



## Health Insurance Exchange Models

States have until November 16, 2012 to decide which of three models they will follow for their Health Insurance Exchanges: State-based Exchange (SBE), Partnership Exchange, or Federally Facilitated Exchange (FFE). Now that the Department of Health and Human Services (HHS) has finalized its [Blueprint for SBE and Partnership Exchanges](#), we highlight the key features of each Exchange type and some issues for state advocates to keep in mind.

### State-based (SBE)

#### Basic Model

State assumes responsibility for all Plan Management, Consumer Assistance, Eligibility & Enrollment, and Financial Management functions.

#### Possible variations (if state elects)

Federal government can determine:

- Eligibility for premium subsidy & cost sharing reductions
- Exemption from free-rider penalty

Federal government can be used to administer:

- Risk adjustment program
- Reinsurance program

#### Important considerations

SBEs give states the greatest range of responsibility and clearest authority over important issues related to health plan standards & consumer protection/assistance.

SBEs may still be the goal for states not ready or able to implement this Exchange initially; advocates in Partnership or FFE states should think about how to foster transition to SBE as they work with state policymakers on the initial design & implementation of non-SBE other Exchanges.

### Partnership

#### Basic Model

State chooses to assume Plan Management or Consumer Assistance responsibilities, or both. HHS is responsible for whichever the state doesn't take on, plus Eligibility & Enrollment and Financial Management functions.

#### Possible variations (if state elects)

State can administer:

- Reinsurance program
- Medicaid & CHIP eligibility determination or assessment (must coordinate with Medicaid and CHIP on decisions & protocols)

#### Important considerations

Plan Management state partners will certify Qualified Health Plans (QHPs) and make other important decisions related to cost and quality, but HHS retains authority to review and/or revise all such decisions.

How aggressively HHS will assert this ultimate authority is unclear; guidance so far has emphasized flexibility & deference to existing state practices, suggesting state partners might enjoy wide latitude before triggering HHS scrutiny.

States will have responsibility for overseeing their state's Navigators, but the selection of Navigators remains under HHS' purview.

### Federally Facilitated (FFE)

#### Basic Model

The federal Department of Health and Human Services (HHS) assumes responsibility for all Plan Management, Consumer Assistance, Eligibility & Enrollment, and Financial Management functions.

#### Possible variations (if state elects)

State can administer:

- Risk adjustment program
- Medicaid & CHIP eligibility determination or assessment (must coordinate with Medicaid and CHIP Services (CMCS) on decisions & protocols)

#### Important considerations

FFE will not negotiate with Qualified Health Plans (QHPs) for premium discounts and/or covered benefit enhancements

Mechanisms for consumer engagement are unclear; advocates have an opportunity to make sure that regulatory language about stakeholder engagement is translated into concrete and meaningful role(s) for consumers

State must designate an agency to coordinate with FFE on:

- Plan Licensure and good-standing
- Network adequacy
- Premium rate review
- Medicaid Eligibility & coordination