



2011 State Legislation: Health Insurance Exchanges

Government Relations Division • 2021 Massachusetts Avenue, NW • Washington, DC 20036

As of March 15, 2011, 49 states convened for legislative session. Legislators in 43 states are considering more than 380 bills referring to health insurance exchanges or a related term, such as connector or clearinghouse. The 89 bills in 33 states listed below concern studying, planning or creating a state exchange or participating in a regional exchange. Wyoming is the only state to enact legislation in 2011 concerning exchanges—HB 50 establishes a steering committee to study whether the state should establish or participate in a regional exchange.

Most state legislation refers to the federal requirements established under the [Patient Protection and Affordable Care Act](#), including provisions requiring exchanges to:

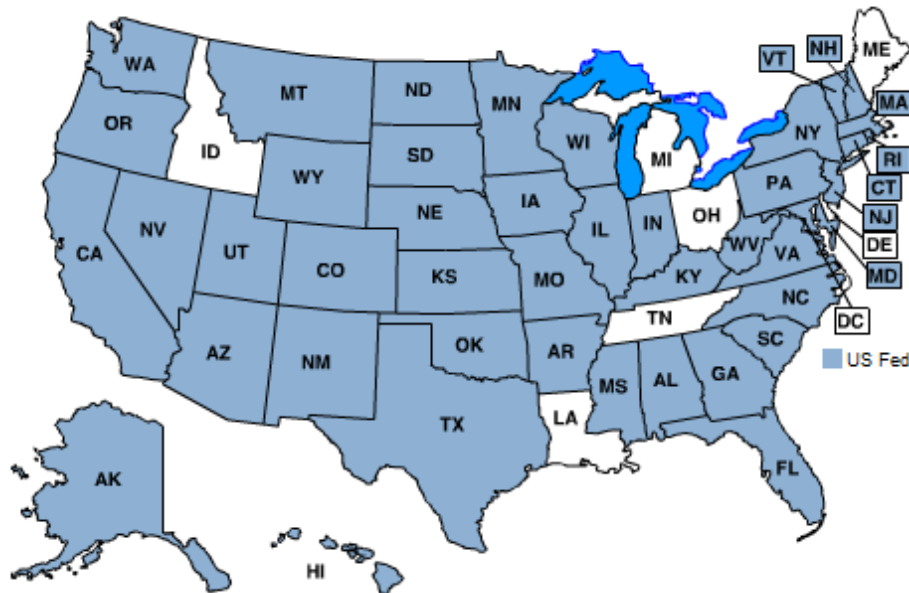
- facilitate the purchase, sale and rating of qualified health plans;
- require certified plans to: (1) include in networks essential community providers that serve low-income, underserved communities; (2) allow individuals to learn the cost-sharing under their plan for furnishing a specific item or service by a participating provider upon request through a website; and (3) contract with a health care provider only if they implement quality improvement mechanisms;
- establish a small business health options program (SHOP) exchange;
- maintain a website providing standardized comparative information on plans;
- implement procedures for certification, recertification and decertification of plans;
- coordinate eligibility of Medicaid, CHIP or other assistance programs;
- select entities qualified to serve as Navigators;
- review the rate of premium growth within and outside the exchange;
- develop policies and procedures to minimize adverse selection;
- enter into information-sharing agreements with federal and state agencies and other state exchanges;
- become self-sustaining by January 1, 2015; and
- consult with various stakeholders, including consumers, those with experience facilitating coverage in qualified health plans, representatives of small businesses, state Medicaid offices, and advocates for enrolling hard-to reach populations.

Under federal law, state exchanges (or entities overseeing an exchange) are allowed to charge assessments or user fees to insurers to generate necessary funding; publish average costs of licensing, regulatory fees and any other payment; and adopt regulations as needed. Exchanges cannot exclude a plan (1) because it is a fee-for-service plan; (2) by imposing premium price controls; or (3) because it provides treatment necessary to prevent deaths that the exchange determines are inappropriate or too costly.

All 50 states convene for session in 2011 with Louisiana scheduled to begin April 25, and Virginia, Wyoming, Kentucky, Utah, and West Virginia the first to adjourn from regular session. Only New Jersey and Virginia carry over bills from 2010 to 2011. Most states are expected to continue considering legislation concerning exchanges in some form—from creating study committees to examine the feasibility of a state exchange to directing the state to seek federal funds to altering existing insurance statutes to prepare for the creation of a state-based exchange.

This summary is only informational intended to provide background on the scope of projects currently before state legislatures. The reader should not consider this document to be comprehensive or to reflect AAFP policy.

**All States Considering Legislation
Referring to Health Insurance Exchanges, 2011**



Source: American Academy of Family Physicians, 2011.

**States Considering Legislation to
Study, Plan for the Implementation of, or Create a Health Insurance Exchange**

[ALASKA](#)
[ARKANSAS](#)
[ARIZONA](#)
[CALIFORNIA](#)
[CONNECTICUT](#)
[GEORGIA](#)
[HAWAII](#)
[ILLINOIS](#)
[INDIANA](#)
[IOWA](#)
[MARYLAND](#)

[MINNESOTA](#)
[MISSISSIPPI](#)
[MISSOURI](#)
[MONTANA](#)
[NEBRASKA](#)
[NEW HAMPSHIRE](#)
[NEW JERSEY](#)
[NEW MEXICO](#)
[NORTH CAROLINA](#)
[NORTH DAKOTA](#)
[OKLAHOMA](#)

[OREGON](#)
[PENNSYLVANIA](#)
[RHODE ISLAND](#)
[SOUTH CAROLINA](#)
[TEXAS](#)
[UTAH](#)
[VERMONT](#)
[VIRGINIA](#)
[WASHINGTON](#)
[WEST VIRGINIA](#)
[WYOMING](#)

ALASKA

2011 SB 70 – An Act Establishing the Alaska Benefit Exchange

Status: Heard and Held by Senate Labor & Commerce Committee – 2/15/2011

- Establishes the Alaska Benefit Exchange as a public corporation of the state in the Department of Commerce, Community and Economic Development but with separate and independent legal existence.
- Creates the Alaska Health Benefit Exchange Board to manage the exchange as provided for under the *Patient Protection and Affordable Care Act*, requiring it to:
 - be made up of 12 Governor appointees, two of whom must be physicians licensed in the state;

- apply for planning and establishment grants made available to the exchange; and
 - study the potential for interstate compacts.
-

ARIZONA

2011 HB 2666 – Health Insurance; Exchange

Status: Amended and passed House Ways and Means Committee – 2/14/2011

- Establishes the Arizona Health Insurance Exchange to serve as the American Health Benefit Exchange for Individuals and the Small Business Health Options Program—but keeps the individual and small group markets separate.
- Creates the Arizona Health Insurance Exchange Board of Directors to oversee the exchange.
- Establishes the Arizona Health Insurance Exchange Fund.
- Prohibits the exchange from being the sole marketplace for individual and group health insurance in the state.
- Determines that no other exchanges shall operate in the state, including subsidiary exchanges or state participation in a regional exchange.
- Requires the exchange to:
 - adhere to requirements established by the *Patient Protection and Affordable Care Act*,
 - consult with relevant stakeholders, including advocates for enrolling hard-to-reach populations; and
 - be self-sustaining by January 1, 2015.

2011 SB 1524 – Health Insurance Exchange

Status: Referred to Senate Banking and Insurance Committee – 2/2/2011

- Establishes the Arizona Health Insurance Exchange Board as the governing body of the Arizona Health Insurance Exchange to:
 - determine the structure of and develop the exchange certified by January 1, 2013 and open for enrollment by July 1, 2013;
 - contract with the Department of Insurance to conduct premium review; and
 - consult with stakeholders, including advocates for hard-to-reach populations.
 - Establishes the Arizona Health Insurance Exchange to adhere to requirements provided in the *Patient Protection and Affordable Care Act*.
 - Prohibits members of the Board or staff of the exchange to be, be an employee of, or be affiliated with a health care provider, a health care facility or clinic, or a health insurer – with the exception of health care providers not receiving compensation for rendering services as a provider who do not have an ownership interest in a professional health care practice.
 - Establishes the Arizona Health Insurance Exchange Fund.
-

ARKANSAS

2011 HB 2104 – To Authorize the Insurance Commissioner to Enforce the ACA

Status: Referred to House Public Health, Welfare & Labor Committee – 3/7/2011

- Authorizes the Insurance Commissioner to enforce the federal Affordable Care Act and to establish the Arkansas Health Benefit Exchange.
-

CALIFORNIA

2011 AB 714 – California Health Benefit Exchange

Status: Referred to Assembly Health Committee – 3/7/2011

- Requires the state Department of Health Care Services and the Managed Risk Medical Insurance Board to disclose information on health care coverage through the California Health Benefit Exchange to every individual who has ceased to be enrolled under the Medi-Cal and Family PACT programs, until June 30, 2013.

- Requires the department and the board, after January 1, 2013, to provide to the Medi-Cal program and to the California Health Benefit Exchange information on every individual who has ceased to be enrolled under those programs, except the cancer treatment and Family PACT programs, for purposes of enrolling those individuals in the Exchange and to disclose that enrollment to those individuals.

2011 AB 792 – California Health Benefit Exchange

Status: Referred to Assembly Health and Judiciary Committees – 3/10/2011

- Requires the disclosure of information on health care coverage through the California Health Benefit Exchange by health care service plans, health insurers, the Employment Development Department, upon an initial claim for disability benefits, or by the court, upon the filing of a petition for dissolution of marriage, nullity of marriage, legal separation, or adoption.
- Requires, as of January 1, 2014, specified health care service plans and health insurers to, upon a renewal in coverage of an enrollee or insured, as specified, or with regard to COBRA or Cal-COBRA coverage under an employer-sponsored group plan, and the Employment Development Department with regard to an applicant for unemployment compensation, provide specified information to the California Health Benefit Exchange for purposes of enrolling those enrollees, insureds, or applicants in the Exchange.

CONNECTICUT

2011 HB 6323 – An Act Conforming Changes to the Insurance Statutes Pursuant to the Federal PPACA

Status: Favorable Change of Reference to Joint Committee on Government Administration and Elections – 3/14/2011

- Establishes the Connecticut Health Partnership Exchange as a body politic and corporate, constituting a public instrumentality and political subdivision of the state.
- Requires the exchange to:
 - report at least annually to the General Assembly; and
 - adhere to all requirements established in the *Patient Protection and Affordable Care Act*;
 - consult with stakeholders, including individuals knowledgeable about the health care system and have backgrounds or experience making informed decisions regarding health, medical and scientific matters, and advocates with experience in enrolling hard-to-reach populations in public assistance programs;
 - collaborate with the Department of Social Services, to the extent possible, to allow an individual to remain enrolled in such individual's plan and provider network in the event such individual changes eligibility status; and
 - determine applicants' eligibility within 90 days of receiving an application.
- Requires qualified health plans to have an adequate number of providers in the plan's network, including providers that serve predominantly low-income, medically underserved individuals, and provide individuals with information about the availability of in-network and out-of-network providers.
- Establishes the Board of Directors made up of 11 appointed members who shall not be, be employed by or be affiliated with a health care provider, a health care facility, a medical clinic or an insurer – with the exception of health care providers not receiving compensation for rendering services as a provider who do not have an ownership interest in a professional health care practice.
- Authorizes the exchange to commission surveys of consumers, employers and providers on issues related to health care and coverage.

2011 SB 55 – An Act Establishing a State Health Insurance Exchange

Status: Referred to Joint Committee on Insurance and Real Estate – 1/10/2011

full bill text not yet available—below is text of proposed bill shell

- Creates a state health insurance exchange pursuant to the federal *Patient Protection and Affordable Care Act*.

2011 SB 921 – An Act Establishing a State Health Insurance Exchange

Status: Favorable Change of Reference to Joint Committee on Government Administration and Elections – 3/15/2011

- Establishes the Connecticut Health Insurance Exchange as a body politic and corporate, constituting a public instrumentality and political subdivision of the state.
 - Creates a Board of Directors to oversee the exchange made up of appointees, at least one of whom must be a representative of health care providers.
 - Requires exchange to consult with stakeholders, including: (1) individuals knowledgeable about the health care system, have backgrounds or experience making informed decisions regarding health, medical and scientific matters, and are enrollees in qualified health plans; and (2) advocates for enrolling hard-to-reach populations.
 - Allows the exchange to borrow money for the purpose of obtaining working capital.
 - Prohibits the exchange and health carriers from charging an individual fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential because the individual has become new eligible for that coverage or the individual's employer-sponsored coverage has become affordable.
-

GEORGIA

2011 HB 476 – Georgia Health Exchange Authority; Establish

Status: Passed favorably by House Insurance Committee – 3/10/2011

- Establishes the Georgia Health Exchange Authority as a body corporate and politic, an instrumentality of the state, and a public corporation.
 - Creates a board of directors composed of nine members, seven of whom shall be appointed by the Governor from the general public, one representing a consumer or health advocacy organization, one to represent small business, and others with expertise on individual health coverage, small employer health coverage, health plan administration, health care finance, administering a public or private health care delivery system, purchasing health plan coverage and state employee coverage.
 - Prohibits members of the board or Authority staff from being employed by or being affiliated with an insurer, a health insurance agent or broker, a health care provider, or a health care facility or clinic.
 - Establishes the Georgia Health Care Exchange Trust Fund.
 - Requires the Governor to appoint an Exchange Advisory Committee to allow for the involvement of the health care industry, business leaders and other stakeholders.
 - Charges the advisory committee with basing recommendations on increasing the number of Georgians with quality health coverage; supporting provider viability; building real competition in the insurance market; making Georgia small business friendly; promoting keeping all family members together on the same plan; promoting customer service and the importance of brokers and navigators; and seeking solutions that are sustainable and best for Georgians whether specifically part of federal law or not.
-

HAWAII

2011 HB 272 – Hawaii Health Authority; Establishment; Appropriation

Status: Referred to House Health and Finance Committees – 1/24/2011

- Creates the Hawaii Health Authority within the office of the governor for administrative purposes, as an autonomous public body corporate and politic and an instrumentality of the state.
- Requires that the Authority be composed of nine governor-appointed members, two of whom shall be practicing physicians.
- Charges the authority will the overall health planning for the state, guiding the governor and director of health, and developing a comprehensive health plan to include recommendations for the implementation of the federal *Affordable Care Act*, including:
 - current and long-term capacity needs of health providers and facilities;
 - initiatives to increase the number of primary care physicians in Hawaii, including loan repayment programs,
 - recommendations regarding patient-centered medical homes; and

- implementation of a health insurance exchange.

2011 HB 1048 – Health Insurance Exchange

Status: Deferred by House Health and Finance Committee – 2/4/2011

- Determines Hawaiians will best be served by a health insurance exchange operated in the state.
- Because a federal grant to support the operations of a health insurance exchange will become available and the Secretary of the United States Department of Health and Human Services will determine whether Hawaii can implement a health insurance exchange, the legislature finds that moving forward in the 2011 legislative session with an enabling statute is prudent.

2011 HB 1201 – Hawaii Health Benefit Exchange

Status: Referred to Senate Commerce & Consumer Protection, Health, and Ways & Means Committees – 3/10/2011

- Creates a private, nonprofit health insurance exchange, the Hawaii Health Benefit Exchange.
- Establishes a board of directors to govern the exchange.
- Charges the exchange with working with the state health insurance exchange task force established in the Department of Commerce and Consumer Affairs to develop policies and necessary proposed legislation.

2011 SB 594 – Hawaii Health Authority; Establishment; Appropriation

Status: Amended, passed the Senate Health Committee and referred to Ways and Means Committee – 2/14/2011

- Creates the Hawaii Affordable Health Care Coordinator within the Office of the Governor for administrative purposes, as an autonomous public body corporate and politic and an instrumentality of the state.
- Charges the Coordinator with the overall health planning for the state, guiding the governor and director of health, and developing a comprehensive health plan to include recommendations for the implementation of the federal *Affordable Care Act*, including the health insurance exchange.

2011 SB 1275 – Health Insurance Exchange

Status: Referred to Senate Commerce & Consumer Protection, Health, and Ways & Means Committees – 1/26/2011

- This measure is a companion of the above 2011 HB 1048. The current versions have the same bill summary.

2011 SB 1348 – Hawaii Health Insurance Exchange

Status: Referred to House Health, Consumer Protection & Commerce and Finance Committees – 3/10/2011

- Establishes a state health insurance exchange, the Hawaii Health Connector as a public, nonprofit organization, enabling consumers to purchase coverage and manage plans electronically and serving as a clearinghouse for information on all qualified plans.
- Creates a Board of Directors comprised of 15 appointed members reflecting geographic diversity and the diverse interests of stakeholders including consumer, employers, insurers, and government entities.
- Requires the board of directors to submit an annual report to the legislature, including a recent audit report.
- Allows the connector to receive contributions, grants, endowments, fees or gifts.
- Provides that the insurance commissioner shall retain full regulatory jurisdiction over all insurers and plans included in the Connector.
- Requires the existing state health insurance exchange task force to recommend to the legislature policies and procedures to further define and operate the Connector.
- Authorizes the task force to work collaboratively with stakeholders to propose legislation to the 2012 legislature implementing the Connector, to ensure the state's compliance with federal law.

ILLINOIS

2011 HB 223 – Health Care Implementation

Status: Amended and passed House Health Care Availability and Accessibility Committee – 3/14/2011

- Amends current state statutes ([20 ILCS 4045](#)) to eliminate the Adequate Health Care Task Force.
- Creates the Health Care Justice Implementation Task Force to monitor the implementation of federal reforms and make recommendations.
- Authorizes the Task Force to consult with health care providers, health care consumers, hospitals, labor unions, businesses, insurers, pharmaceutical manufacturers and other appropriate individuals and organizations.
- Charges the Task Force with making recommendations by March 1, 2013 on implementing the Illinois State Health Insurance Plan—available to all state residents to purchase medical care and services available to recipients of medical assistance—as an affordable option under a state health insurance exchange.

2011 HB 1701 – Health Insurance Exchange Act

Status: Referred to House Executive Committee—2/22/2011

full bill text not yet available—below is text of short title provision

- Creates the Illinois Health Insurance Exchange Act.
-

INDIANA

2011 SB 580 – Indiana Health Exchange

Status: Referred to Senate Health and Provider Services Committee – 1/20/2011

- Requires the Insurance Commissioner to establish the Indiana Health Exchange to facilitate the purchase of qualified health plans by individuals in the individual insurance market, provide for establishing a small business health options program, and apply for federal certification of the exchange no later than October 1, 2012.
 - Charges the commissioner and the Secretary of Family and Social Services with:
 - holding public meetings with stakeholders, including health care providers, consumers, and insurers, concerning the design, establishment, and administration of the exchange; and
 - making recommendations to the Health Finance Commission on: (1) whether the exchange should be administered by an agency of the state or a nonprofit organization; (2) a list of state with which Indiana could form an interstate exchange; and (3) other provisions necessary to implementation of the exchange, by September 30, 2011.
 - Requires the Health Finance Commission, by October 1, 2012, to study and make a recommendation to the General Assembly for legislation necessary to design, establish, and implement the exchange.
-

IOWA

2011 HF 559 (formerly HSB 159) – A Bill Authorizing the Establishment of Health Insurance Exchanges

Status: Introduced in House – 3/7/2011

- Authorizes the establishment of the Iowa Health Insurance Exchange, operated by the Insurance Division of the Department of Commerce – which may be on a statewide, regional or multistate basis – and authorizes additional exchanges to be formed.
- Charges the Insurance Commissioner with:
 - establishing a provider reimbursement system for health benefit plans issued in the state that all carriers and providers may join to facilitate fair and reasonable payments; and
 - creating a value- or outcome-based reimbursement system for plans to which all carriers may subscribe.
- Requires that applicants be enrolled by an insurance producer, who shall receive a commission of at least five percent of the premium paid by the enrollee.
- Charges the exchange or exchanges that are established with requesting a five-year waiver from the certification requirements to enable the exchange to offer mandate-free plans in addition to qualified plans through the exchange.

2011 SF 117 – A Bill Relating to Health Care and Policy and Health Care Infrastructure and Integration of Public and Private Programs

Status: Referred to Senate Human Resources Committee – 1/31/2011

- Directs the Department of Human Services, Division of Insurance of the Department of Commerce, Department of Public Health, Department of Revenue, Department of Workforce Development, and other appropriate agencies to develop a plan to meet the requirements of the federal *Patient Protection and Affordable Care Act* relating to a health benefit exchange, addressing:
 - issues related to eligibility determinations for Medicaid, Hawk-I, and tax credit subsidies; information technology and process reengineering;
 - necessary policy, statutory and regulatory changes;
 - financing;
 - tools and strategies necessary for implementation;
 - an all-payer claims database;
 - evaluation of trends;
 - rural health care resources;
 - workforce resources;
 - a provider payment system; and
 - a blueprint for a healthy Iowa.
- Charges the division of health policy with completing and submitting the components relating to the all-payer claims database, and the provider payment system to the governor and the general assembly by October 1, 2011.

2011 SF 348 (formerly SSB 1063) – A Bill Relating to Establishment of Health Benefit Exchange

Status: Passed Senate State Government Committee – 3/1/2011

- Establishes the Iowa Health Benefit Exchange as a nonprofit corporation under the purview of the Office of the Governor, overseen by the Board of Directors.
- Allows the board, in developing the electronic clearinghouse, to require participating health carriers to make available and regularly update an electronic directory of contracting health care providers so individuals seeking coverage can search by providers' names to determine which plans include a provider in their network, and whether that provider is accepting new patients for that plan.
- Requires the board to establish one or more advisory committees consisting of representatives from the insurance industry, producer organizations, consumer advocacy groups, labor unions, employers, health care providers and other interested parties.
- Requires the exchange to:
 - adhere to federal law;
 - provide referrals to the Office Of Health Insurance Consumer Assistance;
 - consult with stakeholders, including educated health care consumers who are knowledgeable about the health care system, have a background or experience in making informed decisions regarding health, medical and scientific matters and who are enrollees;
 - seek and receive federal grants;
 - assist in the implementation of reinsurance and risk adjustment mechanisms;
 - encourage cross-agency consultation and coordination with the Commissioner, Department of Human Services, Department of Public Health and the Attorney General; and
 - coordinate activities with the state Medicaid program.

2011 SF 391 (formerly SF 235) – A Bill Authorizing the Establishment of Health Insurance Exchanges

Status: Substituted SF 235 and passed Senate Commerce Committee – 3/2/2011

- This measure is similar to the above 2011 HF 559. The current versions have the same bill summary.

MARYLAND

2011 HB 166 – Maryland Health Benefit Act of 2011

Status: Referred to House Health and Government Operations Committee – 1/26/2011

- Establishes a Maryland Health Benefit Exchange as a body politic, corporate, and instrumentality of the state.
- Requires the exchange, in carrying out its duties, through advisory committees or through other means, to consult with stakeholders, including representatives of health care providers.
- Creates a Board of Trustees to oversee the exchange.
- Allows the Board to appoint advisory committees composed of experts and individuals knowledgeable about individual and employer-sponsored health coverage, health benefit plan administration, health care finance, administration of public and private health care delivery systems, purchasing and facilitating enrollment in plan coverage, health care delivery models and payment reform, and others as appropriate;
- Establishes a Maryland Health Benefit Exchange Fund to provide funding to the operation and administration of the exchange.
- Seeks to have the exchange become self-sustaining by 2016.

2011 HB 516 – Health Benefit Exchanges – Establishment and Operation

Status: Referred to House Health and Government Operations Committee – 2/7/2011

- Requires that an exchange be established as a nonprofit entity to focus on carrying out functions established under the federal *Patient Protection and Affordable Care Act*.
- Prohibits an exchange from:
 - being established as a governmental agency;
 - soliciting business from individuals or small employers already participating in the individual market or small group market outside of the exchange; and
 - depending on funding from the public (excluding federal grants) or from fees paid by individuals not enrolled in the exchange.
- Directs the Insurance Commissioner to examine the duties of persons employed by an exchange related to the sale, solicitation or negotiation of health insurance, and to ensure appropriate regulation of such persons, including licensure.

2011 SB 107 – Health Benefit Exchanges – Establishment and Operation

Status: Referred to Senate Finance Committee – 1/21/2011

- This measure is a companion of the above 2011 HB 516. The current versions have the same bill summary.

2011 SB 182 – Maryland Health Benefit Exchange Act of 2011

Status: Referred to Senate Finance & Budget, and Taxation Committees – 1/24/2011

- This measure is a companion of the above 2011 HB 166. The current versions have the same bill summary.

2011 SB 724 – Health Insurance – Exchange Option for Small Business

Status: Reported Unfavorably by Senate Finance Committee – 2/21/2011

- Requires a Small Business Health Options Program (SHOP) exchange to offer health insurance to employers that have 100 or fewer employees.
- Allows employers in the state to purchase health insurance outside of a SHOP exchange.

MINNESOTA

2011 HF 497 – Health Insurance Exchange Created

Status: Referred to House Health and Human Services Reform Committee – 2/14/2011

- Establishes an exchange as a nonprofit entity to facilitate access to qualified health plans available to individuals and employers effective January 1, 2014.
- Creates a board of directors to oversee the exchange.
- Requires the exchange to:
 - develop a plan of operations;
 - adhere to federal law; and

- consult with stakeholders, including health plan companies and advocates for enrolling hard-to-reach populations.
 - Requires individuals employed by or affiliated with Navigators to be health insurance agents licensed and regulated by the Insurance Commissioner.
-

MISSISSIPPI

2011 HB 377 – Health Insurance Exchange Study Committee; extend repealer

Status: Amended, Passed Senate and House Declined to Concur – 3/14/2011

- Amends current state law ([SB 2554](#) enacted in 2010), which created the Health Insurance Exchange Study Committee to conduct a study on health insurance exchanges as proposed at the federal level and to make implementation recommendations.
- Changes the repeal date of the Study Committee from July 1, 2011 to July 1, 2012.

2011 HB 774 – Create Health Benefit Exchange Act

Status: FAILED in House Medicaid and Insurance Committees – 2/1/2011

- Amends current state law ([43-13-115](#), [43-13-121](#), [41-86-15](#)).
- Directs the Division of Medicaid to cooperate with the Mississippi Health Benefit Exchange and to accept the enrollment of those eligible for Medicaid or CHIP by the exchange.
- Establishes the Mississippi Health Benefit Exchange as an Office within the Department of Insurance.

2011 HB 904 – Small Business Health Insurance Pool; Create

Status: FAILED in House Insurance and Ways and Means Committees – 2/1/2011

- Creates a Small Business Health Insurance Pool to provide employer premium incentive payments, employee premium assistance payments, and tax credits for eligible small employers who provide certain group health plan coverage to eligible employees.
- Establishes a Board of Directors to: (1) determine an operating plan, assistance amounts, and eligibility and application requirements, (2) approve no more than six fully insured group health plans with different benefit levels to be offered to participating employers, and (3) contract with no more than three health insurance issuers to underwrite the plans offered.
- Authorizes the Division of Medicaid to pursue Medicaid funding for employee premium assistance.

2011 HB 1220 – Mississippi Health Benefit Exchange Act

Status: Amended, passed Senate and House declined to concur – 3/8/2011

- Establishes the Mississippi Health Benefit Exchange, as a not-for-profit corporation independent of the state, operating under a Board of Directors.
- Requires the board to consist of 16 members, two of whom must be a health care provider—one appointed by the Mississippi State Medical Association and one by the Mississippi State Medical and Surgical Association—both to be approved by the Speaker of the House of Representatives.
- Requires the exchange to be self-sustaining by January 1, 2015 (added by bill substitution).

2011 HB 1336 – Mississippi Health Benefit Exchange Act

Status: FAILED in House Insurance Committee – 2/1/2011

- Establishes the Mississippi Health Benefit Exchange, as a not-for-profit corporation with legal existence separate from the state, operating under a Board of Directors.
- Requires the Board to consist of 16 members, one of whom must be a health care provider appointed by the Mississippi Medical Association and one of whom must be a member of the Mississippi Hospital Association approved by—both must be approved by the commission.

2011 SB 2267 – Health Insurance Exchange Study Committee; extend repealer

Status: FAILED in House Insurance Committee – 3/11/2011

- This measure is a companion of the above 2011 HB 377. The current versions have the same bill summary.

2011 SB 2991 – Mississippi Health Benefit Exchange Act

*Status: **FAILED** in Senate Insurance Committee – 2/1/2011*

- This measure is a companion of the above 2011 HB 1336. The current versions have the same bill summary.

2011 SB 2992 – Mississippi Health Benefit Exchange Act

*Status: **FAILED** in House Insurance Committee – 3/9/2011*

- This measure is a companion of the above 2011 HB 1336. The current versions have the same bill summary.
-

MISSOURI

2011 HB 609 – Establishes the Show-Me Health Insurance Exchange Act

Status: Referred to House Health Insurance Committee – 3/3/2011

- Establishes the Show-Me Health Insurance Exchange as a quasi-governmental agency under the direction of a board of trustees.
 - Requires the executive director of the board to employ employees as authorized by the board to conduct business of the exchange, and requires the board to take into account salaries paid by health carriers, health benefit plans, and health care providers in establishing appropriate pay schedules for employees.
 - Requires participating health carriers to provide timely updates regarding the plan's provider network, including the addition of new providers or withdrawal of an existing provider through a publicly accessible website.
 - Requires the exchange to:
 - adhere to federal law;
 - establish a broker referral network as part of the Navigator program; and
 - consult with stakeholders, including health care providers.
-

MONTANA

2011 HB 124 – An Act Creating a Montana Health Insurance Exchange Authority

*Status: **FAILED** to meet transmittal deadline in House Business and Labor Committee – 2/24/2011*

- Creates a Montana Health Insurance Exchange Authority, a quasi-governmental entity, subject to supervision of the Insurance Commissioner, and incorporated as a nonprofit corporation.
- Establishes an oversight board, required to consult with stakeholders, including the advisory committee, consumers who are enrollees in qualified health plans, and advocates for enrolling hard-to-reach populations.
- Establishes an advisory board with 15 members from the insurance industry, producer organizations, consumer advocacy groups, labor unions, employers, health care providers and other interested parties.
- Authorizes the Insurance Commissioner to:
 - approve or disapprove the plan of operation that the board proposes;
 - develop a uniform health insurance application form and require use both inside and outside of the exchange authority;
 - approve or disapprove the assessment fees that the board proposes to impose to pay for the ongoing administration of the exchange authority;
 - conduct periodic financial and performance audits of the exchange authority;
 - adopt rules necessary to implement provisions; and
 - investigate any complaints received from the public concerning the operation of the exchange authority.
- Requires all health issuers participating in the exchange:
 - to offer at least one gold and one silver plan both inside and outside the exchange, unless the issuer does not operate outside the exchange;

- that offer individual or small employer group preferred provider organization health plans, other plans with incentives for using particular networks of providers, or managed care plans outside the exchange to also offer those network-based plans inside the exchange;
- to comply with existing network adequacy rules or any network adequacy rules for preferred providers adopted by the commissioner for plans issued both inside and outside the exchange;
- to use the same network of providers for health plans offered inside the exchange for plans offered outside.
- Charges the board and the Commissioner of Insurance with jointly researching, investigating and producing reports by August 31, 2012 on strategies to reduce health care costs and an assessment of how implementation of such strategies would affect health care costs and health insurance premiums for exchange enrollees.

2011 SB 228 – Prohibit Creation of Health Insurance Exchange under PPACA

Status: Referred to House Business and Labor Committee – 3/10/2011

- Prohibits the state from creating an American Health Benefit Exchange as provided for in federal law.
- Requires the state to return to the federal government the unexpended portions of any grants obtained to plan for or implement a state-based exchange.

NEBRASKA

2011 LB 240 – Create the Nebraska Insurance Choices Exchange Task Force

Status: Referred to Banking, Commerce and Insurance Committee – 1/13/2011

- Creates the Nebraska Insurance Choices Exchange Task Force as of July 1, 2011 to study, evaluate and develop recommendations regarding the establishment, governance and requirements of the health insurance exchange required by the federal *Patient Protection and Affordable Care Act* to facilitate the purchase and sale of qualified plans in the individual and small market group market and to evaluate the establishment of a small business health options program exchange to assist qualified small employers in facilitation the enrollment of employees.
- Requires the task force to report to the Legislature on or before December 1, 2011 with recommendations to ensure the exchange will reduce health care costs, reduce the number of uninsured individuals, provide a transparent marketplace, and provide consumer education to assist individual with access to programs, premium assistance tax credits and cost-sharing reductions.
- Charges the task force with overseeing implementation of the exchange until June 30, 2012.

2011 LR 85 – Interim Study to Determine How Insurance Laws Should Be Amended

Status: Referred to Executive Board – 2/24/2011

- Forms a study committee to review the development and final provisions of the legislative proposals for exchange implementation resulting from the activities by the state under the federal State Planning and Establishment Grant.
- Charges the study committee with seeking assistance from the Department of Insurance and cooperating with other affected agencies.

NEW HAMPSHIRE

2011 SB 163 – Relative to the New Hampshire Health Benefit Exchange

Status: Rereferred to Senate Commerce Committee – 3/9/2011

- Establishes the New Hampshire Health Benefit Exchange as a public body deemed to be an instrumentality of the state and a public corporation.
- Determines that the Act shall not preclude the establishment of separate, privately-run exchanges or the distribution of coverage outside an exchange.
- Creates the exchange board to provide procedures to facilitate the exchange, ensuring to meet the requirements of the *Patient Protection and Affordable Care Act*.

- Requires that the board be made up of three persons affiliated with an insurer, two health insurance producers, three public members not employed by or affiliated with an insurer, hospital or other health care provider, the commission of the department of health and human services, and the insurance commissioner.
 - Provides the state insurance commissioner with rulemaking authority over the exchange.
-

NEW JERSEY

2010 AB 1930 – New Jersey Health Benefit Exchange Act

Status: Substituted and passed Assembly Health Senior Services Committee and carried over to 2011 session – 12/6/2010

- Establishes in the executive branch of state government the New Jersey Health Benefit Exchange.
- Creates a board of directors that may require carriers participating in the exchange to:
 - make available to the exchange and regularly update an electronic directory of contracting health care providers so exchange enrollees can search by provider to determine which plans include the provider in their network; and
 - provide regularly updated information to the exchange as to whether a provider is accepting new patients in a particular plan.
- Requires the Commissioner of Banking and Insurance to report to the Governor and the Legislature by January 1, 2018 with recommendations for appropriate administrative and legislative action.

2010 AB 3561 – New Jersey Health Insurance Exchange Act

Status: Referred to Assembly Health Senior Services Committee and carried over to 2011 session – 12/6/2010

- Establishes the New Jersey Health Insurance Exchange as an independent public entity, in but not of the Department of Banking and Insurance, with certain authority to facilitate the availability and choice of health benefits plans offered to employees of small employers that employ between two and 50 employees, and other eligible persons not employed by small employers.
- Establishes a board of directors to implement the functions of the exchange.
- Requires an annual study and a report on exchange operations to the Governor and Legislature.
- Authorizes the exchange, in consultation with the Commissioner of Banking and Insurance and the Commissioner of Health and Senior Services, to adopt rules and regulations as necessary.

2011 AB 3733 – New Jersey Healthcare Exchange Act

Status: Referred to Assembly Financial Institutions and Insurance Committee – 1/11/2011

- This measure is similar to above 2010 AB 1930. The current versions have the same bill summary.

2010 SB 1288 – New Jersey Health Benefit Exchange Act

Status: Referred to Senate Commerce Committee – 2/8/2010

- This measure is a companion of the above 2010 AB 3561. The current versions have the same bill summary.

2010 SB 2553 – New Jersey Health Benefit Exchange Act

Status: Referred to Senate Commerce Committee and carried over to 2011 session – 12/6/2010

- This measure is a companion of the above 2010 AB 1930. The current versions have the same bill summary.

2010 SB 2597 – New Jersey Healthcare Exchange Act

Status: Referred to Senate Commerce Committee and carried over to 2011 session – 12/30/2010

- This measure is a companion of the above 2010 AB 3733, which is similar to 2010 AB 1930. The current versions have the same bill summary.
-

NEW MEXICO

2011 HB 33 – New Mexico Health Insurance Exchange Act

Status: Referred to House Health & Government Affairs Committee – 2/24/2010

- Creates the New Mexico health insurance exchange as a nonprofit public corporation, separate from the state and supervised by a board of directors, to provide increased access to health insurance in the state.
- Requires the board to:
 - consist of 11 voting members who shall not have any affiliation with or any income derived from current or active employment as a contract or consultation for a health care provider or health care services finance or coverage sector;
 - create and duly consider the recommendations of standing advisory committees made up of representatives of carriers, health care providers, health care consumers, representatives of employers, advocates for low-income or underserved residents and representatives of American Indians or Alaska Natives;
 - implement strategies to avoid adverse selection;
 - provide quarterly reports on implementation to the legislative health and human services and finance committees; and
 - submit recommendations on (1) changing the number of full-time employees as defined in “small employer,” (2) extending coverage to large employers, (3) combining markets into a single risk pool, and (4) entering into an exchange with other states.
- Requires carriers that offer health benefit plans in the individual or small market in the state to offer qualified health plans through the exchange at the silver and gold levels of coverage.

2011 HB 246 – Amend Health Insurance Alliance Act

Status: Referred to House Health & Government Affairs Committee – 1/31/2010

- Amends current state statutes ([59A-56-2 to 59A-56-20](#)), the Health Insurance Alliance Act.
- Adds large employers to those eligible to receive voluntary health insurance coverage under the existing [New Mexico Health Insurance Alliance](#).

2011 HB 584 – New Mexico Benefit Exchange Act

Status: Referred to House Health & Government Affairs Committee – 1/31/2010

- Creates the New Mexico Health Benefit Exchange as a nonprofit public corporation, separate and apart from the state.
- Establishes a Board of Directors to govern the exchange by:
 - consisting of 11 voting members who shall not have any affiliation with or any income derived from current or active employment as a contract or consultation for a health care provider or health care services finance or coverage sector;
 - creating and duly considering the recommendations of standing advisory committees made up of representatives of carriers, health care providers, health care consumers, representatives of employers, advocates for low-income or underserved residents and representatives of American Indians or Alaska Natives;
 - coordinating with the Superintendent of Insurance to review the establishment and operation of the internet portal;
 - consulting with representatives of New Mexico Native American nations, tribes and pueblos;
 - reporting findings and submitting recommendations on how to avoid adverse selection to the governor, Legislative Health and Human Services Committee, the Legislative Finance Committee and the superintendent; and
 - meeting with the board of directors of the New Mexico Health Insurance Alliance and the New Mexico Medical Insurance Pool.
- Authorizes the superintendent to promulgate rules for resolving disputes within the exchange.

2011 SB 38 – New Mexico Health Insurance Exchange Act

Status: Amended, passed House Consumer & Public Affairs Committee, and referred to Appropriations & Finance Committee – 3/2/2011

- Creates the New Mexico health insurance exchange as a nonprofit public corporation, separate from the state and supervised by a board of directors, to provide increased access to health insurance in the state.
- Provides that the exchange is a governmental entity for purposes of the Tort Claims Act.
- Charges the board with:
 - consisting of 11 voting members who shall not have any affiliation with or any income derived from current or active employment as a contract or consultation for a health care provider or health care services finance or coverage sector;
 - creating and duly considering the recommendations of standing advisory committees made up of representatives of carriers, health care providers, health care consumers, representatives of employers, advocates for low-income or underserved residents and representatives of American Indians or Alaska Natives;
 - annually reporting to the legislative health and human services and finance committees; and
 - submitting recommendations on (1) avoiding adverse selection, (2) changing the number of full-time employees as defined in “small employer,” (3) extending coverage to large employers, (4) combining markets into a single risk pool, and (5) entering into an exchange with other states.
- Requires carriers that offer health benefit plans in the individual or small market in the state to offer qualified health plans through the exchange at the silver and gold levels of coverage.
- Requires the board to cooperate with the human services department to share information and facilitate transitions between the exchange, Medicaid, CHIP and any other state public health coverage program.
- Requires the human services department to cooperate with the exchange to provide funding for implementation, to share information, and to facilitate transitions between the exchange, Medicaid, CHIP and any other state public health coverage program.
- Requires the Insurance Division to cooperate with the exchange to share information and assist in implementation.

2011 SB 90 – Health Insurance Access for Large Employers

Status: Referred to Senate Public Affairs Committee – 1/18/2011

- This measure is similar to the above 2011 HB 246. The current versions have the same bill summary.

2011 SB 370 – Enact “NM Health Insurance Exchange Act”

Status: Amended, passed Senate Public Affairs Committee, and referred to Corporations & Transportation Committee – 2/14/2011

- This measure is similar to the above 2011 HB 38. The current versions have the same bill summary.

NORTH CAROLINA

2011 HB 115 – North Carolina Health Benefit Exchange Act

Status: Referred to House Health and Human Services Committee – 2/17/2011

- Creates the North Carolina Health Benefit Exchange as a nonprofit entity, meeting the requirements of the Affordable Care Act.
- Establishes the Board of the North Carolina Health Benefit Exchange:
 - consisting of 11 members, one representative of a health carrier, two members of the general public not employed by or affiliated with an insurance company, hospital or other health care provider, one health carrier who sells individual policies, one who represents the insurance industry as recommended by the largest carrier in the state, two who represent the medical provider community, one who represents small business, and one who is either a health policy researcher or health economist; and
 - consulting with stakeholders including educated health care consumers and advocates for enrolling hard to reach populations.

2011 HB 126 – North Carolina Benefit Exchange Act

Status: Referred to House Health and Human Services Committee – 2/21/2011

- Creates the North Carolina Health Benefit Exchange as a nonprofit entity, meeting the requirements of the Affordable Care Act.
 - Establishes the Board of the Exchange to consult with stakeholders including advocates for enrolling hard to reach populations and health care professionals and provider groups.
 - Requires the exchange to establish an advisory committee made up of stakeholders, including insurers who sell individual policies, insurers who sell small group policies, agents or brokers, organizations that represent consumer interests, educated health consumers, individuals and entities with experience in facilitating enrollment, qualified employers, advocates for hard to reach populations, health care professionals, essential community providers, and other necessary representatives.
-

NORTH DAKOTA

[2011 HB 1126](#) – Creation of a Health Insurance Exchange

Status: Referred to Senate Human Services Committee – 3/2/2011

- Requires the Insurance Commissioner, to ensure that an American benefit exchange is created in the state, and to plan and implement an exchange.
 - Instructs the Commissioner to take all actions necessary to ensure that the exchange is determined, not later than January 1, 2013, by the federal government to be ready to operate no later than January 1, 2014.
 - Allows the Commissioner to consider seeking federal grant funds for the planning and implementation of the exchange, to contract with outside entities as necessary, and to adopt needed rules.
-

OKLAHOMA

[2011 SB 960](#) – Creating the Oklahoma Individual Market Review Act

Status: Referred to Senate Retirement and Insurance Committee – 2/14/2011

full bill text not yet available—below is text of proposed bill shell

- The *Patient Protection and Affordable Care Act* includes an option for a state to create a health insurance exchange to facilitate the purchase of individual and small group health coverage and to provide assistance with enrollment of eligible individuals in qualified health plans in lieu of the federal government operating a health insurance exchange in the state for that purpose. It is the intent of the Legislature that it would be in the best interest of the State of Oklahoma to create its own health insurance exchange. The design of the exchange shall maximize state control over the exchange and its component functions while at the same time minimizing the associated costs and risks to the state.
-

OREGON

[2011 HB 2918](#) – Relating to Small Businesses

Status: Referred to House Health Care and Ways and Means Committees – 1/21/2011

- Creates the Small Business Health Insurance Pool in Oregon Health Authority, to be administered by the Oregon Medical Insurance Pool Board, to provide quality, affordable health insurance coverage to small employers in the state.
- Specifies that eligible employers have no more than 50 employees.
- Prohibits carriers from canceling coverage because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.
- Requires insurers to participate for at least three years.
- Establishes the Small Business Health Insurance Pool Fund in the State Treasury, separate from the General Fund, consisting of moneys appropriated by the Legislative Assembly and premiums and other fees collected from small employers and insurers.

[2011 HB 3137](#) – Relating to Oregon Health Insurance Exchange

Status: Referred to House Health Care, and Ways & Means Committees – 2/14/2011

- Requires the Oregon Health Authority to establish the Oregon Health Insurance Exchange, as a statewide public corporation to perform governmental functions, governed by the board of directors.
- Requires the exchange to provide uniform information to consumers on costs, benefits, provider networks and other information to assist individual and small businesses in making informed health care decisions.

2011 HB 3510 – Relating to Statewide Coverage of Health Care

Status: Referred to House Health Care, and Ways & Means Committees – 2/28/2011

- Amends current state statutes (Section 17 of [Chapter 595 Oregon Laws 2009](#)).
- Repeals the Oregon Health Insurance Exchange established in 2009.

2011 SB 91 – Relating to Health Benefit Plans

Status: Referred to Health Care Reform Subcommittee of Senate Health Care, Human Services and Rural Health Policy Committee – 1/27/2011

- Amends current state statutes ([743.730 – 743.773](#)) to instruct the Oregon Health Authority in consultation with the Department of Consumer and Business Services to prescribe by rule the requirements for a bronze plan to be used by carriers in the health benefit plan market in the state.
- Requires all carriers to offer a bronze plan: (1) through the Oregon Health Insurance Exchange if the carrier offers a plan through the exchange; and (2) in the market outside of the exchange, if the carrier offers a plan outside of the exchange.
- Authorizes carrier to offer a catastrophic plan only through the exchange to an individual who is under 30 years old and is exempt from any state or federal penalties imposed for failing to maintain minimum coverage during the plan year.

2011 SB 99 – Relating to Oregon Health Insurance Exchange

Status: Referred to Health Care Reform Subcommittee of Senate Health Care, Human Services and Rural Health Policy Committee – 1/27/2011

- Similar to above 2011 HB 3137.

2011 SB 100 – Relating to Health Benefit Plans

Status: Referred to Health Care Reform Subcommittee of Senate Health Care, Human Services and Rural Health Policy Committee – 1/27/2011

- This measure is similar to above 2011 SB 91. The current versions have the same bill summary.

2011 SB 888 – Relating to Statewide Coverage of Health Care

Status: Referred to Senate Health Care, Human Services & Rural Health Policy, and Ways & Means Committees – 2/25/2011

- This measure is similar to above 2011 HB 3510. The current versions have the same bill summary.

PENNSYLVANIA

2011 HB 627 – An Act Providing for the American Health Benefit Exchange Act

Status: Referred to House Insurance Committee – 2/14/2011

- Establishes the Pennsylvania Health Insurance Exchange to meet requirements established under federal law.
- Requires the exchange to consult with stakeholders, including educated health care consumers and advocates for enrolling hard to reach populations.

RHODE ISLAND

2011 HB 5498 – An Act Relating to State Affairs and Government – Health Care – Health Benefit Exchange

Status: Referred to House Health, Education and Welfare Committee – 3/2/2011

- Establishes the Rhode Island Health Benefit Exchange, as a corporation constituted a public instrumentality exercising public and essential governmental functions.
- Requires that the exchange be governed by an executive board that is required to:
 - consist of 11 members representing individual health coverage, small employer health coverage, health benefits plan administration, health care finance, delivery system administration, coverage purchasing, and state employee health purchasing;
 - not have members employed by, a consultant to, or affiliated with an insurer, a health insurance agent or broker, a health care provider (unless the member is no longer receiving compensation for providing health care services or has no ownership interest in a professional health care practice), or a health care facility or clinic, while serving on the board;
 - apply for federal grants to use for planning and establishing the exchange;
 - submit a report to the Governor and the General Assembly on: (1) plans for IT needed to support the exchange; (2) recommendations regarding costs, benefits and market impacts associated with expanding the exchange functions and scope; and (3) elements needed to achieve financial self-sufficiency.
- Prohibits the functions and operations of the exchange from expanding beyond the minimum requirements of federal law.

2011 SB 87 – An Act Relating to State Affairs and Government – Health Care – Health Benefit Exchange

Status: Referred to Senate Health and Human Services Committee – 1/27/2011

- This measure is similar to above 2011 HB 5498. The current versions have the same bill summary.
-

SOUTH CAROLINA

2011 HB 3738 – Health Benefit Exchange Act

Status: Referred to House Ways and Means Committee – 2/24/2011

- Establishes the South Carolina Health Benefit Exchange within the Office of the Governor.
 - Requires that the exchange be governed by the Health Benefit Exchange Board of Directors whose members include three representatives of the health insurance industry, two insurance producers, three consumer advocates, one business owner, one business owner recommended by the National Federation of Independent Business, one member recommended by the South Carolina Small Business Chamber of Commerce, one member recommended by the SC Chamber of Commerce, one member recommended by the SC Nurses Association, one member recommended by the SC Primary Care Association, one physician recommended by the SC Medical Association, one member recommended by the SC Hospital Association, and one actuary recommended by the American Academy of Actuaries.
 - Prohibits persons appointed to the Board from being employed by, a consultant to or affiliated with an entity in the business of the exchange, including carriers that provide coverage of benefits, producers, vendors, and providers selling services directly to the exchange.
 - Authorizes the exchange to create advisory committees to the board consisting of stakeholders.
-

TEXAS

2011 HB 636 – Relating to the Creation of the Texas Health Insurance Connector

Status: **FAILED** to pass House Public Health Committee – 3/1/2011

- Establishes the Texas Health Insurance Connector as the American Health Benefit Exchange and the Small Business Health Options Program Exchange as required by Section 1311 of the *Patient Protection and Affordable Care Act*.
- Creates a board of directors to govern the connector.
- Requires the connector, the department of insurance, and the Health and Human Services Commission to cooperate fully in operating the connector.
- Provides that the connector is not an insurer or HMO, is not subject to regulation by the department, is not subject to any state tax, and is subject to review and expiration September 1, 2019.

- Establishes the connector fund as a special trust fund, outside of the state treasury in the custody of the comptroller, separate from all public money, where the connector can deposit assessments, donations, and any federal funding.

2011 HB 3402 – Relating to Regulation of Health Benefit Plan Issuers in this State

Status: Filed – 3/11/2011

- Establishes the Texas Health Insurance Connector as the American Health Benefit Exchange and the Small Business Health Options Program Exchange as required by Section 1311 of the *Patient Protection and Affordable Care Act*.
- Establishes a Board of Directors consisting of seven members, five of whom must have demonstrated experience in at least two of the following areas: individual health coverage, small employer health coverage, health benefit plan administration, health care finance or economics, actuarial science, administration of public or private health care delivery system, and purchasing health plan coverage.
- Prohibits board members or exchange staff from being employed or affiliated with an insurer, an agent or broker, a healthcare provider (unless the member no longer receives compensation for providing health care services and does not have ownership interest in a professional health care practice), or a health care facility or clinic.
- Requires health carriers to make available to the exchange and regularly update an electronic directory of contracting health care providers so that enrollees can search by provider name to determine which plans include the provider in their network.
- Requires the Board to appoint an advisory committee—allowing for involvement of the health care and health insurance industries and other stakeholders—to provide expertise and recommendations to the board but not to adopt rules or enter into contracts.

2011 SB 1510 – Relating to the Creation of the Texas Health Insurance Connector

Status: Filed – 3/10/2011

- This measure is similar to above 2011 HB 636. The current versions have the same bill summary.

2011 SB 1782 – Relating to Regulation of Health Benefit Plan Issuers in this State

Status: Filed – 3/11/2011

- This measure is similar to above 2011 HB 3402. The current versions have the same bill summary.

UTAH

2011 HB 128 – Health Reform Amendments

Status: Passed Senate – 3/4/2011

- Amends current state statutes ([31A-22-613.5](#), [31A-22-635](#), [31A-30-205](#), [31A-30-209](#), [63M-1-2504](#), [63M-1-2506](#)) to adhere to federal requirements.
- Changes certain responsibilities concerning the exchange from the Department of Insurance to the Insurance Commissioner.
- Changes membership requirements for the Health Data Committee, increasing membership consisting of two, rather than one, physician.
- Requires that reports are published on or after July 1, 2010, based on clinical data that compare a clinic's aggregate results for a physician who practices at a clinic with five or more physicians and a geographic region's aggregate results for a physician who practices a clinic with less than five physicians, unless the physician requests physician-level data to be published on a clinic level.
- Creates the Health System Reform Task Force charged with reviewing and making recommendations on legislation necessary to implement the governance structure for the Health Insurance Exchange, risk adjustment, cost containment, including progress on the demonstration projects and grants that involve health care providers and payers to provide systemwide aligned incentives for the appropriate delivery of, and payment for, health care.
- Removes the large group market from the Health Insurance Exchange.

VERMONT

2011 HB 80 – An Act relating to a Single-Payer Health Care System

Status: Referred to House Committee on Health Care – 1/20/2011

- Creates a single-payer health care system in the state.
- Directs the secretary of human services to seek an exemption from federal requirements to set up and operate a health benefit exchange pursuant to the *Patient Protection and Affordable Care Act*.
- Requires that no later than February 1, 2012, in the event that the secretary cannot obtain such an exemption by November 30, 2011, the Ethan Allen Health board to propose to the general assembly a process and design by which the board would operate an exchange in Vermont and as of January 1, 2014, Ethan Allen Health shall be the secondary payer with respect to any health service covered by a health benefit plan operating within the exchange.
- Prohibits, as of October 1, 2012, private insurance companies from selling health insurance policies in Vermont that cover services covered by Ethan Allen Health, if the secretary obtains an exemption from the exchange requirement.
- Establishes the Ethan Allen Health Board to promote the delivery of high quality, coordinated health care services that enhance health; prevent illness, disease and disability; slow the progression of chronic disease; and improve personal health management.
- Requires the Board to:
 - consist of 15 members, six of whom must be providers—on primary care physician, one registered nurse, one mental health provider, one dentist, on nursing home director, and one hospital director; and
 - establish payment rates for providers which may reflect regional differences to address provider shortages.

2011 HB 82 – An Act Relating to a Vermont Hospital Security Plan

Status: Referred to House Committee on Health Care – 1/21/2011

- Creates a Vermont hospital security fund special committee to recommend to the general assembly the appropriate funding mechanisms for the Vermont hospital security plan—a plan to provide access to and coverage for health services provided in hospitals, while reducing cost.
- Requires the committee to consider various factors including how to operate the program in the event that Vermont is unable to secure an exemption from the federal requirement to set up and operate a health benefit exchange pursuant to the *Patient Protection and Affordable Care Act*.
- Directs the secretary of human services:
 - to seek an exemption from federal requirements to set up and operate a health benefit exchange pursuant to the *Patient Protection and Affordable Care Act*,
 - if such an exemption cannot be obtained, to seek a limited exemption to enable the state to exclude hospital services from exchange plans and receive federal funds to deposit in the Vermont hospital security trust fund in a sufficient amount to provide hospital services for individuals eligible for federal subsidies under the exchange; and
 - if such an exemption cannot be obtained, to seek a waiver from the exchange requirement to take effect on the first day.

2011 HB 146 – An Act Relating to a Public Health Care Coverage Option

Status: Referred to House Committee on Health Care – 2/1/2011

- Requires the Commissioner of Banking, Insurance, Securities and Health Care Administration, by January 15, 2012, to recommend to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance a method by which Green Mountain Care—the public-private single-payer health system established in the bill—may obtain an insurance license and offer the public option through Vermont's Health Benefit Exchange pursuant to the *Patient Protection and Affordable Care Act*.

2011 HB 202 – An Act Relating to a Single-Payer and Unified Health System

Status: Referred to House Committee on Health Care – 2/8/2011

- Charges Green Mountain Care with including health coverage provided under the health benefit exchange with the intent for the exchange to become the foundation for a single-payer health system.
- Requires the exchange, by November 1, 2016, to begin enrolling employers with more than 100 employees for coverage beginning January 1, 2017.
- Requires that, by January 1, 2014, all individual and small group health insurance products be sold only through the exchange and all large group insurance products be aligned with administrative requirements and essential benefits required in the exchange.
- Requires the Secretary of Health to supervise the planning efforts, reports of which due January 15, 2012, including integration of multiple payers into the exchange.
- Requires the Department of Vermont Health Access to establish the Vermont Health Benefit Exchange to be administered by the Department in consultation with an advisory board.
- Establishes a Vermont Health Reform Board consisting of one chair and four members, one of whom must be a practicing physician.

2011 HB 233 – An Act Relating to Global Hospital Budgets and Health Care Reform

Status: Referred to House Committee on Health Care – 2/11/2011

- Directs the Secretary of Human Services to seek an exemption from the requirement to set up and operate a health benefit exchange pursuant to the *Patient Protection and Affordable Care Act*.
- Directs the Secretary to, if unable to obtain such an exemption by December 31, 2011, seek a limited exemption from the requirement to enable Vermont to:
 - exclude hospital services from exchange plans; and
 - receive federal funds to deposit in the Vermont Hospital Security Trust Fund.

2011 SB 57 – An Act Relating to a Single-Payer and Unified Health System

Status: Referred to Senate Committee on Health and Welfare – 2/8/2011

- This measure is similar to above 2011 HB 202. The current versions have the same bill summary.
-

VIRGINIA

2011 HB 2434 – Health Benefits Exchange; Intent to Develop

Status: Passed Senate – 2/17/2011

- Provides that it is the intent of the General Assembly that the Commonwealth creates and operates its own health benefits exchange or exchanges, to facilitate the purchase and sale of qualified health plans in the individual market and to assist qualified small employers in facilitating the enrollment of employees.
- Requires the Virginia Exchange to, at a minimum, meet the relevant requirements of the *Patient Protection and Affordable Care Act*.
- Requests the Governor, through the Secretary of Health and Human Resources, to work with the General Assembly, relevant experts, and stakeholders to provide recommendations for consideration by the 2012 session of the General Assembly regarding the structure and governance of the Virginia Exchange.
- Requires the Governor's recommendations—to be presented to the General Assembly by October 1, 2011—to address:
 - whether to create the exchange within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity;
 - the make-up of a governing board for the exchange;
 - an analysis of resource needs and sustainability of such resources;
 - a delineation of specific functions to be conducted by the exchange; and
 - an analysis of the potential effects of the interactions between the exchange and relevant insurance markets or health programs, including Medicaid.

2011 SB 1366 – Health Benefits Exchange; Intent to Develop

Status: Amended, passed House, and returned to Senate – 2/18/2011

- This measure is similar to the above 2011 HB 2434. The current versions have the same bill summary.
-

WASHINGTON

2011 HB 1740 – Establishing a Health Benefit Exchange

Status: Referred to Senate Health & Long-Term Care Committee – 3/7/2011

- Directs the state to establish a health benefit exchange consistent with the federal Affordable Care Act to be governed by a public-private partnership, with a governing board, whose structure shall be established in legislation by July 1, 2012.
- Requires the Washington State Health Care Authority in consultation with the Joint Select Committee on Health Reform Implementation, to:
 - apply for and implement planning and establishment grants;
 - develop a broad range of options for establishing and implementing a state-administered exchange; and
 - consult with the Insurance Commissioner and stakeholders, including facilities and providers of health care.

2011 HB 1839 – Concerning a Waiver Request for the Preservation of the State's and Health Carriers' Ability to Provide Coverage in the Individual Health Benefits Market

Status: Referred to House Health Care & Wellness Committee – 2/4/2011

- Directs the Insurance Commissioner to submit a waiver request, by January 1, 2012, to the Center for Medicaid and Medicare Services to preserve the state of Washington's ability to provide health coverage to high-risk individuals through the Washington State Health Insurance Pool.
- Requires the waiver request to include:
 - the state shall continue to operate the Washington State Health Insurance Pool;
 - a health carrier shall continue to have the authority to require any person applying for an individual health benefit plan to complete the standard health questionnaire;
 - the health carrier shall continue to have the authority to decide not to accept an application for enrollment if, based on results of the questionnaire, the individual qualifies for coverage under the pool; and
 - individuals enrolled in the pool shall receive the same federal premium subsidies available in the exchange.

2011 SB 5445 – Establishing a Health Benefit Exchange

Status: Referred to House Health Care & Wellness Committee – 3/4/2011

- This measure is a companion of the above 2011 HB 1740. The current versions have the same bill summary.
-

WEST VIRGINIA

2011 HB 3018 – West Virginia Health Benefit Exchange Act

Status: Referred to House Judiciary Committee – 2/7/2011

- Establishes the West Virginia Health Benefit Exchange—as a body corporate and politic that is a governmental instrumentality of the state—within the office of the Insurance Commissioner.
- Establishes a board of directors to oversee the exchange composed of 10 members, one of whom shall represent the interests of health care providers selected by the majority vote of an advisory group comprised of: West Virginia Hospital Association, WV State Medical Association, WV Primary Care Association, WV Nurses Association, WV Society of Osteopathic Medicine, WV Academy of Family Physicians, WV Pharmacists Association, and WV Dental Association.
- Creates a West Virginia Health Benefits Exchange Fund.

2011 SB 408 – Creating WV Health Benefit Exchange Act

Status: Sent to Governor – 3/12/2011

- This measure is similar to above 2011 HB 3018. The current versions have the same bill summary.
-

WYOMING

2011 HB 50 – Health Insurance Exchanges

Status: **SIGNED BY GOVERNOR** – 3/10/2011

- Requires the Governor to:
 - conduct a reconnaissance study of whether to create a Wyoming health insurance exchange or participate in a regional exchange as provided in the *Patient Protection and Affordable Care Act*;
 - pay for the study, to the extent possible, with a federal grant awarded to the state for planning and establishing insurance exchanges; and
 - designate a study oversight task force to conduct the study—which is authorized to contract with outside experts and consultants—to determine whether the exchange will help the operation of the private marketplace, and identify additional work needed to facilitate implementation;
- Creates the Wyoming Health Insurance Exchange Steering Committee, which shall include two representatives from the business community, two from domestic insurance companies, one medical provider, one person representing hospitals, and one person representing consumers.
- Directs the study to consider:
 - the experiences of Utah, Massachusetts, and other states developing and operating exchanges;
 - whether litigation against the federal government for not creating a state exchange is reasonable;
 - if an exchange can facilitate the sale of health insurance across state lines; and
 - if opting-out of the Medicaid program or other federal provisions would affect the ability of other states to join Wyoming in the sale of insurance across state lines.