secretary of Health and Human Services (HHS) determined a state was not prepared to operate an exchange, the law directed HHS to establish a federally facilitated exchange (FFE) in the state. Fourteen states and DC established SBEs in 2014, while the remaining 36 states have FFEs. In some states that have FFEs, the states carry out certain functions of the exchange; in other states, the exchange is wholly operated and administered by HHS.

The ACA provided an indefinite appropriation for HHS grants to states to support the planning and establishment of exchanges. For each fiscal year, the HHS Secretary is to determine the total amount that will be made available to each state for exchange grants. No grant may be awarded after January 1, 2015.

There are three different types of exchange grants. First, planning grants were awarded to 49 states and DC. These grants of about $1 million each were intended to provide resources to states to help them plan their health insurance exchanges. Second, there have been multiple rounds of exchange establishment grants. There are two levels of exchange establishment grants: level one establishment grants are awarded to states that have made some progress using their planning funds, and level two establishment grants are designed to provide funding to states that are farther along in the establishment of an exchange. Finally, HHS awarded seven early innovator grants to states (including one award to a consortium of New England states) to support the design and implementation of the information technology systems needed to operate the exchanges. To date, HHS has awarded a total of more than $4.8 billion to states and DC in planning, establishment, and early innovator grants.

Under the ACA, each exchange is expected to be self-sustaining beginning January 1, 2015. The law authorizes exchanges to generate funding to sustain their operations, including by assessing fees on participating health insurance issuers. To raise funds for each of the FFEs, beginning in 2014, HHS is assessing a monthly fee on each health insurance issuer that offers plans through an FFE.

The Centers for Medicare & Medicaid Services (CMS) is incurring significant administrative costs to support FFE operations. According to CMS, a total of $456 million was used to support exchange operations over the period FY2010-FY2012. CMS spent $1,545 million on exchange operations in FY2013 and an estimated $1,390 million in FY2014. The agency has relied on a mix of annual discretionary appropriations and funding from other sources for these expenditures. Those sources include expired discretionary funds from the Nonrecurring Expenses Fund, mandatory funding from the Health Insurance Reform Implementation Fund and the Prevention and Public Health Fund, and FFE user fees. CMS has budgeted $1.8 billion for exchange operations in FY2015. Most of that funding is projected to come from FFE user fees.

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A health insurance exchange has been established in every state, as required by the Patient Protection and Affordable Care Act (ACA).[1] Each exchange has two parts, a marketplace where individuals can shop for and enroll in health insurance coverage, and a small business health options program (SHOP) exchange for small employers. Some individuals are eligible to receive financial assistance for their coverage obtained through an exchange,[2] and some small employers can obtain tax credits toward coverage purchased through a SHOP.[3] Exchanges are not intended to supplant the private market outside of exchanges, and the ACA does not require that individuals and small businesses obtain coverage through an exchange.

A state can choose to establish its own state-based exchange (SBE). If a state opts not to, or if the Department of Health and Human Services (HHS) determines that the state is not in a position to administer its own exchange, then HHS will establish and administer the exchange in the state as a federally facilitated exchange (FFE). Fourteen states and DC established SBEs in 2014, while the remaining 36 states have FFEs.[4] There are varying levels of state involvement in FFEs. In some cases, a state has partnered with HHS to establish and administer the exchange, and in other cases HHS is administering the individual exchange while the state administers the SHOP exchange. In many states with FFEs, the exchange is wholly operated and administered by HHS.

To fund the establishment of exchanges, the ACA authorizes the HHS Secretary to award grants to states through 2014. Each exchange is expected to generate its own funds to sustain its operations beginning January 1, 2015. This report provides a state-by-state breakdown of the grants awarded to date. It then briefly describes the requirement for exchanges to be self-sustaining, and concludes with a discussion of the sources and amounts of funding that HHS has used and plans to use to support FFE operations.

Federal Grants for Health Insurance Exchanges

Section 1311 of the ACA appropriated indefinite (i.e., unspecified) amounts for planning and establishment grants for health insurance exchanges. For each fiscal year, the HHS Secretary is to determine the total amount that will be made available to each state for exchange grants. Any state that intends to do exchange establishment work can apply for and receive a Section 1311 grant; for instance, a state that is not establishing an SBE may receive a grant provided the state uses the funds for activities related to exchange establishment and implementation. States have had multiple opportunities to apply for Section 1311 grants. One deadline remains for submitting an application this year (i.e., November 14). No grants will be awarded after December 31, 2014.[5]

[1] The ACA was signed into law on March 23, 2010 (P.L. 111-148). On March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152), which amended numerous provisions in the ACA. HCERA also included multiple new freestanding provisions related to the ACA. Several other bills that were subsequently enacted during the 111th and 112th Congresses made additional changes to selected ACA provisions. All references to the ACA in this report refer collectively to the law as amended and to the related stand-alone provisions in HCERA.

[2] For more information about the financial assistance available through exchanges, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

[3] For details, see CRS Report R41158, *Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach.

[4] CRS follows how the Office of The Assistant Secretary for Planning and Evaluation (ASPE) categorizes exchanges in its health insurance exchange enrollment reports. For more detailed information about the type of exchange established in each state, see **Table 1**.

[5] While no grants may be awarded after December 31, 2014, some states may use the funds they receive in 2014 for a period of time after such date. For example, a state with a partnership exchange that plans to transition to a state-based

HHS has awarded three different types of exchange grants, which are described below. **Figure 1** shows the total amount of funding each state has received from the grants as well as the type of exchange (SBE or FFE) each state has in 2014. **Table 1** shows the amount each state has received from the various types of grants.

Exchange Planning Grants

Exchange planning grants were given to 49 states and DC.[6] These grants of about $1 million each were used by states to conduct the research and planning needed to determine how their exchanges would be administered and operated. Three states returned all (Florida and Louisiana) or a portion (New Hampshire) of their exchange planning grants.

Exchange Establishment Grants

There are two levels of exchange establishment grants. Level one establishment grants provide up to one year of funding to states that have made some progress under their exchange planning grants. States may seek additional years of level one funding in order to meet the criteria necessary to apply for level two funds. Level two establishment grants are designed to provide funding through December 31, 2014, to states that are farther along in the establishment of an exchange. States applying for level two establishment grants must meet specific eligibility criteria regarding the structure and governance of the exchange they are developing.

HHS has announced several rounds of exchange establishment grant awards, the most recent of which was on October 14, 2014. To date, 37 states and DC have received a total of approximately $4.7 billion in exchange establishment grant funding.[7] Within that group, 14 states—California, Colorado, Connecticut, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont, and Washington—and DC have received both level one and level two funds.

Early Innovator Grants

On February 16, 2011, HHS announced that it was awarding seven grants to help a group of "early innovator" states design and implement the information technology (IT) infrastructure needed to operate health insurance exchanges.[8] The goal is for these states to develop exchange IT models that can be adopted and implemented by other states. Six states and a consortium of New England states received a total of $249 million in early innovator grant funding. Three states—Kansas, Oklahoma, and Wisconsin—have since returned their early innovator grants.

exchange may use grants awarded in 2014 for a period of one to three years after 2014. For more details, see http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf.

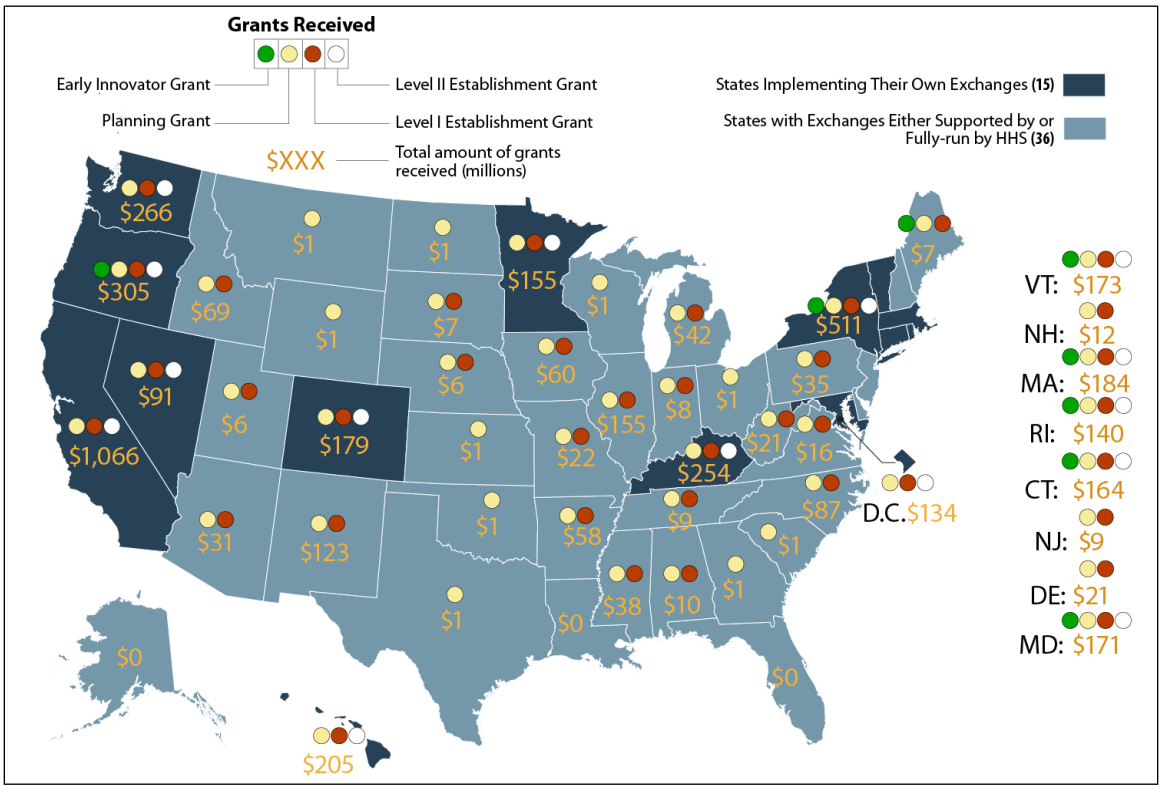
[6] Alaska is the only state that did not apply for a planning grant.

[7] Authors' calculation based on data found in **Table 1**.

[8] HHS press release, February 16, 2011, at http://www.hhs.gov/news/press/2011pres/02/20110216a.html.

Figure 1. ACA Exchange Grants to States (As of October 14, 2014)

Total Amount of Grants Received in Millions of Dollars



Source: The total amount of grants received and the grant types are based on information from **Table 1** of this report.

Notes: The total amount of grants received by each state is rounded to the nearest million. A $0 amount in a state indicates that the state has either not received any grants (Alaska) or has returned all funds received from grants to the federal government (Florida and Louisiana).

The early innovator grant awarded to the University of Massachusetts Medical School is for a multi-state consortium, which includes Connecticut, Maine, Massachusetts, Rhode Island, and Vermont. Each of these states has a green dot in **Figure 1** indicating receipt of an early innovator grant; however, the awarded funds are only included in the funding total for Massachusetts.

CRS follows how the Office of The Assistant Secretary for Planning and Evaluation (ASPE) categorizes exchanges in its health insurance exchange enrollment reports. For more detailed information about the type of exchange established in each state, see **Table 1**.

Table 1. ACA Exchange Funding to States (As of October 14, 2014)

Funding in Dollars

		Health Insurance Exchange Grants				
			Establishment Grants			
State	Type of Exchange [a]	Planning	Level I	Level II	Early Innovator	Total
Alabama	FFE	1,180,312	8,592,139	NA	NA	9,772,451
Alaska	FFE	NA	NA	NA	NA	NA
Arizona	FFE	999,670	29,877,427	NA	NA	30,877,097
Arkansas	FFE[b]	1,200,928	56,948,903	NA	NA	58,149,831

State	Type of Exchange [a]	Health Insurance Exchange Grants				
		Planning	Establishment Grants		Early Innovator	Total
			Level I	Level II		
California	SBE	1,000,000	235,901,012	828,782,044	NA	1,065,683,056
Colorado	SBE	1,247,599	61,437,747	116,245,677	NA	178,931,023
Connecticut	SBE	996,850	31,150,044	132,319,568	NA[c]	164,466,462
Delaware	FFE[b]	1,000,000	20,258,247	NA	NA	21,258,247
DC	SBE	1,000,000	42,619,506	89,954,422	NA	133,573,928
Florida	FFE	0[d]	NA	NA	NA	0
Georgia	FFE	1,000,000	NA	NA	NA	1,000,000
Hawaii	SBE	1,000,000	76,255,636	128,086,634	NA	205,342,270
Idaho	FFE[e]	1,000,000	68,395,587	NA	NA	69,395,587
Illinois	FFE[b]	1,071,784	153,741,352	NA	NA	154,813,136
Indiana	FFE	1,000,000	6,895,126	NA	NA	7,895,126
Iowa	FFE[b]	1,000,000	58,683,889	NA	NA	59,683,889
Kansas	FFE[f]	1,000,000	NA	NA	0[g]	1,000,000
Kentucky	SBE	1,000,000	69,990,613	182,707,738	NA	253,698,351
Louisiana	FFE	0[h]	NA	NA	NA	0
Maine	FFE[f]	1,000,000	5,877,676	NA	NA[c]	6,877,676
Maryland	SBE	999,227	27,186,749	136,599,681	6,227,454	171,013,111
Massachusetts	SBE	1,000,000	67,241,852	80,225,650	35,591,333[c]	184,058,835
Michigan	FFE[b]	999,772	40,517,249	NA	NA	41,517,021
Minnesota	SBE	1,000,000	112,169,007	41,851,458	NA	155,020,465
Mississippi	FFE[i]	1,000,000	37,039,341	NA	NA	38,039,341
Missouri	FFE	1,000,000	20,865,716	NA	NA	21,865,716
Montana	FFE[f]	1,000,000	NA	NA	NA	1,000,000
Nebraska	FFE[f]	1,000,000	5,481,838	NA	NA	6,481,838
Nevada	SBE	1,000,000	39,757,756	50,016,012	NA	90,773,768
New Hampshire	FFE[b]	334,000[j]	11,534,078	NA	NA	11,868,078
New Jersey	FFE	1,223,186	7,674,130	NA	NA	8,897,316
New Mexico	FFE[e]	1,000,000	122,281,600	NA	NA	123,281,600
New York	SBE	1,000,000	255,951,013	226,871,215	27,431,432	511,253,660
North Carolina	FFE	1,000,000	86,357,315	NA	NA	87,357,315
North Dakota	FFE	1,000,000	NA	NA	NA	1,000,000
Ohio	FFE[f]	1,000,000	NA	NA	NA	1,000,000
Oklahoma	FFE	1,000,000	NA	NA	0[k]	1,000,000

State	Type of Exchange [a]	Health Insurance Exchange Grants				
		Planning	Establishment Grants		Early Innovator	Total
			Level I	Level II		
Oregon	SBE	1,000,000	17,574,301	226,472,074	59,917,212	304,963,587
Pennsylvania	FFE	1,000,000	33,832,212	NA	NA	34,832,212
Rhode Island	SBE	1,000,000	72,943,231	66,466,860	NA[c]	140,410,091
South Carolina	FFE	1,000,000	NA	NA	NA	1,000,000
South Dakota	FFE[f]	1,000,000	5,879,569	NA	NA	6,879,569
Tennessee	FFE	1,000,000	8,110,165	NA	NA	9,110,165
Texas	FFE	1,000,000	NA	NA	NA	1,000,000
Utah	FFE[i]	1,000,000	5,407,987	NA	NA	6,407,987
Vermont	SBE	1,000,000	67,462,116	104,178,965	NA[c]	172,641,081
Virginia	FFE[f]	1,000,000	14,862,889	NA	NA	15,862,889
Washington	SBE	996,285	107,576,432	157,453,343	NA	266,026,060
West Virginia	FFE[b]	1,000,000	19,832,828	NA	NA	20,832,828
Wisconsin	FFE	999,873	NA	NA	0[l]	999,873
Wyoming	FFE	800,000	NA	NA	NA	800,000
Total	**—**	**48,049,486**	**2,114,164,278**	**2,568,231,341**	**129,167,431**	**4,859,612,536**

Source: Table prepared by Congressional Research Service based on grant award announcements and other information provided by the Center for Consumer Information and Insurance Oversight (CCIIO) at http://cciio.cms.gov/Archive/Grants/exchanges-map.html.

Notes: NA = not applicable (i.e., state has not applied for or received funding).

a. CRS follows how the Office of The Assistant Secretary for Planning and Evaluation (ASPE) categorizes exchanges in its health insurance exchange enrollment reports.

b. The following states have entered into agreements with HHS to have partnership exchanges in 2014: Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia. These states have opted to run the exchange's plan management functions or consumer assistance functions, or both. HHS administers all other aspects of the exchange and retains authority over the exchange.

c. The early innovator grant awarded to the University of Massachusetts Medical School is for a multi-state consortium, which includes Connecticut, Maine, Massachusetts, Rhode Island, and Vermont; however, the awarded funds are only included in the funding total for Massachusetts.

d. In February 2011, Florida Governor Rick Scott returned the state's $1 million exchange planning grant.

e. HHS refers to Idaho and New Mexico as "federally supported SBEs." Both states planned to have SBEs in 2014 but are currently using the FFE information technology (IT) platform.

f. According to HHS-issued guidance, states can opt to conduct certain plan management functions without entering into an agreement with HHS to operate a partnership exchange. In such cases, HHS administers all other aspects of the exchange and retains authority over the exchange. It has been reported that the following states have such an arrangement: Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia. See *Implementing the Affordable Care Act: State Decisions about Health Insurance Exchange Establishment*, Georgetown University Health Policy Institute, April 2013.

g. In August 2011, Kansas Governor Sam Brownback returned the state's $31.5 million early innovator grant.

h. Louisiana's $998,416 exchange planning grant was returned in March 2011.

i. States have the option to elect to administer their SHOP exchanges while HHS administers the state's individual exchange. Two states have elected this option for 2014: Mississippi and Utah.

j. A New Hampshire bill (HB 601) that became law in July 2011 instructed the state insurance commissioner to return $666,000 in exchange planning grant funds.

k. Oklahoma's $54 million early innovator grant was returned in April 2011.
l. In January 2012, Wisconsin Governor Scott Walker returned the state's $37.7 million early innovator grant.

Self-Sustaining Requirement for Health Insurance Exchanges

Beginning January 1, 2015, the ACA requires that each exchange is self-sustaining. The ACA provides that an exchange may charge an assessment or user fee to participating issuers, but also allows an exchange to find other ways to generate funds to sustain its operations.

A description of how each SBE intends to generate funding is currently beyond the scope of this report; however, HHS has described how it intends to generate funding for the 36 FFEs it administers. Beginning in 2014, HHS will charge a monthly user fee to all issuers that sell plans through an FFE. The fee for an issuer is equal to the product of the billable members enrolled in the plan through an FFE and a monthly user fee rate. For benefit years 2014 and 2015, the monthly user fee rate is 3.5% of the plan's monthly premium.[9]

Federal Administrative Funding for Exchanges

CMS is incurring significant administrative costs supporting exchange operations. CMS operates a number of IT systems that control various FFE functions including eligibility and appeals, certification and oversight of qualified health plans, and payment and financial management. It also operates the data services hub, which routes information about exchange applicants to and from trusted data sources at other federal agencies (e.g., Internal Revenue Service) in order to verify eligibility. In addition, CMS provides consumer assistance through a call center and website for the FFEs, and it funds navigators who offer in-person support. Finally, CMS provides technical assistance to states operating SBEs.

Table 2 summarizes the sources and amounts of administrative funding for exchange operations to date. This information was included in CMS's FY2015 budget submission. During the period FY2010 through FY2012, a total of $456 million was used to support exchange operations. Of that amount, $331 million came from annual discretionary appropriations that cover the routine costs of running federal agencies, including salaries and expenses: $307 million from CMS's Program Management account, and an additional $24 million from the HHS Departmental Management account. The remaining $125 million came from the Health Insurance Reform and Implementation Fund (HIRIF), a $1 billion fund within HHS that was established and funded to help pay for the administrative costs of ACA implementation.[10]

CMS's administrative costs to support exchange operations totaled $1,545 million in FY2013. In the FY2013 budget, CMS requested an increase of $1,001 million for its Program Management account for ACA implementation and other activities. However, Congress did not provide any additional discretionary funds for ACA implementation in FY2013. CMS instead used funds from other sources to help pay for ongoing administrative costs associated with exchange operations. Those funds included (1) discretionary funds transferred from other HHS accounts under the Secretary's transfer authority;[11] (2) expired discretionary funds from the Nonrecurring Expenses

[9] HHS issues the user fee rate in its annual Notice of Benefit and Payment Parameters.

[10] The HIRIF was created and funded by Section 1005 of HCERA.

[11] Each year the Departments of Labor, Health and Human Services, and Education, and Related Agencies (L-HHS-

Fund (NEF);[12] (3) mandatory funds from the HIRIF; and (4) mandatory funds from the Prevention and Public Health Fund (see **Table 2**).[13]

Table 2. Administrative Funding for Exchange Operations

Dollars in Millions, by Fiscal Year

Funding Source	2010-2012 Actual	2013 Actual	2014 Estimate	2015 Request
Discretionary Appropriations				
CMS Program Management[a]	307	520	711[b]	629
HHS Departmental Management	24	—	—	—
Secretary's Transfer Authority	—	114	109	—
Nonrecurring Expenses Fund	—	300	350	—
Mandatory and Other Funds				
Health Insurance Reform Implementation Fund	125	158	20	—
Prevention and Public Health Fund	—	454	—	—
FFE User Fees	—	—	200	1,159
Total	**456**	**1,545**	**1,390**	**1,788**

Source: Table prepared by the Congressional Research Service based on data provided in the Centers for Medicare & Medicaid Services' FY2015 congressional budget justification document, available at http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2015-CJ-Final.pdf.

Notes: Figures in each column may not add to total due to rounding.

a. Includes spending under both the Program Operations and the Federal Administration budget accounts.

b. This amount includes $100 million in budget authority that was made available by using NEF funds for non-FFE activities.

CMS estimated that its FY2014 administrative costs for exchange operations would total $1,390 million. The agency requested an increase of $1,397 million for its Program Management account in the FY2014 budget for ACA implementation and other activities. But, as in FY2013, Congress chose not to give CMS any additional funding. Once again, the agency relied on transferred departmental funds as well as NEF and HIRIF funding to help support exchange operations in FY2014. In addition, CMS projected that it would collect an estimated $200 million in FFE user fees in FY2014 (see **Table 2**).

The President's FY2015 budget includes a total of $1,788 for exchange operations. Of that amount, $629 million is from CMS's Program Management account, and the remaining $1,159 million is projected to come from FFE user fees. The FY2015 budget does not identify any other

ED) Appropriations Act provides the HHS Secretary with limited authority to transfer funds between appropriations accounts. No more than 1% of the funds in any given account may be transferred, and recipient accounts may not be increased by more than 3%. Congressional appropriators must be notified in advance of any transfer.

[12] The Nonrecurring Expenses Fund is an account within the Department of the Treasury. The HHS Secretary is authorized to transfer to the NEF unobligated balances of expired discretionary funds. NEF funds are available until expended for use by the HHS Secretary for capital acquisitions including facility and information technology infrastructure. Congressional appropriators must be notified in advance of any planned use of NEF funds.

[13] Section 4002 of the ACA established the Prevention and Public Health Fund (PPHF) and provided it with a permanent annual appropriation. PPHF funding is intended to support prevention, wellness, and other public health programs and activities.

sources of funding to support exchange operations (see **Table 2**). CMS has requested an increase of $227 million for its Program Management account in FY2015 for ACA implementation and other activities.[14]

Additional Information

The Center for Consumer Information and Insurance Oversight (CCIIO) at CMS is responsible for implementing ACA's private health insurance reforms and administering the grant programs discussed above. Detailed information on the grants, including funding opportunity announcements, guidance, news releases, and amounts awarded, is available on CCIIO's website.[15]

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[14] Congress has yet to complete work on any of the regular appropriations bills for FY2015, which began on October 1, 2014. On September 19, 2014, the President signed the Continuing Appropriations Resolution, 2015 (P.L. 113-164), which provides continuing appropriations through December 11, 2014. Generally, P.L. 113-164 funds discretionary programs at the same rate (and under the same conditions) as in FY2014, minus an across-the-board reduction of 0.0554%.

[15] http://cciio.cms.gov/.