



Health Insurance Exchanges: Variation in State Efforts

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As state policymakers discuss how to establish health insurance exchanges as provided in federal health reform law, the *Patient Protection and Affordable Care Act* (ACA), questions have risen over what exactly this term means. Although an exchange can take a number of forms and involve a variety of factors, there is consensus over one key element: options.

A health insurance exchange does not *necessarily* provide health insurance coverage but rather offers a menu of health insurance options. This allows health care consumers to not only review the health insurance companies that offer coverage but also compare the details of the plans, including the prices each carrier offers. Both public and private insurers in theory can offer such insurance plans. A requirement that consumers have access to a health insurance exchange—whether national- or state-based—helps consumers make informed choices about their health care coverage by allowing them to make an “apples-to-apples” comparison.

A health insurance exchange can be available to all or can be limited to those without access to employer-sponsored health insurance. This would mostly consist of the self-employed, small business employees, and those who cannot afford private coverage but do not qualify for public programs such as Medicaid. Proponents contend that health insurance exchanges can increase flexibility, portability, and transparency, while lowering cost by enhancing competition.ⁱ

TYPES OF EXCHANGES ⁱⁱ

In addition to “exchange,” other terms used to describe this concept of an organized marketplace include “connector,” “alliance,” “purchasing pool,” “clearinghouse,” “group purchasing arrangements” and “purchasing cooperative.” While each of these terms share the same foundation—providing health insurance options enhances competition and leads to increased rates of coverage and overall lower costs for consumers—the following defines the varying types of exchanges.

- **Passive clearinghouses** are merely “price takers” willing to accept all health plans. In theory, this is a place where employers and individuals can go to find a range of coverage offerings

and compare price, quality, and service levels. Participating plans compete for exchange enrollees based on cost and quality.

Example: [Federal Employees Health Benefit Program](#)*

- **Active purchasers** negotiate and contract with select insurers to provide coverage to large employers, small employers, and/or individuals. When these types of exchanges have existed, a market both within and outside of the exchange seeks to attract the same customers.

Example: [PacAdvantage](#)* and other health insurance purchasing cooperatives / arrangements / alliances

- **Hybrid market organizers** do not directly negotiate prices or selectively contract but may define standard benefit packages, provide some degree of endorsement, and otherwise indirectly encourage health plans to offer high-value coverage.

Example: [Massachusetts Connector](#)*

VARYING COMPONENTS TO EXCHANGES

In addition to the types of exchanges that exist, a multitude of variables can directly affect the success of the exchange. Various combinations have existed, some more sustainable than others. When establishing an exchange, the following factors should be considered.

- **Enrollment eligibility:** Can anyone have access to coverage through the exchange or is access limited to only small employers? Can individuals enroll? Are those with access to employer-sponsored health insurance also able to purchase coverage? Eligibility for enrollment is often limited based on employment status but does not necessarily need to be.
- **Number of insurers:** In order to set up an exchange, designers must determine rules regarding how many insurers can participate and how many plans can be offered. The more carriers involved, the more competitive prices will be. However, too many options could overwhelm consumers.
- **Types of plans:** While some exchanges do not limit what insurers offer, others require a standardized plan. Is there a minimum level of benefits that need to be provided? Also, are the mandated benefit requirements outside of the exchange applicable to plans within the exchange?
- **Regulation:** In addition to mandated benefits, do other insurance requirements fall under the exchange? For instance, are rating factors and rating bands the same for businesses and individuals?
- **Operational issues:** The exchange must be determined as public or private—or something in-between. States may establish an exchange as a nonprofit organization, providing an initial

* Further details of the program provided below.

appropriation with the expectation the exchange will become self-sufficient. Government officials may serve on the board of directors without the entity operating as a governmental body. When determining the organizational structure, one must also consider whether the exchange will be responsible for processing applications, collecting premiums, marketing, outreach education, and website maintenance.ⁱⁱⁱ

- **Risk-adjustment:** In order to prevent the risk of “cherry-picking,” or an imbalance of healthy and unhealthy enrollees, a risk-adjustment plan must be implemented. The plan should create “fair competition by requiring health plans with a disproportionate share of low-risk people to transfer funds to plans with a disproportionate share of high-risk people.”^{iv}
- **Other possible components:** Geographical scope is another potential component. Although an exchange can be available across an entire state, establishing regional exchanges throughout a state is an option.

Often states establish an exchange as part of statewide health insurance reform. This allows the state to institute other mechanisms intended to increase coverage and decrease costs. For instance, in addition to creating the Connector in 2006, the Massachusetts legislature also included a mandate that nearly all individuals residing in the state have health insurance. An exchange can subsidize and expand existing public programs and prohibit the denial of coverage based on preexisting conditions.

FEDERAL HEALTH REFORM

The ACA requires state-based exchanges to be operational by January 1, 2014. The American Health Benefit Exchanges will sell health insurance to qualified individuals, including non-incarcerated U.S. citizens and legal immigrants without access to affordable employer coverage, while the Small Business Health Options Program (SHOP) Exchanges will be comprised of businesses with up to 100 employees.^v In states that opt out of creating their own exchanges, HHS will establish the exchange(s).

Timeline for Implementing Health Insurance Exchanges under the ACA^{vi}

- 2010 - 11:** States create commissions and task forces to advise lawmakers on implementing health insurance exchanges and the national health reform law in general.
- 2011 - 12:** State legislatures convene and adopt bills to create exchanges.
- 2013:** The U.S. Department of Health and Human Services (HHS) certifies individual states prepared to run exchanges—otherwise, HHS will run the exchanges.
- 2014:** The state exchanges open on January 1, as many provisions in the ACA take effect.
- 2014 - 16:** The individual penalty for not having qualified health insurance begins.

Requirements for States

Although states have some flexibility in setting up these exchanges, they, at a minimum, must meet the following requirements (Section 1311 of the ACA):^{vii}

- **Consumer usability and enrollment requirements:** Exchanges must be able to enroll individuals and small businesses in a user-friendly way.

- **Plan certification requirements:** An exchange must be able to certify that plans sold in the exchange meet the standards outlined in the ACA.
- **Consumer and public input:** Exchanges must consult with stakeholders, including educated health care consumers, enrollment experts, small business representatives and self-employed individuals, and advocates with experience enrolling hard-to-reach populations.
- **Transparency:** Exchanges must publish specified financial information and pass annual audits by the Secretary of the U.S. Department of Health and Human Services.
- **Financial stability:** Exchange administration must be self-financing by January 1, 2015 through premiums or other sources. Until then, federal grants are available to help states implement exchanges.

Options for States

The National Association of Insurance Commissioners (NAIC) released [Draft Model Legislation](#) in September 2010, providing options based on the choices states have when establishing an exchange. A National Academy of Social Insurance (NASI) project built upon the work of the NAIC, designing a [Toolkit for State Policymakers](#). The Toolkit includes recommendations for legislative language with alternatives and additions to the NAIC document for state policymakers.

Federal Funding for State Exchanges

The [U.S. Department of Health and Human Services](#) awarded planning grants to help [49 states and the District of Columbia](#) plan for the implementation of health insurance exchanges. These grants of up to \$1 million each will provide states with resources to conduct the research and planning needed to determine how their exchanges will operate to improve the health insurance marketplace. Future funding will support development and implementation activities that states will undertake through 2014. [Alaska](#) was the only state that did not apply for a planning grant. [Minnesota](#) Governor Mark Dayton (D) submitted a delayed application as former Governor Tim Pawlenty (R) barred state agencies from seeking federal grants. HHS approved the state's application in February 2011.

The ACA also created the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services (CMS) of HHS. Although HHS has not yet issued regulations determining state exchange standards, CCIIO published [Initial Guidance to State on Exchanges](#) providing principles and priorities, outlining statutory requirements, clarifying policies, and specifying federal support for the establishment of state-based exchanges.

In February 2011, HHS [awarded](#) Early Innovator grants to six states—Kansas, Maryland, New York, Oklahoma, Oregon, and Wisconsin—and a multi-state consortium led by the University of Massachusetts Medical School. The grants will allow for the design and implementation of the information technology needed to operate exchanges. These states will develop technology that is reusable and transferable to help other states quickly and efficiently adopt a model specific to their needs.

STATE EXAMPLES

Twenty-six states have laws that explicitly permit health insurance purchasing arrangements: Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, and Wisconsin.^{viii} However, not all of these states have taken an active role in establishing exchanges.

States with Established Health Exchanges

Massachusetts

The [Commonwealth Health Insurance Connector Authority](#), known as “the Connector,” was established in 2006 when the state legislature passed system-wide health care reform legislation, which included a mandate that most residents be insured. The state provided the exchange with an initial \$25 million appropriation with the expectation that it will become self-sustaining through retention of premiums.^{ix} The Connector is an independent public entity with a board of directors whose members include state officials and appointees of the governor and attorney general.^x

Through the Connector, individuals with incomes up to 300 percent of the federal poverty level, not eligible for Medicaid or Medicare, and, who do not have access to employer-sponsored insurance, can enroll in plans with premiums based on a sliding income scale. The Connector also provides access to health plans that employers with fewer than 50 employees can purchase, and in which higher-income individuals without an employer-sponsored plan can participate.

New Mexico

In 1994, the state legislature passed [legislation](#) establishing the [New Mexico Health Insurance Alliance](#) to provide increased access to health insurance for small businesses with less than 50 employees and self-employed. The Alliance operates as a nonprofit public corporation and is governed by a board of directors, five of whom carrier members elect and 10 of whom the Governor appoints. All insurance companies covering public employees or retirees in New Mexico are required to participate in the Alliance.

In January 2011, the New Mexico Office of Health Care Reform issued a [report](#) on implementation of planning pursuant to the health benefits exchange planning grant. The report includes recommendations for legislation and regulation needed to bring state law in line with federal mandates and a state exchange planning and implementation work plan and timeline. In December 2010, the Office also published a [Transition Plan](#), providing a history of health reform in the state and plans to begin implementing the ACA.

Utah

Following the enactment of state health system reform legislation, [HB 133 of 2008](#) and [HB 188 of 2009](#), the state Office of Consumer Health Services created the [Utah Health Exchange](#), an internet portal designed to electronically connect consumers with information on the cost and quality of available health insurance programs. Companies choose a fixed amount to contribute towards employee health benefits and employees can contribute pre-tax earnings. The intent of this exchange is to make health care costs more predictable for employers and to increase choice and portability of health care plans for consumers. The health exchange initially was available to a limited number of companies in the small group market with between two and 50 employees. As of January

2010, eligibility expanded to all small businesses in the state, and the exchange will begin taking large employers and individuals in 2011.

During the 2010 legislative session, Governor Gary Herbert (R) signed [SB 294](#), which included provisions giving insurance carriers the option to participate in the defined contribution market on the health insurance exchange but prohibiting carriers not participating in the exchange by January 1, 2011 from joining until January 1, 2013. The measure allows insurance carriers to offer defined benefit products in the traditional market outside the exchange only if the same rating and underwriting practices are used, but carriers cannot treat renewing groups—transitioning between the traditional market and the exchange—as new business, subject to premium rate increases. Small employers can select insurance products in the exchange or in the traditional market outside of the exchange, and effective January 1, 2013, a risk adjuster mechanism will be imposed on the small group market inside and outside of the exchange. The bill requires health care providers to supply consumers with information about prices and clarifies the type of information an insurer must submit to the exchange and to the state Insurance Department. The new law also requires the health insurance exchange to: (1) create an advisory board of appointed producers and consumers; (2) establish electronic standards for delivering the uniform application; and (3) appoint an independent actuary to monitor the risk and underwriting practices of carriers to ensure that these practices are the same inside and outside of the exchange. [SB 459](#) also enacted in 2010 requires greater choice of benefit plans for employers in the defined contribution market of the health insurance exchange.

States in the Process of Establishing an Exchange

California

California was the first state to begin establishing an insurance exchange following the enactment of federal health reform. On September 30, 2010, Governor Arnold Schwarzenegger (R) signed two bills into law. [SB 900](#) creates the California Health Benefit Exchange within the state's government and establishes a board—composed of the Secretary of California Health and Human Services and members appointed by the Governor and the Legislature—to govern the exchange. [AB 1602](#) specifies the powers and duties of the board governing the exchange relative to determining eligibility for enrollment in the exchange and arranging for coverage under qualified health plans. The bill also creates the California Health Trust Fund as a continuously appropriated fund and allows for the development of various requirements on participating plans and insurers. California law prohibits the sale of catastrophic plans and requires all participating insurers to offer plans within four levels of benefits both inside and outside the exchange, which should help to minimize adverse selection.^{xi}

Oregon

[HB 2009 of 2009](#) requires the [Oregon Health Policy Board](#) to develop a health insurance exchange to allow comparison-shopping for insurance plans. At an [October meeting in 2010](#), Board members endorsed moving forward with an innovative health insurance exchange to drive health care system change. Board members agreed that a well-designed exchange can improve access to insurance and health care, increase consumers' ability to compare health plans, and support efforts to improve health care delivery in Oregon. The Board will present recommendations on the structure and governance of the exchange to the legislature in December for discussion in the 2011 session.

Washington

[HB 1569 of 2007](#) established an exchange, the [Health Insurance Partnership](#) (HIP), to help small employers offer affordable, reliable health coverage. [The Health Insurance Partnership Program Development Report](#) issued January 2009 reported that due to a \$5.7 billion budget shortfall forecasted for the state's 2009-2011 Biennium, the Washington State Health Care Authority (HCA) delayed implementation of HIP, not accepting applications for coverage until September 2010 with coverage beginning January 2011. The state was able to continue with the HIP initiative, despite the deficit, after receiving a five-year, \$34.7 million federal grant in October 2009 from the State Health Access Program (SHAP) within the Health Resources and Services Administration (HRSA).

According to the [office of Governor Christine Gregoire](#) (D), over 1,100 employees of small businesses can enroll in the new program and the state will cover program costs for approximately 650 low-income enrollees. The program is open to employers with 50 or fewer employees, providing them with access to the same health insurance coverage available in the small group health insurance market, but at a significant savings. The employer contribution rate within the exchange is only 40 percent of the cost of coverage, compared to the standard 75 percent in the small group market.

States Considering Establishing a Health Insurance Exchange

Colorado

In April 2010, Governor Bill Ritter (D) issued an [executive order](#) creating the [Interagency Health Reform Implementation Board](#) to implement health reform in the state. The Board currently hosts community [health insurance exchange forums](#) to build shared understanding about exchanges, collect input from wide range of stakeholders on best way to structure exchanges, and gather information to develop a "Stakeholder Perspective" report to inform the efforts of the general assembly and new governor during the 2011 session.

Connecticut

Governor M. Jodi Rell (R) issued an [executive order](#), in April 2010, creating the Health Care Reform Cabinet, comprised of commissioners from various state health agencies. The cabinet will develop strategies to implement federal health reform, while building upon existing state health programs and pursuing federal money available for implementation. The cabinet also is responsible for informing state residents on the effects of the ACA, including insurance exchanges and insurance market reforms. The Cabinet's [Insurance Exchange Workgroup](#) issued a [report](#) in September indicating that the state received a \$996,850 federal grant to beginning planning an insurance exchange.

In 2009, the Governor created the [Connecticut Health Care Reform Advisory Board](#) to prepare a set of proposed health care policies in response to federal health care reforms. In the Advisory Board's [final report](#) issued June 2010, exchange-related recommendations focused on consumer choice, plan competition, innovation, quality of care, and cost-control. The Board recommended Connecticut design an exchange that:

- Focuses on individuals and small employers;
- Contracts with other state or private entities, as appropriate;
- Is administered by a quasi-state authority (similar in structure to the Massachusetts Connector);

- Has a multi-stakeholder Board of Directors; and
- Collaboratively works with state agencies and within the state’s regulatory framework to avoid duplication and to enhance interoperability.

Illinois

Governor Pat Quinn’s (D) twelfth [executive order](#) of 2010 created the [Illinois Health Reform Implementation Council](#) and required it to provide recommendations on how the state initially should implement the ACA. The council’s first report—due to the Governor Quinn by December 31, 2010—will include directives on how Illinois should establish a health insurance exchange and other related consumer protection reforms.

Maine

In April 2010, the Maine Legislature created a [Joint Order](#) establishing the [Joint Select Committee on Health Reform Opportunities and Implementation](#), a bi-partisan group of 17 legislators appointed by the speaker of the House and the president of the Senate. The order charges the committee with studying the ACA and determining the state’s role in implementing health reform and potential effects on current state programs and laws. The committee, responsible for consulting with other stakeholders including the Governor’s Office of Health Policy and the Department of Health and Human Services, must submit a report to the legislature by November 2010. [September and October meetings](#) covered policy recommendations from organizations such as the Commonwealth Fund and the National Conference of State Legislators, state-specific information concerning the ACA requirements, and recently-enacted legislation establishing an exchange in California.

Also in April 2010, Governor John Baldacci (D) issued an [executive order](#) creating the [Health Reform Implementation Steering Committee](#), appointing various members of the administration representing the state’s health and insurance agencies, and charging the group to immediately develop a plan for the creation of the State Health Exchange and to coordinate efforts with the legislative Joint Select Committee. The Steering Committee presented [exchange recommendations](#) to the Joint Select Committee on October 20, proposing that the state create two separate exchanges for small businesses and individuals to operate independently or as a quasi-state agency. Maine also should coordinate such efforts with other New England states.

Minnesota

Governor Tim Pawlenty (R) included establishing a statewide health insurance exchange in his [2007 health care reform plan](#). During the 2007 legislative session, the state legislature passed a bill requiring the Department of Health to conduct a study on establishing a health insurance exchange to provide individuals with greater access, choice, portability, and affordability of health insurance products. The Department published the [study’s findings](#) in February 2008, providing nine issues to address before establishing an exchange.

In May 2010, the state legislature passed the 2010 omnibus health and human services bill, which among many things, directed the commissioners of commerce, health and human services to apply for planning grants authorized in the ACA, including those related to the state’s creation of American Health Benefit Exchanges. The commissioners also would need to analyze the advantages and disadvantages to the state planning to have an exchange prior to the federal deadline of January 1, 2014. The Governor vetoed [HF 2614](#), which would cut \$114 million in HHS spending. In his [veto](#)

[message](#), Governor Pawlenty contended the fiscal savings in the bill were not sufficient and disagreed with establishing new hospital surcharges to pay for expanded care. Because the legislative session was nearing the end, the Governor also sighted a lack of global budget agreement as reason not to approve the bill.

Governor Pawlenty ultimately enacted many of the provisions from the vetoed legislation—including those concerning the establishment of a health benefits exchange—as part of the global budget agreement, passed on May 17 during the legislature’s brief special session. [HF 1](#) included additional reductions in spending of approximately \$70 million for state FY 2011. The supplemental budget also included funding and authority for the Governor to apply for early expansion of Medical Assistance for adults without children up to 75 percent FPL.

Mississippi

In January 2008, the Mississippi Center for Public Policy published an [issue brief](#), recommending the legislature establish a statewide health insurance exchange, for which Governor Haley Barbour (R) expressed support in a [March 2008 press release](#). Although legislators introduced several bills during the 2008 and 2009 legislative sessions, the legislature failed to enact legislation on the topic until 2010. Signed by the Governor on April 14, [SB 2554](#) creates a Health Insurance Exchange Study Committee to conduct a study of exchanges as proposed in the ACA and to make implementation recommendations by December 1, 2010.

Nevada

[SB 316 of 2009](#) requires the [Legislative Committee on Health Care](#) to consider the establishment of a health insurance exchange to promote options of insurance products. Following this examination during the 2009-2011 interim, the committee will report recommendations to the Legislature. An [April 21, 2010 meeting](#) included discussion of the benefits of health insurance exchanges and related IT requirements Nevada needs to consider. Other issues for the state to determine include: (1) the number of exchanges; (2) possible partnerships with other states; and (3) federal government involvement. The Division is required to make substantial progress toward a plan for the health insurance exchange by 2013.

North Carolina

The state established eight workgroups through the [North Carolina Institute of Medicine](#) on health care reform which are coordinated by an [Overall Advisory Group](#). The [Health Reform Health Benefits Exchanges and Insurance Oversight Workgroup](#) will meet monthly until August 2011, exploring options to establish a health benefits exchange, providing guidance on insurance oversight and the consumer ombudsman program, and identifying steps needed to coordinate Medicaid and the Health Benefit Exchange.

Pennsylvania

In July 2010, Governor Ed Rendell (D) issued an [executive order](#) creating the Commonwealth Health Care Reform Implementation Committee and the [Commonwealth Health Care Reform Advisory Committee](#). The Implementation Committee is responsible for designing models for exchanges as well as finding technical assistance, preparing a strategic plan for implementation, and identifying necessary legislative action. The implementation committee and the advisory committee will work together to fully implement health reform in Pennsylvania.

The Committee issued a [final report](#) in January 2011 recommending that the state create an exchange with a consumer-oriented mission as an independent public agency or authority governed by a diverse board with clear prohibitions on conflicts of interest and a strong management team. Qualified individuals should be able to access insurance inside and outside the exchange and plans offered in both have the same premiums and are subject to consistent rate review. The group also supports an exchange that has authority to negotiate as an active purchaser to drive the best value for employers and individuals.

Rhode Island

During the 2008 legislative session, Lieutenant Governor Elizabeth Roberts (D) filed legislation to establish a health insurance exchange called HealthHub RI.^{xii} The legislature did not pass [HB 5699](#) but referred it for further study. The committee charged to carry out the study released a [final report](#) in January 2009, reviewing insurance exchange initiatives established in other states and considering several options for Rhode Island. Although legislation introduced during the 2010 legislative session would have established a state exchange, neither [HB 7560](#) nor [SB 2552](#) passed the legislature. Instead, the state Senate passed a resolution ([S 3021](#)), in June 2010, to create a special Senate Commission to study cost containment, efficiency, and transparency in the delivery of quality patient care. The resolution specifically authorizes the commission to study the development and establishment of a state-based health insurance exchange as provided in the ACA.

Separately, to coordinate health reform efforts in the state, the Lieutenant Governor formed a [Healthy RI Task Force](#), encompassing a diverse mix of more than 150 stakeholders—including business owners, insurance brokers, health care providers, and state officials. The Task Force's insurance exchange workgroup consults experts on the Rhode Island insurance markets and the Massachusetts Connector. The incoming governor and General Assembly may choose to build on the group's [work](#), which includes recommendations on facilitating subsidized coverage for low-income individuals and families and improved means for informing consumers on purchasing health insurance.

[Resolution 341](#) enacted in June 2010, establishes a 17-member special Senate commission to study cost containment, efficiency, and transparency in the delivery of quality patient care and access by hospitals. The commission will study cost containment, efficiency, and rate reimbursements, and at its own discretion, the commission also may study the development and establishment of a state-based insurance exchange. The members will present findings and recommendations on the exchanges to the clerk of the Senate no later than May 31, 2011.

Vermont

In May 2010, Governor Jim Douglas (R) allowed [SB 88](#) to become law without his signature, stating he supports cost-containing provisions but does not approve of the bill because the state cannot pursue certain plans until 2017 as required by federal law. The new Vermont law charges the [Health Care Reform Commission](#) with proposing as many as three design options for creating a single system of health care in the state, one of which must be a government-administered and publicly financed single-payer benefits system. Included in the report, due February 1, 2011, must be a comparative analysis on the new federal insurance exchange, as well as a proposal for the state to participate in an exchange established by the ACA.

Posted on the state's [Health Care Reform webpage](#) are the [abstract](#), [project narrative](#), and [workplan](#) for Vermont's HHS State Insurance Exchange Grant Application. Under the grant, Vermont proposed to:

- Analyze the current insurance market to determine the quality and type of health insurance coverage, the appropriate regulatory environment for implementing the exchange, and the potential impacts on the market of various options;
- Assess various exchange organizational models and the policy and fiscal implications of each, as well as resources needed to operate the exchange;
- Model potential funding mechanisms to achieve exchange sustainability; and
- Develop proposed legislation for the 2011 and 2012 sessions.

[HHS](#) awarded Vermont the full \$1 million available to create an American Health Benefit Exchange.

Virginia

On May 14, 2010, the Virginia Secretary of Health and Human Resources [announced](#) the establishment of the [Health Care Reform Initiative](#) (HCRI) to manage activities related to federal health care reform. Serving as the liaison between the governor's office, agencies and entities affected by health care reform, the initiative will lead development of the required health insurance exchange, as well as identify and coordinate grants to fund such efforts.

In December 2010, the [HCRI Advisory Council](#) issued a [report of recommendations](#) concerning the ACA. Included in the recommendations was that the state create and operate its own Health Benefits Exchange (HBE) to preserve and enhance competition. The Governor and legislature should create a process to work through the various issues in detail, with broad stakeholder input, in time for implementation to satisfy the timing requirements of the federal law. Regardless of the specific form, the HBE should:

- provide small employers with an opportunity to be financially successful while providing health insurance to their workers;
- provide a marketplace that works well for those without insurance today;
- provide a marketplace that facilitates the transformation of the delivery system to produce more value per dollar spent, by focusing on quality and transparency;
- be transparent in all things to promote choice, stability and innovation;
- address the cost of health care and competitive disadvantages faced by small firms;
- help educate employees and employers through a user-friendly website;
- engage individuals and employees in their own care as well as in regular wellness and prevention activities;
- maximize effective competition and number of competitors with qualified health plans and ensure absolute transparency about the implications of consumer choices in cost and quality; and
- include long term care insurance.

Above all, the taskforce recommended that Virginia keep it simple, so that small employers and citizens can understand how to use and benefit from the HBE marketplace.

Wisconsin

Governor Jim Doyle (D) issued [Executive Order #312](#) in April 2010 to create the [Office of Health Care Reform](#) led by the Secretary of the state Department of Health Services and the Commissioner of Insurance. The office is responsible for developing a plan that uses national health reform to build on the state's existing programs. The office also is to assess insurance markets reforms to prepare for national health reform, develop a plan to pursue federal funding for implementation, and create a health insurance purchasing exchange.

Posted on the Office's website are the [Guiding Principles for the Wisconsin Exchange](#):

1. **Keep It Simple** – one single website for everyone with concise, easy to understand information about pricing, benefit plans and options;
2. **Bring about Real Change** – make the Wisconsin exchange a vehicle to expand coverage, lower prices, and change the way we pay for health care in our state;
3. **Build off Regional Strengths** – Wisconsin has the benefit of strong regional hospitals and insurance providers;
4. **Focus on Customer Service** – the website must be easy to use, and community partners and insurance brokers should help consumers make informed decisions; and
5. **Coordinate with Existing Health Care Reform Efforts** – take advantage of efforts already underway and seek to not duplicate work.

In January 2011, the state submitted the [first quarterly](#) report to the U.S. HHS as required for a federal exchange planning grant. The report describes market surveys completed for non-group, small group and large group markets and state meetings held with stakeholders. The state also reported on developing an exchange prototype to integrate the exchange with the Medicaid and other state assistance programs.

Wyoming

On March 10, 2011, Governor Matthew Mead (R) signed into law [HB 50](#) 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*—paid for with a federal grant. The Governor will 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.

The measure also 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.

In completing the study, the task force shall 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.

Examples of Failed Exchanges

California's [PacAdvantage](#)

- Established in 1993 by the state legislature as Health Insurance Plan of California (HIPC) with a government loan of \$5.5 million
- Governed by the Managed Risk Medical Insurance Board, a government agency in the Health and Welfare Agency
- Offered health insurance plans to small businesses of two to 50 employees throughout California
- Negotiated premium prices with potential health plans and could elect to not include unsatisfactory plans
- Privatized in 1999 by legislature, changing name to PacAdvantage
- Closed in 2006
- Despite efforts by Governor Schwarzenegger and state legislators until 2008, the state was not able to form another exchange
- An [issue brief](#) released by the California HealthCare Foundation in July 2009 attributes the failure to not being the exclusive source of coverage for that population

Florida's Community Health Purchasing Alliances

- State legislature established 11 alliances throughout the state in 1993
- Enrollment available for self-employed and small employers with up to 50 employees
- Initial funding provided by state but after several years the alliance was expected to be self-financing
- Enrollment peaked at 92,000 in 1998^{xiii}
- Faced resistance from insurance brokers, who made low commissions
- Closed in 2000; insurers withdrew from the program due to an inability to help small businesses pool resources effectively.

North Carolina's Carolinace

- State legislature established six alliances in 1993, providing \$6 million initially
- Each had a governing board of local small-business owners, an executive director, support staff, and a third-party administrator
- Enrollment peaked at 4,300 in 1995
- Closed in the late 1990s because healthy groups purchased less expensive policies outside of the exchange

Texas Insurance Purchasing Alliance

- State legislature established in 1993 as pilot in Houston and expanded to statewide in 1995
- Modeled after California HIPC but organized as a private non-profit corporation, rather than a governmental entity
- Offered coverage to small employers with 3 to 50 employees
- Administered by a participating health plan, Blue Cross and Blue Shield of Texas
- More than 20 health plans participated at some point
- Peak enrollment was about 1,000 firms with 13,000 people total
- Closed July 1999 as it could not remain competitive with policies offered outside of the alliance

Other Examples of Current Exchanges

California Public Employees' Retirement System (CalPERS)

- Public program (state)
- Covers 1.3 million California public employees, retirees, and their families^{xiv}
- Offers three HMO plans, three PPO plans, and three special PPOs – for members of specific employee associations
- Established in 1932 for retirement benefits; began health benefits program in 1967

Connecticut Business and Industry Association's Health Connections

- Private-sector program
- Available to employers with three to 100 employees in Connecticut
- Four participating health insurance companies
- More than 6,000 businesses with 88,000 covered lives participate^{xv}
- Established in 1995

Council of Smaller Enterprises

- Private-sector program
- Available to Northeastern Ohio region employers with less than 100 employees
- 17,000 members (providing several programs in addition to health insurance benefits)
- Established in 1972

Federal Employees Health Benefits Program

- Public program (federal)
- Covers more than 8 million federal employees, annuitants and dependents^{xvi}
- Offers four different types of plans
- The federal Office of Personnel Management negotiates and oversees carrier contracts

Medicare Advantage

- Public program (federal)
- Covers nearly 10 million Medicare beneficiaries (more than one-fifth of Medicare population as of November 2008)^{xvii}
- Allows Medicare enrollees to choose from local HMOs and PPOs, private fee-for-service plans, special needs plans, and medical savings accounts

New York Health Pass

- Nonprofit program founded by City of New York and New York Business Group on Health
- Available to small business and sole proprietors of New York City boroughs and surrounding counties
- Offers 30 different plans from four carriers

State of Wisconsin Group Health Insurance Program

- Public program (state)
- Covers state, local government, and University of Wisconsin employees, retirees, and dependents
- Offers HMO and PPO plans from 16 insurers
- Over 100,000 participants in 2008^{xviii}

NOTES

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- ^{xviii} Wisconsin Department of Employee Trust Funds. [State of Wisconsin Group Health Insurance Fact Sheet 2008](#). November 2008.