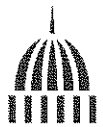

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States and Health Insurance Marketplace Funding
A 2014 interim report

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Rev. 3 – prepublication memo -- Subject to future additions/changes

Between 2010, when the federal ACA was enacted and signed, and early 2013 (when states and HHS confirmed the governmental structure of Exchanges or Marketplaces), most focus was on the various federal grants to states for planning, implementation, start-up and initial operation. Because the ACA requires state-run Exchanges to be "self-sufficient" beginning January 2015 there is a recent focus on how, when and where such funding will be authorized and collected.

For state run and state partnership exchanges, this report features and highlights the recent decisions or structures for "self-sufficient" state-related financing.

- In all states using the Federally-Facilitated Marketplaces, health insurers will be subject to a 3.5 percent premium assessment, applied toward plans sold through the Marketplace. Special variations or exceptions in individual states are noted below.
- This report features **20** states with some type of state exchange structure: **Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New York, Oregon, Rhode Island, Utah, Vermont and Washington.**
- Of these 20, 16 states are using or have authorized a premium fee or assessment, with amounts and formulas set by the individual states.

This summary and report was developed from several state and original sources. Individual state descriptions may reflect progress reported as of a point in time in 2013 or 2014, and may not include late-breaking changes. Optional web links (some of which appear as footnote numbers) provide selected details or source documentation. Parts of the material and links below are adopted from KFF's interactive online page at http://kff.org/state-health-marketplace-profiles/

ARKANSAS

On April 23, 2013, Governor Beebe signed HB 1508 which authorizes the transition of the Marketplace from a state-federal Partnership Marketplace to a State-based Marketplace to take effect on July 1, 2015.

State Financing/Insurer Fee: By October 1, 2014, the Arkansas Health Insurance Marketplace is required to develop recommendations for the initial assessment or user fee that will be needed to support the Marketplace operations and must recommend increases or decreases in the amount of future assessments or user fees, by

October 1 of each subsequent year. These recommendations will require approval by the Arkansas Health Insurance Marketplace Legislative Oversight Committee and the Arkansas General Assembly. Act 1500 of 2013

Grants: The Arkansas Insurance Department received a federal Exchange Planning grant of almost $1 million in 2010. In September 2011, Governor Beebe contemplated applying for a Level One Establishment grant but declined after hearing lawmakers' objections. A few months later however, the state submitted an application for $7.6 million in federal funding to implement the partnership exchange (link). In February 2012, the grant was awarded and Arkansas planned to use the funds to design and implement IT systems to connect Arkansas Medicaid and state-run exchange functions to the federally-operated eligibility and enrollment portal, implement systems to support state-operated consumer assistance functions, and develop plan management functions of the Exchange. In September 2012, Arkansas received a second Level One Establishment grant of $18.6 million to work in partnership with the federal government and other state stakeholders to implement plan management and consumer assistance components of the Exchange. In April 2013, Arkansas received a third Level One Establishment grant of $16.5 million to fund the IPA Guide program, provide oversight and coordination for Federal Navigators working in Arkansas, implement an outreach and education campaign, develop an Arkansas Health Connector Resource Center, and update QHP certification and monitoring criteria. link In October 2013, Arkansas received a fourth Level One Establishment grant of $10.6 million to continue supporting the state's role in consumer assistance and plan management functions. The Board of the Arkansas Health Connector will apply for additional federal funding by November 15, 2013 to support the transition of to a fully State-based Marketplace.

CALIFORNIA

On September 30, 2010, former Governor Arnold Schwarzenegger (R) signed into law two related bills, AB 1602 and SB 900, to establish the California Health Benefit Exchange (CA-HBEX). The state legislation creates the California Health Trust Fund within the State Treasury, which will be continuously appropriated and used to manage the finances of Covered California. The legislation also authorizes a loan of up to $5 million from the California Health Facilities Financing Authority to assist in establishment and operation of the Marketplace. The California HealthCare Foundation and the Blue Shield California Foundation also funded activities in preparation for applying for the federal Establishment grant. Link

State Financing/Insurer Fee: The California Health Benefit Exchange will charge a participation fee on Qualified Health Plans sold by issuers both inside and outside of the Exchange. The participation fee charged for enrollment outside the Exchange will be at 50% of the in-Exchange rate and only apply to enrollment in the same product, not carrier wide.
Year 1 (2014): 3% of premium fee (supplemented by Federal grants)
Year 2 (2015): 3% of premium fee
Year 3 (2016): 2.5% of premium fee
Year 4 (2017): 2% of premium fee

Grants: In September 2010, the California Health and Human Services Agency received a federal Exchange Planning grant of $1 million. The state also received a federal Level One Establishment grant of $39.4 million on August 12, 2011 which was used for overall business and operational planning, research and analysis, and implementation of an information technology system. The state was awarded a second Level One Establishment grant in June 2012 for $196.4 million for continued Marketplace development.[27] In January 2013, the state received a $674 million federal Level Two Establishment grant that will enable the state to finance Covered California's operations through December 2014.[28]

Examples of Expenditures: In September 2013, Covered California launched its advertising campaign, with TV, radio and digital media ads in three test markets—San Diego, Sacramento, and Chico/Redding. Ads in both English and Spanish were included in the launch. The campaign expanded to additional markets in October and

included print ads and ads in additional languages. The campaign also includes out-of-home advertising and a presence on social media, including Facebook and Twitter. Covered California plans to spend $20 million in marketing through the end of December and $45 million for the entire open enrollment period from October 1, 2013 through March 31, 2014.[21]

COLORADO

State Financing/Insurer Fee: SB 11-200 prohibits Colorado from financing its Exchange (C4HCO) using the General Fund. In March 2013, the Board approved a recommendation to assess a carrier administrative fee of 1.4% of premium for products sold on the Marketplace in 2014. In May 2013, the General Assembly passed HB 13-1245, establishing three funding mechanisms for C4HCO that will supplement the revenue generated by the assessment. HB 13-1245 imposes a broad-based assessment on carriers for individual and small group insured lives in the state. The assessment, which will be up to $1.80 per member per month, will last for a maximum of three years. Dental plans will be assessed $0.18 per member per month.

The law also shifts excess reserves to C4HCO from CoverColorado, the state's high risk pool that will close in 2014. C4HCO will receive $15 million from CoverColorado in 2014 and $8.5 million in 2015. In June 2013, the Board set a $0 market assessment for medical and dental plans in 2014, determining that funds beyond those being transferred from Cover Colorado would not be needed for the first year of operations.[15] C4HCO's annual operating budget is expected to be around $26 million.[16]

Grants: The legislation prohibits appropriations of state funds for the Marketplace, though Colorado can apply for federal grant funding. The Colorado State Office of the Governor received a federal Exchange Planning grant of approximately $1 million in 2010. In February 2012, the state received a Level One Establishment grant for $17.9 million to build the operational staff and consulting support necessary to progress on key design requirements of the Marketplace. In September 2012, Colorado received a second Level One grant of $43.5 million to support technology development, specifically in order to meet deadlines for certification, testing, and deployment of systems and operations. In July 2013, Colorado received a Level Two Establishment grant for $116.2 million to support technology enhancement, develop the consumer center and education campaign, design a quality improvement program, and fund the Connect for Health Assistance Network.[18]

Colorado, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance Marketplaces, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.[19]

CONNECTICUT

State Financing/Insurer Fee: Public Act 11-53 authorizes the Marketplace to charge health carriers capable of offering a qualified health plan through Access Health CT an assessment or user fee. In May 2013, the CT Board approved a 1.35% marketplace assessment on all small group and individual market insurers, as well as dental carriers.[20] The assessment rate is based on Access Health CT's estimated annual operating cost of $34.5 million.[21]

Grants: The Connecticut State Office of Policy and Management received a federal Exchange Planning grant of $1 million in September 2010 and a federal Level One Establishment grant of $6.7 million in August 2011 to work on IT systems and develop appropriate capacity for consumer assistance and reporting requirements. The state filed a Level One grant application request for $21.9 million in September 2013. The Exchange was awarded a Level Two Establishment grant in August 2012 for $107.3 million to fund Exchange development through December 2014. In February 2013, the state was awarded a second Level One Establishment grant for $2.1 million to fund the implementation of an In-Person Assisters program.[25]

In addition, Connecticut is a member of the consortium of New England states that received a federal Early Innovator Grant of $44 million to develop, share, and leverage insurance exchange technology. The multi-state consortium also includes Rhode Island, Maine, Vermont, and Massachusetts with the University of Massachusetts Medical School as the grant holder.[26]

DELAWARE

On December 20, 2012, Delaware received conditional approval from the U.S. Department of Health and Human Services (HHS) to establish a Partnership Marketplace.[15] The Choose Health Delaware Marketplace portal became operational on October 1; consumers may download a paper application from the website but cannot apply for Marketplace or Medicaid coverage directly through Delaware's site. The federal government is operating the online eligibility and enrollment system and consumers must use the federal portal to apply for coverage online.

The Delaware Department of Health and Social Services received a federal Exchange Planning grant of $1 million in 2010. In November 2011, Delaware was awarded a Level One Establishment grant for $3.4 million to ready business and information technology systems for an exchange. Delaware received a second Level One Establishment grant for $8.5 million in January 2013 to support the review of qualified health plan (QHP) applications, to implement a consumer assistance program, and to fund an outreach and education campaign.[14]

DISTRICT OF COLUMBIA

District Financing/Insurer Fee: The legislation authorizes the Health Benefit Exchange Authority to charge user fees, licensing fees, and other assessments on health carriers selling qualified dental or health plans inside and outside the Marketplace. All revenue will be maintained in a non-lapsing fund to be administered by the Board. In May 2013, the Financial Sustainability Working Group recommended using the existing 2% premium tax and/or the .3% DISB operating assessment to support DC Health Link. If the Health Benefit Exchange Authority staff determines this is not feasible or that additional funds are needed, a broad-based assessment on all health insurance premiums should be used.[24] The Board approved the recommendation by Resolution, June 23, 2013.[25]

- *Insurance Premium Tax* - Carriers are required to pay a 2% tax on premiums written in the district. The portion of tax revenues derived from health insurance premiums are allocated to the Department of Health, while revenues from other insurance markets are allocated as general tax revenues. Certain health insurance premiums are not subject to the premium tax, including benefits of federal employees (FEHB).
- *DISB Assessment* DISB assesses the insurance market to fund the department's operational costs. DISB determines its operational budget for the following year and calculates the percentage fee that will be placed on the premiums written in the district by each carrier. By law the assessment cannot exceed 3/10 of one percent on premiums.

Grants: In September 2010, the District of Columbia Department of Health Care Finance received a federal Exchange Planning grant of $1 million. The same Department received a federal Level One Establishment grant of $8.2 million in August 2011 to leverage the data, information, and indicators gathered in the preliminary planning effort into a comprehensive project design. In September 2012, the District of Columbia received a Level Two grant of $73 million to develop an IT system and to fund creation of the DC Health Link Marketplace and the first year of operations.[27]

Hawaii

State Financing/Insurer Fee: In August 2013, the Board approved a sustainability plan to assess issuers a user fee of 2% of monthly premiums charged for QHPs sold through the individual Marketplace, beginning January 1, 2014. Beginning July 1, 2014 the Connector will charge issuers the same fee for QHPs sold through the SHOP Marketplace.[18]

Grants: The Hawaii DCCA received a federal Exchange Planning grant of $1 million. In November 2011, the DCCA awarded a Level One Establishment grant of $14.4 million to create a web portal for the Connector. In August 2012, the Department of Health and Human Services was awarded a second Level One Establishment grant of $61.8 million to support outreach efforts, design and develop IT architecture and engage a quality assurance program.[20]

IDAHO

Idaho is relying on the Federally-Facilitated Marketplace for 2014 operation.

State Financing/Insurer Fee: HHS has waived the 3.5% administrative fee in Idaho. The State Exchange has decided to impose a 1.5% fee on insurers to create a reserve fund for 2014 and 2015.

KENTUCKY

State Financing//Insurer Fee: Kynect will cost an estimated $39.5 million to operate in its first year. The KHBE is considering funding the Marketplace through an assessment of insurers inside and outside of Kynect, which is the current funding mechanism for Kentucky's high risk pool. The Marketplace will not be financed through the General Fund.[16]

Grant Funds: In September 2010, the Kentucky Cabinet for Health and Family Services' Office of Health Policy received a federal Exchange Planning grant of $1 million and in August, the same agency was awarded a federal Level One Establishment grant for almost $7.7 million to fund IT systems. In February 2012, the agency was awarded a $57.8 million grant to continue planning and building the requisite IT systems which will provide integrated eligibility and enrollment with the Medicaid program. In September 2012, Kentucky received a third Level One grant of $4.4 million to support the development of a Navigator program and assess access to health care services. The state was awarded a Level Two Establishment Grant for $182.7 million in January 2013 to develop a consumer and stakeholder support network and to complete an interoperable IT system that will integrate Kentucky's Health Benefit Exchange with all of Kentucky's existing health and human services programs.
> Kentucky Affordable Insurance Exchange Grants Awards List.

MARYLAND

The DHMH has received three federal grants: an Exchange Planning grant of $1 million; an Early Innovator grant of $6.2 million to develop a Marketplace IT infrastructure that could be replicated by other states; a Level One Establishment grant of $27 million to conduct data and policy analysis that will inform the technical and operational infrastructure of Maryland Health Connection and enable rapid implementation of the IT platform; and a Level Two Establishment Grant of $123 million to support continued policy development and consumer outreach, assistance, and education.[33]

In addition, Maryland, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance Marketplaces, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.[34]

State Financing/Insurer Fee: Maryland Health Connection is authorized to collect fees or assessments from participating plans, though not to the extent that the fees create a competitive disadvantage with plans offered outside the Health Connection.

In September 2012, a subcontractor providing analytic support to the Joint Committee recommended a financing model that blends multiple approaches rather than relying on a single revenue source.[30] An example hybrid financing approach might include a combination of revenue collected from the non-group, small group, and large group markets, providers, and cigarette sales. In December 2012, the Joint Committee submitted a report to the Governor and General Assembly which included the following recommendations: the state should use a combination of at least two revenue streams; a transaction-based assessment on the whole non-group and small group market is preferable to an assessment applied only to plans inside Maryland Health Connection; and a broad-based assessment on the larger group market and/or an increase in the tobacco tax should be considered, while an assessment on hospitals should not be considered.
> http://kff.org/health-reform/state-profile/state-exchange-profiles-maryland/ -12/13/2013

MASSACHUSETTS

In September 2010, the Massachusetts Commonwealth Insurance Connector Authority received a federal Exchange Planning grant of $1 million. In February 2012, the Connector Authority also received a Level One Establishment grant of $11.6 million to analyze coverage transitions and the operational interface between the Exchange and the state's Medicaid program.[19] In addition, Massachusetts is a member of the consortium of New England States Collaborative Insurance Exchange Systems that received a federal Early Innovator grant of $36 million to develop, share, and leverage insurance exchange technology.[20] The University of Massachusetts Medical School is the grant holder. In September 2012, Massachusetts received a second Level One grant of $41.7 million dollars to create a risk-adjustment program and support IT development lead by the HIX/IES. In January 2013, the Connector received a Level Two grant of $81.3 million to support creation of a state-specific risk adjustment program, development of an outreach and education campaign, and the first year of operations of the Connector as an ACA-compliant exchange.[21]

State Financing/Insurer Fee: Massachusetts initially appropriated $25 million to operate the Health Connector, but it is now financially self-sustaining and authorized to apply a surcharge to all health benefit plans offered through the Connector. The collected funds pay for the Health Connector's administrative and operational expenses, not premium assistance payments, under Commonwealth Care.

The Health Connector is developing a long-term financing strategy that involves continued state funding and a carrier administrative fee targeted at or below 2.5% of premium. Because of the availability of federal Establishment Grant funding to support Health Connector operations in 2014, the carrier administrative fee for 2014 has been temporarily eliminated.[18]

Prior to 2013-14 operations, initially, the Connector fee was established at 5% of premium revenue for both the organization's subsidized program (Commonwealth Care) and its non-subsidized program (Commonwealth Choice). As enrollment in the Health Connector has grown, it has been able to reduce the administrative fee to approximately 3% for the larger subsidized program, and 3.5% for the smaller non-subsidized program
> Massachusetts Profile – 9/29/2013

MICHIGAN

On March 5, 2013, Michigan received conditional approval from the U.S. Department of Health and Human Services (HHS) to establish a State-federal Partnership Marketplace.[14]

Michigan's Department of Community Health was awarded a federal Exchange Planning grant of $1 million. In November 2011, Michigan's Department of Licensing and Regulatory Affairs was awarded a $9.8 million federal Level One Establishment grant to conduct further insurance market analysis and technology planning; however, the Legislature has yet to approve spending the funds. In January 2013, Michigan received a second Level One grant of $30.7 million to support creation of a consumer assistance partnership program, establishment of an IT system that coordinates with federal partners, and the plan management functions that Michigan will carry out. However, the Senate failed to vote on HB 4111, which would authorize the state to spend the funds.[12]

Michigan, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance Marketplaces, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.[13]

MINNESOTA

On March 20, 2013, Gov. Dayton signed enacted legislation HF 5; (Session law Ch. 9), creating the Minnesota Insurance Marketplace, named MNsure.

State Financing/Insurer Fee: In August 2012, the finance workgroup explored multiple long-term funding options for the Marketplace and compared different options, including a user fee, an assessment on premiums in the Marketplace, an assessment on fully-insured products sold by insurers, a broad-based health care tax, an appropriation, or some combination of these options. In October 2012, the workgroup released a report highlighting the results of subcontractors' projections of budgetary needs and enrollment, and recommendations on financial transparency, accountability, flexibility, and timing.[18]

Prior to January 1, 2015, the authorizing legislation imposes a 1.5% user fee on individual and small group plans and dental plans sold through MNsure to fund operations. Beginning in January 2015, the user fee will increase to 3.5% of premiums.

Grants: The Minnesota Department of Commerce received a federal Exchange Planning grant of $1 million in February 2011. The state has also received four Level One Establishment grants: $4.2 million in August 2011, $26 million in February 2012, $42.5 million in September 2012, and $39 million in January 2013 to support the development and implementation of the exchange. In addition, in October 2013, the state received a $41 million Level Two Establishment grant to support general operations, IT and related systems, technology-related costs including security training and system improvements, and to evaluate future quality rating systems and consumer satisfaction surveys.

> Minnesota Affordable Insurance Exchange Grants Awards List.

In addition, Minnesota, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance exchanges, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.[24]

NEVADA

State Financing/Insurer Fee: In June 2012, the Board approved exempting insurers from being taxed on fees charged by the Exchange.[20] The Board also rejected a proposal by the Committee to use a General Fund appropriation as a supplementary source of Exchange revenue by subsidizing individuals' enrollment fees. In January 2013, the Board adopted a regulation establishing a monthly fee charged to insurers for each member enrolled in the insurer's plans.[22] The Marketplace adopted separate fees for 2014, as follows:

QHPs that do not include a dental coverage = $4.95 Per Member per Month
QHPs that include dental= $5.31 Per Member per Month
Stand-alone dental plans= $0.36 Per Member per Month

Grants: In September 2010, the Nevada State Department of Health and Human Services received a federal Exchange Planning grant of $1 million. The Department has since received four federal Level One Establishment grants: $4 million in August 2011, $15.3 million in February 2012, $4.4 million in May 2012, and $9 million in July 2013. The grants will be used to develop a rules-based eligibility engine that will serve as the single, streamlined eligibility process for all medical assistance programs in the state, to support information technology security requirements, and to fund training for EEFs. In August 2012, the state received a federal Level Two Establishment grant for $50 million; this will fund Exchange operations through December 2014.[25]

NEW YORK

Grants: The Department of Insurance received a federal Exchange Planning grant of $1 million in 2010. The state has since received multiple federal grants. In 2011, the Department of Health received an Early Innovator grant of $27.4 million to develop an information technology infrastructure that could be replicated by other states. The Department has also received three federal Level One Establishment grants: $10.7 million, $48.5 million, and $95 million to fund IT systems, expand consumer assistance, redesign the state's eligibility and enrollment system, and create an all payer database, hire Marketplace executive leadership and staff, develop back-end customer support functions, and conduct consumer outreach and program integration.. In January 2013, the state received a Level Two Establishment Grant for $185.2 million to support outreach and marketing, fund IPA training and certification, purchase an accounting system, and support IT development.[21]

New York, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance Marketplaces, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.[22]

OREGON

State Financing/Insurer Fee: Oregon has established an Issuer Fee, set at 2.68% in 2014 and 3.38% in 2015. The fee is to be capped depending on actual enrollment between 3 to 5%.

RHODE ISLAND

State Financing: The Governor's Executive Order authorizes the Exchange to receive funds from insurers or other entities, including the United States Department of Health and Human Services. The Board will determine how the funds are to be received from insurers and the amounts. The projected cost for operations in 2015: $17,500,000.

News background. http://www.providencejournal.com/breaking-news/content/20131009-healthsource-ri-proposes-26-million-spending-plan.ece

UTAH

State Financing/Insurer Fee: The UTAH SHOP-style Exchange charges an assessment fee to participating employers on an $8 per employee per month basis.

VERMONT

State Financing/Insurer Fee: Vermont is using a broad-based tax, with authority based on their 2011 Act . The initial rate is 0.999 percent of paid claims. A rate increase of one percent of paid claims would be phased in over two fiscal years, FY 2015 and FY 2016. In 2015, it will be 1.499 percent of claims paid with respect to claims paid in fiscal year 2014 and increase to 1.999 percent of paid claims with respect to claims paid in fiscal year 2015. The claims assessment looks back at the prior year paid claims. Accordingly, rate increases on claims paid in fiscal years 2014 and 2015 would affect the state budget for state FY 15 and FY 16.
> http://www.leg.state.vt.us/reports/2013ExternalReports/286250.pdf

Grants: In September 2010, the Vermont Agency of Human Services received the federal Exchange Planning grant of $1 million. In addition, Vermont is a member of the consortium of New England states that received a federal Early Innovator Grant of $44 million to develop, share, and leverage insurance exchange technology. The multi-state consortium also includes Connecticut, Rhode Island, Maine, and Massachusetts with the University of Massachusetts Medical School as the grant holder. The state has received three Level One Establishment grants: $18 million in November 2011 to further plan and develop the Exchange; $2.2 million in January 2013 to implement and operate an In-person Assister program; and $42.7 million in July 2013 to support the implementation of an integrated eligibility system, consumer support center functionality and individual and SHOP premium processing. In August 2012, Vermont received a $104.2 million Level Two Establishment grant to fund Exchange development and operations through December 2014.[16]

WASHINGTON

State Financing/Insurer Fee: Washington's exchange has a broad based tax and issuer fee, with a Premium tax assessment of 1% on all premiums and prepayments for underwritten health care services; and service charge payable by QHPs in Exchange. The operating costs are estimated to be:
2014: $47,213,000
2015: $51,078,000
2016: $53,588,000

Appendix – Private non-profit funding

Robert Wood Johnson Foundation provides support for 9 states. May 6, 2011.

- Building on more than 40 years of commitment to expanding health insurance coverage, the Robert Wood Johnson Foundation (RWJF) on May 6, 2011 unveiled a plan to provide states with essential resources to implement key health insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA). RWJF will support technical assistance, research, consumer engagement, online networking and leadership development to help states most effectively expand and improve coverage, and will share critical lessons learned to ensure that all states are making the best decisions for their unique circumstances.

    - In addition to providing technical assistance to states, the Foundation will work with researchers and analysts to monitor and analyze the progress of state coverage gains. Recognizing that consumers' voices will be critical to successful implementation, the Foundation will support consumer engagement in the policy development process in these 10 states through an initiative led by Boston-based Community Catalyst.
    - Participating states were selected through a competitive process to ensure that, as a whole, they represent diversity in terms of geography, demographics, coverage statistics and progress-to-date on implementation of the reform law's provisions. The selected states are **Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia.** The Foundation deliberately chose to work with states that will offer a variety of models for expanding coverage, so that other states will be able to learn from the selected states' experiences and achievements. RWJF will synthesize the lessons from these states and others, and make the lessons learned available to policy-makers across the U.S.