

Governance Issues for Health Insurance Exchanges

By Paul N. Van de Water and Richard P. Nathan

Federal health reform legislation encourages states to establish health insurance exchanges that will promote effective competition for health insurance and offer a wide selection of coverage options to individuals and small businesses. The law gives states four options for structuring the governance of an exchange: a state government agency (either existing or newly created), a nonprofit entity established by the state, or a multi-state exchange. It also provides states the flexibility to establish one or more sub-state exchanges serving geographically distinct areas within a state. If a state does not wish to establish an exchange, the federal government will operate an exchange in the state.

States offer a range of models for health insurance exchanges, and there is no one correct approach. The Utah Health Exchange was established within an existing state agency. The Commonwealth Health Insurance Connector Authority in Massachusetts is an independent public authority inside state government. New Mexico is considering establishing a nonprofit public corporation.

Whatever form of governance a state chooses, it will have to address most of the same issues, including the exchange's political independence and accountability, preventing conflicts of interest, the extent to which the exchange will be subject to various general laws affecting its operations (such as hiring and procurement), the exchange's sources of funding, financial reporting requirements, and more. Establishing a nonprofit entity, multi-state exchange, or sub-state exchanges would raise additional issues. A state must also consider what forms of governance are permissible under its own constitution.

Because a health exchange will face many unanticipated challenges, states should consider giving the exchange substantial flexibility and discretion in setting policies. The statute establishing a state's exchange can leave many issues to be worked out later by the exchange as more information becomes available and the exchange gains experience.

Summary

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The new federal health reform legislation (the Patient Protection and Affordable Care Act, or ACA) relies heavily on the creation of state-administered health insurance exchanges to make health coverage available to individuals and small businesses. The Congressional Budget Office (CBO) estimates that by 2019 approximately 24 million people will purchase their own coverage through the new insurance exchanges. In addition, certain employers can allow their workers to choose among the plans available in the exchanges, and another 5 million people will obtain coverage in that way. In total, an estimated 29 million people will be enrolled in exchange plans in 2019.¹

The ACA offers states several choices for structuring the governance of their health insurance exchange. This paper explores the issues that arise in choosing among the possible forms of governance and identifies advantages and disadvantages of each approach. It focuses on structural issues that need to be addressed in a state's initial legislation establishing an exchange — not on the specific administrative and policy decisions that an exchange will ultimately have to make, which are largely independent of governance.

Functions of a Health Insurance Exchange

In deciding which form of governance to choose, it is important to keep in mind the purpose and functions of an exchange. The governance and organizational design of an exchange, like that of other agencies, must be tailored to reflect the requirements of the programs that it must administer. As a panel of the National Academy of Public Administration has written, “The architectural principle that form follows function also applies to the design of government.”²

Health insurance exchanges are designed to promote effective competition for health insurance by increasing consumer choice and providing transparency on the cost and quality of plans. Exchanges will offer a wide selection of affordable, good-quality health coverage options to individuals and small businesses. To achieve this goal, exchanges will perform a wide range of functions, including the following:³

- Administer a system of qualified health plans
 - Certify plans that are qualified to participate in the exchange
 - Rate plans based on their quality and price
 - Review plans' premium increases
- Support enrollment in health plans and assist consumers
 - Facilitate initial, annual, and special open enrollment periods for individuals
 - Facilitate participation by small businesses in a separate Small Business Health Options Program (SHOP) exchange or a single unified exchange
 - Maintain a website that provides standardized information on the price and quality of health plans, and operate a telephone assistance line

1 Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

2 National Academy of Public Administration, Standing Panel on Executive Organization Management, *Principles of Federal Organization*, January 1997.

3 Most of these functions are listed in section 1311(d)(4) of the *Patient Protection and Affordable Care Act*, Public Law 111-148. Section 6 of the National Association of Insurance Commissioners' *American Health Benefit Exchange Model Act* also lists the duties of an exchange, http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

- Establish a system of Navigators, entities that will conduct consumer education activities and facilitate enrollment in qualified health plans
- Determine eligibility for assistance in obtaining health insurance
 - Determine which participants in the exchange are eligible for advance premium tax credits and cost-sharing subsidies, subject to appeal of decisions to the Secretary of Health and Human Services (HHS)
 - Assure that eligible applicants are enrolled in the appropriate health program (Medicaid, CHIP, basic health, or exchange subsidies) and health insurance plan
 - Administer the system of employee free-choice vouchers
 - Certify exemptions from the requirement for individuals to maintain health insurance coverage and from the penalty for failing to meet the requirement
- Consult with relevant stakeholders with regard to carrying out these activities.

Defining Governance

“Governance” encompasses questions such as the following: Where is the exchange located institutionally? Who are the policy-making and administrative officials of the exchange, and how are they chosen? How is the exchange funded? What kinds of policy decisions is the exchange empowered or required to make? What flexibility does the exchange have with regard to personnel, procurement, and other administrative matters?

Issues of governance must be distinguished from issues of policy, although no bright line separates the two. For example, some exchanges may be highly selective in certifying health plans to participate in the exchange, whereas others may decide to accept all plans that meet specified standards.⁴ The outcome of that policy choice does not necessarily depend on whether the exchange is operated by an existing state agency, a new state agency, or some other entity. Nevertheless, the governance of the exchange could in some cases affect the outcome of its policy decisions.

The amount of operational flexibility that an exchange is permitted is also distinct from how the exchange decides to use that flexibility. The ACA explicitly authorizes an exchange to contract with a company (other than a health insurer) or the state Medicaid agency to carry out one or more of the exchange’s functions.⁵ For example, the exchange has the responsibility to determine eligibility for the advance tax credits, but it could contract with a private firm or the Medicaid agency to perform much of that function, subject to review and appeal. Many public entities contract out call centers, websites, or data processing facilities; others operate them in-house.

Current Situation

To be fully operational in 2014, as the law requires, exchanges will have to certify health plans, hold an initial enrollment period, and complete many other tasks in 2013. By January 1, 2013, the Secretary of HHS must determine whether a state’s exchange is on track to meet the 2014 deadline; if not, she must establish a federal fall-back exchange in the state.⁶ The amount of work required to create a functioning

4 Robert Pear, “Health Care Overhaul Depends on States’ Insurance Exchanges,” *New York Times*, October 23, 2010, <http://www.nytimes.com/2010/10/24/health/policy/24exchange.html>.

5 Section 1311(f)(3).

6 Section 1321.

exchange is substantial and will consume all of the time available. Legislative calendars add to the pressure. Some states will hold short biennial legislative sessions in 2011 and will not meet again in regular session before the planning deadline.

Inside state governments, the wheels of implementation are spinning.⁷ Since March 23, 2010, when the ACA was signed, rapidly increasing activity, consultation, and planning have been going on. In September 2010, the Secretary of HHS awarded initial planning grants of about \$1 million each to the 48 states that had applied for them. Even in states that are challenging the law, lawmakers recognize that they need to be ready to implement it. Some cite the threat of the federal government operating an exchange in place of a state version as motivation, although HHS has not yet specified the form that the federal fall-back exchange will take. Most states have established several planning groups and subgroups addressing a range of issues posed by the ACA. Choosing a governance structure is the first decision that states must make. Many specific implementation issues can be addressed through later legislation, or can be delegated to the exchange to decide, but governance issues must be settled soon.

Choices for Structuring Exchange Governance

The Affordable Care Act offers states four basic choices for structuring the governance of a health insurance exchange: a state government agency (which may be either an existing agency or a new one), a nonprofit entity established by the state, or a multi-state exchange.⁸

Existing State Agency

Several existing state agencies could become the home for the new health insurance exchange. These include:

- The state Medicaid agency;
- The insurance department or commission;
- The consumer protection agency;
- The department of administration and finance or other agency responsible for the coordination and management of state government;
- The department of labor or other agency responsible for overseeing the terms and conditions of the workplace;
- The department of revenue or other agency responsible for tax collection; or
- The agency administering health benefits for state employees.

On the one hand, placing the exchange within an existing agency would allow it to benefit from established administrative systems and procedures. This might ease the job of establishing an exchange and enable states to act with greater dispatch. Relying on a tried and true organizational structure could also facilitate inter-agency coordination, which will be essential for the effective implementation of health reform. Finally, each of these agencies has expertise in at least one area of the exchange's operations.

On the other hand, the work of the exchange will be substantial and could easily overwhelm an existing agency. No existing state agency has experience with all of the functions that an exchange will have to

7 See National Conference of State Legislatures, *State Actions to Implement the American Health Benefit Exchange*, <http://www.ncsl.org/default.aspx?TabId=21388>.

8 Section 1311(d)(1) and section 1311(f)(1).

perform. An existing agency might attempt to fit its new activities into old ways of doing business rather than seek better, innovative solutions. It could easily focus on the areas most closely related to its traditional areas of responsibility and not give enough attention to other tasks of the exchange. It is also likely to have long-established relationships with certain interest groups and may be insufficiently attentive to the needs and desires of stakeholders with which it has not previously had much contact.⁹

In particular, a careful balance must be struck between the exchange and the insurance department. The department's current task is to determine that insurers are financially solvent, meet regulatory requirements, and are otherwise legally qualified to sell insurance in the state. The exchange's job is to structure and referee the competition for health insurance and make the market work better for consumers. A single agency would find it challenging to reconcile these two substantially different roles, and locating the exchange within the insurance department could therefore prove problematic.

The Utah Health Exchange is operated by the Office of Consumer Health Services, which was established within an existing state agency (the Governor's Office of Economic Development) in 2008.¹⁰ The Utah exchange currently performs only a few of the functions required by the ACA. It serves exclusively as a technology backbone for the state's new defined-contribution insurance market for small employers. It offers comparative information on health insurance plans, provides a standardized on-line application and enrollment system, and facilitates the aggregation of premium payments by individuals and employers. Premiums in the Utah exchange are not subsidized, and participation by small employers has so far been very limited. The regulatory aspects of Utah's health reform are housed in the state's Insurance Department.

Health planners in Utah recognize that their exchange will need major changes to be able to deliver subsidies to low- and moderate-income families and perform the many other tasks set forth in the ACA. The state has begun a planning process for implementing the new law, but how Utah will respond to the ACA's requirements is still to be determined.

New Governmental Agency

Another possibility is to establish the health insurance exchange as a new state agency, which could itself take various forms. The new agency could be an executive department reporting to the governor, or it could be an independent public entity with its own governing board. A new agency would be able to devote its full energies to establishing the exchange without being distracted by other responsibilities. Depending on its structure, it could also be freed from various existing procedural constraints (such as those on hiring and procurement), more insulated from political influence, and less likely to be swayed by particular interest groups.

Executive Department. The exchange could be operated by a new department in the executive branch of state government, although we are not aware of any state that is currently considering this approach. As with other executive departments, the department head would be appointed by and responsible to the governor. Some people would see this approach as assuring a high degree of political accountability, but others could view it as being overly subject to political considerations. It might also be difficult to exempt the exchange from administrative requirements that applied to other departments of government.

9 Jost describes these potential problems in more detail. Timothy S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, Commonwealth Fund, September 30, 2010, pp. 6-7, http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf.

10 Utah State Legislature, H.B. 133 (2008), Second Substitute, Health System Reform, <http://le.utah.gov/~2008/bills/hbillenr/hb0133.pdf>.

Independent State Agency. The Commonwealth Health Insurance Connector Authority, established by the Massachusetts health reform legislation of 2006, exemplifies the independent agency approach.¹¹ The Connector is a public authority overseen by a board of ten directors. It runs two major programs: Commonwealth Care, which offers a choice of subsidized health insurance plans to those with low incomes, and Commonwealth Choice, which provides individuals and small businesses with access to a range of unsubsidized products. The Connector is also assigned other critical policymaking and administrative responsibilities, such as defining minimum creditable coverage for purposes of the state's individual mandate to obtain insurance, determining when coverage is affordable, establishing regulations for employers' section 125 plans, and informing individuals and employers about their options and responsibilities.

Although independent, the Connector is closely tied to the political process. Four members of the board are state officials who serve *ex-officio*, three are appointed by the governor, and three are appointed by the attorney general. The appointed members come from outside government, are chosen from specified categories (actuaries, health economists, small business, consumer organizations, organized labor, and employee benefit specialists), and serve for three-year terms.¹² The chair of the board, who is the governor's Secretary of Administration and Finance, selects the executive director, but the executive director views himself as being responsible to the entire board.

As a government agency, the Connector has the authority to issue rules and fill in details of the state's health reform that the legislature deliberately did not specify. It is also in a position to work cooperatively with the many other state agencies that also have important roles in Massachusetts health reform. By including on its board consumers, small employers, and other outsiders, as well as state officials, it has been effective in maintaining political legitimacy and popular support. Exemption of the Connector from various state contracting and personnel rules is viewed as making it a more nimble organization. The Connector is not exempt, however, from the state's rulemaking procedures or requirement for open meetings. The Connector operates with a staff of only about 45 full-time-equivalent employees and out-sources most of its activities. The state Medicaid agency determines eligibility for subsidized health coverage, and private firms run the Connector's website, call centers, and enrollment and billing processes.

California has recently created the California Health Benefit Exchange, which follows the Massachusetts approach in many ways.¹³ The California exchange is an independent public entity governed by a five-member board. The board comprises the Secretary of California Health and Human Services, two members appointed by the governor, one appointed by the Speaker of the Assembly, and one appointed by the Senate Committee on Rules. To avoid conflicts of interest, persons employed in health insurance or health care may not serve on the board. The board is subject to the state's open meeting rules, but its key executives are exempt from state salary limitations.¹⁴

11 Amy M. Lischko, Sara S. Bachman, and Alyssa Vangeli, *The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions*, Commonwealth Fund, May 2009, <http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/May/Issue%20Brief.pdf>. National Academy of Social Insurance and National Academy of Public Administration, *Administrative Solutions in Health Reform*, July 2009, <http://www.nasi.org/research/2009/administrative-solutions-health-reform>.

12 A recent law increases the size of the Connector board to 11 members in July 2011 and adds an insurance broker to be appointed by the governor. Critics have suggested that a broker member could face conflicts of interest. *Chapter 288 of the Acts of 2010*, August 10, 2010.

13 California State Legislature, *Senate Bill No. 900, Chapter 659, Statutes of 2010*, September 30, 2010, http://info.sen.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.pdf. *Assembly Bill No. 1602, Chapter 655, Statutes of 2010*, September 30, 2010, http://info.sen.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.pdf.

14 For more information about the rationale, purposes, and role of the California exchange, see California Health Care Foundation, *Briefing Transcript: The Role of the Exchange in California's Implementation of National Health Reform*, October 21, 2010, <http://www.chcf.org/~media/Files/PDF/S/PDF%20Sacto10212010HealthBenefitExchangeTranscript.pdf>.

States with stronger provisions regarding the separation of powers may not be able to adopt a governance structure like California's, in which legislative leaders appoint members of the board of the exchange. In general, the legislative branch of government enacts laws, and the executive branch is responsible for carrying them out. Also, the legislature may lack the capacity to screen public appointments, which in most states is the task of the executive branch.

Nonprofit Entity

Establishing the exchange as a nonprofit entity, separate from state government, may provide even more independence from politics and more flexibility in operational matters. Too great a degree of separation, however, could leave the exchange politically isolated and make it difficult to communicate and coordinate with the other state agencies involved in implementing health reform. Since the state would retain ultimate responsibility for the exchange, it might be reluctant to assign its operation to an organization over which it would have limited control.

A state's constitution will affect in important ways its ability to establish a nonprofit exchange. In some states certain functions of the exchange could be considered inherently governmental because they involve exercise of one of the government's sovereign powers, such as levying taxes or regulating economic activity. Any such functions could probably not be turned over to a non-governmental nonprofit entity and would have to be performed by the state government or subject to state review. As Washington and Lee University law professor Timothy Jost emphasizes, "it is imperative that before considering the delegation of exchange responsibility to private entities states determine that doing so is constitutionally permissible."¹⁵ Regardless of a state's constitutional constraints, to promote legitimacy and accountability, a nonprofit exchange should be required to adhere to the minimum constitutional requirements for due process. In addition, a nonprofit exchange could be required to meet additional statutory requirements applicable to government agencies, such as those regarding disclosure of public records, open meetings, conflicts of interest, financial reporting, auditing, and so on. The authorizing statute would also need to specify the immunity of employees and board members of the exchange from liability arising from performance of their legal duties.

In New Mexico, the Legislative Health and Human Services Committee has endorsed a bill that would create the New Mexico health insurance exchange as a "nonprofit public corporation, separate and apart from the state."¹⁶ New Mexico's proposed nonprofit exchange would have many similarities to state-run exchanges. It would be run by a nine-member board that included two state officials as *ex-officio* members, three members appointed by the governor, and four members appointed by the legislature from designated categories. Although outside government, the proposed New Mexico exchange would be subject to the state's Open Meetings Act, Administrative Procedures Act, and "other statutes and rules applicable to state agencies." Employees of the exchange would be considered public employees for purposes of New Mexico's Tort Claims Act, thereby shielding them from most tort liability. The day-to-day operations of the exchange would be carried out by an executive director, who would be authorized to hire and fix the compensation of staff members. The exchange would be authorized to contract with the state Medicaid agency, other state or local public health coverage programs, insurance brokers ("producers"), or other vendors to carry out one or more of its functions — but not with an insurance company. As a non-governmental entity, however, the exchange's decisions about eligibility for participation in the exchange, exemption from the individual mandate, and certain other matters would not be final and would be subject to review by the state's Superintendent of Insurance. Because the proposed New Mexico exchange would lack rulemaking authority, the superintendent rather than the exchange would also be responsible for promulgating rules to certify health benefit plans as qualified plans and for certify-

15 Jost, *Eight Difficult Issues*, p. 3.

16 New Mexico, Legislative Health and Human Services Committee, *An Act Relating to Health Insurance*, Endorsed Bill, November 10, 2010, <http://www.nmlegis.gov/lcs/handouts/183033%205.pdf>.

ing plans, although the exchange would determine which qualified plans could be offered through the exchange. Of course, other states interested in establishing a nonprofit exchange may face more or fewer constitutional constraints than New Mexico.

States have created a large number of public authorities and public-benefit corporations to construct, operate, or provide financing for a range of infrastructure projects and other activities.¹⁷ These entities combine aspects of government agencies and private corporations and may suggest additional governance models for health exchanges. The legal arrangements are often specific to a particular state, however, and may not be applicable elsewhere.

Assigning governance of an exchange to a nonprofit entity is likely to raise a number of issues that would not arise if the exchange were a state agency or authority. For example, establishing the exchange as a private entity with providers or insurers in positions of control could increase the potential for conflicts of interest and heighten the likelihood of scrutiny under the antitrust laws. Whether the exchange's actions could be found to be in restraint of trade, or whether they would be protected as actions of the state, is not clear. Giving a non-governmental entity access to personal tax information, as would be necessary to determine eligibility for advance premium credits, could raise privacy questions. Other federal and state laws that do not apply to state governments could also have uncertain implications for a nonprofit exchange.

Multi-State Exchange

For some states — particularly small states, states with interstate metropolitan areas, or other states served by overlapping health plans — a multi-state exchange may be an attractive option.¹⁸ A multi-state exchange could achieve economies of scale in administration. With a larger pool of participants, it might also attract more health insurance plans and lead to greater competition and lower premiums. Several states are said to be exploring the possibility of establishing regional multi-state exchanges.

Establishing a multi-state exchange would be more complicated than setting up a single-state exchange, however, and this paper can only touch on some of the issues involved. The participating states would have to enter into an interstate compact, most likely through the adoption of identical statutes, and Congressional approval might be required.¹⁹ Most existing interstate compacts involve the operation of parks, bridges, or other infrastructure and provide little guidance for creating multi-state health exchanges. Since states could be reluctant to relinquish substantial authority and flexibility to an interstate body, working out the details could be time consuming, and states might be reluctant to embark on the process of creating a multi-state exchange when time is short and the probability of success uncertain.

Once created, a multi-state exchange could also face operational challenges. It would have to coordinate its activities with Medicaid, the insurance department, and other relevant agencies in each participating state. It would also likely have to deal with different regulatory regimes in each state. If the rules governing plans within a multi-state exchange differed from those governing plans operating outside the exchange in even one state, the exchange would find it difficult to prevent risk segmentation.²⁰

17 See, for example, Public Authorities Information Clearinghouse of the Government Law Center, Albany Law School, <http://www.publicauthority.org/>.

18 States may operate multi-state exchanges starting in 2014 if the participating health plans meet all the regulatory requirements of each participating state. Section 1333 of the ACA allows two or more states to enter into health care choice compacts that would allow qualified health plans to be sold in all such states but not be subject to all their laws and regulations; these compacts could not become effective until 2016.

19 See Council of State Governments, *Introduction/Overview: Interstate Compacts*, undated, <http://www.csg.org/knowledgecenter/docs/ncic/Overview.pdf>. The provision of the ACA authorizing multi-state exchanges could be interpreted as implicit Congressional approval of such compacts.

20 Linda J. Blumberg and Karen Pollitz, *Cross-State Risk Pooling Under Health Care Reform*, Urban Institute, March 2010, <http://www.urban.org/UploadedPDF/412124-cross-state-risk.pdf>.

Other Governance Issues

In addition to or as part of choosing an appropriate governance structure for an exchange, states must consider several related issues.²¹

Funding Sources

The ACA provides federal start-up funding to plan and establish the exchanges.²² Beginning in 2015, states are to assure that the exchanges are self-sustaining, and an exchange may “charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.”²³ If an exchange is financed through assessments solely on plans that are offered in the exchange, plans that are offered only outside the exchange would have a competitive advantage.²⁴ Moreover, some functions of the exchange — notably the responsibilities to determine eligibility for subsidies and certify exemption from the individual mandate — constitute governmental tasks whose cost should be widely shared. States may therefore wish to consider a broad range of funding possibilities that are not limited to assessments on health insurance plans inside the exchange. Possibilities include a tax on all health insurers, including administrators of self-insured plans, or a tax on health care providers.²⁵

Operational Flexibility

Whatever an exchange’s form of governance, the state will need to determine the extent to which the exchange will be subject to various general laws affecting its operations. They include civil service and other personnel rules, contracting and other procurement requirements, and freedom of information or government-in-the-sunshine rules. These requirements were originally adopted to assure organizational accountability or prevent misuse of public positions and funds, but they are now sometimes viewed as impediments to government efficiency. Depending on a state’s constitution, choosing a particular organizational form need not preclude granting additional operational flexibility. Conversely, public-private organizations can be made subject to some of the same procedural requirements as government agencies. In any event, the statute authorizing the exchange should avoid imposing overly detailed administrative requirements or constraining the exchange’s operational decisions through personnel ceilings, limitations on contracting, or other legislative directives.

Political Independence and Accountability

A public or public-private exchange must maintain political accountability yet avoid undue political interference. There is no clear line, however, that separates accountability from interference, and different observers may view the same circumstances differently. State agencies and authorities are generally subject to established rules and procedures for executive management and legislative oversight. In contrast, a new nonprofit entity will be starting from a largely blank slate, and the authorizing legislation will need to specify the entity’s legal responsibilities and the procedures for holding it accountable. In any event, maintaining a high level of public awareness and transparency is particularly important, as success of the Massachusetts Connector demonstrates. No matter what organizational form is chosen for the exchange, voters will hold their elected officials responsible if anything goes wrong.

21 Some of the material in this section is based on Paul N. Van de Water, “Designing Administrative Organizations for Health Reform,” in Terry F. Buss and Paul N. Van de Water (eds.), *Expanding Access to Health Care: A Management Approach*, Armonk, NY: M.E. Sharpe, 2009.

22 Section 1311(a).

23 Section 1311(d)(5).

24 Section 1301(a)(1)(C)(iii) requires a qualified health plan to charge the same premium both inside and outside the exchange. However, some plans may be offered only inside or only outside the exchange.

25 Jost, *Eight Difficult Issues*, p. 50. Medicaid provides a precedent for the use of provider taxes.

Management Structure

Independent authorities and nonprofit entities are generally governed by a multi-member board rather than a single administrator. Multi-member boards can help insulate agencies from possible political interference, but they may also impede accountability, since no one person is fully responsible for decisions, and they may be less capable of timely decision making. A relatively small board would be more efficient but would encompass fewer types of expertise and points of view. Whatever its size and makeup, the board must be constituted and viewed as impartial, experienced, and professional. A key issue is whether the board should include health care providers, health insurers, or brokers, who might stand to gain financially from the position, or whether it should be comprised largely of individuals representing consumers and small businesses, who will be the exchange's customers.²⁶

The ACA requires exchanges to consult with various relevant stakeholders, including health care consumers, representatives of small businesses and the self-employed, individuals with experience in facilitating enrollment in health plans, and state Medicaid offices.²⁷ Some of these categories are likely to be included on an exchange's board. An exchange will have to develop procedures for additional consultation, if needed, but these procedures need not be specified in the authorizing statute.

Sub-State Dimensions

In many states, health insurance markets do not encompass the entire state. The ACA requires states to establish one or more health insurance rating areas, within which rates for a plan can vary only by age and tobacco use.²⁸ For example, the Commonwealth Connector in Massachusetts — with 6.6 million residents — has three rating areas. The California public employee system (CalPERS) has five rating areas. In addition, the ACA allows network health plans, such as health maintenance organizations, to have service areas that cover only portions of a state.²⁹

The ACA gives states the flexibility to establish one or more “subsidiary exchanges” serving geographically distinct areas (but no smaller than a rating area) within a state.³⁰ The law does not specify, however, whether subsidiary exchanges would be independent or would be subordinate to state-wide governance. If subsidiary exchanges allowed more local control, they could lead to significant variations in policies, procedures, and health plans from one region of a state to another. For example, if subsidiary exchanges adopted different criteria for certifying health plans, the choice of plans could vary depending on where in a state an individual lived or worked. However, such variation would seem to conflict with the ACA's requirement that plans accept every individual or employer in a state that applies for coverage — a provision that might ultimately limit the independent authority that subsidiary exchanges could be allowed.³¹

A state considering the establishment of subsidiary exchanges should carefully examine which functions of the exchange would best be carried out uniformly throughout the state and which ones might benefit from regional variation. The state must then weigh these benefits against the additional administrative costs that would result from the duplication of activities by multiple exchanges. States looking at this option should also consider whether and how to coordinate subsidiary exchanges to avoid confusion among consumers and employers, achieve efficient administration, and facilitate dealing with insurance carriers and state and federal agencies.

26 Jost, *Eight Difficult Issues*, pp. 6-7.

27 Section 1311(d)(6).

28 Section 2701 of the Public Health Service Act, as amended by section 1201 of the ACA.

29 Section 2702 of the Public Health Service Act, as amended by the ACA.

30 Section 1311(f)(2).

31 Section 2702 of the Public Health Service Act, as amended by the ACA.

Few, if any, local health program structures now exist that could serve as the basis for sub-state health exchanges, so new entities would have to be created. Health planning bodies have atrophied and, moreover, never had the capabilities and clout that would be needed for such a major undertaking. Similarly, neither county health departments nor county-based public-benefit corporations for health are likely to be prepared to take on the operation of a health insurance exchange.

Conversely, organizing a single state-wide exchange appears to have a number of advantages. It can provide residents with information the availability and cost of plans in different parts of the state without incurring the expense of establishing multiple exchanges. At the same time, it still might administer or deliver certain services (such as outreach, education, or enrollment) on a local basis.³²

Small Employers

The ACA allows for two types of exchanges: one to serve qualified individuals and another (termed a “SHOP exchange”) to serve qualified small businesses and their employees. A state may establish a single unified exchange to provide services to both individuals and small employers, however, as long as the exchange has sufficient resources to assist both classes of customers.³³ Creating separate individual and SHOP exchanges would raise many of the same issues of coordination and administrative efficiency that would apply to subsidiary exchanges within a state. Structuring exchanges to make them attractive to small businesses also involves many other issues that go far beyond governance.³⁴

Conclusions

Several conclusions emerge from this analysis. First, there is no single right way to organize a state-based health exchange. Whatever form of governance a state chooses for its exchange, it will have to address most of the same issues, and the pieces can be combined in many different ways. For example, a given funding source or a particular set of operational flexibilities could be combined with virtually any organizational form, subject only to a state’s constitutional requirements.

Second, the way an exchange is governed and organized does not determine its substantive policy choices. There is no reason to believe that an independent public authority would make systematically different decisions than a nonprofit entity in the same state. Nor would an independent authority in one state necessarily adopt the same policies as a similar authority in a different state.

Third, because a health exchange will face circumstances and challenges that cannot be fully anticipated, states should consider giving the exchange a substantial amount of flexibility and discretion in setting policies. Just as the ACA did not attempt to specify in law every detail of federal health reform, the statute establishing a state’s exchange need not resolve all the important policy issues but can leave many of them to be worked out by the exchange as more information becomes available and as exchanges gain experience in performing their assigned responsibilities.

32 Robert Carey, *Health Insurance Exchanges: Key Issues for State Implementation*, AcademyHealth and State Coverage Initiatives, September 2010, p. 4, <http://www.rwjf.org/files/research/70388.pdf>.

33 Section 1311(b).

34 Jost, *Eight Difficult Issues*, pp. 22-27. Note that establishing a unified individual and SHOP exchange does not require merging the individual and small-group insurance markets (that is, charging the same rates for the same plan in both markets).

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