STATE EFFORTS TO ENACT HEALTH INSURANCE EXCHANGES

As of August 15, 2011

Background

A major focus of the Patient Protection and Affordable Care Act (the ACA) is the reform of the health insurance market. The ACA requires the creation and establishment of state, regional or interstate American Health Benefit Exchanges (Exchanges) to facilitate the purchase of health insurance coverage by qualified individuals and small businesses. The ACA and subsequent federal regulatory guidance give states a significant amount of flexibility in setting up an Exchange. While the federal legislation provides a basic framework, individual states can customize an Exchange solution to meet their specific needs and that of their constituents.

This brief outlines the high-level decisions each state must make to determine how their Exchange, or Exchanges, will be governed and operated. State progress to-date is then covered in detail. Finally, the brief summarizes the key trends and probable subsequent steps in state approaches to the ACA's vision for American Health Benefit Exchanges.

Exchange Efforts Prior to the Affordable Care Act

The health insurance exchange is not a new idea. Both Massachusetts and Utah operated state health insurance exchanges before the passage of the Affordable Care Act. Additionally, purchasing alliances have functioned in several states.

However, Massachusetts and Utah represent two different Exchange models. The Massachusetts Exchange acts as an active purchaser, requiring plans to meet standards for benefits and pricing, as well as limiting plan participation in the Exchange through a rigorous selection process. The Utah model operates as a clearinghouse, connecting consumers to health plans in an open marketplace. Massachusetts took a universal coverage approach, serving both small businesses and individuals at the outset. Utah chose a phased-in approach, offering participation in the health insurance clearinghouse to small businesses first. Much has been written on both approaches, so this brief provides a simple overview of the Massachusetts and Utah models.

The Massachusetts Health Connector

In April 2006, Massachusetts established the Commonwealth Health Insurance Connector Authority (The Health Connector) as its state Health Insurance Exchange. In establishing its Exchange, Massachusetts also enacted insurance reforms to merge individual and small group markets.[1] The Health Connector is an independent, quasi-governmental agency that contracts with other state agencies and private businesses as an active purchaser of health insurance plans.[2] Initially, the Health Connector received a $25 million state appropriation, but it is now a self-sustaining entity through surcharges on health plan premiums.[3] Currently, a 10-member board governs the Health Connector. The board consists of private and public representatives appointed by the governor or attorney general, and is chaired by the Commonwealth's secretary for administration and finance. The board approves decisions regarding policy and programs, and completes regulatory and implementation duties for health reform in the Commonwealth.[4]

The Utah Health Insurance Exchange

The creation of the Utah Health Insurance Exchange began in 2008, with the establishment of the Health System Reform Legislative Task Force spearheaded by then-Governor, Republican, Jon Huntsman.[5] The

Task Force was created through HB133, *Health System Reform*, which was signed by Gov. Huntsman on March 19, 2008.[6] The purpose of the Task Force was to develop and implement Utah's strategic plan for health reform.[7]

Legislation passed in 2009, officially establishing the Utah Health Exchange, which is administered by the Office of Consumer Health Services within the Governor's Office of Economic Development.[8] The Exchange operates as a clearinghouse for the state's small group health insurance market.[9]

The Utah Health Exchange aims to:

- Provide consumers with helpful information about their health care and health care financing
- Provide a mechanism for consumers to compare and choose a health insurance policy that meets their families' needs
- Provide a standardized, electronic application and enrollment system[10]

There are currently more than 160 small employer groups participating in the Utah Health Exchange. By February 2011, the Exchange had served 811 small business employees and 1,370 dependents.[11] Ranging from 2 to 50 employees, the average size of participating small employers is 9. A pilot program for large employers, with more than 51 employees, is currently under way.[12]

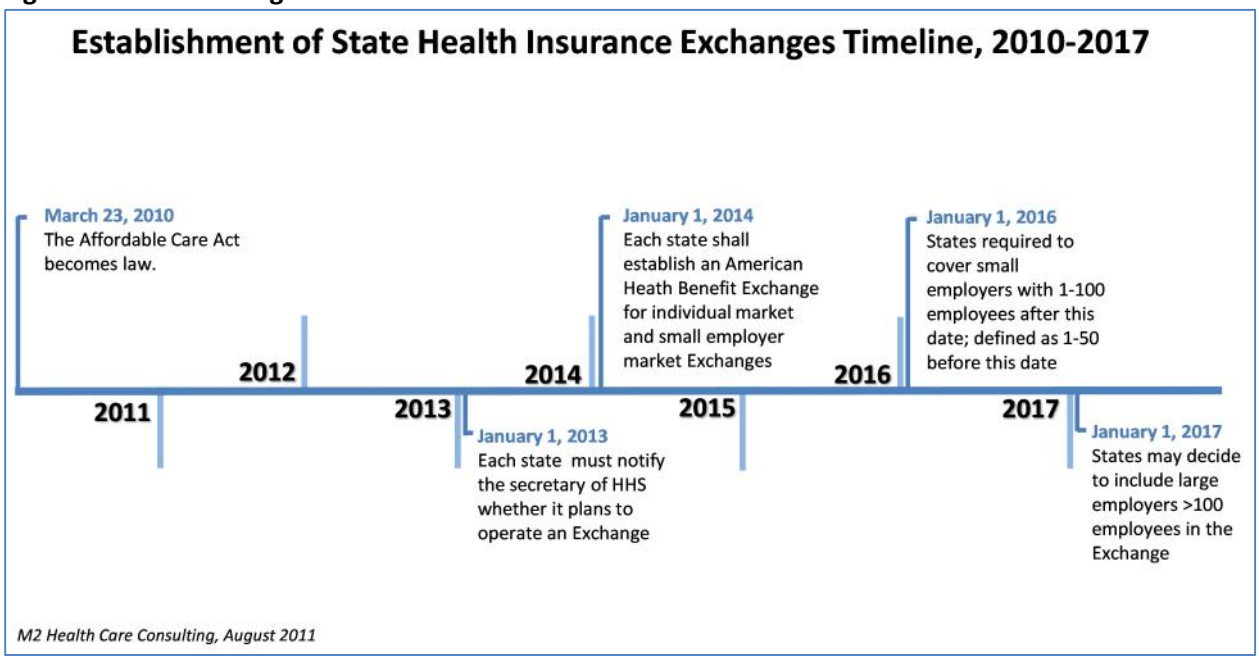
Requirements of the Affordable Care Act

The ACA requires states to establish an Exchange by January 1, 2014. Should a state choose not to create an Exchange, the secretary of the U.S. Department of Health and Human Services (HHS) will establish and operate one for the state (see Figure 1).

The minimum functions of an Exchange, as outlined by the ACA,[13] are:

- Certification, recertification and decertification of plans
- Operation of a toll-free hotline
- Maintenance of a website for providing information regarding plans for current and prospective enrollees
- Assignment of a price and quality rating to plans
- Presentation of plan benefit options in a standardized format
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs
- Provision of an electronic calculator to determine the actual cost of coverage, taking into account the eligibility for premium tax credits and cost-sharing reductions
- Certification of individuals exempt from the individual responsibility requirement
- Provision of information on certain individuals identified to the U.S. Treasury Department and to employers
- Establishment of a Navigator program that provides grants to entities assisting consumers

Figure 1. State Exchange Establishment Timeline



Exchange Funding and Federal Grant Support

The ACA requires Exchanges to be financially self-sustaining beginning in 2015, generating revenue through assessments, user fees or by other means. In the interim, the federal government has offered grants to states to assist in covering the cost of establishment and implementation of Exchanges. On July 29, 2010, HHS announced the Exchange Planning Grant; a $51 million grant available to assist states in creating Exchange legislation, planning activities and determining governance structures for the Exchanges. On September 30, 2010, 48 states and the District of Columbia received between $800,000 and $1 million in grant funding.[14] Initially, Alaska and Minnesota chose not to apply for the planning grants.[15] Since that time, Minnesota has applied for and received the grant, and Florida and Louisiana have returned their grants (see Figure 2).[16]

In addition to the Exchange Planning Grant, on January 20, 2011, HHS announced the Exchange Establishment Grant. The purpose of this grant is to support applicants in conducting background research, consulting with stakeholders, making legislative and regulatory changes, establishing information technology systems, conducting financial management and oversight reviews, and ensuring program integrity.[17]

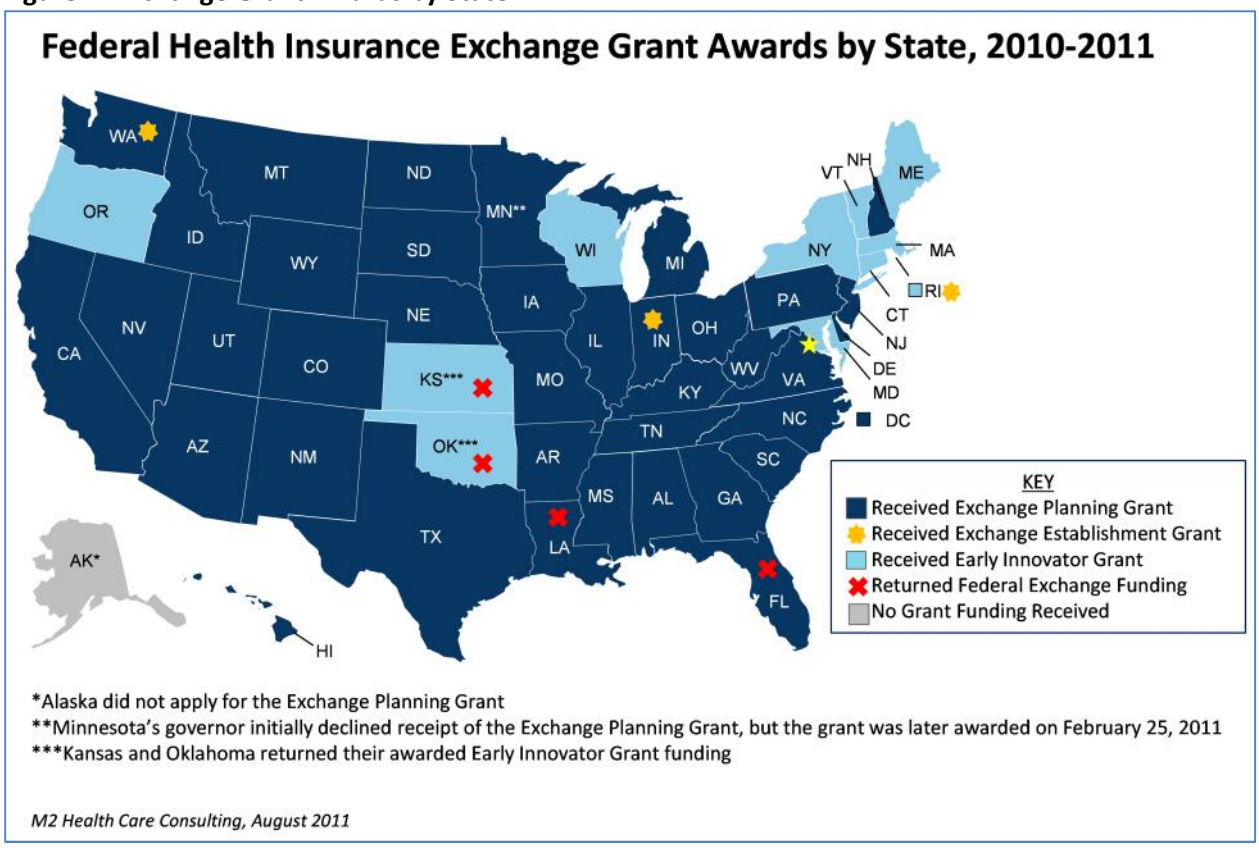
All 50 states, the District of Columbia and/or a consortium of states, are eligible to receive either a level-one or level-two establishment grant. Level-one establishment grants provide up to one year of funding to states that have shown some progress under its Exchange planning grant.[18] Level-two establishment grants provide funding through December 31, 2014, to states that are further along in establishing an Exchange.[19] States that meet eligibility requirements for level-two establishment grants will have:

- "Legal authority to establish and operate an Exchange that complies with Federal requirements available at the time of the application;
- A governance structure for the Exchange;

- A budget and initial plan for financial sustainability by 2015;
- A plan outlining steps to prevent fraud, waste, and abuse; and
- A plan describing how consumer assistance capacity in the State will be created, continued, and/or expanded, including provision for a call center."[20]

Two application dates for level-one and level-two grants have passed (March 30, 2011, and June 30, 2011). Level-one establishment grants were awarded to Indiana ($6.8 million), Rhode Island ($5.2 million), and Washington ($22.9 million).[21] No level-two grants have been awarded thus far (see Figure 2). The remaining application due dates for level-one grants are September 30, 2011, and December 30, 2011. The remaining application due dates for level-two grants are September 30, 2011; December 30, 2011; March 30, 2012; and June 29, 2012.[22]

Figure 2. Exchange Grant Awards by State



Key Oversight and Operational Questions

States are moving ahead, despite limited guidance at the federal level. On July 11, 2011, HHS published a proposed rule providing some additional guidance to states regarding the design, establishment and operation of its Exchanges. *The Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans* proposed rule aimed to set expectations for what constitutes the minimum in Exchange functions, provides modest criteria for qualified health plan certifications and establishes specific individual, employer and special enrollment periods. In some circumstances, the rule also permits states to request extended deadlines to create their Exchanges.[23]

States must answer a minimum of four key questions about the management of their Exchange:

1. What governance model will the Exchange use?
2. What certification and/or purchasing role will the Exchange have?
3. What structure will the Exchange have?
4. How will the Exchange's regulatory powers coordinate with state insurance regulators?

Governance

States must decide what governance structure to choose for their Exchange. The ACA requires the Exchange to be either a governmental agency or a non-profit entity established by the state.[24] A state can follow one of three courses: 1) Place the Exchange inside an existing government agency, for example, the Department of Health; 2) Create a new government agency tasked with overseeing the Exchange; or 3) Establish a non-profit entity responsible for the management of the Exchange. States must determine how to balance the key concerns of flexibility, accountability and independence when making their decisions regarding governance of the Exchange.

Purchasing Role

The ACA requires state Exchanges to certify health plans as "qualified" to participate in the Exchange.[25] States could decide to stop there, allowing all qualified health plans to offer health insurance products in the Exchange, or, in other words, a "clearinghouse" model. States could also choose to take a more active role, as permitted by the flexibility provided in the ACA. A state could endow its Exchange with the power to negotiate actively with health plans based on criteria such as cost, benefits and network adequacy, for example. States need to determine the best way to provide health insurance coverage to a broad range of people at a cost that individuals, families and small business can afford.

Structure

The ACA requires states to create an Exchange that, in turn, establishes a Small Business Health Options Program (SHOP Exchange). States have the option to run separate Exchange offerings for individuals and small businesses, or run a combined Exchange that services both groups.[26] Further, a state can establish subsidiary Exchanges that serve distinct geographies in its state or can collaborate with other states to offer a regional or interstate Exchange.[27] States must determine how to weigh reduced administrative burdens that integration might provide against meeting the unique needs of the individual vs. the small group market, as well as the plans that service them.

Regulatory Authority

Coordination between the existing health insurance market and the new Exchange will require several important decisions for states in their Exchange planning efforts. States will need to determine the roles and responsibilities of the Exchange as a regulator and reviewer of rates, and how that practice aligns with the existing powers of the state insurance regulators. States can choose from a broad range of coordination paths. States could place responsibility for assuring certification, licensure and solvency requirements for plans offered in the Exchange with the Department of Insurance, effectively relieving the Exchange of regulatory duties. Alternatively, states could require the Exchange to ensure that plans meet all requirements of the ACA, as well as perform insurance regulatory functions, such as verifying solvency.[28]

Current State Exchange Efforts

Exchange Legislation

As of August 10, 2011, 32 states had introduced legislation regarding health insurance Exchanges since the ACA was enacted (see Table 1).[29] As of the date of publication, legislation is pending in five jurisdictions: the District of Columbia, Illinois, New Jersey, North Carolina and Pennsylvania. In addition, bills have been carried over to the next legislative session in Maine and New Hampshire.[30]

Of the states that considered Exchange legislation:

- Ten states enacted a law to establish a state Exchange (CA, CO, CT, HI, MD, NV, OR, VT, WA, WV)
- Three states enacted a law declaring their intent to establish an Exchange (IL, ND, VA)
- Three states created a committee or panel to study the establishment or operation of an Exchange (MS, MT, WY)

Additionally:

- Three governors issued Executive Orders to create a committee or commission to evaluate and provide recommendations on Exchange creation (AL, GA)
- One governor issued an Executive Order declaring an intention to establish an Exchange (IN)

Table 1. State Health Insurance Exchange Efforts

State	Exchange Creation Effort	Resulting Action
Alabama	Executive Order	Study Committee
Alaska	No Legislation Enacted	N/A
Arizona	No Legislation Enacted	N/A
Arkansas	No Legislation Enacted	N/A
California	Enacted Legislation	Exchange Establishment
Colorado	Enacted Legislation	Exchange Establishment
Connecticut	Enacted Legislation	Exchange Establishment
Delaware	No Legislation Enacted	N/A
District of Columbia	Legislation Pending	N/A
Florida	No Legislation Enacted	N/A
Georgia	Executive Order	Study Committee
Hawaii	Enacted Legislation	Exchange Establishment
Idaho	No Legislation Enacted	N/A
Illinois	Enacted Legislation	Intent to Establish
Indiana	Executive Order	Intent to Establish
Iowa	No Legislation Enacted	N/A
Kansas	No Legislation Enacted	N/A
Kentucky	No Legislation Enacted	N/A
Louisiana	No Legislation Enacted	N/A
Maine	Legislation Carried Over	N/A
Maryland	Enacted Legislation	Exchange Establishment
Massachusetts	Enacted Legislation*	Exchange Establishment
Michigan	No Legislation Enacted	N/A
Minnesota	No Legislation Enacted	N/A
Mississippi	Enacted Legislation	Study Committee
Missouri	No Legislation Enacted	N/A

State	Exchange Creation Effort	Resulting Action
Montana	Enacted Legislation	Study Committee
Nebraska	No Legislation Enacted	N/A
Nevada	Enacted Legislation	Exchange Establishment
New Hampshire	Legislation Carried Over	N/A
New Jersey	Legislation Pending	Pending
New Mexico	Legislation Vetoed	N/A
New York	No Legislation Enacted	N/A
North Carolina	Legislation Pending	Pending
North Dakota	Enacted Legislation	Intent to Establish
Ohio	No Legislation Enacted	N/A
Oklahoma	No Legislation Enacted	N/A
Oregon	Enacted Legislation	Exchange Establishment
Pennsylvania	Legislation Pending	Pending
Rhode Island	No Legislation Enacted	N/A
South Carolina	No Legislation Enacted	N/A
South Dakota	No Legislation Enacted	N/A
Tennessee	No Legislation Enacted	N/A
Texas	No Legislation Enacted	N/A
Utah	Enacted Legislation*	Exchange Establishment
Vermont	Enacted Legislation	Exchange Establishment
Virginia	Enacted Legislation	Intent to Establish
Washington	Enacted Legislation	Exchange Establishment
West Virginia	Enacted Legislation	Exchange Establishment
Wisconsin	No Legislation Enacted	N/A
Wyoming	Enacted Legislation	Study Committee

*Massachusetts enacted its Exchange legislation in 2006; Utah, in 2008

Exchange Opposition

Several states have expressed disinterest in creating a state Exchange through the governor or by way of the legislature, including Florida, Louisiana, Texas and Montana. Louisiana has told HHS that it will opt out of establishing an Exchange and instead will leave the federal government to establish it.[31] The only governor to veto legislation was New Mexico Governor Susana Martinez. Republican Governor Martinez vetoed legislation in early April 2011, saying, "How are we going to be spending taxpayers' dollars right now when we're playing, 'Let's figure this out on our own because we don't have that kind of information from the federal government'?"[32] The legislation would have created a clearinghouse-style Exchange in New Mexico.

Newly Created State Exchanges

The following is a summary of how the 10 states that enacted Exchange establishment legislation addressed the four key focus areas of governance, purchasing role, structure and regulation in their laws.

Governance

The majority of states enacting legislation in 2011 chose to establish the Exchange as a quasi-governmental body (generally a private entity, with some attributes of government). Of the 10 states that have enacted Exchange legislation, seven states created a quasi-governmental entity, two

established the Exchange within a state agency, and one will operate its Exchange as a private, non-profit organization (See Table 2).

Table 2: Governance of Newly Created State Exchanges

State	Governmental Agency	Quasi-Governmental	Non-Profit
California		◆	
Colorado		◆	
Connecticut		◆	
Hawaii			◆
Maryland		◆	
Nevada		◆	
Oregon		◆	
Vermont	◆		
Washington		◆	
West Virginia	◆		

Vermont and West Virginia chose to position their Exchanges within existing government agencies. Vermont chose to establish its Exchange in the state department responsible for publicly funded health insurance programs, the Department of Vermont Health Access (DVHA).[33] Vermont's state-operated model will be governed by a 22-member advisory committee, including one representative of licensed health insurers, five beneficiaries of Medicaid or Medicaid-funded programs, five individuals, self-employed individuals and representatives of small business, five advocates for consumer organizations in the state, and five representatives from a range of health care professions. The deputy commissioner of health will serve on and oversee the committee.[34]

West Virginia established its Exchange within the Offices of the Insurance Commissioner. The governing board will operate within the state government. West Virginia's state-operated model will possess a strong state government influence with four ex-officio board members, including the insurance commissioner and four industry experts appointed by Democratic Governor Earl Ray Tomblin. The four ex-officio voting members on the West Virginia Exchange board represent the highest number of voting members of any state that has enacted an Exchange law since the ACA was passed.

Maryland chose a quasi-governmental model, but left the door open for change. The legislation instructs the Exchange advisory committee to "conduct a study and report its findings and recommendations to the Governor and the General Assembly, on whether the Exchange should remain an independent public body or should become a nongovernmental, nonprofit entity."[35]

Purchasing Role

Five of the states with newly enacted state legislation have elected to operate their Exchange as active purchasers: California, Connecticut, Oregon, Vermont and Washington. Three state Exchanges will take the role of a clearinghouse: Colorado, Hawaii and West Virginia. Maryland chose to solicit findings and recommendations from its Exchange board, staff and advisory committees before defining and authorizing the power, duties and functions of the Exchange. The purchasing role of the Nevada Exchange will also be determined by its Exchange board (see Table 3).

Table 3. Purchasing Role of Newly Created State Exchanges

State	Clearinghouse	To Be Determined	Active Purchaser
California			◆
Colorado	◆		
Connecticut			◆
Hawaii	◆		
Maryland		◆	
Nevada		◆	
Oregon			◆
Vermont			◆
Washington			◆
West Virginia	◆		

An active purchasing Exchange allows the Exchange board to select the carriers with which it will contract to make available within the Exchange. As described in the California legislation, the Exchange board will: "determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. . .the [Exchange] board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."[36]

States with a clearinghouse model have committed to contract with, or make available within the Exchange, all "qualified" health plans and products that meet the minimum federal requirements established in the ACA. Colorado's Exchange legislation states, ". . .the exchange shall foster a competitive marketplace for insurance and shall not solicit bids or engage in the active purchasing of insurance. All carriers authorized to conduct business in this state may be eligible to participate in the exchange."[37]

Structure of State Exchanges

The ACA gives states the option to run separate Exchange offerings for individuals and small businesses, or run a combined Exchange that services both groups.[38] Further, the ACA allows states to determine, before January 1, 2016, whether a "small employer" is comprised of 50 or fewer employees or 100 or fewer employees.[39] States must also open the Exchange to large businesses by 2017. Of the 10 states that enacted legislation to create an Exchange, six have specifically indicated what entities will be allowed to purchase in the Exchange marketplace and when. Of those four states, only two, Connecticut and Vermont, addressed the topic of large employer inclusion, and only Vermont gave a specific timeframe for large employers entering the Exchange. Four states will establish separate Exchanges at least in the near term for individuals and small employers. No states thus far have chosen to include both individuals and employers in one Exchange, and six states have yet to determine the composition of their Exchange (see Table 4).

California and Colorado specifically address the "merger of markets" option in state legislation. Both states establish separate individual and SHOP Exchanges, but California will issue a report addressing the combining of the Exchanges. Colorado will ask the Exchange to "consider the desirability of structuring the exchange as one entity that includes two underlying entities to operate in the individual and the

small employer markets" in its annual report to the governor and legislature, due as early as January 15, 2012.[40]

Many states that have enacted legislation have not decided on separated or merged Exchanges for the individual and SHOP markets, and almost all are deferring to the expertise of the state's board of directors or advisory committees to make this decision. Connecticut, for example, directs the Exchange board to determine the structure of the Exchange by January 1, 2012.

Table 4. Structure of Newly Created State Exchanges

State	Separate	Merged	Composition TBD	Large Employers Addressed?
California	◆			
Colorado	◆			
Connecticut			◆	◆
Hawaii			◆	
Maryland			◆	
Nevada			◆	
Oregon			◆	
Vermont	◆			◆
Washington			◆	
West Virginia	◆			

Marketplace Regulation by State Exchanges

The ACA allows both an Exchange market and outside insurance market to exist in the state. States are permitted to implement regulations within the Exchange that differ from regulations outside the Exchange. Only two states with enacted legislation address market regulation directly: California and West Virginia. Connecticut requires the Exchange to provide annual recommendations on market regulation. Five states, Colorado, Hawaii, Maryland, Nevada and Washington, leave market regulation up to the state health insurance commissioner. Two states, Vermont and Oregon, do not specifically address market regulation in their legislation (see Table 5).

Table 5. Regulatory Authority of Newly Created State Exchanges

State	Addressed, but Left to Future Determination	Not Explicitly Addressed	Regulation Left to State Insurance Commissioner
California		◆	
Colorado			◆
Connecticut		◆	
Hawaii			◆
Maryland			◆
Nevada			◆
Oregon			◆
Vermont		◆	
Washington	◆		
West Virginia			◆

State-by-State Analysis of Newly Created Exchanges

California

The California legislature passed two Exchange bills in 2010: SB900, *The California Health Benefit Exchange Act* and AB1602, *The California Patient Protection and Affordable Care Act*. Then-Governor, Republican Arnold Schwarzenegger, signed both bills into law on September 30, 2010.[41]

California Overview

Governance
- Quasi-governmental

Purchasing role
- Active purchaser

Structure
- Separate SHOP and individuals Exchanges; Report to be issued December 1, 2018, on merger

Regulatory authority
- Not addressed

Bill SB900 established the California Health Benefit Exchange.[42] Bill AB1602, which specified the powers and duties of the Exchange Board, imposed requirements on participating plans and insurers, established the California Health Trust Fund and authorized a working capital loan.[43]

The California Health Benefit Exchange is a quasi-governmental independent agency within the state government.[44]

California's Health Benefit Exchange will operate as an active purchaser. The Exchange Board is tasked with establishing and using "a competitive process to select participating carriers and any other contractors under this title" with the goal of choosing providers that offer "the optimal combination of choice, value, quality, and service".[45] Additionally, insurance carriers will be required to offer five levels of plans to be considered for participation in the Exchange. Carriers that do participate in the Exchange will be required to offer the same products inside and outside the Exchange.

Beginning January 1, 2014, insurance carriers not participating in the California Health Benefit Exchange will be required to offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage contained in subdivision (d) of Section 1302 of the Federal act.[46]

The individual and SHOP Exchanges will operate separately from one another beginning in 2014.

Colorado

The Colorado Legislature introduced the *Colorado Health Benefit Exchange Act,* SB200, which was signed by Democratic Governor John Hickenlooper on June 1, 2011. Bill SB200 established the Colorado Health Benefit Exchange as a quasi-governmental non-profit public entity.[47]

Colorado Overview

Governance
- Quasi-governmental

Purchasing role
- Clearinghouse

Structure
- Separate SHOP and individual exchanges

Regulatory authority
- Exchange will not duplicate duties of insurance commissioner

The Colorado Health Benefit Exchange will operate as a a health insurance clearinghouse where "all carriers authorized to conduct business in [the] state may be eligible to participate in the exchange."[48]

Colorado will operate a SHOP Exchange within the Colorado Health Insurance Exchange for small businesses to purchase insurance, opting to keep the risk pools separate.

Colorado's enacted legislation explicitly gives regulatory power of the Exchange to the insurance commissioner: "The exchange shall not duplicate or replace the duties of the commissioner…"

Connecticut

The Connecticut legislature introduced SB921*, An Act Establishing a State Health Insurance Exchange,* on February 8, 2011. Democratic Governor Dannel P. Malloy signed the bill on June 8, 2011.

The Exchange will be a quasi-public agency but not a state department, institution or agency. Connecticut's Health Insurance Exchange will operate as an active purchaser authorized to "limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided individuals and employers have an adequate number and selection of choices."[49]

Connecticut Overview

Governance
- Quasi-governmental

Purchasing role
- Active purchaser

Structure
- To be determined, recommendations to be made by January 1, 2012

Regulatory authority
- Not addressed

Beginning January 1, 2012, the Exchange will report annually to the General Assembly on the effect of adverse selection on the operations of the Exchange and make legislative recommendations on health benefit plan regulations in and outside of the Exchange and on reducing the negative impact of any adverse selection on the sustainability of the Exchange. The report will also include a discussion on "whether to establish an individual health insurance market and one for the small employer health insurance market, or to establish a single exchange."[50]

Connecticut is one of only three states with enacted Exchange legislation to address the treatment of essential health benefits. Connecticut law directs the head of the Exchange to report on whether to require qualified health plans to provide only the essential benefits or include additional state-mandated benefits no later than January 1, 2012. The ACA requires a state to pay for any benefits for which it mandates that health insurance plans should cover beyond those agreed upon at the federal level. This is an important issue for all states to consider. [51]

Hawaii

On May 5, 2011, the Hawaii state legislature passed SB1348, the *Hawaii Health Insurance Exchange Act.* Democratic Governor Neil Abercrombie signed this legislation on July 8, 2011. The law establishes the Hawaii Health Insurance Exchange (the Hawaii Health Connector) as a private, non-profit organization.[52]

Hawaii Overview

Governance
- Private, not-for-profit

Purchasing role
- Clearinghouse

Structure
- To be determined

Regulatory authority
- Insurance commissioner retains full regulatory jurisdiction

The Hawaii Health Connector will operate as a health insurance clearinghouse governed by a board of directors. An interim board of directors will be appointed by the governor to provide legislative recommendations regarding Exchange implementation during the 2012 legislative session.

In Hawaii, one of the few states to address regulation of insurers in the enacted legislation, the insurance commissioner "shall retain full regulatory jurisdiction. . .over all insurers and qualified plans. . . included in the connector," including rate regulation.[53]

The Hawaii Health Connector is eligible to receive appropriations from the state, receive aid and contributions, and may charge assessments or user fees to participating health and dental carriers.

Maryland

On April 6, 2011, the Maryland state legislature passed HB166, the *Maryland Health Benefit Exchange Act of 2011.* Democratic Governor Martin O'Malley signed the legislation on April 12, 2011. The law establishes the Maryland Health Benefit Exchange, specifies its board composition and creates the Maryland Health Benefit Exchange Fund.[54]

HB166 established the Maryland Health Benefit Exchange as a quasi-governmental entity that is a public corporation and independent unit of state government. By December 1, 2015, the Exchange board, staff and advisory committees will report study findings on whether the Exchange should remain an independent, public body or become a non-government, non-profit entity.

Maryland Overview

Governance
- Quasi-governmental

Purchasing role
- To be determined

Structure
- To be determined

Regulatory authority
- To be determined

Gov. O'Malley and the Maryland General Assembly will decide the purchasing role of the Exchange following a study and recommendations from the Exchange board, staff and advisory committees.

The Exchange study will address "whether the current individual and small group markets should be merged; and whether the SHOP Exchange should be made available to employers with 50 to 100 employees prior to 2016, as authorized by the Affordable Care Act."[55]

Regulation beyond the current jurisdiction of the Maryland insurance commissioner will be a component of the Exchange study. Specifically, "whether carriers offering health benefit plans outside the Exchange should be required to offer either all the same health benefit plans inside the Exchange, or alternatively, at least one health benefit plan inside the Exchange."[56] The study recommendations will also include ways to avoid adverse selection.

Maryland is one of only three states to address mandated benefits in its Exchange law by requiring a study of the issue: "The Exchange study must also include recommendations on whether additional benefits should be required within the Exchange beyond those outlined in the ACA."

Nevada Overview

Governance
- Quasi-governmental

Purchasing role
- To be determined

Structure
- To be determined

Regulatory authority
- Insurance commissioner retains full regulatory jurisdiction

Nevada

On March 28, 2011, the Nevada state legislature introduced SB440, *An Act Relating to Health Insurance; Creating the Silver State Health Insurance Exchange*. Republican Governor Brian Sandoval signed the legislation

on June 16, 2011, which creates the Silver State Health Insurance Exchange and specifies the powers, duties and composition of the Exchange board.[57]

The Silver State Health Insurance Exchange will be a quasi-governmental entity. The purchasing role and structure of the Exchange will be developed, along with the implementation plan by the Exchange Board on or before December 31, 2011. The legislation details that the Exchange must "facilitate the purchase and sale of qualified health plans. . .and provide for the establishment of a program to assist qualified small employers in Nevada in facilitating the enrollment of their employees in qualified health plans offered in the small group market."[58]

As with several other states with enacted Exchange laws, Nevada is explicit in explaining that the insurance commissioner, not the Exchange board, has the authority to regulate the business of insurance within the state, stating that "nothing shall be construed to preempt or supersede the authority of the Commissioner to regulate the business of insurance within this state."[59]

Oregon

On January 10, 2011, the Oregon state legislature introduced SB99, *A Bill for an Act Relating to Oregon Health Insurance Exchange; Appropriating Money and Declaring an Emergency.* Democratic Governor John Kitzhaber signed the legislation on June 17, 2011, which establishes the Oregon Health Insurance Exchange Corporation, specifies board composition and establishes the Oregon Health Insurance Exchange Fund.[60]

Oregon Overview

Governance
- Quasi-governmental

Purchasing role
- Active purchaser

Structure
- Not specified

Regulatory authority
- The Department of Consumer and Business Services will maintain market regulation authority

Bill SB99 establishes the Exchange as an independent, quasi-governmental public corporation.

The Exchange will operate as an active purchaser, authorized to selectively contract with health plans using its own standardized evaluation criteria. The Exchange Corporation will guarantee that an insurer charges the same premiums for plans sold through the exchange as it charges for identical plans sold outside of the exchange.

The Department of Consumer and Business Services will maintain market regulation authority under the insurance code.

While several states provide that Exchanges can collect fees and accept grants, the Oregon Exchange law is explicit about the formula it will use to assess insurance carriers. The fees must be "based on the number of individuals, excluding individuals enrolled in state programs, who are enrolled in health plans offered by the insurer through the exchange. . .a) Five percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is at or below 175,000; (b) Four percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 175,000 and at or below 300,000; and (c) Three percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 300,000."[61]

Vermont

On February 8, 2011, the Vermont state legislature introduced HB202, *An Act Relating to a Universal and Unified Health System.* Democratic Governor Peter Shumlin signed the legislation on May 26, 2011,

which creates the Vermont Health Benefit Exchange, establishes Green Mountain Care, creates the Green Mountain Fund, and proposes a strategic plan for creating a single-payer, unified health system.[62]

One of only two states to place the Exchange as a government entity, the Vermont Exchange law establishes the Exchange as a division of the Department of Vermont Health Access (DVHA) in the Agency of Human Services.

The Exchange will function as an active purchaser that selectively contracts with health care plans according to criteria developed by the Commissioner of the DVHA, and will not separate the individual and small employer markets.

Vermont Overview

Governance
- Governmental agency

Purchasing role
- Active purchaser

Structure
- Combined

Regulatory authority
- Not addressed

A plan regarding how to best fully integrate or align Medicaid, Medicare, private insurance, associations, state employees and municipal employees into or with the Exchange and Green Mountain Care is due no later than January 15, 2012, to the Senate and House Health Care Committees.

Vermont is one of three states with enacted Exchange legislation to address the issue of state-mandated benefits beyond those required by federal law in the essential health benefits requirements.[63] The Vermont law indicates that qualified health benefits inside the Exchange will be consistent with the requirements of the ACA, but the state will explore whether to include benefits beyond the ACA requirements.[64]

Washington

On January 25, 2011, the Washington state legislature introduced SB5445*, An Act Relating to the Creation of a Health Benefit Exchange.* Democratic Governor Christine Gregoire signed the legislation on May 11, 2011, which establishes the Washington Health Benefit Exchange, specifies board composition and creates the Washington Health Benefit Exchange Account.[65]

Washington Overview

Governance
- Quasi-governmental

Purchasing role
- Active purchaser

Structure
- To be determined

Regulatory authority
- To be determined

Bill SB5445 establishes the Washington Health Benefit Exchange as a non-profit, public-private partnership, making it an entity that does not fall within an existing state agency. This Exchange will operate as an active purchaser.

The Washington State Health Care Authority and the Joint Select Committee on Health Reform Implementation will report to Gov. Gregoire and the legislature no later than January 1, 2012, on whether to "merge the risk pools for rating the individual and small group markets in the Exchange and the private health insurance markets."[66] The Health Care Authority will also report recommendations on the coverage of "spiritual care services" in the Exchange.

Less explicit than many other states with enacted Exchange legislation, Washington state's law acknowledges the ". . .many policy decisions associated with establishing an exchange that need to be made that will take a great deal of effort and expertise. . ." With that in mind, the law explains that it

should be the intent of the Exchange to "that the regulation of the health insurance market, both inside and outside the exchange, should continue to be performed by the insurance commissioner."[67]

West Virginia

On February 3, 2011, the West Virginia state legislature introduced SB408, *the West Virginia Health Benefit Exchange Act.* Democratic Governor Earl Ray Tomblin signed the legislation on April 5, 2011, which establishes the West Virginia Health Benefit Exchange, specifies board composition and creates the West Virginia Health Benefits Exchange Fund.[68]

West Virginia Exchange Overview

Governance

- State agency

Purchasing role

- Clearinghouse

Exchange Structure

- Separate

Regulatory authority

- Duties of insurance commissioner shall not be superseded

The Exchange will operate as a government entity within the office of the insurance commissioner and will function as a clearinghouse.[69]

West Virginia's enacted Exchange legislation is explicit about the continuing role of the insurance commissioner, stating, "Nothing in this article, and no action taken by the exchange pursuant to this article, preempts or supersedes the authority of the commissioner to regulate the business of insurance within this state."[70]

After July 1, 2011, the Exchange will be authorized to assess fees on health carriers licensed in West Virginia, including those that do not participate in the Exchange. Grants may also be accepted.

Conclusion

Since the passage of the ACA, 10 states have enacted legislation establishing health insurance Exchanges, and most have addressed four key operational areas: governance, purchasing role, structure and regulatory authority (see Table 7). These states provide a first look at the decisions states need to make in order to create and implement American Health Benefit Exchanges. At this point, most states still need to establish their exchanges, but the forward movement in the 2010-2011 legislative session in many states is likely to serve as a building block in the next sessions.

Table 7. Summary of Enacted Exchange Legislation, State-by-State

State	Governance	Purchasing Role	Structure	Regulatory Authority
California	Quasi-governmental	Active purchaser	Separate	Not addressed
Colorado	Quasi-governmental	Clearinghouse	Separate	Insurance commissioner retains jurisdiction
Connecticut	Quasi-governmental	Active purchaser	TBD	Not addressed
Hawaii	Non-profit	Clearinghouse	TBD	Insurance commissioner retains jurisdiction
Maryland	Quasi-governmental	To be determined	TBD	To be determined
Nevada	Quasi-governmental	To be determined	TBD	Insurance commissioner retains jurisdiction
Oregon	Quasi-governmental	Active purchaser	TBD	Insurance commissioner retains jurisdiction
Vermont	Government agency	Active purchaser	Combined	Not addressed
Washington	Quasi-governmental	Active purchaser	TBD	To be determined
West Virginia	Government agency	Clearinghouse	Separate	Insurance commissioner retains jurisdiction

Notes

[1] Corlette S, Alker J, Touscher J, et al. The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned. March 2011. The Robert Wood Johnson Foundation. http://www.rwjf.org/files/research/72105massutah201103.pdf.
[2] Lischko A, Bachman S, Vangeli A. The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions. May 2009. The Commonwealth Fund. http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/May/The-Massachusetts-Commonwealth-Health-Insurance-Connector.aspx.
[3] Corlette S, et al. The Massachusetts and Utah Health Insurance Exchanges.
[4] Lischko A. Fixing the Massachusetts Health Exchange. March 2011. Pioneer Institute. http://www.pioneerinstitute.org/pdf/110309_Fixing_Connector.
[5] State of Utah. Utah History To Go. 2010. http://historytogo.utah.gov/people/governors/state/huntsman.html.
[6] Utah Department of Health. Utah Health Status Update: Health System Reform. January 2009. http://health.utah.gov/opha/publications/hsu/09Jan_Reform.pdf.
[7] Ibid.
[8] Utah Health Exchange. About the Exchange. 2011. http://www.exchange.utah.gov/about-the-exchange.
[9] Corlette S, et al. The Massachusetts and Utah Health Insurance Exchanges.
[10] Utah Health Exchange. Frequently Asked Questions. 2011. http://www.exchange.utah.gov/learn-more/exchange-frequently-asked-questions.
[11] Corlette S, et al. The Massachusetts and Utah Health Insurance Exchanges.
[12] Utah Health Exchange. About the Exchange.
[13] ACA, Sec. 1311 (d)(4).
[14] U.S. Department of Health and Human Services (HHS). Exchange Planning and Establishment Grants: Grant Awards List. 30 September 2010. http://www.healthcare.gov/news/factsheets/grantawardslist.html.
[15] U.S. Department of Health and Human Services (HHS). Health Insurance Exchanges: State Planning and Establishment Grants. 2011. http://www.hhs.gov/ociio/initiative/grant_award_faq.html.
[16] National Conference of State Legislatures. Three States Receive Exchange Establishment Grants. 2011. http://www.ncsl.org/IssuesResearch/Health/AffordableCareActStateActionNewsletter11/tabid/23138/Default.aspx#Three.
[17] U.S. Department of Health and Human Services Office of Consumer Information and Insurance Oversight (HHS OCIIO). Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges. 20 January 2011. http://cciio.hhs.gov/resources/fundingopportunities/foa_exchange_establishment.pdf.
[18] U.S. Department of Health and Human Services (HHS). Health Insurance Exchange Establishment Grants Fact Sheet. 20 January 2011. http://www.healthcare.gov/news/factsheets/exchestannc.html.
[19] Ibid.
[20] Ibid.
[21] Healthcare.gov. Health Insurance Exchange Establishment Awards. 23 May 2011. http://www.healthcare.gov/news/factsheets/exchanges05232011a.html.
[22] U.S. Department of Health and Human Services Office of Consumer Information and Insurance Oversight (HHS OCIIO). Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges.
[23] U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act; Establishment of Health Insurance Exchanges. 11 July 2011. Federal Register. http://www.ofr.gov/OFRUpload/OFRData/2011-17610_PI.pdf.
[24] ACA, Sec. 1311 (d)(1).
[25] ACA, Sec. 1311 (b).
[26] ACA, Sec. 1311 (b)(1).
[27] ACA, Sec. 1311 (f).
[28] For a thoughtful treatment of the various alternative states could pursue regarding coordinating the regulation of health insurance in the states and in the new exchanges see, National Academy of Social Insurance (NASI). "Designing an Exchange: A Toolkit for State Policymakers," January 2011.
[29] Kaiser Family Foundation (KFF). Health Insurance Exchanges. 5 July 2011. http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17#notes-1.
[30] Center on Budget and Policy Priorities. Analysis of State Health Insurance Exchange Legislation: Establishment Status and Governance Issues. 21 July 2011. http://www.cbpp.org/files/CBPP-Analysis-of-Exchange-Legislation-Establishment-and-Governance.pdf.
[31] Moller J. Louisiana to opt out of health insurance exchange in federal law. 23 March 2011. The Times-Picayune. http://www.nola.com/politics/index.ssf/2011/03/louisiana_to_opt_out_of_health.html.
[32] Jennings T. Health care exchange bill vetoed. 8 April 2011. Santa Fe New Mexican. http://www.santafenewmexican.com/local%20news/Health-care-exchange-bill-vetoed.
[33] Department of Vermont Health Access. 2011. http://ovha.vermont.gov/.

[34] Vermont. HB202, An Act Relating to a Universal and Unified Health System. http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf.
[35] Maryland. HB166, Maryland Health Benefit Exchange Act of 2011. http://mlis.state.md.us/2011rs/bills/hb/hb0166t.pdf.
[36] California. AB1602, California Health Benefit Exchange. http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.pdf.
[37] Colorado. SB200, Colorado Health Benefit Exchange Act. http://www.leg.state.co.us/clics/clics2011a/csl.nsf/fsbillcont3/7233327000DC9A078725780100604CC4?open&file=200_enr.pdf.
[38] ACA, Sec. 1311 (b)(1).
[39] ACA, Sec. 1304 (b)(3).
[40] Colorado. SB200.
[41] California. AB1602.
[42] California. SB900, California Health Benefit Exchange. http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.pdf.
[43] California. AB1602.
[44] California. SB900.
[45] California. AB1602.
[46] Ibid.
[47] Colorado. SB200.
[48] Ibid.
[49] Connecticut. SB921, An Act Establishing a State Health Insurance Exchange. http://www.cga.ct.gov/2011/ACT/PA/2011PA-00053-R00SB-00921-PA.htm.
[50] Ibid.
[51] ACA, Sec. 1311 (d)(3)(B), as amended by Sec. 10104(e).
[52] Hawaii. SB1348, Hawaii Health Insurance Exchange Act. http://www.capitol.hawaii.gov/session2011/bills/SB1348_CD1_.pdf.
[53] Ibid.
[54] Maryland. HB166.
[55] Ibid.
[56] Ibid.
[57] Nevada. SB440, An Act Relating to Health Insurance; Creating the Silver State Health Insurance Exchange. http://www.leg.state.nv.us/Session/76th2011/Bills/SB/SB440_EN.pdf.
[58] Ibid.
[59] Ibid.
[60] Oregon. SB99, A Bill for an Act Relating to Oregon Health Insurance Exchange; Appropriating Money; and Declaring an Emergency. http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0099.en.pdf.
[61] Ibid.
[62] Vermont. HB202.
[63] ACA, Sec. 1302. See also, ACA, Sec. 1311 (d)(3)(B).
[64] Vermont. HB202.
[65] Washington. SB5445, An Act Relating to the Creation of a Health Benefit Exchange. http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Session%20Law%202011/5445-S.SL.pdf.
[66] Ibid.
[67] Ibid.
[68] West Virginia. SB408, West Virginia Health Benefit Exchange Act. http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=SB408%20SUB2%20ENR.htm&yr=2011&sesstype=RS&i=408.
[69] Ibid.
[70] Ibid.