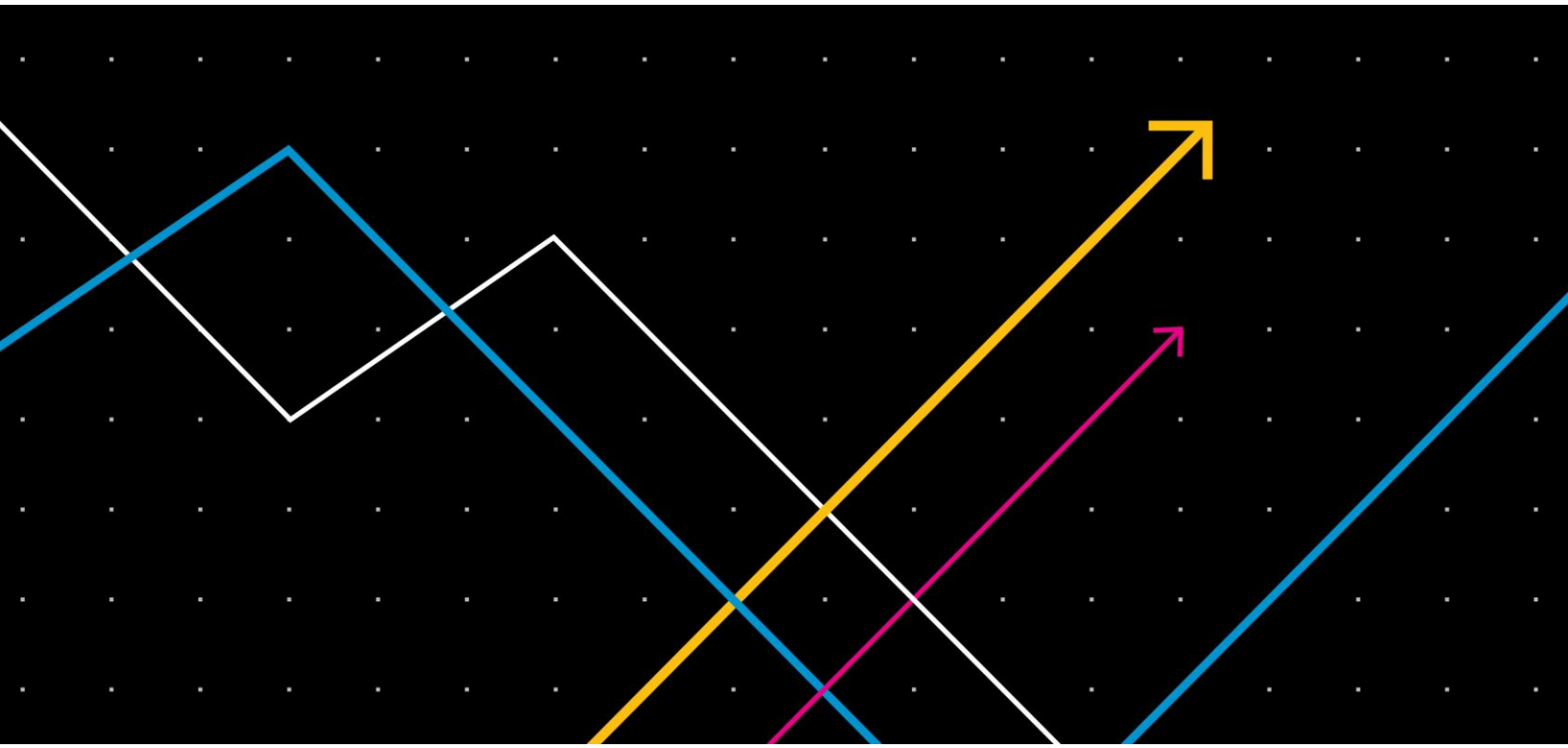

RESEARCH REPORT

Considerations for a Potential State-Based Marketplace in Texas

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Executive Summary

Nationwide in 2024, over 20 million consumers received health insurance through the Affordable Care Act (ACA) Marketplaces—government-operated entities with websites for purchasing coverage, often with income-based premium subsidies. The 2024 open enrollment period was the third consecutive year of record Marketplace enrollment, reaching 21.4 million, an increase of almost 7 million people since the 2022 open enrollment period. Marketplace coverage plays a large—and swiftly growing—role in Texas's coverage landscape: more than 3.4 million individuals had enrolled in Texas's Marketplace in the 2024 open enrollment period, an increase of 37 percent since 2023 and nearly double the 2022 figure (CMS 2024).

During the 2023 legislative session, Texas lawmakers introduced two bills to transition the state's Marketplace from the federally facilitated Marketplace (FFM) to a state-based Marketplace (SBM).[1] Under a transition, Texas would join 21 other states and the District of Columbia that currently have SBMs or are in the process of establishing them.[2] Transitioning to an SBM requires building the new entity and taking over a range of functions, including eligibility determination and enrollment, coordination with Medicaid, customer service, enrollment assistance, marketing and outreach, health plan management and certification, financing, and oversight and compliance.

Running an SBM gives states flexibility to customize Marketplace policies and practices within federal guidelines. Other states have used this autonomy to support health coverage through means like state-funded supplemental premium subsidies and facilitated enrollment. A range of evidence suggests SBM states have been successful in expanding coverage. However, there is no guarantee an SBM in Texas would play out the same way. SBM states are self-selected and have generally embraced the ACA and other policies supporting coverage. The flexibility from an SBM could be used to support coverage or the opposite. In short, an SBM is what a state makes of it.

Texas's health care system is unusual in several ways. Despite some recent efforts to support coverage, including adopting "state rate review" to support some Marketplace consumers' affordability, Texas has the highest rate of uninsurance, more than twice the national average in 2023;[3] is one of 10 states that have not expanded Medicaid under the ACA; and is one of only five states not enforcing the ACA's market reforms, leaving that responsibility to the federal government. Therefore, shifting to an SBM in Texas would involve a unique set of considerations.

In this study, we set out to summarize and analyze perspectives on a potential Texas transition to an SBM, including risks and benefits, best practices to mitigate risks to coverage if Texas elects to establish

an SBM, and other potential measures to improve coverage. The study consisted of two main components: (1) a review of research literature, legal and regulatory landscape, and publicly available documents on SBMs and Texas, and (2) 25 interviews with 35 national and Texas-based experts and stakeholders representing the following perspectives:

- Texas-based consumer and advocacy groups
- Texas-based insurer and provider organizations
- Texas-based health insurance navigators and brokers
- Texas policymakers
- vendors that help states establish and run SBMs
- national experts on Marketplace coverage and SBMs
- officials in SBM states

Benefits and Risks of a Potential SBM in Texas

Interviewees broadly agreed that Texas faces both risks and potential benefits in transitioning to an SBM. Some interviewees, including representatives of state-level policy organizations, SBM officials in other states, and consultants and vendors that help with SBM transitions, thought an SBM would likely benefit the state overall. But those who would be most directly affected, including representatives of Texas-based Marketplace enrollment assistors, insurers, providers, and consumer advocates in the state, uniformly thought that any potential benefits for Texas of adopting an SBM were substantially outweighed by the risk of worse outcomes, especially given the recent strong performance of the FFM.

CURRENT OPERATION OF THE FFM IN TEXAS

Both proponents and opponents of Texas establishing an SBM generally agreed that the FFM in Texas is currently performing very well:

- ***Enrollment growth.*** As noted, Texas's FFM has experienced tremendous growth in recent years.
- ***Experience for consumers, enrollment assistors, and others.*** Experiences with the FFM were reported to be positive across various industries and perspectives.
- ***Market participation.*** Interviewees praised the health and competitiveness of the individual insurance market in Texas.

POTENTIAL BENEFITS OF AN SBM IN TEXAS

When asked about the risks and benefits of transitioning to an SBM, several interviewees pointed to potential benefits related to increased flexibility and state control and other SBMs' success. Other interviewees expressed concern that these benefits would not be realized, in part because other states' success relates to the particular choices they have made. Potential benefits that were mentioned include the following:

- ***Flexibility to improve policy and consumer experience.*** Establishing an SBM permits operational and policy improvements, such as better coordination with Medicaid, state supplemental subsidies to improve affordability for consumers, and facilitated enrollment programs. Although other SBM states have implemented such improvements, these outcomes resulted from specific choices, and Texas would not necessarily make the same choices.
- ***Local control***. SBMs can use the flexibility they are afforded to meet specific state needs, including better-targeted marketing with real-time enrollment and call center data and the capacity to hire local employees in call centers.
- ***Rebranding***. Rebranding the Marketplace from "Obamacare" or "Healthcare.gov" to a Texas-specific name could boost participation by assuaging aversion to the ACA, though high FFM enrollment suggests that ACA aversion may not be a widespread problem.
- ***Cost savings to support coverage.*** Establishing an SBM may generate savings that could be used to support state health care programs since running an SBM might cost less than is collected through the FFM user fee that is paid to the federal government. That said, recent reductions in the FFM user fee and uncertainty about future changes complicate this calculus, and the benefits of any savings would depend on using these funds to effectively support coverage.
- ***Ability to address fraud***. The recent increase in agent and broker fraud, including unauthorized enrollment and plan-switching, has been concentrated in FFM states. Establishing an SBM could reduce such risks. However, the fraud has been heavily tied to enhanced direct enrollment (EDE), which, until recently, has only existed in the FFM. As a result, if the state adopted an SBM but continued to permit EDE, it might do little to reduce fraud.

POTENTIAL RISKS OF AN SBM IN TEXAS

Every interviewee, whether national or Texas-based, and supportive of or opposed to an SBM, noted some risks from a transition. Stakeholders in Texas that would be directly affected by a transition,

including representatives of insurers, providers, navigators, and consumer advocacy groups, uniformly expressed strong concerns. Risks that were raised included the following:

- ***Transition risks***. Some consumers would likely lose coverage in a transition; even strong supporters of states transitioning to SBMs expected some initial attrition.
- ***Risk of operational shortcomings, given experience with other Texas programs***. Based on experiences with Texas's Medicaid program and other state-run programs, there are strong concerns that a Texas SBM could have operational shortcomings, such as with eligibility and enrollment systems and call centers, that would worsen experiences for consumers and navigators and reduce coverage in the state.
- ***Lack of clear goals***. There was widespread concern about the lack of consensus about the goals of establishing an SBM, and that legislation might not include guardrails to ensure an SBM would protect coverage.
- ***Risk from competing policy priorities.*** Given Texas's complex and unpredictable political landscape, an SBM could be susceptible to interference by policy goals other than expanding enrollment in comprehensive health insurance.
- ***New burdens on the state.*** Adopting an SBM would impose substantial new responsibilities on the state. States face unpredictability in federal policy, premiums, and enrollment rates, and while Marketplace systems are more reliable and less expensive today than in the early years of ACA implementation, SBM states may still need to absorb unexpected costs that are likely to rise.
- ***Risks to health sector.*** Transition could disrupt Marketplace enrollment and timely provider payments, affecting health plans, health centers, and providers.
- ***Jeopardizing FFM gains***. Numerous interviewees contrasted the risks from an SBM with the FFM's current strong performance.

Key Elements of an SBM under a Potential Transition

If Texas were to move forward with an SBM, stakeholders raised the following important features to include:

- ***Clear goal of supporting coverage.*** A wide range of stakeholders emphasized the need for broad consensus and guardrails to ensure a potential Texas SBM is run with the primary goal of expanding health coverage.
- ***Agency structure.*** Although some interviewees argued for placing a new Texas SBM within an existing state agency, most recommended running an SBM as an independent agency. Many also raised the importance of transparency and oversight.
- ***Stakeholder input.*** Universally, interviewees recommended that the governance structure of a potential Texas SBM include a range of affected parties, including consumers, providers, insurers, and brokers.
- ***Avoiding noncompliant coverage.*** Some interviewees expressed the importance of the Marketplace not encouraging enrollment in plans that did not include ACA protections.
- ***Use of funding.*** An SBM can generate funding for state uses, and many interviewees cautioned that Texas would need to take active steps to ensure that this funding is used for initiatives that best support coverage.
- ***Standards for customer support and outreach.*** According to some interviewees, an SBM should include standards for investment in spending for navigators, outreach, call centers, and language access.
- ***Marketplace-Medicaid coordination.*** Interviewees inside and outside the state emphasized the importance of a potential Texas SBM being well coordinated with the state's Medicaid program to ensure a smooth experience for consumers applying for coverage or transitioning between the two programs.
- ***Call center implementation.*** Policymakers would need to weigh several tradeoffs when making decisions about SBM call center functioning.
- ***Transition timeline and funding.*** Several interviewees highlighted the importance of an adequate implementation timeline and funding for technology, setting up a new entity, coordination with the Centers for Medicare & Medicaid Services, and systems testing.
- ***Permissibility of EDE.*** Interviewees varied in assessing whether a Texas SBM should permit EDE, which performs enrollment through websites outside of the official Marketplace platform.

Other State Actions to Support Coverage, Regardless of Marketplace Type

Many interviewees, especially those concerned about establishing an SBM, suggested other measures the state could adopt to support coverage that would not bring risks related to an SBM transition:

- ***Raise awareness of currently available subsidized coverage options and affordability protections***, such as through Texas-based marketing and outreach campaigns and consumer education about available coverage options.
- ***Improve oversight of consumer Marketplace experiences***, such as through regulation of spam calls and enforcement action on brokers who commit fraud.
- ***Improve consumer experiences with Medicaid and the Children's Health Insurance Program***, such as by streamlining the enrollment process and increasing the size, capacity, and training of state workforces.
- ***Improve Medicaid-Marketplace coordination***, such as by streamlining account transfers between programs and considering becoming a Medicaid "determination state" (as opposed to an "assessment state").
- ***Expand eligibility for public coverage***, such as by adopting Medicaid expansion and exploring options to cover immigrant populations.

Stakeholders' assessment of the risks and benefits of transitioning to an SBM could shift under several scenarios, making an SBM transition more or less attractive. These include the policies of the incoming presidential administration, changes in federal regulations and decisions, and Congressional action on extending enhanced premium subsidies or other matters, which could affect the number of people enrolled in Marketplace plans and associated funds available to the state under an SBM.

Considerations for a Potential State-Based Marketplace in Texas

Introduction

During the 2023 legislative session, Texas lawmakers proposed two bills to transition the state from the federally facilitated Marketplace (FFM) to a state-based Marketplace (SBM). Under the potential shift, Texas would join 21 other states and the District of Columbia that currently have SBMs or are establishing one.[4]

Shifting to an SBM can provide states flexibility in program design and potentially act as a funding source. Existing SBMs have a strong record of success in expanding enrollment. But there is no guarantee that Texas would use the flexibility in the same ways as other states. Thus, an SBM poses both opportunities and risks.

Drawing on research literature, publicly available documents, and 25 interviews with 35 national and state-based experts representing a range of perspectives, this report describes key considerations for Texas as it considers this policy change. We begin with background on Marketplaces and the current conditions in Texas's health care system. After describing our study methods, we present findings on the benefits and risks of Texas transitioning to an SBM, best practices to mitigate risks if Texas elects to establish an SBM, and other potential measures to improve coverage. We conclude with a discussion of how these considerations could shift under several potential upcoming changes.

Background

The Affordable Care Act and the Current Landscape of SBMs

Besides a host of other changes to the health care system, the Affordable Care Act (ACA) created "health insurance Marketplaces" (hereafter "Marketplaces," also referred to as "health insurance Exchanges") to address barriers individuals faced purchasing affordable health insurance in the individual market.[5] With goals of increasing transparency, equity, and the accessibility of information on insurance products, Marketplaces emerged as government-operated portals where consumers can find

and enroll in health insurance that complies with standards established in the ACA. In addition, Marketplace plans are subsidized for many enrollees using premium tax credits (PTCs) and cost-sharing reductions, which are income-based and limited to enrollees who do not qualify for Medicaid, Medicare, or affordable employer coverage. Under the ACA, a Marketplace is available in every state; however, each state can choose to rely on the FFM (sometimes referred to as its website, Healthcare.gov) or operate its own SBM.[6] Establishing an SBM requires submitting a Blueprint detailing implementation plans and working closely with the Centers for Medicare & Medicaid Services (CMS) and the Internal Revenue Service to receive conditional approval and meet a series of guardrails. Box 1 provides additional details about the process for becoming an SBM.

As of plan year 2025, 19 states and the District of Columbia run SBMs,[7] and two states are in the process of transitioning to SBMs, while policymakers in some other states, including Texas, are considering such a transition (Corlette and Levitis 2024a; Ario and Zhan 2024). At the close of the 2024 open enrollment period (OEP), CMS reported that, of the nearly 21.4 million consumers who had enrolled in Marketplace coverage, 16.4 million selected plans in the 32 states that rely on the FFM, and 5.1 million enrolled in plans offered by SBMs (CMS 2024).

The 21 existing and planned SBMs represent a significant increase over earlier levels. Following initial ACA implementation, the number held steady at around a dozen for several years.[8] In 2020, Nevada kicked off a raft of new SBMs, with another six states following thereafter, and Illinois and Oregon on track to follow suit.

BOX 1

Process for Becoming an SBM

Regulations from CMS lay out the process for states to establish an SBM. States must have legal authority to operate and administer an SBM and indicate through a letter signed by the governor to the federal government their intention to move from the FFM to an SBM.[a] States must submit to the federal government a plan for complying with all federal requirements associated with implementing and launching an SBM. The application must be formally submitted to CMS through what is known as the Blueprint for Approval of State-Based Health Insurance Exchanges (Blueprint).[b]

The Blueprint is a comprehensive compliance roadmap detailing SBM requirements and responsibilities. These include but are not limited to legal authority, consumer assistance, outreach, eligibility and enrollment, plan management, technology, privacy and security, financial management, program integrity and oversight, and the Small Business Health Options Program. For each Blueprint section, states must indicate if they have already completed each underlying activity, the date by which they will have it completed, or, where allowable, if it is not applicable. The Blueprint must be submitted

at least 15 months before the start of the eventual SBM's first open enrollment period. So, if a state intends to transition to an SBM by November 1, 2026, it must submit its Blueprint by August 1, 2025.

CMS recently revised the Blueprint application and SBM transition requirements to enhance transparency around the process and to specify steps states must take to successfully move from an FFM to an SBM. During the implementation process, the Blueprint submission must be publicly disclosed, and states need to solicit public input and comment, including through public meetings. States may also be required to submit detailed consumer assistance plans to CMS, and notably, states are now required to first transition to a state-based Marketplace on the federal platform for a year before becoming an SBM.[c]

Besides complying with the application and approval process, states must do the heavy lifting of standing up a state program. This includes implementing a new state office, division, or agency; procuring vendors and service providers; hiring staff; ensuring compliance with data security protocols, including Internal Revenue Service tax data rules; developing policies and procedures; creating a new name and brand; engaging stakeholders; developing and launching a public awareness campaign; working with CMS to migrate existing FFM customers; training navigators and brokers; and many other tasks and activities. Key to and inherent in SBM implementation is the nimble navigation of state administrative processes, such as procurement and hiring, which may not be designed to move quickly or accommodate major changes.

Sources: [a] 45 CFR §155.100
[b] "Section I: Overview of Blueprint Application and Approval Requirements," CMS, accessed November 13, 2024.
[c] 45 CFR §155.100(b)(4)
Notes: CMS = Centers for Medicare & Medicaid Services; SBM = state-based Marketplace; FFM = federally facilitated Marketplace.

SBM Functions and Responsibilities

Marketplaces, including SBMs, must perform core functions prescribed by the ACA and associated regulations. SBMs are afforded some flexibility in performing these functions and can take on additional responsibilities. SBM responsibilities were clarified and expanded in CMS regulations finalized in April 2024 (Corlette and Levitis 2024a).[9]

ELIGIBILITY AND ENROLLMENT

SBMs must maintain a centralized platform for applying for coverage and financial assistance, selecting a plan, and enrolling. Customers must be able to apply for enrollment in medical and dental plans with assistance from PTCs and cost-sharing reductions. This platform must also identify and redirect customers eligible for Medicaid and the Children's Health Insurance Program (CHIP) to those programs, either through an eligibility assessment or determination. This platform generally includes a consumer

portal, navigator,[10] and broker portals and interfaces with the Medicaid program, participating insurers, and external data sources for eligibility verification purposes, including the Federal Data Services Hub. The platform must be able to generate legally required notices and federal reports, including enrollment reports to CMS to authorize advance PTC payments to insurers and Internal Revenue Service forms necessary for customers to report and reconcile advance PTC payments on federal income tax returns.

MEDICAID COORDINATION

Along with Medicaid assessment or determination responsibilities, SBMs must be able to receive and support consumers transferred from the Medicaid program and notify and support consumers moving from one program to the other.

CUSTOMER SERVICE

Marketplaces must assist Marketplace customers through a call center staffed with live customer service representatives. Customer service operators answer general questions, provide application and enrollment assistance, and help with technical issues, consumer complaints, and filing eligibility appeals. In addition, the Marketplace must accept applications through the call center, which is important for customers with technical challenges or without access to the internet. Materials and assistance must be available in multiple languages.

ENROLLMENT ASSISTANCE

SBMs must provide in-person application and enrollment assistance, including navigators, certified application counselors, brokers, and agents. SBMs must administer certification programs for these assistors, which generally involve initial and ongoing training requirements, as well as oversight activities to ensure compliance and to monitor and address instances of poor or bad faith enrollment assistance. Navigators must be funded by the SBM.

MARKETING AND OUTREACH

SBMs perform marketing to reach consumers about the services and offerings of the Marketplace. This generally includes broad advertising through traditional, digital, and social media engagement, as well as "boots on the ground" education and outreach at in-person events and in communities across a state.

HEALTH PLAN MANAGEMENT AND CERTIFICATION.

SBMs must review and approve qualified health and dental plans for sale through the Marketplace. SBMs must validate that plans comply with state and federal standards, including requirements related

to benefit design, licensing and accreditation, network adequacy, nondiscrimination, and operational practices, among others. States can also impose additional participation requirements, such as quality, equity, choice, or customer service standards, to "actively purchase" the plans they offer.

The ACA's market reform provisions allow states to regulate and enforce the law's consumer protections, coverage requirements, and rate oversight responsibilities. A state health insurance regulator generally conducts this enforcement, but if a state does not do so, CMS will step in and directly act as the enforcement entity, as they do in Texas.[11]

FINANCING

Marketplaces must pay for their budget, including start-up and ongoing costs. Most SBMs and the FFM fund their Marketplaces with a user fee on plans sold through the Marketplace. States can also leverage general revenue, other fees or assessments, and other state funding sources. It also may be possible for Marketplaces to work with Medicaid agencies to secure federal funding to help pay for functions they perform to enroll consumers into Medicaid and CHIP.

SMALL BUSINESS HEALTH OPTIONS PROGRAM

Marketplaces must permit qualified small businesses and their employees to enroll in small group plans. The ACA created the Small Business Health Options Program (SHOP) to make coverage available to small businesses through the Marketplace and include a two-year tax credit for qualified employers to help reduce the cost of offering health insurance.[12]

SHOP functions originally included determining businesses eligible, facilitating enrollment, establishing employer contributions, offering a choice of plans within and across insurers, and premium billing aggregation. In 2018, CMS changed the SHOP requirements, allowing Marketplaces to defer most enrollment and operational responsibilities to insurers and brokers, and removed the requirement for insurers participating in the individual Marketplace to also offer SHOP qualified health plans. The FFM and most SBMs currently take this approach, including all SBMs established since 2014.

PROGRAM OVERSIGHT AND COMPLIANCE

SBMs must ensure compliance with all applicable state and federal requirements and address any issues related to fraud, waste, and abuse. SBMs are subject to ongoing oversight by CMS and must participate in an annual compliance process known as the State Marketplace Annual Reporting Tool, which includes independently conducted programmatic and financial audits. In addition, starting in plan year 2024, SBMs must participate in an Improper Payment Pre-Testing and Assessment program to prepare for an

annual planned measurement of improper payments of advanced PTCs required under the Payment Integrity Information Act of 2019.

State Flexibility with an SBM

SBMs give states flexibility to customize Marketplace policies and practices within federal guidelines. This flexibility extends to a broad range of features that affect the consumer experience, plan options, and receipt of subsidies.

Generally, SBMs have used this autonomy in ways designed to support health coverage (Corlette et al. 2019). For example, SBMs may make larger investments in outreach and enrollment assistance and be better able to customize these efforts to the needs of state residents (Schwab, Swindle, and Giovannelli 2022). SBMs can improve the user experience by integrating Marketplace and Medicaid program applications, eligibility and enrollment systems, or data exchanges (Ario and Zhan 2024). And some SBM states have leveraged control over their platforms to reduce health disparities, tailoring plans to meet the needs of their communities.[13]

SBMs also have the flexibility to create state-based programs that support coverage. For example, several SBMs offer state-based subsidies that supplement federal PTCs or cost-sharing reductions (Levitis and Pandit 2021). States have also started to use SBM-based facilitated enrollment programs as tools to expand coverage (Levitis and O'Brien 2023). To date, 19 states, most of which operate SBMs, have adopted some form of facilitated enrollment, relying on existing points of contact between states and consumers to simplify, encourage, or automate enrollment through incentives and innovation (Levitis and O'Brien 2023). Some states have also found establishing an SBM to be an opportunity to generate funding that can be used to support individual market coverage beyond core Marketplace functions, generally because they can collect more in user fees than it costs to run the Marketplace (Corlette et al. 2019). Pennsylvania, for example, generated enough funds to pay for the state share of a reinsurance program through a Section 1332 waiver.[14]

However, this flexibility could also be used in ways that do not support coverage. For example, a state could reduce its capacity or spending on call centers, outreach, and navigators. Although CMS rules require SBMs to provide a call center that gives Marketplace consumers access to live representatives, there are no quantitative standards or quality metrics for SBM-run call centers, outreach efforts, or navigator programs.[15] While SBMs generally have an incentive to retain enrollment, which is the source of their funding, a state could also modify the consumer experience in ways that impede enrollment relative to what would occur under the FFM. In addition, SBMs could encourage

enrollment in inadequate plans that do not comply with ACA standards and consumer protections. SBMs also have some discretion around eligibility rules and processes, which could be used to restrict enrollment.

Evidence about SBMs

SBMs are widely seen as a key state tool to increase enrollment and expand coverage. Their impact is difficult to measure because states' other policies and circumstances vary widely. SBM states are a self-selected group that is generally more likely to have embraced the ACA and other policies supporting coverage. For example, to date, evidence about SBMs has been derived only from states that have expanded Medicaid coverage under the ACA.

Still, a range of evidence suggests SBM states have successfully expanded coverage. For one, they have lower uninsured rates than FFM states that have expanded Medicaid. In 2022, the average uninsured rate for nonelderly people in SBM states was 6.9 percent, compared with 8.3 percent in FFM states that have expanded Medicaid. At the same time, 31.8 percent of those eligible for PTCs were uninsured in SBM states, compared with 39.8 percent in FFM expansion states.[16]

Marketplace insurance premiums are also lower in SBM states. In 2024, the average monthly benchmark premium for a 40-year-old was $104 lower in SBM states than in FFM states after controlling for the number of participating insurers, the type of participating insurers, and other factors such as area wage index, Medicaid expansion status, and hospital concentration (Holahan, O'Brien, and Wengle 2024).

As noted above, it is unclear how much of this difference is attributable to the SBM as opposed to other factors in SBM states. It might be possible to isolate the impact of SBMs themselves by looking at how these metrics have changed when states adopt SBMs. However, it is too early to analyze the recent transitioning states, and high-level comparisons do not paint a clear picture.

Regardless, experience with SBMs could be a poor indication of how future SBMs will perform if the flexibility afforded to states is used differently. A state could closely mirror FFM practices, in which case the switch might have little effect. It could follow existing SBMs in pursuing policies that support coverage or use the flexibility to reduce enrollment. In short, an SBM is what a state makes of it.

Beyond the long-term effects, transitioning to an SBM has sometimes come with challenges. In the early stages of its SBM transition, New Mexico experienced challenges with structuring, managing, and operating its systems, such as filling workforce gaps, addressing consumer problems on a timely basis,

and eliminating conflicting or incorrect information provided by carriers (New Mexico Health Insurance Exchange 2022).

Recent Marketplace Trends

As discussed above, SBMs have generally been established only in states that embrace the ACA more broadly. But that may be changing. Beyond efforts in Texas, Georgia recently opened its SBM for coverage year 2025, becoming the only SBM state that has not expanded Medicaid.[17] Mississippi may be next—in 2024, it enacted legislation giving the insurance commissioner authority to establish an SBM.[18] The commissioner, however, has not moved forward and has indicated he will not do so without support from the governor, who so far has not committed.[19] In 2023, Alabama also considered legislation to establish an SBM.[20]

Another key trend is a substantial increase in Marketplace enrollment nationwide, especially in FFM states. The 2024 OEP was the third consecutive year of record Marketplace enrollment, reaching 21.4 million plan selections—an increase of almost 7 million since the 2022 OEP. Enrollment growth has been especially large among nonexpansion states, all of which relied on the FFM during this period (CMS 2024). A key reason is the PTC enhancements enacted in the American Rescue Plan Act (ARPA) and extended in the Inflation Reduction Act, which disproportionately benefit nonexpansion states (Banthin et al. 2024; Banthin, Simpson, and Akel 2024).[21] This pattern also likely reflects that FFM states started with lower take-up and higher uninsured rates.[22] But even among FFM states that have expanded Medicaid, recent enrollment growth has generally exceeded that in SBM states. This may reflect recent improvements in the FFM consumer experience. Since 2021, CMS has taken various actions to reduce consumer burdens and expand enrollment support and education. Another possible factor is enhanced direct enrollment (EDE). Since 2018, CMS has allowed FFM enrollment through private entities that enroll consumers in Marketplace plans through certified websites outside the official Marketplace. As of 2021, 17 percent of plan selections were through EDE, and evidence suggests the use of EDE is growing, though it is unclear how much of this enrollment would have occurred through the Marketplace if EDE had not been available (CMS 2021; CMS and CCIIO 2023; Gürel 2024). Georgia recently became the first SBM state to allow EDE, but it's too early to assess the effects.

Another recent development is growing concern about agent and broker fraud, including unauthorized enrollment and plan-switching. The problem has been tied to EDE, which focuses on being

straightforward for agents and brokers.[23] CMS recently affirmed its commitment to protect consumers on the FFM, announcing updated guidance and action steps for addressing fraud associated with EDE.[24]

The FFM user fee has also shifted over recent years. It fell from 3.5 percent in 2019 to 3.0 percent in 2020 and 2021 to 2.25 percent in 2022. Following a small increase to 2.75 percent in 2023, it fell again to 2.2 percent in 2024 and 1.5 percent in 2025.[25] CMS recently indicated its intention to moderately increase it for 2026, though the precise value is uncertain (Corlette and Levitis 2024b).

Future Marketplace Developments

Looking forward, upcoming changes could affect Marketplaces and considerations for potential transitions. The ARPA/Inflation Reduction Act PTC enhancements are set to expire after 2025 (Swagel 2024). The Urban Institute estimates that the end of this policy would lead to 7.2 million fewer people receiving subsidized Marketplace coverage and 4 million more uninsured, with Texas facing disproportionate losses of a projected 2.1 million (Banthin et al. 2024).[26] Other actions of the new Congress or the incoming Trump administration may also affect state decisions, depending on the evolution of FFM policy and federal policies governing SBMs.

CURRENT CONDITIONS IN TEXAS'S HEALTH CARE SYSTEM

Texas's health care system has struggled on several fronts. As of 2023, Texas has the highest uninsured rate in the nation at 16.4 percent, twice the national average.[27] A 2024 poll showed Texans would like the state to do more to help vulnerable populations access needed care, such as low-income adults, children, and pregnant women (Sim et al. 2024). Accessing coverage that is affordable also remains a challenge for Texans, with over 60 percent of low-income residents struggling to pay for health care (Sim et al. 2024). Hispanic and Black Texans were especially likely to experience difficulty affording care (Sim et al. 2024).

Texas's distribution of insurance sources is generally on par with other states, with just under half the population in employer-sponsored coverage and most of the rest split between Medicaid, Medicare, and nongroup coverage.[28] Finally, Texas is one of only ten states that has not expanded Medicaid under the ACA, despite recent polling data suggesting that more than 70 percent of Texans would support expansion (Sim et al. 2024).

TEXAS'S ACA IMPLEMENTATION

Alongside declining to expand Medicaid coverage as permitted under the ACA, Texas is one of only five states that does not enforce the ACA's market reforms.[29] Like most states that rely on the FFM, Texas is an "assessment state," meaning that Healthcare.gov can make initial eligibility assessments for Medicaid and CHIP, but only the state Medicaid agency can make final eligibility determinations.[30]

Texas has recently generally been permissive of allowing the sale of ACA-noncompliant health plans. For example, Texas permits the sale of noncompliant farm bureau plans and short-term limited-duration plans (GAO 2023).[31] Unlike ACA-compliant options, short-term plans can exclude people with pre-existing conditions and have hidden costs, leaving enrollees with significant financial risk (Young 2020).[32]

TEXAS'S MEDICAID PROGRAM

The Texas Health and Human Services Commission (HHSC) administers one of the nation's largest Medicaid/CHIP programs. Children's Medicaid/CHIP eligibility in Texas extends to 255 percent of the federal poverty level (FPL), and pregnancy-related eligibility extends to 207 percent of FPL, while the eligibility threshold for parents is 15 percent of FPL and there are no eligibility pathways for other nondisabled adults (Brooks et al. 2024). Like other states, Medicaid enrollment in Texas grew steeply under the pandemic-related continuous coverage requirement, rising to 5.9 million in March 2023 from 4.2 million in February 2020.[33] By June 2024, it fell back to 4.2 million as Texas and other states conducted Medicaid "unwinding" and resumed regular redetermination processes. Both nationwide and in Texas, most who lost coverage were procedurally disenrolled because the state could not determine whether or not they remained eligible.[34] During unwinding and otherwise, HHSC has faced several challenges, including failing to promptly process Medicaid/CHIP applications, having one of the nation's lowest rates of "ex parte" renewals (performed using administrative data without requiring enrollee action), and experiencing staffing shortages.[35] In early 2024, the National Health Law Program, the Electronic Privacy Information Center, and Upturn jointly filed a complaint against Deloitte Consulting, the developer of Texas's Medicaid eligibility system, related to the state's eligibility determination system.[36]

EFFORTS TO EXPAND COVERAGE IN TEXAS

In recent years, Texas has made some efforts to expand coverage. As of November 2024, nearly all states have leveraged new flexibilities offered under ARPA to use state plan amendments to extend Medicaid postpartum coverage for 12 months.[37] In January 2024, Texas received approval for a 12-month postpartum coverage extension.[38]

In June 2021, Governor Greg Abbott signed SB 1296, initiating "state rate review" and outlining steps for the Texas Department of Insurance to regulate the price of health plans to ensure that insurers price silver plans in a way that adequately reflects the value of cost-sharing reductions, which improves Marketplace affordability for consumers who receive PTCs.[39]

RECENT MARKETPLACE ENROLLMENT GROWTH IN TEXAS

Before the ACA, fewer than 700,000 individuals received coverage through the individual market in Texas (TAHP 2024). By the end of the 2024 enrollment period, 3.5 million individuals had enrolled in Texas's Marketplace, an increase of 44.5 percent since 2023 and more than triple the enrollment in 2020 (table 1). In 2014, around 3 percent of the population enrolled in Marketplace plans both nationally and in Texas (figure 1). However, Marketplace enrollment in Texas has far outpaced the US as a whole; in 2024, 13 percent of Texans enrolled in Marketplace coverage compared to 8 percent of US residents. In 2022, 31 percent of nonelderly Texas Marketplace enrollees were small business owners or self-employed.[40] Marketplace coverage likely plays an even larger role today, given recent enrollment growth.[41] Overall, nearly 6 million people, or 19.0 percent of Texans, have been enrolled in Marketplace plans in Texas over the past decade.[42]

TABLE 1

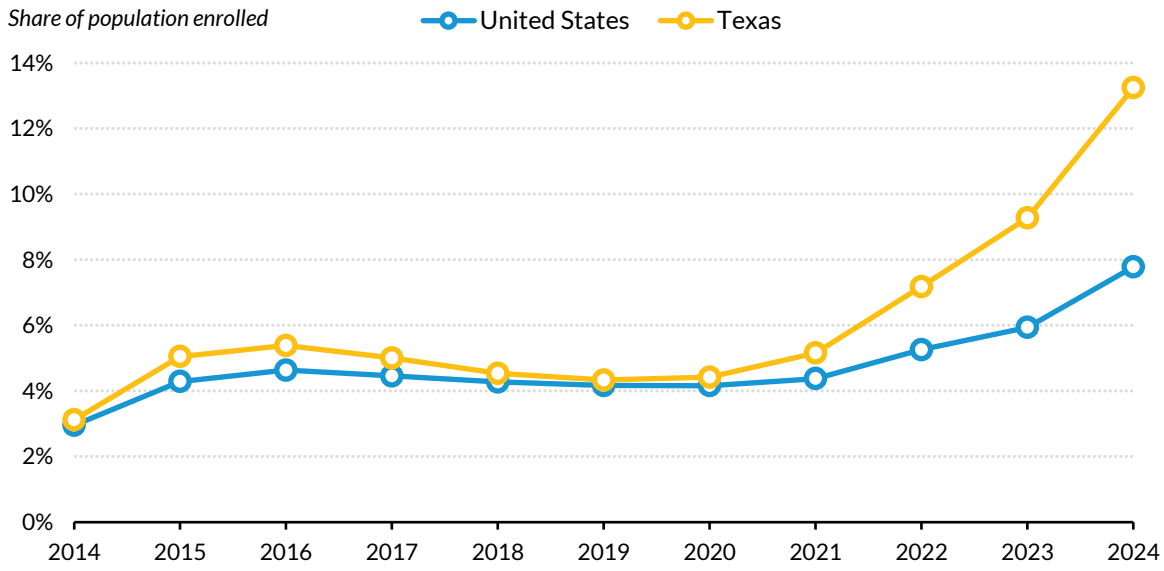
Marketplace Plan Selection (in Millions) at Open Enrollment in Texas and the United States, 2014–24

	United States	Texas
2014	8.0	0.7
2015	11.7	1.2
2016	12.7	1.3
2017	12.2	1.2
2018	11.8	1.1
2019	11.4	1.1
2020	11.4	1.1
2021	12.0	1.3
2022	14.5	1.8
2023	16.4	2.4
2024	21.4	3.5

Source: CMS Open Enrollment Public Use Files, see "Marketplace Products," CMS, accessed November 13, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.

FIGURE 1

Share of the Population Under 65 Who Selected a Marketplace Plan at Open Enrollment, Texas and the United States, 2014–24



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Source: Coverage year 2014–24 enrollment data from CMS Open Enrollment Public Use Files, see "Marketplace Products," CMS, accessed November 13, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products. 2014 enrollment data from "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," ASPE, May 1, 2014. Population data from American Community Survey (ACS), see "DP05ACS Demographic and Housing Estimates," ACS, accessed November 14, 2024, https://data.census.gov/table/ACSDP1Y2023.DP05?q=population.
Notes: Population reflects the population at open enrollment, the year before the plan year. 2014–19 and 2021–24 population data comes from the 1-year ACS file. 2020 population data comes from the 5-year ACS file.

Texas is now a leader among states in market competition, with 15 insurers participating in the Marketplace (TAHP 2024). During a 2024 Texas Senate Committee Hearing on Health and Human Services, Jamie Dudensing, CEO of the Texas Association of Health Plans, highlighted these strides, attributing the substantial decline in Texas's uninsured rate to the success of the individual market.[43]

In 2023, two Texas lawmakers introduced bills to transition the state's Marketplace to an SBM (box 2).

BOX 2

Recent SBM Proposals in Texas

In 2023, two bills to establish a Texas SBM were introduced but not enacted. It is uncertain whether similar bills will be proposed in future legislative sessions.

HB 700. On March 30, 2023, Republican Representative Tom Oliverson introduced HB 700 to establish an SBM in Texas. The Texas Health Insurance Exchange proposed by HB 700 would be governed by an eleven-member board appointed jointly by the governor, lieutenant governor, and legislature, including some members with health insurance industry experience. The board may also appoint an advisory committee. The Texas exchange would "cooperate and coordinate with the Health and Human Services Commission to facilitate a seamless user experience" for Texans purchasing insurance on the exchange.

The bill includes little detail about the functioning and authority of the Marketplace and no provision for a funding source. It sets July 1, 2024, as a deadline for the Marketplace to make recommendations "regarding the feasibility of implementing a state-administered subsidy program" and state innovation (1332) waivers, which would include strategies to mitigate the risk for "individuals with high health care costs," reimburse coverage for employees of small and large business, provide financial assistance for "nonqualified health plans," and create "account-based premium credits" for exchange enrollees.[44]

SB 344. On February 15, 2023, Democratic Senator Nathan Johnson introduced SB 344 to establish a Texas SBM, along with a cost-sharing reduction program to increase financial assistance for consumers. Under Johnson's bill, the Texas exchange would be governed by a nine-member board. The exchange commissioner and the executive commissioner would serve as "ex officio" voting members, and the remaining seven members would be appointed by the governor, with a range of experience in consumer advocacy, health care public education and consumer assistance, and the provision of health benefit plans on the exchange. SB 344 outlines the "powers and duties" of the exchange authority, stating priorities such as working with federal and state agencies to pursue waivers "as necessary." These powers include planning to staff a workforce with sufficient navigators and assisters, centralizing training and technical assistance for an exchange workforce, funding marketing and outreach activities, and leveraging a "special team with knowledge and authority" to expand coverage by meeting predetermined enrollment targets for the exchange, Medicaid, and CHIP.

The SBM would also be responsible for assisting prospective users in eligibility determinations for government programs, premium tax credits, and cost-sharing reductions. Moreover, it would be charged with addressing coverage gaps based on geographic location, negotiating premium rates, standardizing the design and cost-sharing offered by plans, and redirecting fees collected from plan issuers to support exchange operations and financial assistance options for users. Although the exchange would be permitted to collect a fee from user premiums, absent unanimous board approval, the fee would not exceed 3 percent of users' monthly premiums, and a portion of the funds collected would be dedicated to increasing subsidies for enrollees.

Source: Tom Oliverson, "Relating to Creation of the Texas Health Insurance Exchange; Authorizing an Assessment," March 30, 2023, https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB700; and Nathan Johnson, "Relating to the Creation of the Texas Health Insurance Exchange and Premium Assistance and Cost-Sharing Reduction Programs; Authorizing a Fee," February 15, 2023, https://legiscan.com/TX/text/SB344/id/2622252.
Notes: SBM = state-based Marketplace; CHIP = Children's Health Insurance Program.

Methods

This study consisted of two main components: (1) a review of research literature, legal and regulatory landscape, and publicly available documents on SBMs and Texas, and (2) interviews with national and Texas-based experts and stakeholders.

First, we conducted a scan of research literature on relevant topics, including evidence of the impacts of SBMs, the extent to which effects related to state policy choices, the pros and cons of states transitioning to SBMs, and health insurance coverage in Texas. We also assessed the legal and regulatory landscape and process for becoming an SBM. Additionally, we reviewed testimony from committee hearings during the 2023 legislative session and publicly available policy statements related to proposed legislation to understand the views of various stakeholders within the state.

Second, we identified experts and other stakeholders representing the following perspectives: Texas-based consumer and advocacy groups, Texas-based insurer and provider organizations, Texas-based health insurance navigators and brokers, Texas policymakers, vendors that help states establish and run SBMs, national experts on Marketplace coverage and SBMs, and officials in SBM states. Between February and July 2024, we conducted 25 semistructured interviews with 35 individuals from these perspectives (table 2).

TABLE 2

Number of Study Interviews, by Interviewee Type

	Number of interviews	Number of individuals included in interviews
Texas-based consumer/advocacy groups	4	6
Texas-based insurer/provider organizations	6	6
Texas-based navigators and brokers	5	6
Texas policymakers	2	3
Vendors that help states establish and run SBMs	1	1
National experts on Marketplace coverage and SBMs	4	9
Officials in SBM states	3	4
Total	**25**	**35**

Source: Urban Institute interviews conducted between February and July 2024.
Notes: SBM=state-based Marketplace.

Interview topics included overall assessments of implications if Texas were to transition to an SBM, the largest benefits and risks of such a shift, the most important features of a potential Texas SBM, unique state characteristics that could affect the transition and likely outcomes, timing considerations, and reflections on how a shift could affect various stakeholders in the state. The research team took detailed notes of each interview and recorded interviews when study participants granted permission

to record. Team members analyzed meeting notes to identify key insights on each topic and variation in insights across different perspectives. This analysis presents findings from both the literature scan and interviews. The Urban Institute's Institutional Review Board reviewed and approved the research study protocols.

Limitations

Interviews aimed to assess a variety of viewpoints, including from Texas-based stakeholders from a wide range of industries, political affiliations, and perspectives; national experts; and officials in other states. However, some important perspectives may not be captured. Importantly, while we asked those who work with the public about their clients' experiences, we could not talk directly with Texas consumers regarding their experiences with current state programs or their perspectives on a potential shift to an SBM. As consideration of an SBM continues in Texas, assessing a broad range of consumer perspectives will be important. Though many of our findings apply to other states considering SBMs, others are specific to Texas. Finally, interviews occurred before the 2024 elections and therefore reflect the views of interviewees without knowing the results.

Findings

Interviews with a range of Texas-based and national stakeholders and other research and analysis suggest a range of benefits and risks of Texas transitioning to an SBM, best practices to mitigate risks to coverage if Texas elects to establish an SBM, and other potential measures to improve coverage.

Benefits and Risks of a Potential SBM in Texas

Interviewees raised several important considerations for transitioning to an SBM in Texas. There was broad recognition of potential benefits and risks, including some related to the current functioning of the FFM and the potential functioning of an SBM. Some interviewees, including representatives of state-level policy organizations, SBM officials in other states, and consultants and vendors that help with SBM transitions, thought an SBM would likely benefit the state overall. But those who would be most directly affected, including representatives of Marketplace enrollment assistors, insurers, providers, and consumer advocates in the state, uniformly thought that any potential benefits for Texas of adopting an SBM were substantially outweighed by the risk of worse outcomes, especially given the recent strong performance of the FFM.

CURRENT OPERATION OF THE FFM IN TEXAS

Although some interviewees pointed to shortcomings, especially in past years, proponents and opponents of an SBM generally agreed that the FFM in Texas is currently performing very well. In particular, interviewees representing insurers, brokers, providers, assisters, and enrollees unanimously said the FFM functions well. Specific elements of Texas's Marketplace that interviewees highlighted included the following:

Enrollment growth. Many interviewees referenced the recent tremendous growth in Marketplace coverage noted above. Although recent research notes large numbers of Texans who appeared eligible for subsidized Marketplace coverage but were uninsured,[45] this analysis is based on data from 2022, when Texas FFM enrollment was less than half its current level, suggesting that patterns of eligibility and enrollment may have shifted since then.

Experience for consumers, enrollment assistors, and others. Experiences with the FFM were reported to be positive across various industries and perspectives. For example, a Texas-based insurer group representative noted, "We have a really good thing with the federal exchange; I never hear complaints about how it is working," while a representative of a consumer advocacy group likewise indicated, "There's just no question about how well Texas is doing with the federal exchange and how well the federal exchange is doing here." A representative of a navigator organization specifically pointed to the benefits of the FFM website, navigator trainings, and call center assistance:

> "The website [Healthcare.gov] has come a mighty long way. The application process [has come] a long way. Even the training that they [CMS] give us as navigators [has grown] every year in that process to help make [navigators] equipped as well to serve the community…. [Regarding the call center, it] seems as if they have done a little more training because CMS heard us in our meetings with them."

Likewise, a representative of a provider group positively characterized experiences with the FFM for providers:

> "Despite the early days of it not working, it works very well now; it's not something… we ever got complaints about. There are always ways to improve it, but overall, our physicians felt like they could get patients signed up quickly. [The FFM is] a really important program that has been successful and effective [for patients] who get signed up easily, understand their coverage, and can easily compare pricing."

Market participation. A range of stakeholders described the health of the individual insurance market as positive. In a presentation in 2024, the Texas Association of Health Plans noted, "the Individual Market is growing, stabilizing, and becoming more competitive" (TAHP 2024). In a recent Texas Senate hearing, Texas Department of Insurance commissioner Cassie Brown testified that

"enrollment in the individual market has grown significantly in recent years" and attributed these trends to federal legislation that "increase[d] the affordability" of coverage, along with 2023 Texas legislation that "increased competition in rural counties" and "ensur[ed] that silver plans on which subsidy amounts are based are priced appropriately."[46]

Remaining challenges. Nevertheless, some interviewees said certain improvements are possible for the FFM, such as addressing fraud propagated by some broker entities, more clearly communicating with navigators, and improving call center wait times, as discussed in greater detail in the next section.

POTENTIAL BENEFITS OF AN SBM IN TEXAS

When asked about the risks and benefits of transitioning to an SBM, several interviewees pointed to potential benefits related to increased flexibility and state control, as well as the success other SBMs had enjoyed. Other interviewees expressed concern that these benefits would not be realized, partly because other states' success related to their choices, which Texas might not emulate. Potential benefits that were mentioned include the following:

Flexibility to make improvements in policy and consumer experience. Establishing an SBM permits operational and policy improvements like integration with Medicaid, state subsidies to improve affordability for consumers, and facilitated enrollment. Several interviewees pointed to experiences in other states after transitioning to SBMs, such as smoother transitions between Medicaid and the Marketplace, tailored outreach, programs like state subsidies and facilitated enrollment, and higher take-up. For instance, a strong supporter of SBMs noted, "If you want to innovate, it's not going to be on the federal exchange because that's not what they're built for… they were intended as the backstop for states that either could not or were unwilling or unable."

However, many interviewees noted that these outcomes resulted from specific choices made by other SBM states and raised concerns that Texas would not necessarily make the same choices. Several stakeholders discussed ways a Texas SBM could smooth the switch for those transitioning between Medicaid and the Marketplace but expressed concern that Texas would not choose these policies. For instance, a national expert identified greater integration with Medicaid as the most promising potential benefit of an SBM but noted that such a change "does not seem to fit the general ideology of Texas…without an alternate funding source, there's probably not a desire to use state health care dollars to support affordability—if there was, we would see Medicaid expansion first." In addition, there may be less potential benefit of Medicaid-Marketplace integration in an ACA nonexpansion state because Medicaid eligibility is much more limited than in expansion states.

Another potential benefit highlighted was improvements in the consumer experience. For example, one interviewee said the large number of texts and calls from brokers after applying for FFM coverage was "common knowledge among the uninsured population, which was actively discouraging people and preventing people from going to the exchange to sign up" and was "creating decision paralysis." They added that even the perception that applying for Marketplace plans would generate texts and calls from brokers was "itself an independent barrier" and suggested that establishing an SBM could help reduce such hassles by strengthening the state's relationships with brokers. Other interviewees were concerned that a Texas SBM might have a worse consumer experience given the history of the Texas Medicaid program, as discussed below. Texas might also take a different approach to regulating brokers than other states.

Additionally, some misconceptions exist about the role of an SBM in making some improvements. For example, one interviewee mentioned that a Texas SBM could improve the enrollment process by providing a list of information the enrollee will need in advance. However, the FFM already provides this list of information when applying through Healthcare.gov. Another lamented that FFM navigators in Texas are available only during OEP, though, in fact, they are available year-round.

Local control. Several interviewees argued that SBMs are uniquely positioned to use flexibility to meet specific state needs. One SBM director said, "If you talk to any state exchange in the country, they're likely to put local control at the top of the list [of benefits]" and that their state has leveraged local control to find "the solutions that work best for [their] citizens." With local control, Texas may also better target marketing with real-time enrollment and call center data. Local control could also allow the state to hire local employees in call centers. More broadly, a national expert on Marketplace policy who helps states establish SBMs pointed out that SBMs are in line with the general philosophy of the ACA, noting, "It's important for states like Texas to take ownership of their exchange and run it" and "that's what the intent is behind the Affordable Care Act."

Rebranding. Several interviewees argued that rebranding the Marketplace from "Obamacare" or "Healthcare.gov" to a Texas-specific name could help overcome aversion to the ACA, thus boosting participation. A Texas-based broker who was in support of an SBM transition stated that a "big benefit" would be "that it's not Obamacare," given that Texas "is a red state and [where people] hate Obamacare, [even] 10 years later." However, we heard from others that high FFM enrollment suggests that few people are forgoing Marketplace coverage because of ACA aversion. Others argued that those opposed to "Obamacare" would also reject a Texas SBM because it would still be a government program.[47] Moreover, a Texas-based consumer advocacy organization representative worried that potential

coverage losses under an SBM would likely offset any benefit of increased participation under rebranding.

Cost savings available for supporting coverage. Several interviewees argued that running an SBM would cost less than is collected through the FFM user fee and, therefore, that establishing an SBM would generate savings that could be used to support state health care programs. As noted above, Pennsylvania has used this approach to support its state reinsurance program. Texas's large size could make this approach especially beneficial. One SBM supporter emphasized, "There are potential cost savings, especially for a state the size of Texas, which is probably paying the lion's share of the user fee to the federal government." However, the amount of potential savings is uncertain because of reductions in and ongoing uncertainty about the FFM user fee—it fell from 2.75 percent in 2023 to 1.5 percent in 2025 and could range from 1.8 percent to 2.5 percent in 2026, depending on factors including whether Congress extends enhanced PTCs.[48] Pennsylvania's user fee is 3 percent. Setting a fee that high today would mean increasing premiums. Moreover, user fee revenue is likely to fall if the enhanced subsidies expire at the end of 2025.

Regardless of the size of the savings, many interviewees cautioned that the benefits of any savings would depend on using them effectively. A national Marketplace expert noted, "A distinction here that's maybe worth keeping in mind: it's not just about saving money, it's about harnessing this money and putting it toward something that's actually helpful."

Other SBM supporters argued that establishing an SBM would "keep money in the state" rather than sending it to CMS. Most SBMs contract with national vendors for technology functions but may use local vendors for marketing, call centers, and other functions.

Addressing fraud. Several interviewees mentioned the recent increase in agent and broker fraud concentrated in FFM states and thought an SBM could reduce such risks. One navigator noted, "Agent and broker fraud has been a huge, huge, huge problem. I've heard that, in the states where you have your state-based website or Marketplace application, they don't have that problem as much as Healthcare.gov… that would be a benefit [of shifting to an SBM]." Some interviewees theorized that SBMs may have lower rates of fraud because they can build stronger relationships with state insurance departments and brokers. However, other Marketplace experts noted that such improvements may require the Marketplace to deliberately establish such relationships and rigorously enforce broker standards. Others noted the prevalence of fraud in the FFM appears to be tied to the use of EDE and therefore an SBM that permitted EDE might face similar problems.[49]

POTENTIAL RISKS OF AN SBM IN TEXAS

Every interviewee, whether national or Texas-based and supporting or opposed to an SBM, noted some risks from a transition. Stakeholders in Texas who would be directly affected by a transition, including representatives of navigators, insurers, providers, and consumer advocacy groups in the state, uniformly expressed strong concerns. The primary concern they expressed is the risk of reductions in enrollment in both the short and long term that could harm consumers and the state health care sector. In expressing this concern, they highlighted a lack of consensus about the goals of the transition, uncertainty about the problem a Texas SBM was trying to solve, and their experience with other Texas programs.

Transition risks. Nearly every interviewee expected that some consumers would lose coverage in a transition. Transitioning to an SBM means that enrollees accustomed to the FFM will need to know to go to different website and establish a new account. Multiple interviewees were worried about Texas implementing the technological shifts needed for a transition. A consumer advocate pointed to the complex systems that underlie an SBM:

> "We're concerned about what could get lost in the process of transitioning, whether it's branding or name recognition, but also all the technical things that the Marketplace does; it's not just a call center, it's not just a place where you go pick [a health plan]. Healthcare.gov does a lot of complex eligibility determination, and… that took a really long time to get working really well in Texas."

Even strong supporters of states transitioning to SBMs expected some attrition, with one saying that "any time you're transitioning that many lives from one system to another… there's going to be a risk [of some people losing coverage]."

Risk of operational shortcomings, given experience with other Texas programs. Many interviewees raised strong concerns that a Texas SBM would have operational shortcomings that could worsen enrollment experiences for consumers and navigators and fail to support coverage in the state, based on other experiences with state government agencies. Interviewees described HHSC, which runs the state Medicaid program, as overwhelmed and underfunded. These concerns were especially acute considering Texas's challenges with unwinding the Medicaid continuous coverage requirement. Assistors and insurers reported that their experience with the state Medicaid program has been difficult, contrasting it with better experiences with the FFM. These concerns extended to eligibility and enrollment systems and call centers. One representative of a navigator organization explained their experience with Texas Medicaid's call center:

> "For Your Texas Benefits, calling 211 is such a dreadful process. First of all, the wait is so long. When you finally get with someone, like a representative on the phone, it's always not a guarantee they can help you; it's so limited with [whether] they can help you or not."

National experts who work with states nationwide worried that Texas may be particularly unprepared for such efforts, given experience with other programs in the state. Additionally, some interviewees pointed to the current upheaval associated with Medicaid managed care contracts as an indicator of potential disruption if Texas implements an SBM.[50]

Other interviewees said that the performance of Texas Medicaid is not a predictor of a Texas SBM because they are set up differently, and Texas Medicaid is treated with hostility because of the budget risk, which would not be the case with an SBM. However, none of the stakeholders who would be most directly affected by an SBM transition were optimistic about the risk.

Beyond the Medicaid program, interviewees pointed to operational challenges with other programs in Texas. A Texas insurer group representative said, "Whenever we [Texas] have new implementations at the state, things are always rocky; they never go smoothly." Moreover, any increases in challenges navigating enrollment systems under an SBM could be especially pronounced for vulnerable subgroups of consumers, including people of color, rural Texans, and Texans with limited English proficiency.

Lack of clear goals. Insurers, consumer advocates, and other stakeholders in the state expressed strong concern about the lack of specific coverage goals or guardrails to ensure an SBM would protect coverage. Several interviewees noted that the main piece of SBM legislation under consideration in the 2023 legislative session, HB 700, includes no language about the goal of supporting coverage nor any mechanism for ensuring it does so. In a statement of principles responding to this legislation, a wide range of stakeholders argued that "it is imperative that [HB 700] establish clear policy goals and timelines as well as an understanding of the significant administrative, technical, financial, and health system challenges such an undertaking will entail."[51] One Texas consumer advocacy group described a Texas SBM proposal as:

> "[A] solution in search of a problem…a conversation that's focused more on the Marketplace as an end, not a means…There's not a clear consensus from state leadership that what we want to do is encourage coverage and facilitate coverage;… this conversation is happening in a different space about revenue generation and other goals… Broadly, we'd just be concerned that we're not approaching this as one part of a big plan to cover more Texans, with a focus on those Texans that have been historically excluded from coverage and will have the most barriers to enrolling."

Risk from competing policy priorities. Multiple interviewees worried that a Texas SBM would be susceptible to interference by policy goals other than expanding enrollment in comprehensive health insurance. Several interviewees raised concerns that an SBM would support ACA-noncompliant plans. A representative of insurers described this concern as follows:

> "[The state has] a long-term effort to sell subsidized coverage that we would essentially call 'junk coverage' that doesn't meet the guarantees of the ACA plans. There's a long-term effort to sell

> those alongside products that then compete with our plans but not offer the same guarantee of coverage, ultimately siphoning off healthier members."

A representative of providers raised similar concerns:

> "If you're putting plans on the Marketplace that don't have the same level of benefits, would Texas make that really apparent that you're getting a super cheap plan and you're not getting all the benefits that you would get in an ACA-regulated plan? [At] a recent hearing,… Brian Blaise from the Paragon Institute talked about why we need these limited benefits plans or just catastrophic plans in general, and there was a lot of agreement… Would people really not end up understanding that they're getting potentially a lower quality plan when they could have had a better one with subsidies?"

Interviewees also expressed concern about competing social policy goals affecting health care. For example, the state has recently taken action to require hospitals to report data on patients' immigration status and to target certain health care providers.[52] A leader of an SBM in another state said that they "don't see how [an SBM] won't be used as a political football."

New burdens on the state. Adopting an SBM would impose substantial new responsibilities on the state. One former SBM director noted that the state would no longer benefit from the FFM's economies of scale in performing key tasks like running call centers and regulating EDE. Although starting an SBM has gotten easier since the ACA was first implemented, given vendor experience,[53] many interviewees cautioned the change could be more difficult to implement than expected. A national expert with extensive experience with SBMs explained that:

> "There is a lot of hard work to [running an SBM]… You don't know what you're bargaining for necessarily when you take [an SBM] on, and if you don't want to… put in the hard work to do it, then you may end up with more work than you expected."

States also face unpredictability in federal policy (including, as noted above, FFM user fees) and in premiums and enrollment rates. Furthermore, while Marketplace systems are more reliable and less expensive today than in the early years of ACA implementation, SBM states may still need to absorb unexpected costs that are likely to rise (Corlette et al. 2019).[54]

Risks to health sector. Representatives of the state's health care sector expressed concern about disruption in Marketplace enrollment and timely provider payments, which could affect health plans, health centers, and providers. Several interviewees raised the example of New Mexico's SBM transition, where there were delays in health plans being notified about who was enrolled and confusion around receiving claims for people for whom plans could not confirm enrollment. Stakeholders were further concerned that, because Texas has far more enrollees than New Mexico, a similar incident would be even more disruptive in Texas—introducing an especially large financial risk for health plans that

currently have many members enrolled through the Marketplace. One representative of providers noted that this risk of disruption is especially concerning following the turbulent years for providers during the COVID-19 pandemic. Another interviewee noted that private coverage—especially Marketplace coverage—is a key source of revenue for federally qualified health centers (FQHCs) in Texas, which serve many uninsured patients. One interviewee noted that between 2018 and 2022, the share of revenue for Texas FQHCs from private payers doubled, with most of it from Marketplace coverage.

Jeopardizing FFM gains. Numerous interviewees contrasted the risks from an SBM with the FFM's current strong performance. In a presentation in 2024, a representative of the Texas Association of Health Plans said, "Lawmakers should be cautious of any changes to the individual market that could create instability and drive out competition" (TAHP 2024). A representative from a provider group said that "it's very short-sighted and potentially dangerous to even consider [a transition]." This representative expressed confusion as to why, "given all the issues that [Texas has] to address, [policymakers would] tinker with something that is actually working well and that has been a success story when we have such a dire situation with the number of uninsured, and… such a disastrous Medicaid unwinding experience, where we have more uninsured people now?"

Even FFM critics conceded this was a concern, with one pointing to the improved state of the FFM in Texas and asking whether it was worthwhile to risk a well-functioning system for one that may or may not be as successful: "Do we want to jeopardize that mediocre-to-good [system] for the potential of [a] very bad [system] so that we could also potentially have a very good [system]?"

"If we don't have aligned stakeholder commitment to doing this well…this risk is that this goes poorly … If there is not a shared mission to doing this to reduce the uninsured rate rather than just using it as a piggy bank, that is a potentially high risk."
—Study participant who supports establishing an SBM

Key Elements of an SBM under a Potential Transition

If Texas policymakers were to decide to transition to an SBM, interviewees argued that it would be crucial for it to include certain key elements. Based on research, analysis, and suggestions from interviewees, we identified several design features that could help mitigate the risks described.

Clear goal of supporting coverage. Nearly all interviewees, including those expressing strong concerns about a transition but also many of those generally supportive, said an SBM should be adopted only if there is broad consensus and clear guardrails to ensure it is run with the primary goal of expanding health coverage. For example, one SBM supporter said, "If we don't have aligned stakeholder commitment to doing this well… this risk is that this goes poorly… If there is not a shared mission to doing this to reduce the uninsured rate rather than just using it as a piggy bank, that is a potentially high risk." A letter of SBM principles from Texas stakeholders detailed some of the ways that legislation could support coverage:

> "[Legislation transitioning to an SBM should] increase enrollment in comprehensive, affordable health care coverage. Legislation should ensure that Texas keeps what is working well today: comprehensive and affordable Marketplace coverage. All Marketplace coverage should be subject to community rating, guaranteed issue, essential health benefits, cost-sharing limits, and a prohibition on preexisting condition exclusions. Texas should maintain true affordability protections that ensure premiums do not exceed a percentage of income."[55]

Agency structure. Many interviewees argued for running an SBM as an independent agency rather than embedding it within an existing state agency. An SBM vendor commented the following:

> "I'd say, across the board, the most advantageous model of an SBM is a quasi-governmental agency. I say that because Medicaid is a really great example of an organization that cannot keep smart, capable, policy-oriented, and technology-oriented people because they cannot pay them… [The independent agency] model allows for connective tissue to the state and the procurement roles and the transparency roles, but it allows for flexibility…I think that it would work well for Texas."

Some interviewees specifically raised the need to place a new SBM outside of HHSC because they perceived that HHSC is overwhelmed, underfunded, and heavily scrutinized. A leader of an SBM in another state stated that the arguments for setting up an SBM as an independent agency were especially strong for Texas:

> "If it's not independent, especially [in Texas], I don't know how it works well… you just can't move quickly if you're a state agency and… every year is so different because all the stuff you have to do."

But a few interviewees argued that a potential SBM should be placed within existing state agencies, such as the Texas Department of Insurance or HHSC, because it could be inefficient to set up a whole new independent agency, and others argued for locating an SBM within HHSC since it has enrollment experience, could strengthen Medicaid and Marketplace coordination, and has a public health lens.

Many interviewees also raised the need for transparency and oversight of a new SBM, reiterating concerns raised in a letter of SBM principles from multisector Texas stakeholders declaring:

> "The Marketplace should be transparent and accountable. Marketplace implementation and operations should be transparent and provide ample opportunity for public input. Marketplace vendor contracts should be competitively bid."[56]

Stakeholder input. Universally, interviewees recommended that the governance structure of a potential Texas SBM include a range of affected parties, including consumers, providers, insurers, and brokers. Many said this can best be achieved by explicitly naming the parties represented on the potential SBM's board in the establishing legislation. Additionally, we heard other ideas for stakeholder input, including that the board should have representatives from both the executive and legislative branches and that the SBM should have a public meeting requirement.

Use of funding. As discussed above, an SBM could create excess funding. However, many interviewees cautioned that Texas would need to take active steps to ensure this funding is used for initiatives that best support coverage. Some interviewees expressed concern that those involved in drafting HB 700 have been focused on small business subsidies, which may not support coverage to the extent that individual and family subsidies do. Indeed, research suggests subsidies for small businesses may be less effective at targeting and reaching low-income people since (1) small employers are less likely to offer coverage, and a subsidy is frequently insufficient to get them to offer coverage, (2) small employers have a mix of workers of different incomes and thus subsidies do not target those with lower incomes, and (3) many low-income people are not consistently attached to the workforce (Blumberg and Holahan 2008). As a consequence, small business subsidies may do more to help employers that already support coverage than to reach the uninsured population (Blumberg and Holahan 2008). Many interviewees also emphasized the importance of dedicating excess funding to enhanced outreach and navigator assistance.

Avoiding noncompliant coverage. As discussed above, some interviewees expressed strong concerns that the Marketplace would display and encourage consumers to choose ACA-noncompliant plans, given Texas policymakers' particular interest in these plans. This could be addressed by requiring the Marketplace to sell and display only ACA-compliant plans.

Standards for customer support and outreach. According to some interviewees, the FFM's investment in spending for navigators, outreach, call centers, and language access has contributed to strong Marketplace enrollment. They argued that any SBM legislation should set similar standards.

Transition timeline and funding. Several interviewees highlighted the importance of an adequate implementation timeline for technology, setting up a new entity, coordination with CMS, and systems testing. Some also raised the need for state funding during the full transition period. A representative

from a Texas-based insurer group raised concerns that, although there "could be initial enthusiasm" about an SBM, "there could be an upfront underfunding of all the administration that has to happen."

Marketplace-Medicaid coordination. Several interviewees inside and outside the state emphasized the importance of a potential Texas SBM being well coordinated with the state's Medicaid program to ensure a smooth experience for consumers applying for coverage or transitioning between the two programs. An expert who has been part of SBM transitions noted:

> "A lot of enabling statutes [have] some sort of requirement around Medicaid-Marketplace coordination and alignment and data sharing—that sort of thing is important to get in there for purposes of program alignment."

Some options for providing strong Marketplace-Medicaid coordination include: (1) having an integrated eligibility system that performs eligibility and enrollment functions for both Medicaid and Marketplace coverage; (2) operating as a determination state, meaning the Marketplace agency can make binding Medicaid eligibility determinations; and (3) putting in place effective "account transfer" systems for consumers transitioning between Medicaid and the Marketplace (Levitis and O'Brien 2023; Boozang, Kahn, and Dave 2021; Wagner 2020). All these options require substantial investments, including from the Medicaid agency.

Call center implementation. Some interviewees raised the benefits of having a potential SBM call center in Texas, including creating jobs in the state and the potential for a more customized caller experience. However, Texas Medicaid's call center is run in-state by law,[57] and several interviewees expressed concerns about its staff capacity, turnover, training, and wait times. One even cautioned that running a Marketplace call center could be more complicated than running one for Medicaid because of the volatility of call volume throughout the year for Marketplaces. Thus, policymakers would need to weigh several tradeoffs when making decisions about an SBM call center.

Permissibility of EDE. Interviewees expressed a wide range of opinions about whether a potential Texas SBM should permit EDE. Some argued that a Texas SBM should adopt EDE to preserve continuity for consumers since it would permit many to enroll the same way they had under the FFM. If a Texas SBM did not permit EDE, interviewees said it should engage in a massive outreach campaign to ensure current EDE consumers are informed about the change. Others also attributed some recent FFM enrollment growth to EDE, although this connection has not been rigorously evaluated.

However, other interviewees noted that permitting EDE has important downsides for an SBM. Several noted that enforcing the detailed federal requirements for EDE—as required of any SBM permitting it—would be a substantial undertaking for a state, even one with robust enforcement

resources. Georgia's SBM transition has dedicated an entire team of staff to EDE, and it remains to be seen how that will play out. Second, the current problem of agent and broker fraud has been linked to EDE (Appleby 2024b).[58] As noted above, CMS is working to address this fraud, but permitting enrollment through private portals streamlined for brokers will likely continue to entail a higher risk of fraud. Navigators and others we interviewed also raised concerns that brokers and EDE vendors may not be presenting all plan options to consumers since they have a profit motive to sell plans offered by the insurer they represent. Others worried that permitting EDE sacrifices local control and customization, two of the major benefits of transitioning to an SBM. EDE may also increase the risk of consumers falling victim to scam websites since there is not one clear website for Marketplace enrollment (Straw 2019).

Other State Actions to Support Coverage, Regardless of Marketplace Type

Many interviewees, especially those concerned about establishing an SBM, suggested other measures the state could adopt to support coverage that would not bring the risks detailed above related to an SBM transition (table 3). Some could be combined with an SBM, but others could not. Options include raising awareness of currently available subsidized coverage options and affordability protections, improving consumer experiences with the Marketplace, improving consumer experiences with Medicaid/CHIP, improving Medicaid-Marketplace coordination, and expanding eligibility for public coverage. Options for expanding eligibility could include using federal dollars to fill the Medicaid coverage gap with Marketplace coverage, as Arkansas has done, which could build on recent FFM success in Texas (Maylone and Sommers 2017).[59]

Many interviewees also argued that the state should maintain policies that seem to work well, such as recent rating rule reforms on silver loading and rating areas. No interviewees suggested that Texas should switch to an SBM on the federal platform (SBM-FP), in which an SBM has many Marketplace responsibilities but uses the federal platform for eligibility and enrollment. This could be because the federal user fee for an SBM-FP is only slightly lower than the FFM user fee and thus provides fewer opportunities for states to keep substantial revenue. In addition, the functions performed by the state under an SBM-FP—consumer outreach and support—do not offer the economies of scale that other functions, like technological platforms, do for a large state like Texas.

TABLE 3

Other State Policies and Practices to Support Coverage in Texas

Actions that could reduce coverage barriers for Texans regardless of Marketplace type

Goals	Suggested state actions to support goals
Raise awareness of currently available subsidized coverage options and affordability protections	▪ Conduct Texas-based marketing and outreach to inform consumers about the availability and comprehensiveness of existing subsidized coverage options ▪ Provide consumer education to reduce enrollment barriers (e.g., explain why Medicaid should be considered an "insurance program" rather than a "welfare program," educate consumers about differences between more and less comprehensive coverage options) ▪ Increase funding for assistors and trusted community-based organizations to reach and assist eligible uninsured people
Improve oversight of consumer experiences with Marketplace	▪ Regulate agents and brokers to address fraud, reduce spam calls, etc. ▪ Help educate consumers about Marketplace coverage and application processes (e.g., information required to apply)
Improve consumer experiences with Medicaid/CHIP	▪ Streamline enrollment processes, including allowing for virtual application assistance ▪ Reduce wait times on the "211" helpline ▪ Increase the size and capacity of the workforce in state offices and ensure staff are adequately trained to provide needed assistance ▪ Place eligibility staff in safety net provider locations (e.g., federally qualified health centers) so they can provide direct assistance ▪ Increase ex parte renewal rates so fewer eligible consumers lose coverage at renewal because of burdensome Medicaid/CHIP redetermination processes ▪ Expand presumptive eligibility (allowing providers, community-based organizations, and other "qualified entities" to enroll individuals who appear eligible for Medicaid/CHIP to access services without delays while applications are processed) ▪ Adopt multiyear continuous eligibility for children ▪ Ensure stability of Medicaid managed care plan offerings
Improve Medicaid-Marketplace coordination	▪ Streamline account transfers between Medicaid/CHIP and Marketplace systems to address "ping-ponging" across programs (e.g., half of a family is approved for Marketplace coverage and half directed to Medicaid, only to be denied Medicaid coverage and redirected back to the Marketplace) ▪ Consider making Texas a determination state (as opposed to an assessment state)
Expand eligibility for public coverage	▪ Adopt Medicaid expansion ▪ Address the Medicaid coverage gap using the Marketplace and federal funding with a Section 1115 waiver[a] ▪ Explore options to cover immigrant populations, including eliminating the waiting period for pregnancy-related coverage for lawfully present immigrants without qualified status, leveraging federal funding for emergency Medicaid, or using state funding to cover noncitizens excluded from most federal programs[b]

Source: Key informant interviews.

Notes: CHIP = Children's Health Insurance Program.

[a] Bethany Maylone and Benjamin D. Sommers, "Evidence from the Private Option: The Arkansas Experience," New York: The Commonwealth Fund, February 22, 2017, https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/evidence-private-option-arkansas-experience.

[b] Laura Buddenbaum, "State-Funded Affordable Health Coverage for Non-Citizen Populations," State Health and Value Strategies, June 14, 2024, https://www.shvs.org/state-funded-health-coverage-programs-for-non-citizen-populations/; and Akash Pillai, Drishti Pillai, and Samantha Artiga, "State Health Coverage for Immigrants and Implications for Health Coverage and Care," *KFF*, May 01, 2024, https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/.

Discussion

With the nation's highest uninsured rate and an ongoing crisis of access and affordability (Sim et al. 2024), Texas has a great need to focus on options for supporting coverage. The question for state policymakers is whether establishing an SBM would be a step forward. The FFM has shown success in recent years and plays a vital role in Texas's health care system, with over 3 million enrollees. Marketplace enrollment nearly doubled between 2022 and 2024—the largest growth among any state. Over the past decade, nearly 6 million people have been enrolled in Marketplace plans in Texas, including hundreds of thousands of small business owners and entrepreneurs (ASPE 2022).[60] Moreover, providers rely on revenue from Marketplace-enrolled consumers, especially in states like Texas, which have not adopted the ACA's Medicaid expansion (Larson et al. 2020). Thus, any shifts to the Marketplace in Texas could have wide-reaching impacts on consumers, insurers, providers, and the health care system overall.

Proponents of a transition point to potential benefits, including more state control and flexibility in Marketplace operations. Other SBM states have successfully used this flexibility to support coverage through measures like means-tested subsidies and improving outreach and enrollment processes. However, interviewees generally agreed that positive outcomes under the autonomy of an SBM depend on effective implementation and specific policy choices. Interviewees representing those most directly affected by the Marketplace—including insurers, providers, enrollment assistors, and consumers in the state—were consistently skeptical that these benefits would materialize. Moreover, interviewees identified significant risks that a transition would jeopardize recent successes. Many expressed concerns that enrolling in the new program would become more burdensome for consumers, the state might be unprepared for the substantial new responsibilities of an SBM, other state policy goals might interfere with program operation, and the shift could harm providers and disrupt the stability of the individual health insurance market. It was widely expected that some enrollees would likely lose coverage during an SBM transition. All these burdens could fall especially hard on vulnerable populations, including people of color, people with limited English proficiency, and rural populations. Overall, stakeholders who would be most directly affected agreed that, given the recent success of the FFM in Texas, the potential benefit is not worth the risk.

If the state does move forward with an SBM, several best practices emerged in our research. A broad cross-section of interviewees thought a key prerequisite for a transition was a clear consensus—codified in statute—that the central goal of the SBM is to maximize enrollment in ACA-compliant coverage. Many interviewees also suggested that some risks could be minimized by codifying features

such as a transparent and independent agency structure, avenues for broad stakeholder input, enforcement of ACA protections, and strategic use of funding into a proposal with clear coverage goals.

These findings represent a snapshot of views and facts as of November 2024. But upcoming developments could change this calculus in several ways, including the following:

- ***CMS policy changes.*** The actions of the incoming Trump administration could affect the future of SBM proposals in Texas and other states. The interviews described here took place during the Biden administration, which has taken measures to expand coverage under the FFM and to impose stronger standards on SBMs. The incoming Trump administration might make countervailing changes.

  CMS could also make additional changes affecting SBMs. For example, CMS has recently tightened rules and added responsibilities related to EDE, network adequacy, and other issues, and further changes could be coming.[61] CMS has also repeatedly changed the FFM user fee, creating uncertainty about projected "savings" available to Texas and potentially changing state calculations about how available funds should be used. These changes could affect both the functioning of the FFM in Texas as well as the risks and opportunities of establishing an SBM, thus making an SBM transition more or less attractive.

- ***Congressional action on the continuation of enhanced PTCs or other issues.*** The surge in Marketplace enrollment between 2020 and 2024, with plan selections during OEP rising from 11.4 million to 21.4 million nationwide, was driven in large part by the PTC enhancements enacted under ARPA in 2021 and extended in the Inflation Reduction Act of 2022 (Banthin et al. 2024; CMS 2024). These enhancements increased the size of premium subsidies and extended subsidies to people with moderately higher incomes who had previously been excluded from financial assistance. These changes will expire in 2025 unless Congress votes to extend them.62 Expiration of the enhancements is projected to reduce the number of people enrolled in subsidized Marketplace plans by 7.2 million nationally and by 2.1 million in Texas (Banthin et al. 2024). Thus, Congress's decision could affect the size of the population affected by an SBM shift, the revenue generated by user fees, and the costs of administering the program. Congress may also make other policy changes that would have implications for an SBM transition, including other changes in Marketplace or Medicaid policy.

- ***Progress on state-level consensus about the design and goals of an SBM in Texas.*** Interviewees frequently raised the lack of consensus on the goals of an SBM transition. Alignment of the

purposes, structure, and plan for implementing an SBM across various sectors and interests in the state could change various stakeholders' perspectives on the likely repercussions of a shift.

Transitioning to an SBM is far from the only action that could change the state's health insurance landscape. Interviewees raised several other actions that could support coverage in Texas, with or without an SBM. These include better informing consumers about the availability and comprehensiveness of existing subsidized coverage options and how to apply, educating consumers about the comprehensiveness of various insurance options and the limitations of ACA-noncompliant plans, and increasing access to enrollment assistance in locations visited by communities and in the languages they use.[63] The state could also improve coordination between the Marketplace and the state Medicaid program to ease transitions between the programs. Finally, the state could take up Medicaid expansion for adults.

Conclusion

Although an SBM comes with opportunities and risks, key stakeholders who would be most directly affected consistently expressed that the risks outweigh the likely benefits. However, uncertainty about future developments could change this calculus. Policymakers should continue to track developments and evaluate this option's implications as events unfold and the state's policy goals are clarified.

Notes

[1] Texas State Senate. *Relating to the Creation of the Texas Health Insurance Exchange and Premium Assistance and Cost-Sharing Reduction Programs; Authorizing a Fee*. TX SB 344, 88th Legis. Introduced February 15, 2023; and Texas State House of Representatives. *An Act Relating to Creation of the Texas Health Insurance Exchange; Authorizing an Assessment.* TX HB 700, 88th Legis. Introduced March 10, 2023.

[2] "State-Based Exchanges," CMS, accessed August 29, 2024, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/state-marketplaces.

[3] "United States Census Bureau Table," US Census Bureau, accessed September 19, 2024, https://data.census.gov/table/ACSST1Y2023.S2701?q=Health%20Insurance&g=040XX00US48&moe=false.

[4] "State-Based Exchanges," CMS.gov, accessed November 19, 2024, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/state-marketplaces.

[5] *Patient Protection and Affordable Care Act*. Public Law 111–48, 124 Stat. 119 (2010).

[6] *Patient Protection and Affordable Care Act*.

[7] "State-Based Exchanges," CMS.gov.

[8] Rachel Schwab and JoAnn Volk, "States Looking to Run Their Own Health Insurance Marketplace See Opportunity for Funding, Flexibility," The Commonwealth Fund (blog), June 28, 2019, https://www.commonwealthfund.org/blog/2019/states-looking-to-run-their-own-health-insurance-marketplace-see-opportunity.

[9] "HHS Notice of Benefit and Payment Parameters for 2025," CMS, April 02, 2024, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule.

[10] According to the Healthcare.gov, a navigator is "An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers." See "Navigator," HealthCare.gov, accessed August 30, 2024, https://www.healthcare.gov/glossary/navigator.

[11] "Compliance and Enforcement," CMS, accessed September 20, 2024, https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement.

[12] "Small Business Health Care Tax Credit and the SHOP Marketplace," Internal Revenue Service, accessed August 22, 2024, https://www.irs.gov/affordable-care-act/employers/small-business-health-care-tax-credit-and-the-shop-marketplace.

[13] For example, Washington, DC's SBM, DC Health Link eliminated cost sharing for patients with type 2 diabetes and identified additional conditions where cost-sharing requirements could be eliminated to increase access for communities of color (Lewis 2022). Massachusetts announced similar policy objectives for its 2023 plan designs, eliminating cost-sharing for diabetes, asthma, coronary artery disease and hypertension; see Katie Lannan, "Connector Tying Copay Relief To Health Conditions," *Health Care For All Massachusetts* (blog), March 10, 2022, https://hcfama.org/connector-tying-copay-relief-to-health-conditions-state-house-news-service-march-10-2022/.

A 2022 Commonwealth Fund survey also highlights the efforts of states, such as DC, Nevada, Oregon, and Rhode Island, that have worked to eliminate language barriers (Schwab, Swindle, and Giovannelli 2022).

[14] "CMS Approves Pennsylvania's State Relief and Empowerment Waiver," CMS, July 24, 2020, https://www.cms.gov/newsroom/press-releases/cms-approves-pennsylvanias-state-relief-and-empowerment-waiver.

[15] "HHS Notice of Benefit and Payment Parameters for 2025," CMS.

[16] Authors' tabulations based on estimates weighted by the size of the population aged 0 to 64 drawing from data from the Census Bureau's American Community Survey. See "Population Distribution by Age," *KFF*, accessed August 16, 2024, https://www.kff.org/other/state-indicator/distribution-by-age/; "Uninsured Rates for the Nonelderly by Age," *KFF*, accessed August 16, 2024, https://www.kff.org/uninsured/state-indicator/people-0-64-uninsured-rate-by-age/; and "Distribution of Eligibility for ACA Health Coverage among the Uninsured," KFF, accessed August 16, 2024, https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/.

[17] "State-Based Exchanges," CMS.

[18] Bobby Harrison, "Commissioner Won't Create State Insurance Exchange Unless Gov. Reeves Approves," *Mississippi Today*, June 19, 2024, http://mississippitoday.org/2024/06/19/insurance-exchange-mississippi-tate-reeves-state-based-chaney-medicaid/.

[19] Harrison, "Commissioner Won't Create State Insurance Exchange Unless Gov. Reeves Approves."

[20] Alabama State House of Representatives. *Regarding Health Insurance; to Provide for a State Health Care Exchange Pursuant to the Federal Affordable Care Act; to Establish a Governing Board of Directors and an Executive Director and Require the Board to Operate the Exchange; and to Provide for Coordination with and Assistance from the Department of Insurance.* AL HB 518, Introduced May 24, 2023.

[21] Highlighting this benefit, more than 53 percent of enrollment in nonexpansion states is below 138 percent of FPL, compared with 12 percent in expansion states where consumers at these income levels are largely ineligible for PTC. See "2024 Marketplace Open Enrollment Period Public Use Files," CMS, accessed November 11, 2024, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files ("2024 OEP State, Metal Level, and Enrollment Status Public Use File").

[22] "Population Distribution by Age," *KFF*; "Uninsured Rates for the Nonelderly by Age," *KFF*, and "Distribution of Eligibility for ACA Health Coverage among the Uninsured," *KFF*. Estimates are weighted by the size of the population ages 0 to 64. Data is based on analyses of the Census Bureau's American Community Survey.

[23] Julie Appleby, "ACA Plans Are Being Switched Without Enrollees' OK," *KFF Health News* (blog), April 2, 2024, https://kffhealthnews.org/news/article/aca-obamacare-plans-switched-without-enrollee-permission-investigation/; Julie Appleby, "After Public Push, CMS Curbs Health Insurance Agents' Access to Consumer SSNs," *KFF Health News* (blog), April 9, 2024, https://kffhealthnews.org/news/article/aca-marketplace-ssn-social-security-numbers-agents/; and Julie Appleby, "Rising Complaints of Unauthorized Obamacare Plan-Switching and Sign-Ups Trigger Concern," *KFF Health News* (blog), April 8, 2024, https://kffhealthnews.org/news/article/aca-unauthorized-obamacare-plan-switching-concern/.

[24] "CMS Statement on System Changes to Stop Unauthorized Agent and Broker Marketplace Activity," CMS, July 24, 2024, https://www.cms.gov/newsroom/press-releases/cms-statement-system-changes-stop-unauthorized-agent-and-broker-marketplace-activity.

[25] "HHS Notice of Benefit and Payment Parameters for 2019," *Federal Register* 83 (74), April 17, 2018; "HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans," *Federal Register* 85 (94), May 14, 2020; "HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards," *Federal Register* 86 (85), May 5, 2021; "HHS Notice of Benefit and Payment Parameters for 2023," *Federal Register* 87 (88), April 28, 2022; "HHS Notice of Benefit and Payment Parameters

for 2024," *Federal Register* 88 (81), April 27, 2023; and "HHS Notice of Benefit and Payment Parameters for 2025," *Federal Register* 89 (73), April 15, 2024.

[26] See also "The Effects of Permanently Extending the Expansion of the Premium Tax Credit and the Costs of That Credit for Deferred Action for Childhood Arrivals Recipients." 2024. Congressional Budget Office. https://www.cbo.gov/publication/60437.

[27]United States Census Bureau Table," US Census Bureau, accessed September 19, 2024. https://data.census.gov/table/ACSST1Y2023.S2701?q=Health+Insurance.

[28] "Health Insurance Coverage of the Total Population, 2022," *KFF*, accessed October 23, 2024, https://www.kff.org/other/state-indicator/total-population/.

[29] "Compliance and Enforcement," CMS, accessed November 11, 2024, https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement.

[30] "Medicaid & CHIP Marketplace Interactions," Medicaid.gov, accessed July 8, 2024, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-chip-marketplace-interactions/index.html.

[31] Erin O'Malley, "CMS' New Rules Govern 'Junk' Short-Term Health Coverage and Insurance-Like Products," *Every Texan* (blog), April 30, 2024, https://everytexan.org/2024/04/29/cms-new-rules-govern-junk-short-term-health-coverage-and-insurance-like-products/.

[32] Shanoor Seervai, Munira Z. Gunja, and Sara R. Collins, "Health Plans That Don't Comply with the ACA Put Consumers at Risk," The Commonwealth Fund (blog), November 14, 2019, https://www.commonwealthfund.org/blog/2019/health-plans-that-dont-comply-with-aca-put-consumers-at-risk.

[33] "Medicaid Enrollment and Unwinding Tracker," *KFF*, June 14, 2024, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/.

[34] "Medicaid Enrollment and Unwinding Tracker," *KFF*.

[35] "Medicaid Enrollment and Unwinding Tracker," *KFF*; and Sarah deLone, "Texas Application Timeliness Review Letter," CMS, May 22, 2024.

[36] "Complaint and Request for Investigation, Injunction, and Other Relief," National Health Law Program, Electronic Privacy Information Center, and Upturn, Inc., January 31, 2024.

[37] "Medicaid Postpartum Coverage Extension Tracker," *KFF*, May 10, 2024, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

[38] Karen Brooks Harper, "Feds Approve 12 Months of Medicaid for Texas Moms," *The Texas Tribune,* January 17, 2024, https://www.texastribune.org/2024/01/17/texas-medicaid-postpartum/.

[39] Andrew Sprung, "How the Texas Legislature Learned to Stop Worrying and Love the ACA Marketplace," *The American Prospect*, April 21, 2022, https://prospect.org/health/texas-legislature-learned-to-stop-worrying-and-love-aca-marketplace/.

[40] "Affordable Care Act Marketplace Coverage for the Self-Employed and Small Business Owners," US Department of the Treasury, accessed November 11, 2024.

[41] "2022 Marketplace Open Enrollment Period Public Use Files," CMS, accessed August 16, 2024, https://www.cms.gov/files/zip/2022-oep-state-level-public-use-file.zip; and "Population Distribution by Age," KFF. Estimates are weighted by the size of the population ages 0 to 64. Data is based on analyses of the Census Bureau's American Community Survey.

[42] "Number of People Who Have Ever Enrolled in ACA Marketplace Coverage, 2014–2024," US Department of the Treasury Office of Tax Analysis, accessed November 19, 2024.

[43] "Senate Committee on Health and Human Services," The Texas Senate, accessed November 19, 2024, Video, https://tlcsenate.granicus.com/MediaPlayer.php?view_id=54&clip_id=18499.

[44] *An Act Relating to Creation of the Texas Health Insurance Exchange; Authorizing an Assessment.* TX HB 700, 88th Legis.

[45] "Who Are the Uninsured in Texas?," Texas 2036, accessed November 18, 2024, https://texas2036.org/uninsured/.

[46] Texas State Senate. *Relating to the Authority of the Commissioner of Insurance to Review Rates and Rate Changes for Certain Health Benefit Plans*. TX SB 1296, 87th Legis. Introduced April 26, 2021.

[47] A representative of a community-based organization that provides health insurance navigator services explained, "You have some folks in Texas who are so opposed to anything that appears to be assistance or public assistance or something from the government that I don't know if having a Texas-related name would help that much."

[48] "HHS Notice of Benefit and Payment Parameters for 2023," *Federal Register*; "HHS Notice of Benefit and Payment Parameters for 2025," *Federal Register*; and "Proposed HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program," *Federal Register* 89 (197), October 10, 2024.

[49] Appleby, "Rising Complaints of Unauthorized Obamacare Plan-Switching and Sign-Ups Trigger Concern."

[50] Karen Brooks Harper, "Proposed Changes to State Medicaid Plans Could Shake up Health Coverage for 1.8 Million Low-Income Texans," *The Texas Tribune*, April 18, 2024. https://www.texastribune.org/2024/04/18/texas-medicaid-provider-contracts/; and Karen Brooks Harper, "State's Premature Release of Bid Proposal Info Touches off New Battle over $116 Billion in Medicaid Contracts," *The Texas Tribune*, April 26, 2024, https://www.texastribune.org/2024/04/26/texas-medicaid-contracts/.

[51] "Principles for a Texas-Run Health Insurance Marketplace and Health Care Innovation Waiver," TexMed.org, accessed November 19, 2024.

[52] Vianna Davila, "Here Are the Organizations That Ken Paxton Targeted Using Consumer Protection Laws," *The Texas Tribune*, May 30, 2024, https://www.texastribune.org/2024/05/30/texas-ken-paxton-consumer-protection-law-investigations/; Vianna Davila, "How Ken Paxton Is Stretching the Boundaries of Consumer Protection Laws to Pursue Political Targets," *The Texas Tribune*, May 30, 2024, https://www.texastribune.org/2024/05/30/ken-paxton-texas-ag-political-targets-health-care-lgbtq/; and Lauren Irwin, "Texas Gov. Abbott Orders Hospitals to Collect and Send State Data on Patients' Immigration Status," *The Hill*, August 9, 2024, https://thehill.com/homenews/state-watch/4819901-texas-gov-abbott-hospitals-patients-immigration-status/.

[53] For example, when testifying about a possible transition in Pennsylvania, the insurance commissioner noted that technological innovations have made the process of transitioning to an SBM less daunting and burdensome, given that states can now outsource preverified technology systems instead of having to build their own (Altman 2019).

[54] Corlette et al. (2019) also gave the following illustrative example: "While the up-front price tag of implementing the HRA rule is an estimated $46.8 million in the twelve SBM states, CMS estimates the cost across the FFM states to be just $3.9 million."

[55] "Principles for a Texas-Run Health Insurance Marketplace and Health Care Innovation Waiver."

[56] "Principles for a Texas-Run Health Insurance Marketplace and Health Care Innovation Waiver."

[57] "Texas Administrative Code," Texas Register, accessed August 12, 2024, https://texreg.sos.state.tx.us/public/readtac$ext.TacPage.

[58] Appleby, "After Public Push, CMS Curbs Health Insurance Agents' Access to Consumer SSNs."

[59] Anne Dunkelberg, "Arkansas' Private Option Could Be Model for Texas," *Every Texan* (blog), March 25, 2015. https://everytexan.org/2015/03/25/arkansas-private-option-could-be-model-for-texas/.

[60] "Number of People Who Have Ever Enrolled in ACA Marketplace Coverage, 2014–2024," US Department of the Treasury Office of Tax Analysis; and Cynthia Cox and Jared Ortaliza, "Where ACA Marketplace Enrollment Is Growing the Fastest, and Why," *KFF*, May 16, 2024, https://www.kff.org/policy-watch/where-aca-marketplace-enrollment-is-growing-the-fastest-and-why/.

[61] "HHS Notice of Benefit and Payment Parameters for 2025," *Federal Register*.

[62] *Inflation Reduction Act of 2022*. Public Law 117–69, 136 Stat. 1818 (2022).

[63] Many of these recommendations are reinforced by other research. For instance, a 2023 survey of adults in Texas with incomes below 138 percent of FPL with prior Medicaid enrollment (for themselves or a child) since March 2020 found that only 14 percent had heard "a great deal" and 25 percent "something" about the Marketplace, with the majority hearing "not very much" or "nothing at all" (Figueroa et al. 2024). Analysis of national survey data finds that knowledge about available financial assistance is even lower than knowledge about the availability of Marketplace coverage (Haley and Wengle 2021). This suggests that expanded efforts to inform consumers about Marketplace coverage options could help fill knowledge gaps.

References

Altman, Jessica K. 2019. "Testimony Before the House Insurance Committee." Harrisburg, PA: Pennsylvania Insurance Department.

Ario, Joel S., and Amy Zhan. 2024. *Emerging Opportunities for State-Based Marketplaces (SBMs)*. Los Angeles: Manatt.

ASPE (Assistant Secretary for Planning and Evaluation). 2022. "Marketplace Coverage and Economic Benefits: Key Issues and Evidence." Washington, DC: ASPE.

Banthin, Jessica, Matthew Buettgens, Michael Simpson, and Jason Levitis. 2024. "Who Benefits from Enhanced Premium Tax Credits in the Marketplace?." Washington, DC: Urban Institute.

Banthin, Jessica, Michael Simpson, and Mohammed Akel. 2024. "The Impact of Enhanced Premium Tax Credits on Coverage by Race and Ethnicity." Washington, DC: Urban Institute.

Blumberg, Linda, and John Holahan. 2008. "Targeting Subsidies: Employers versus Individuals." Washington, DC: Urban Institute.

Boozang, Patricia, Jess Kahn, and Ashka Dave. 2021. "The End of the COVID-19 Public Health Emergency: Data and IT 'Table Stakes' for Retaining Coverage Gains." Princeton, NJ: State Health and Value Strategies.

Brooks, Tricia, Jennifer Tolbert, Allexa Gardner, Bradley Corallo, Sophia Moreno, and Anna Mudumala. 2024. *A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Continuous Enrollment and Beyond*. San Fransisco: KFF.

CMS (Centers for Medicare & Medicaid Services). 2021. "CCIIO Data Brief Series: Impact of Enhanced Direct Enrollment During the Open Enrollment Period for 2021 Coverage." Baltimore, MD: CMS.

———. 2024. *Health Insurance Marketplaces 2024 Open Enrollment Report.* Baltimore, MD: CMS.

CMS and CCIIO (Center for Consumer Information & Insurance Oversight). 2023. "2023 Agent and Broker Summit." Baltimore, MD: CMS. Presentation.

Corlette, Sabrina, and Jason Levitis. 2024a. "Final 2025 Payment Notice: Marketplace Standards and Insurance Reforms." *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20240407.546948.

———. 2024b. "Proposed 2026 Payment Notice: Marketplace Standards and Insurance Reforms," *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20241008.504516.

Corlette, Sabrina, Kevin Lucia, Katie Keith, and Olivia Hoppe. 2019. "States Seek Greater Control by Converting to State-Based Marketplaces." Washington, DC: Urban Institute.

Figueroa, Jose F., Adrianna McIntyre, Gaby Aboulafia, Benjamin Sommers, and Arnold Epstein. 2024. *Tracking the 'Unwinding' of the Medicaid Continuous Enrollment Provision in Texas*. Houston, TX: Episcopal Health Foundation.

GAO (US Government Accountability Office) 2023. *Private Health Coverage: Information on Farm Bureau Health Plans, Health Care Sharing Ministries, and Fixed Indemnity Plans.* GAO-23-106034.

Gürel, Aleka. 2024. "The Impact of Brokers on ACA Marketplace Growth." *Risk Management and Insurance Review* 2 7(2): 227–36. https://doi.org/10.1111/rmir.12280.

Haley, Jennifer M., and Erik Wengle. 2021. "Uninsured Adults' Marketplace Knowledge Gaps Persisted in April 2021." Washington, DC: Urban Institute.

Holahan, John, Claire O'Brien, and Erik Wengle. 2024. *Targeting Highly Concentrated Insurer and Provider Markets for Rate Regulation*. Washington, DC: Urban Institute.

Larson, Anne E., Megan Hoopes, Heather Angier, Miguel Marino, and Nathalie Huguet. 2020. "Private/Marketplace Insurance in Community Health Centers 5 Years Post-Affordable Care Act in Medicaid Expansion and Non-Expansion States." *Preventive Medicine* 141:106271. https://doi.org/10.1016/j.ypmed.2020.106271.

Levitis, Jason, and Claire O'Brien. 2023. "Expanding Health Coverage through Marketplace Facilitated Enrollment Programs." Washington, DC: Urban Institute.

Levitis, Jason, and Sonia Pandit. 2021. "Supporting Insurance Affordability with State Marketplace Subsidies." Princeton, NJ: State Health and Value Strategies.

Lewis, Diane C. 2022. "Washington, DC's State-Based Marketplace is Addressing Health Disparities and Systemic Racism In Health Care." *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20220315.92335.

Maylone, Bethany, and Benjamin D. Sommers. 2017. "Evidence from the Private Option: The Arkansas Experience." New York: The Commonwealth Fund. https://doi.org/10.26099/p8gn-ws23.

New Mexico Health Insurance Exchange. 2022. "BeWellnm Board Meeting." Presentation.

Schwab, Rachel, Rachel Swindle, and Justin Giovannelli. 2022. "State-Based Marketplace Outreach Strategies for Boosting Health Plan Enrollment of the Uninsured." New York: The Commonwealth Fund. https://doi.org/10.26099/27tp-8k06.

Sim, Shao-Chee, Ann Barnes, Jazmyne Sutton, and Eran Ben-Porath. 2024. *Episcopal Health Foundation Annual Poll Shows Continuing Health Care Affordability and Access Crisis in Texas*. Houston, TX: Episcopal Health Foundation.

Straw, Tara. 2019. "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm." Washinton, DC: Center on Budget and Policy Priorities.

Swagel, Phillip. 2024. "The Effects of Permanently Extending the Expansion of the Premium Tax Credit and the Costs of That Credit for Deferred Action for Childhood Arrivals Recipients." Congressional Budget Office.

TAHP (Texas Association of Health Plans). 2024. "Texas Covered: Individual Market, Uninsured, and Healthcare.gov." Austin, TX: TAHP. Presentation.

Wagner, Jennifer. 2020. "Streamlining Medicaid Enrollment During COVID-19 Public Health Emergency." Washington, DC: Center on Budget and Policy Priorities.

Young, Christen Linke. 2020. *Taking a Broader View of 'Junk Insurance.'* Washington, DC: Brookings.

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