State Health Insurance Exchanges: Assessing Rural Implications of Statutes

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Introduction

During 2012, many states took steps to form state-based health insurance exchanges (also referred to as marketplaces[1]) provided for in the Patient Protection and Affordable Care Act (ACA), either through legislation or executive order. The purpose of the new exchanges is to ease the process of purchasing and enrolling in health plans, and to increase access to affordable health insurance for individuals, households, and small employers. These will be the exchanges through which low-income households can purchase individual/family insurance and gain access to tax credits to subsidize premiums. States establishing the Small Business Health Options Program will be managing the market for small firms to select health plans and for those who are eligible to receive tax credits toward premium costs. In early 2013 nine states (Arkansas, Delaware, Illinois, New Hampshire, Iowa, Michigan, Ohio, South Dakota, and Virginia) applied to participate as partners in federally facilitated exchanges.

This paper examines the elements of state-based exchanges using the rubric established by a previous RUPRI Center paper[2] and the implications of those elements for rural health care markets. When we began analyzing state plans for this paper, 15 states (and the District of Columbia) had taken the initial steps to set up a state-based marketplace. Subsequently (on January 3, 2013), the Center for Consumer Information & Insurance Oversight in the Centers for Medicare & Medicaid Services (CMS) announced that 17 states were conditionally approved to operate health insurance exchanges, including the states used in this analysis.[3] West Virginia enacted a statute in 2011 but has not chosen to create a state exchange, so we did not include that state in this analysis, leaving the 14 states listed in the appended tables. Minnesota and New Mexico are not included in our analysis because they had not yet established the exchange by statute or executive order. Given the rural interests of this paper, we excluded the District of Columbia from the analysis.

Key Findings

- Standards requiring that exchanges contract with Qualified Health Plans (QHPs) to provide an "optimal combination of choice, value, quality, and service" (see examples within California and Rhode Island statutes) could result in improved insurance markets in rural areas.
- Two states (Oregon and Hawaii) require geographic diversity among members of the exchange governing boards.
- Four states (Massachusetts, Oregon, Vermont, and Utah) require community-based activities to facilitate consumer enrollment into QHPs through the exchange; Massachusetts specifically requires outreach activities that target persons "who may require individualized support due to geography."
- All statutes and executive orders that we analyzed incorporate the network adequacy standards as stated in the ACA and subsequent regulations issued by CMS, which could require contracting with rural providers.

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[1] In materials implementing federally-facilitated exchanges and engaging the public in the process of enrolling for insurance, the terminology is changing from "exchanges" to "marketplaces" to convey the use of information to select an insurance plan.

[2] Garter B, Mueller KJ. (2012). Affordable Insurance Exchanges and Enrollment: Meeting Rural Needs. Paper No. 2012-1. RUPRI Center for Rural Health Policy Analysis. January. http://cph.uiowa.edu/rupri/publications/policypapers/Exchanges%20Summary%20FINAL.pdf

[3] "State Health Insurance Exchanges" accessed January 17, 2013: http://www.cciio.cms.gov/resources/factsheets/state-exchanges.html

Overview

Following on earlier work published by the RUPRI Center, this paper is organized using five key characteristics of exchanges that would have the most effect on rural populations and locations: (1) market function, (2) governance, (3) enrollment, (4) access standards, and (5) certifying Qualified Health Plans (QHPs). This paper addresses each characteristic below. The characteristics and rural implications as developed in the first paper are available as a one-page summary.[4] A previous RUPRI Center paper on rural considerations in developing exchanges included two characteristics that are not included in this paper—insurance plan and exchange boundaries, and the Small Business Health Options Program. We did not include these characteristics because states have not pursued separate considerations of either beyond what is embedded in the other five characteristics.

1. Market Function

As the RUPRI Center has previously said, state approaches to establishing an exchange will fall within a range of options that are characterized at one end by instructing a governing body to establish detailed, prescriptive criteria to use in certifying qualified health plans (QHPs), and at the other end by instructing the administrative unit managing the exchange to certify all QHPs that meet minimum standards specified in federal rules. The first option, using the new exchanges as a means to influence the structure of the market, could help ensure that plans available to rural residents meet expectations related to total out-of-pocket costs, provider networks, and proximity to services. The other end of the range of options, following the non-intrusive approach of letting all plans that meet minimum standards, as set in federal regulations, sell through the exchanges, may increase the number of choices available to rural residents, including a wider range of premiums and total out-of-pocket costs.

Most states' enabling legislation or executive orders do not specify requirements of QHPs, leaving those determinations to governing bodies and administrative committees. However, some states have specified QHP requirements (sources of the quoted passages below are in the Appendix):

- California's exchange board must contract with carriers "that offer the optimal combination of choice, value, quality, and service."
- Rhode Island also requires the "optimal combination of choice, value, quality, and service."
- In Oregon, QHPs must provide, at a minimum, "essential health benefits and have acceptable consumer and provider satisfaction ratings."
- Connecticut and Oregon authorize the governing body to limit the number of QHPs while ensuring that individuals and employers have "an adequate number and selection of choices."
- Vermont states an intent to "provide, as a public good, comprehensive, affordable, high-quality publicly financed health care coverage for all Vermont residents in a seamless manner regardless of income assets, health status, or availability of other health coverage."

States that establish exchanges with the intent of keeping QHP requirements minimal may simply set general goals to provide access to plans, or may state general parameters for QHPs to meet, which may become more specific as policies become operational:

- Hawaii establishes a connector for the purpose of "facilitating the purchase and sale of qualified plans and qualified dental plans." And while the commissioner determines eligibility for

[4] "Affordable Insurance Exchanges: A Summary of Characteristics and Rural Implications." Summary of Paper No. 2012-1. January 2012. http://cph.uiowa.edu/rupri/publications/policypapers/Exchanges%20Summary%20FINAL.pdf

inclusion, “all qualified plans and qualified dental plans that apply for inclusion shall be included in the connector.”

- Utah establishes a plan to increase “the number of affordable health insurance policies available.”

Rural Implications

States that aim to achieve choice among competing QHPs that vary in price and benefits, along with value, quality, and service, should develop measures that apply to different places within the state. Thus, comparability of choices (including characteristics of plans) across places could be achieved by comparing QHP performance in large urbanized, micropolitan, and rural areas. The same approach can be taken to determine if the exchange goals of increasing choices among plans for residents of the state do so regardless of where those residents live. Oregon’s inclusion of measures of consumer and provider satisfaction provides yet another opportunity for comparisons, and for assessment of differences that might occur as a result of provider-QHP relationships that differ because of provider type (e.g., health profession, independent practices) and place (which could affect network affiliation).

2. Governance

The RUPRI Center’s previous paper describing rural considerations in designing exchanges suggested there could be different implications to choosing a private versus a governmental structure. However, the states profiled in this document, except for Hawaii, which established a “connector” not as an agency of the State, have opted to create either a governmental or quasi-governmental (Oregon and Colorado created exchanges as unincorporated public entities performing governmental functions) entity to govern the exchanges. Therefore, we focus on the composition of the governing body, setting aside considerations of private versus governmental. Nearly all states require that individuals with specific expertise be included on the governing body, sometimes matching the expertise to source of appointment (e.g., the governor in Connecticut appoints experts in health insurance coverage of individuals and small employers). Areas of specific expertise typically include the following:

- Health care finance
- Health benefit administration
- Health economics
- Health care professionals
- Health care facilities

A few types of expertise are less common:

- Public or private health care system administration (California)
- Information technology (Colorado)
- Federally qualified health center (Hawaii)
- Labor management (Hawaii)
- Public health research (Maryland)

Several states also require consumer membership on the governing body, without specifying the type of consumer (e.g., individuals seeking insurance through the exchange, or representatives of particular demographic groups or communities).

Rural Implications
Any of the required experts or consumer representatives could represent rural interests. Individuals with expertise in health care finance, health economics, and public health research, because of their professional inclination to examine impacts on the general population and different subgroups, might be more likely than others to consider rural implications of decisions made by the governing body, and could consider differential impacts of decisions. More direct means of ensuring that rural effects are considered include statutory requirements that the governing body, as is done in just two of the state documents reviewed in this paper, "to the greatest extent practicable, represent the geographic, ethnic, gender, racial and economic diversity of this state" (Oregon); or in the unique case of Hawaii, that a health care provider from "a neighbor island" be part of the governing body. Another direct approach would be to require that rural interests be included in any deliberations.

3. Enrollment
Statutes and executive orders creating state exchanges enumerate the duties and responsibilities of those entities, which include facilitating enrollment into QHPs. However, much of the detail regarding how exchanges will function, and how navigators under contract to exchanges will reach individuals and small employers eligible to enroll through exchanges, remains to be determined. The general language of statutes may indicate the extent to which specific efforts will be undertaken to reach out to all populations in a state, including sparsely populated remote rural areas. The most common approach is a general statement of responsibility to ensure that the general public has the opportunity to enroll in QHPs through the exchanges:

- "Raise awareness of the availability of qualified health plans sold through the exchange" (Connecticut)
- "Connecting consumers to the information necessary to make informed health care choices" (Hawaii)

States may focus specifically on giving consumers access to information through an electronic portal (e.g., Colorado), enabling electronic purchase (Hawaii), or creating a transparent market (e.g., Nevada). All states describe contracting with navigators to execute the tasks of consumer education and enrollment, and four states provide for working with community-based groups.

Rural Implications
Enrollment strategies may be designed explicitly for rural communities. One approach for doing so combines the provisions requiring consumer education about all options with a requirement that each region of the state have a minimum number of choices. For example, in California, according to the state statute, each region should have a choice in each of the five levels of coverage specified in the ACA, Section 1302, subdivisions (d) and (e). States may also require that exchanges work with partners that reach into rural communities:

- "Facilitate community-based assistance" (Oregon)
- "Involve community partners, insurance agents and producers, community-based service organizations" (Utah)
- "Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals" (Vermont)

Finally, states could be very direct in stating that enrollment assistance and outreach activities may target individuals "who may require individualized support due to geography" (Massachusetts).

4. Access Standards

Adequate access to health care services includes both affordability and availability. The former is addressed through ensuring choices of QHPs with varying direct (out-of-pocket) consumer costs, and the latter through access standards imposed on QHPs. Enabling legislation and executive orders analyzed for this paper do not incorporate access standards beyond affirming that the exchanges will enforce the federal standards as specified in Section 1311(c)(1) of the ACA and Section 156.230 of the Final Rule published in March 2012 (45 CFR Parts 155, 156, and 157) that implements that section. In addition to the standards imposed by the federal regulations, QHPs would have to adhere to insurance plan standards already in place in each state, which could specify network adequacy and/or contracting with essential community providers (required in Section 155.1050 of the federal regulation).

State statutes and executive orders include goals of providing affordable choices for those enrolling through exchanges (e.g., Colorado), and general goals of providing access to insurance choices (e.g., Hawaii, New York). Four states (California, Connecticut, Maryland, and Oregon) require considering the needs of hard-to-reach populations, but without specifying the characteristics, such as geography or limited access to broadband services, that make them hard-to-reach.

Rural Implications

As state exchanges develop more specific definitions of hard-to-reach populations, there may be opportunities to focus on rural populations, especially those in sparsely populated and/or remote areas. Rural residents will benefit from having full information about all consumer costs for a range of affordable insurance options, especially if there is much market segmentation based on geographic rating and/or provider networks. Exchanges may require detailed information about the cost-sharing provisions in each QHP, similar to the law enacted in Connecticut: “permit individuals to learn … the amount of cost-sharing, including deductibles, copayments and coinsurance ... that such individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider.” State exchanges may want to follow the lead of the Colorado statute, which says the exchange board shall “consider the unique needs of rural Coloradans as they pertain to access, affordability, and choice in purchasing health insurance.” That comprehensive statement would include development of state-specific network adequacy standards that go beyond the general statements in the federal regulations.

5. Qualified Health Plans

Each state is required to certify that health plans meet the minimum requirements in the ACA and the subsequent CMS regulation published in the *Federal Register* on March 27, 2012 (45 CFR Parts 155, 156, and 157). In order to determine the quality of health plans, exchanges will need to conduct consumer satisfaction surveys and may have to decertify plans in order to ensure sustained quality of the health plans offered through the exchange. Most of the statutes and executive orders reviewed for this paper simply stated that the state exchanges would certify QHPs using the criteria described in the ACA, as specified in CMS regulations. Some statutes lay out more conditions for certification, including that carriers offer plans at the various levels of actuarial value (e.g., Maryland) or that consumer and provider ratings be “acceptable” (e.g., Oregon). Vermont includes more extensive duties, requiring its commissioner to consider the plan’s “promotion of high-quality care, prevention, and wellness” and “promotion of access to health care.” Maryland, in requiring that QHPs meet the standards of the ACA, provides more specificity, to include “network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health plan performance.”

Rural Implications
As of the time of this analysis, states had not gone far beyond the requirements in the ACA and CMS regulations. To the extent more details were provided, they were general standards measuring the quality of plans and adequacy of offerings for consumer choice. As more detailed standards are written and applied, there could be implications for ensuring equity of choices across urban and rural areas of each state.

Conclusion

In this paper, we captured state activities at a point prior to when detailed blueprints for state exchanges were becoming available. The chief value of the paper is to illustrate how, across five areas of consideration, the interest of rural populations might be best served by state exchanges. The full effect of each state's legislative and/or executive requirements for its exchange will not be apparent until enrollment begins in October 2013 and coverage begins in 2014. The RUPRI Center will continue to monitor the design of state exchanges, focusing on the 17 states that have committed to having operational state exchanges in time for enrollment in late 2013. We will also monitor the development of federally facilitated exchanges, which include state-federal partnerships.

Appendix: Relevant Passages of State Statutes or Executive Orders, Retrieved as of December 1, 2012

Market Function			
State	**Market Type**	**Statutory/Executive Order Language**	**Citation**
California	Active Purchaser	"In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following: . . . Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."	A.B. 1602 Ch. 655 § 7(c) (Ca. 2010)
Colorado	Clearing House	"The board shall: (k) investigate requirements, develop options, and determine waivers, if appropriate, to ensure that the best interests of Coloradans are protected."	S.B. 11-200 § 10-22-106 (1)(k) (Co. 2010)
Connecticut	Active Purchaser	"The exchange is authorized and empowered to: (16) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided individuals and employers have an adequate number and selection of choices;"	S.B. No. 921 § 5(c)(16) (Ct. 2010)
Hawaii	Clearing House	"The connector shall serve as a clearinghouse for information on all qualified plans and qualified dental plans listed or included in the connector."	Hawaii Health Insurance Exchange Act, S.B. 1348, 26th Leg. §3(2)(c) (2011)
Kentucky	Not Addressed	N/A	N/A
Maryland	Board Will Determine	The Exchange shall "make qualified health plans available to qualified individuals and qualified employers"	HB 166 31-108 (B) (1)
Massachusetts	Active Purchaser	"The purpose of the board of the connector shall be to implement the commonwealth insurance connector. The goal of the board is to facilitate the purchase of health care insurance products through the connector at an affordable price by eligible individuals, groups and commonwealth care health insurance plan enrollees. For these purposes, the board is authorized and empowered as follows: . . . establish procedures for the selection of and the seal of approval certification for health benefit plans to be offered through the connector."	An Act Providing Access to Affordable, Quality, Accountable Health Care, Chapter 176Q § 3(a)(3) (Ma. 2006)
Nevada	Board Will Determine	"The Board of Directors of the Silver State Exchange shall adopt a plan for the implementation and operation of the Silver State Health Insurance Exchange and shall submit the plan to the Governor and the Legislature."	S.B. No. 440 § 30 (Nev. 2010)
New York	Not Addressed	N/A	N/A

Market Function			
State	**Market Type**	**Statutory/Executive Order Language**	**Citation**
Oregon	Active Purchaser	"The Oregon Health Insurance Exchange Corporation shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings. The corporation may limit the number of qualified health plans that may be offered through the exchange as long as the same limit applies to all insurers."	S.B. 99-A § 11(4), 76th Oregon Leg. (Or. 2011)
Rhode Island	Active Purchaser	"The [Rhode Island Health Benefits Exchange] RIHBE shall have the discretion to determine whether health plans offered through the Exchange are in the interests of qualified individuals and qualified employers. The RIHBE shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."	Exec. Order No. 11-09, 6 (RI, Sept. 19, 2011)
Utah	Clearing House	"The state's strategic plan for health system reform shall include consideration of the following: . . . Increasing the number of affordable health insurance policies available to a person responsible for obtaining health insurance under Subsection (8)(a) by creating a system of subsidies and Medicaid waivers that bring more people into the private insurance market."	H.B. 133 § 12(10)(a), (Ut. 2008)
Vermont	Active Purchaser	"It is the intent of the general assembly to create Green Mountain Care to contain costs and to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health coverage."	H.202 No. 48 § 1(a) (Vt. 2011)
Washington	Not Addressed	"The authority in collaboration with the joint select committee on health reform implementation and the board, shall develop a broad range of options for operating the exchange and report the options to the governor and the legislature on an ongoing basis. The report must include analysis and recommendations on the following: . . . (e) Certifying, selecting, and facilitating the offer of individual and small group plans through an exchange, to include designation of qualified health plans and the levels of coverage for the plans;"	S.B. 5445 § 5 (2)(e), 62nd Leg. (Wa. 2011)

Governance		
State	**Pertinent Language**	**Citation**
California	2 appointed by Governor; 1 appointed by Senate Rules Committee; 1 appointed by Assembly Speaker (5 total). Ex-officio Members: Secretary of Health and Human Services. Conflict of Interest Provisions: Members cannot be affiliated with carrier or insurer, agent or broker, provider, facility or clinic, or trade association for these entities; cannot be a provider paid for services rendered or have ownership interest in health care practice. Expertise: Each person appointed to the board shall have demonstrated and acknowledged expertise in at least two of the following areas: • Individual health care coverage • Small employer health care coverage • Health benefits plan administration • Health care finance • Administering a public or private health care delivery system • Purchasing health plan coverage	S.B. 900 § 2 (Ca. 2010)
Colorado	5 appointed by Governor; 1 each appointed by President of Senate, Majority and Minority Leader of Senate, Speaker of House, Minority leader of House (12 Total). Ex-officio Members: Executive Director of Department of Health Care Policy and Financing, Commissioner of Insurance, and Director of the Office of Economic Development and International Trade. Conflict of Interest Provisions: Majority of voting members cannot be directly affiliated with insurance industry; cannot be state employee; cannot participate in Exchange activities in which they have financial interest.	S.B. 11-200 § 10-22-105 (Co. 2010)
Connecticut	2 appointed by Governor with expertise in health insurance coverage of individuals and small employers; 1 health care finance specialist appointed by Senate President; 1 health benefit administration specialist appointed by Speaker of the House; 1 expert in health care delivery appointed by Senate Majority Leader; 1 health economist appointed by House Majority Leader; 1 expert in health care access for the self-employed appointed by Senate Minority Leader; 1 specialist in barriers to individual health care coverage by House Minority Leader (14 Total). Ex-officio Members: Commissioner of Social Services, Special Advisor to the Governor on Healthcare Reform, Secretary of the Office of Policy and Management, Insurance Commissioner, Commissioner of Public Health, and the Healthcare Advocate. Conflict of Interest Provisions: Members cannot be affiliated with an insurer, insurance producer or broker, provider, facility or clinic, or trade association for these entities; cannot be a provider paid for services rendered or have ownership interest in health care practice; are prohibited from working for a carrier that offered a plan through the Exchange for the year after serving on the Board; and must abstain from deliberation, action, or vote when they have financial interest in the issue.	S.B. No. 921 § 2(a)-(b)
Hawaii	11 appointed by Governor with the following affiliations: 3 insurance plans, 1 provider group located on a neighbor island, 1 hospital trade association, 1 health care consumer, 1 labor management, 1 native Hawaiian health care organization, 1 federally qualified health center, 1 business, 1 from health information exchange (15 Total, interim board until 15 member board is chosen by July 12, 2012). Ex-officio Members: Director of Health, Director of Human	Hawaii Health Insurance Exchange Act, S.B. 1348, 26th Leg. § 4 (2011)

Governance		
State	Pertinent Language	Citation
	Services, Director of Labor and Industrial Relations, and Director of Commerce and Consumer Affairs. Conflict of Interest Provisions: To be decided by Board; members must recuse themselves from matters in which they have financial interest before joining Board.	
Kentucky	8 appointed by Governor with the following affiliations: 1 insurer, 1 insurance agent, 1 non-facility based health care provider, 1 facility based health care provider, 1 small business, 1 individual purchaser of health plans, and 2 consumer representatives.	Exec. Order 2012-587 § II (Ky. July 17, 2012)
Maryland	Appointed by Governor with 3 representing employers and individuals using Exchange and 3 with specific expertise (9 Total). Ex-offico Members: Secretary of Health and Mental Hygiene, Commissioner of Insurance, and Executive Director of the Maryland Health Care Commission. Conflict of Interest Provisions: Members cannot be affiliated with carrier, insurance producer, third-party administrator, managed care organization, person contracting with Exchange, or trade associations for these entities.	H.B. 166 § 31-104 (Md. 2011)
Massachusetts	4 appointed by Governor with following affiliation or expertise: actuary, health economist, small business, underwriter; 3 by attorney general representing employee health benefits plan specialists, health consumer organizations, organized labor (11 Total). Ex-offico Members: Secretary for Administration and Finance, Director of Medicaid, Commissioner of Insurance, Executive Director of the Group Insurance Commission. Conflict of Interest Provisions: Appointees cannot be employee of carrier.	An Act Providing Access to Affordable, Quality, Accountable Health Care, Chapter 58 § 3 (Ma. 2006)
Nevada	5 appointed by Governor; 1 appointed by Senate Majority Leader; 1 appointed by Speaker of Assembly (10 Total). Ex-officio Members: Director of Department of Health and Human Services, Director of Department of Business and Industry, and Director of Department of Administration. Conflict of Interest Provisions: Voting member cannot be legislator, elected official in state government, state or municipality employee, or affiliated with health insurer. Expertise: Each member must have expertise in one of the following areas: • Individual or small employer insurance market • Health care administration, health care financing or health information technology • Administration of health care delivery systems • Experience as a consumer • Experience as a consumer advocate	S.B. No. 440 (Nev. 2010)
New York	Not Addressed in Executive Order	
Oregon	7 appointed by Governor, at least 2 must be individual or small employer consumers of the Exchange (9 Total). Ex-offico Members: Director of Oregon Health Authority and Director of Department of Consumer and Business Services. Conflict of Interest Provisions: No more than 2 appointed members can be affiliated with: insurer or third-party administrator; insurance producer; health care provider, facility, or clinic; or trade association for these parties. Members must declare any conflicts of interest and abstain from voting on those issues.	S.B. 99-A § 4, 76th Oregon Leg. (Or. 2011)
Rhode Island	13 Member board. Conflict of Interest Provisions: Board members cannot be affiliated with any insurer, agent, broker or provider.	Exec. Order No. 11-09, 4 (RI, Sept. 19, 2011)
Utah	Not Addressed in Legislation	

Governance		
State	Pertinent Language	Citation
Vermont	Existing Agency (The Deputy Commissioner of the Department of Health Access): 5 appointed by Governor (5 Total). Ex-officio Members: None. Conflict of Interest Provisions: Members cannot be affiliated with entities supervised or regulated by the Board, except for health care practitioners; cannot participate in issue in which member or members family has financial interest; cannot discuss future employment or appear before the Board of other state agency on behalf of person subject to supervision or regulation of Board in year after leaving the Board	H.202 No. 48 § 9374(a)(1) (Vt. 2011)
Washington	9 appointed by Governor with 4 selected from nominees submitted by House and Senate (representing employee benefit specialist, health economist or actuary, consumer advocate, small business), 4 with specific expertise, and Board Chair to vote only as tie-breaker (11 Total). Ex-offico Members: Commissioner of Insurance and Administrator of Health Care Authority. Conflict of Interest Provisions: Members cannot be appointed if board decisions benefit their own financial interests or financial interests of entity they represent.	S.B. 5445 § 3, 62nd Leg. (Wa. 2011)

Enrollment		
State	**Pertinent Language**	**Citation**
California	"The board shall . . . (k) Undertake activities necessary to market and publicize availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake to outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency."	AB 1602 § (3)(k)
Colorado	"Each person appointed to the board should have demonstrated expertise in at least two, and in any case shall have demonstrated expertise in no less than one, of the following areas . . . Healthcare consumer navigation or assistance."	S.B. 11-200 § 10-22-105 (b)(VIII) (Co. 2010)
Connecticut	"The exchange shall establish a Navigator grant program that shall award grants to certain entities to market the exchange for the purposes of:(1) Conducting public education activities to raise awareness of the availability of qualified health plans sold through the exchange; (2) distributing fair and impartial information concerning enrollment in qualified health plans; (3) distributing fair and impartial information about the availability of premium tax credits and cost-sharing reductions pursuant to the Affordable Care Act; (4) facilitating enrollment in qualified health plans; (5) referring individuals with a grievance, complaint or question regarding a plan, a plan's coverage or a determination under a plan's coverage to the Office of Healthcare Advocate or any customer relations unit established by the exchange; and (6) providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange."	S.B. No. 921 § 9(b)(1-6) (Ct. 2010)
Hawaii	"The purposes of the connector shall include: (1) Facilitating the purchase and sale of qualified plans and qualified dental plans; (2) Connecting consumers to the information necessary to make informed health care choices; and (3) Enabling consumers to purchase coverage and manage health and dental plans electronically."	Hawaii Health Insurance Exchange Act, S.B. 1348, 26th Leg. § 3(2)(b) (2011)
Kentucky	"Whereas, the Patient Protection and Affordable Care Act . . . And the regulations promulgated there under require the establishment of an American Health Benefit Exchange ("Exchange") for every state in America for purposes of: . . . 2. Assisting qualified small employers in the Commonwealth in facilitating the enrollment of their employees in qualified health plans offered in the small group market; 3. Providing one-stop shopping by helping eligible individuals enroll in qualified health plan offered through the Exchange or coverage through other federal or state health care programs."	Exec. Order 2012-587 (Ky. July 17, 2012)
Maryland	"On or before January 1, 2014, in compliance with § 1311(D)(4) of the Affordable Care Act, the Exchange shall: . . . (17) establish a Navigator Program in accordance with § 1311(I) of the Affordable Care Act and any requirements established under this title."	H.B. 166 § 31-108 (B)(17) (Md. 2011)
Massachusetts	"Funds shall be awarded as grants to community and consumer-focused public and private nonprofit groups to provide enrollment assistance, education and outreach activities directly to consumers who may be eligible for MassHealth or subsidized health care coverage, and who may require individualized support due to geography, ethnicity, race, culture, immigration or disease status and representative of communities throughout the commonwealth; provided further, that funds shall be allocated to provide informational support and technical assistance to recipient organizations and to promote appropriate and effective enrollment activities through the statewide health access network;"	An Act Providing Access to Affordable, Quality, Accountable Health Care, Chapter 58 § 104 (Ma. 2006)

Enrollment		
State	**Pertinent Language**	**Citation**
Nevada	"The Silver State Health Exchange is hereby established to: 1. Facilitate the purchase and sale of qualified health plans in the individual market in Nevada; 2. Assist qualified small employers in Nevada in facilitating the enrollment and purchase of coverage and the application for subsidies for small business enrollees; 3. Reduce the number of uninsured in Nevada; 4. Provide a transparent marketplace for health insurance and consumer education on matters relating to health insurance; and 5. Assist residents of Nevada with access to programs, premium assistance tax credits and cost-sharing reductions."	S.B. No. 440 § 13 (Nev. 2010)
New York	Not mentioned in the Executive Order	
Oregon	"The duties of the Oregon Health Insurance Exchange Corporation are to: (j) Facilitate community-based assistance with enrollment in qualified health plans by awarding grants to entities that are certified as navigators as described in 42 U.S.C. 18301(i)."	S.B. 99-A § 3(1)(b)(C)(j), 76th Oregon Leg. (Or. 2011)
Rhode Island	Not mentioned in the Executive Order	
Utah	"The department, including the Division of Health Care Financing within the department shall: . . . Involve community partners, insurance agents and producers, community based service organizations, and the education community to increase enrollment of eligible employees and individuals in Utah's Premium Partnership for Health Insurance and the Children's Health Insurance Program;"	H.B. 133 § 1(4)(b), (Ut. 2008)
Vermont	"Navigators shall have the following duties: (1) Conduct public education activities to raise awareness of the availability of qualified health plans; (2) Distribute fair and impartial information concerning enrollment in qualified health benefit plans and concerning the availability of premium tax credits and cost-sharing reductions; (3) Facilitate enrollment in qualified health benefit plans, Medicaid, Dr. Dynasaur, VPharm, VermontRX, and other public health benefit programs; (4) Provide referrals to the office of health care ombudsman and any other appropriate agency for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage; (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Vermont health benefit exchange; and (6) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, VermontRX, other public health benefit programs, or the Vermont health benefit exchange in order to ensure that all eligible individuals are enrolled."	H.202 No. 48 § 1807 (Vt. 2011)
Washington	"The authority in collaboration with the joint select committee on health reform implementation and the board, shall develop a broad range of options for operating the exchange and report the options to the governor and the legislature on an ongoing basis. The report must include analysis and recommendations on the following: . . . (f) The role and services provided by producers and navigators, including the option to use private insurance market brokers as navigators."	S.B. 5445 § 5 (2)(f), 62nd Leg. (Wa. 2011)

Access Standards		
State	**Pertinent Language**	**Citation**
California	"The board shall: Consult with stakeholders relevant to carrying out the activities under this title, including, but not limited to . . . Advocates for enrolling hard-to-reach populations."	A.B. 1602 Ch. 655 § 7(t)(5) (Ca. 2010)
Colorado	"The board shall: (i) Consider the unique needs of rural Coloradans as they pertain to access affordability, and choice in purchasing health insurance."	S.B. 11-200 § 10-22-106 (1)(i) (Co. 2010)
Connecticut	"The exchange shall: . . . (22) Consult with stakeholders relevant to carrying out the activities required under sections 1 to 13, inclusive, of this act, including, but not limited to: . . . (E) Advocates for enrolling hard-to-reach populations;"	S.B. No. 921 § 6(22)(E) (Ct. 2010)
Hawaii	"The intent of the health insurance exchange is to reduce the number of uninsured individuals, provide a transparent marketplace, conduct consumer education, and assist individuals in gaining access to assistance programs, premium assistance tax credits, and cost-share reductions."	Hawaii Health Insurance Exchange Act, S.B. 1348, 26th Leg. §2 (2011)
Kentucky	Not addressed in Executive Order	
Maryland	"The State intends to ensure that all populations can access the products offered by the Exchange by requiring cultural competence in all of its operations and outreach;" and "To carry out the purposes of this title the board shall: . . . Appoint to the committees representatives of . . . Consumers, including individuals who: belong to other hard-to-reach or special populations."	H.B. 166 § 31-104 (Md. 2011), S.B. 182 § 31-106(G)(2)(IX)(3)
Massachusetts	"There shall be in the division of insurance a health care access bureau overseen by a deputy commissioner for health care access, whose duties shall include, subject to the direction of the commissioner of insurance, administration of the division's statutory and regulatory authority for oversight of the small group and individual health insurance market, oversight of affordable health plans, including coverage for young adults, as well as the dissemination of appropriate information to consumers about health insurance coverage and access to affordable products."	An Act Providing Access to Affordable, Quality, Accountable Health Care, Chapter 58 § 7A (Ma. 2006)
Nevada	"The Silver State Health Exchange is hereby established to: . . . 5. Assist residents of Nevada with access to programs, premium assistance tax credits and cost-sharing reductions."	S.B. No. 440 § 13 (Nev. 2010)
New York	"Whereas, the implementation of a Health Benefit Exchange and other reforms in New York will: (1) result in lower premiums for individuals and small businesses; (2) allow individuals and small businesses purchasing coverage through such Exchange to receive $2.6 billion in federal tax credits and cost sharing subsidies; and (3) provide one million additional New Yorkers access to affordable, comprehensive health insurance, reducing the percentage of New Yorkers who are without health insurance;"	Exec. Order No. 42, Establishing the New York Health Benefit Exchange (April 12, 2012)
Oregon	"The Oregon Health Insurance Exchange Corporation board of directors shall establish an Individual and Employer Consumer Advisory Committee for the purpose of facilitating input from a variety of stakeholders on issues related to the duties of the corporation, the operation of the health insurance exchange and related issues. The board shall determine the membership, terms, and organization of the committee and shall appoint the members. Members of the committee shall be representative of: . . . (e) Organizations that help individuals to enroll in health plans through the exchange, including insurance producers and advocates for hard-to-reach populations."	S.B. 99-A § 7(e), 76th Oregon Leg. (Or. 2011)
Rhode Island	"The RIHBE shall establish and operate an Exchange to provide benefits for persons lacking adequate insured coverage and to lower costs to improve the quality, availability and accessibility of health services."	Exec. Order No. 11-09 § 2 (RI, Sept. 19, 2011)

Access Standards		
State	**Pertinent Language**	**Citation**
Utah	"This bill amends the Insurance Code and the Governor's Office of Economic Development Code to expand access to the health insurance market, increase market flexibility, and provide greater transparency in the health insurance market."	H.B. 188 (Ut. 2008)
Vermont	"The general assembly adopts the following principles as a framework for reforming health care in Vermont: (1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting."	H.202 No. 48 § 3 (Vt. 2011)
Washington	"The exchange is intended to: (a) Increase access to quality affordable health care coverage, reduce the number of uninsured persons in Washington state, and increase the availability of health care coverage through the private health insurance market to qualified individuals and small employers."	S.B. 5445 § 1, 62nd Leg. (Wa. 2011)

Qualified Health Plans		
State	**Pertinent Language**	**Citation**
California	"In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following: (c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers."	A.B. 1602 Ch. 655 § 7(c) (Ca. 2010)
Colorado	Not mentioned in Statute	
Connecticut	"(a) The exchange may certify a health benefit plan as a qualified health plan if: (1) The plan includes, at a minimum, essential benefits as determined under the Affordable Care Act and the coverage requirements under chapter 700c of the general statutes,"	S.B. No. 921 § 8 (Ct. 2010)
Hawaii	"The commissioner shall determine the eligibility for inclusion of insurers and plans; provided that all qualified plans and qualified dental plans that apply for inclusion shall be included in the connector." and "'Qualified plan' means a health benefit plan offered by an insurer that meets the criteria for certification described in Section 1311(c) of the Federal Act."	Hawaii Health Insurance Exchange Act, S.B. 1348, 26th Leg. § 6, § 1 (2011)
Kentucky	"The Office shall, at a minimum, carry out the functions and responsibilities required under § 1311 of the Affordable Care Act to implement and comply with federal regulations issued under § 1321(a) of the Affordable Care Act, including the submittal of an application for approval of Exchange certification."	Exec. Order 2012-587 § IX (Ky. July 17, 2012)
Maryland	Requires that: (1) the commissioner gives prior approval of contract language and rates for plans, (2) the plan is offered by a carrier that is in good standing w2ith accept able offerings at all levels of the exchange including the SHOP exchange, (3) the plan be in the best interest of qualified individuals and employers, (4) the plan provides additional benefits as determined by the exchange, and (5) meets all other requirements as established by the title (from the ACA) "'Qualified health plan' means a health benefit plan that has been certified by the Exchange to meet the criteria for certification described in § 1311(c) of the Affordable Care Act and § 31-109 of this title."	H.B. 166 § 31-101 (J), 31-109 (Md. 2011)
Massachusetts	To be determined by the board	An Act Providing Access to Affordable, Quality, Accountable Health Care, Chapter 176Q § 3(a)(3) (Ma. 2006)
Nevada	"Except as otherwise provided in section 22 of this act, 'qualified health plan' has the meaning ascribed to it in § 1301 of the Federal Act."	S.B. No. 440 §9 (Nev. 2010)
New York	Not mentioned in Executive Order	
Oregon	"The Oregon Health Insurance Exchange Corporation shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings. The corporation may limit the number of qualified health plans that may be offered through the exchange as long as the same limit applies to all insurers."	S.B. 99-A § 11(4), 76th Oregon Leg. (Or. 2011)
Rhode Island	Not mentioned in Executive Order	

Qualified Health Plans		
State	**Pertinent Language**	**Citation**
Utah	"An insurer who offers health care plan under Chapter 30, Individual, Small, Employer, and Group Health Insurance Act, shall: (b) beginning January 1, 2010, offer the basic health care plan described in Subsection (4) subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act, that: (i) is a federally qualified high deductible health plan; (ii) has the lowest deductible that qualifies under a federally qualified high deductible health plan, as adjusted by federal law; and (iii) does not exceed an annual out of pocket maximum equal to three times the amount of the annual deductible."	H.B. 188 § 31A-22-613.5 (3)(b), (Ut. 2008)
Vermont	"The Vermont health benefit exchange shall have the following duties and responsibilities consistent with the Affordable Care Act: (1) Offering coverage for health services through qualified health benefit plans, including by creating a process for: (A) the certification, decertification, and recertification of qualified health benefit plans as described in section 1806 of this title." Vermont adds to the requirements of § 1302 of the ACA the requirement that "the commissioner shall determine . . . [whether the plan] is in the best interest of individuals and qualified employers in [Vermont] . . . [by considering] affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state's health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate." (§ 1806)	H.202 No. 48 § 1805 (1)(A) (Vt. 2011)
Washington	"In no case later than January 1, 2012, the authority in collaboration with the joint select committee on health reform implementation and the board, shall develop a broad range of options for operating the exchange and report the options to the governor and the legislature on an ongoing basis. The report must include analysis and recommendations on the following: . . . (d) Creation of uniform requirements, standards, and criteria for the creation of qualified health plans offered through the exchange, including promoting participation by carriers and enrollees in the exchange to a level sufficient to provide sustainable funding for the exchange;"	S.B. 5445 § 5 (2)(d), 62nd Leg. (Wa. 2011)