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# Issue Brief

## Establishing Health Insurance Exchanges: Three States' Progress

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**ABSTRACT:** California, Colorado, and Maryland were among the first states to enact legislation establishing health insurance exchanges called for in the Affordable Care Act. This brief outlines differences that stand out in the states' initial approaches: the numbers and types of people initially appointed to the boards governing the exchanges; the role of the board relative to the state legislature; how the exchanges interact with existing insurance markets; and the involvement of stakeholders in each state. The decisions made by these states provide information that will be useful for other states implementing their exchanges. Going forward, these states will face a more challenging set of decisions, including how to finance the exchanges, how to make risk-adjusted payments to insurers for people likely to have high medical expenses, and how to avoid gaps in coverage and care for people who may have changes in income.

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### OVERVIEW

California, Colorado, and Maryland were among the first 10 states to enact legislation establishing health insurance exchanges, as called for in the Affordable Care Act.<sup>1</sup> The three states made some similar choices in setting up their exchanges. All three structured their exchanges as freestanding governmental or quasi-governmental (i.e., not connected to any existing agencies) bodies, and all set up advisory committees to guide their governing boards. Despite the differences in the structure of the states' individual and small-group markets, by the end of 2011, all three states chose to maintain the conventional market structure separating individuals and small firms (i.e., no more than 50 employees) within the exchange.<sup>2</sup> The similarities end there.

The diverse paths the three states have taken reflect differences in the states' laws and political environments in each state. This issue brief highlights

differences that stand out when examining the three states' initial decisions regarding their exchanges (Exhibit 1). These differences are around:

- the numbers and types of people initially appointed to the boards governing the exchanges;
- the role of the board relative to the legislature;
- how the exchanges interact with existing insurance markets;
- the role of stakeholders;
- the relative market shares of the insurers who do business in each state; and
- the number of people expected to purchase coverage in each state's exchange.

### **How the States Vary in Approaches to Establishing a Health Insurance Exchange**

**The numbers and types of people initially appointed to the boards governing the exchanges are significantly different across the states**, in spite of each state's legislation that required board members to have health- or insurance-related expertise. In California and Maryland, the secretaries of the respective departments of health and human services chair the boards, while Colorado's chair is a public interest advocate. Colorado explicitly forbids any state employees from serving on the board, although three agency heads are nonvoting members. In contrast, California's five initial board members are current or former government employees. Three of the initial 12 board members in Colorado are heads or managers of the largest insurers in the state; Maryland and California forbid any insurance representatives from serving on their boards.

**The role of the board relative to the legislature differs among the states.** In Colorado, the board will develop an initial operating and financial plan for the exchange and it may apply for grants to support planning for the exchange, but it must make recommendations regarding key decisions to the legislature. A legislative review committee was established to guide implementation of the exchange, which it does by reviewing plans, grants, and recommendations of

the board.<sup>3</sup> The committee can introduce legislation that may be needed for further steps in implementing the exchange. The committee's oversight activities appeared to initially slow the hiring of an executive director for the exchange and the state's application for their second federal grant, which did not occur until the end of 2011.

As in Colorado, Maryland's board was given the authority to develop an operations and financial plan for the exchange and to apply for grants. Additionally, Maryland's board was directed to provide the legislature with recommendations for next steps that require further legislation, which it did six months after it started meeting. The fast pace for the board's report was motivated by a desire to give the legislature sufficient time to develop legislation that may need to be passed in the 2012 session. Compared with Colorado, Maryland's legislature has given the exchange board more authority to implement key operational features without obtaining further legislative approval.

In contrast to Maryland and Colorado, California's legislature embedded several key operational decisions in the statute creating the exchange rather than leaving such decisions to the board. These include creating separate exchanges for small groups and individuals and requiring that plans sold in the exchange be consistent with those sold outside the exchange.

**The exchanges' interaction with existing insurance markets differs among the states.** States can choose to allow any willing insurer or health plan that meets minimum certification requirements to participate or, alternatively, they can be selective in determining which insurers and health plans offer the best value.<sup>4</sup> This latter option is known as the active purchaser model. Colorado's law states that all qualified insurers are eligible to sell insurance plans in the exchange and the exchange may not pursue an active purchaser model. In contrast, California's law requires its exchange to adopt an active purchaser model and engage in selective contracting with health plans to maximize consumer value and help change the health care delivery system. Maryland's board recommended

**Exhibit 1. Different State Approaches to Key Exchange Design Issues**

Choices	California	Colorado	Maryland
Exchange Board Structure and Composition	Five board members, chair is secretary of Dept. of HHS. Four of five initial board members are current or past state employees. No insurance representatives may be on board.	Twelve board members, chair is public interest advocate. State employees cannot be on board. Three of initial board members are from largest insurers in the state.	Nine board members, chair is secretary of Dept. of HHS. No insurance representatives may be on board. Two of initial board members are academics.
Relationship Between Board and Legislature	Legislature made some key operational decisions in statute authorizing exchange rather than leaving these to the board.	Board develops initial operating and financial plans but makes recommendations to legislature re key decisions.	Board can develop operations and financial plans, and apply for federal planning grants. Directed to recommend further legislation needed to continue implementation.
Interaction with Existing Insurance Markets	Statute requires board to adopt an active purchaser model and engage in selective contracting with health plans.	All qualified insurers are eligible to sell plans in exchange, and the board cannot pursue an active purchaser model of operations.	Board recommended exchange have flexibility in setting minimum standards rather than conduct selective contracting. Board recommended minimum standards.
Roles of Relevant Stakeholders	Advisory working groups have met less frequently and have had more of a consultative role.	Stressed need for substantial stakeholder participation in advisory working groups to gain stakeholder support. Transparency emphasized.	Four advisory committees, each with 17 to 20 experienced people. Built momentum and consensus. Transparency emphasized.
Related State Differences	Competitive individual insurance market. An estimated 7.2 million uninsured population (19% of state pop.).	Competitive individual insurance market. An estimated 656,000 to 830,000 uninsured (13%–19% of state pop.).	Concentrated individual and small-group insurance markets with one insurer having more than 70% of market. An estimated 747,000 uninsured population (13% of state pop.).

to the legislature that the exchange initially should have “flexibility in setting minimum standards for qualified health plans” rather than directly engage in selective contracting, but the board left the door open to pursue selective contracting sometime after 2014.<sup>5</sup> As part of the minimum standards, the board recommended that health plans meet certain minimum thresholds of annual premium revenue—\$20 million in the small-group market and \$10 million in the individual market—to participate in the state’s exchange.<sup>6</sup> In addition, the Maryland board recommended that health plans could not sell small-group or individual policies outside the exchange unless they also sell policies inside the exchange and that this requirement be implemented at the parent company level rather than at subsidiary levels to minimize shifting of enrollees among subsidiaries.

**Stakeholders play different roles in each state.** Each state established advisory committees to engage stakeholders and to help the boards reach decisions about key implementation issues. Maryland

originally created four committees, each with at least 17 people drawn from stakeholder groups across the state. The committees maintained a rapid pace of discussions in the fall of 2011, with consultants providing data analyses and evaluations about the effects various decisions might have on the uninsured, insurers, and the insurance markets. In the spring of 2012, Maryland continued one committee, named three new advisory committees (each with 20 people), and created an implementation advisory committee.

Colorado’s advisory working groups include the major insurance market participants—insurers, brokers, and employers—and stakeholders. Colorado has stressed the need for substantial stakeholder involvement in the implementation process to ensure that stakeholders support the exchange’s structure and operations, and so far, stakeholders have been participating actively and constructively.

California’s advisory working groups, in contrast, have met only a few times and have not had as central a role. They appear to be providing consultative

feedback rather than taking the active deliberative role that Maryland's and Colorado's advisory committees have. In place of advisory committees, California has sought broad stakeholder input through a series of public meetings across the state.

**The three states' individual and small-group insurance markets are quite different** in terms of their competitiveness, as measured by insurers' market shares. California's and Colorado's individual markets are more competitive than many other states. The largest insurer in California's individual market has a market share of 48 percent and only four insurers have market shares of 5 percent or more.<sup>7</sup> The largest insurer in Colorado's individual market has a market share of 31 percent while seven other insurers have market shares of at least 5 percent.<sup>8</sup> Maryland has the most concentrated individual and small-group markets

of the three states. CareFirst, a division of Maryland Blue Cross, has a 72 percent market share in the individual market and a 70 percent market share in the small-group market, and only one other insurer has a market share of at least 5 percent in the individual market.<sup>9</sup> It bears watching whether these differences in overall competitiveness of the states' insurance markets will affect how their exchanges function.

**The numbers of people expected to purchase coverage through the exchanges differ across the states.** California has an estimated 7.2 million uninsured people (19.2 percent of its population),<sup>10</sup> but the estimates for how many people might enroll in coverage through the exchange are highly uncertain, ranging from 1.25 million to more than 8 million.<sup>11</sup> The Census estimates that Colorado has 656,000 uninsured people (13 percent of its population), but

### What Are Health Insurance Exchanges?

"Exchange" is another term for a marketplace. Under the Affordable Care Act, states will establish two health insurance exchanges—one for individuals who do not qualify for Medicaid or Medicare, and the other for eligible small firms so they can obtain group health plans for their employees. The purpose of the exchanges is to offer individuals and small firms the same competition-driven advantages that people working in large companies have: lower premiums and quality insurance plans. The exchanges will provide a choice of standardized plans and user-friendly information technology (IT), which will improve consumers' ability to choose a health plan and thereby increase competition among insurers for consumers' business.

In many ways, the exchange rules will be similar to current state markets in which individual (i.e., nongroup) and small-group health insurance policies are bought and sold, which are regulated by states to varying degrees. However, the exchanges differ in three significant ways from the existing state markets. First, they provide a gateway, "one-stop shopping" for people with lower and moderate incomes (under 400 percent of the federal poverty level, or \$92,200 for a family of four) to learn if they qualify for Medicaid or a premium subsidy for purchasing a policy in the exchange. Second, small firms will not be forced to pick a single policy for all workers. Instead, they can offer their employees a choice of policies sold in the exchange while paying only one bill. Also, eligible small businesses will receive tax credits if employers pay at least half of the premium. And third, policies sold by insurers and health plans through the exchanges must meet certain minimum standards, making it easier for consumers to compare premiums and benefits covered.

States have some flexibility in how they set up their exchanges. States can decide whether their exchanges should be operated by a nonprofit organization or a public agency, and whether the individual and small-group components should be separate or combined. They can choose to allow any insurer or health plan to participate that meets minimum certification requirements or they can be selective ("active purchaser") in determining which insurers and health plans offer the best value. States also can create different exchanges for different parts of the state or a state can join with other states in setting up a regional or shared exchange. Finally, if a state delays or chooses not to create its exchange, the federal government will set up and operate the exchange until the state is ready to do so.

another source estimates there are closer to 830,000 uninsured (19 percent of its population) and that anywhere from 540,000 to 960,000 people will purchase coverage through the exchange.<sup>12</sup> Maryland has an estimated 747,000 uninsured people (13.1 percent of its population), and an estimated 170,000 are expected to enroll in health plans through the exchange initially.<sup>13</sup> It bears stressing that these estimates have large degrees of uncertainty and are derived using different methodologies.

The remainder of this issue brief describes in more detail the activities and decisions that the three states have taken between the time when their state laws were enacted and May 2012.

### **California: First Out of the Gate, Then Catching Up from Delays**

In August 2010, California became the first state to adopt legislation creating a health benefit exchange. California formed its exchange as a governmental entity, with strict conflict of interest rules that bar employment or board membership for anyone affiliated with insurers, agents, or providers. The California board is chaired by Diana Dooley, the state's secretary of Health and Human Services. Its executive director, Peter Lee, was most recently an official with the U.S. Department of Health and Human Services. Three other board members are either current or past employees of state or county governments, and one is a human resources executive.

Board meetings, which began in April 2011, are usually conducted in open public session, with substantial time devoted to receiving verbal comments from members of the public, following board members' discussion of each agenda item. Various public interest and advocacy groups have been very active in making public comments while industry representatives appear in the meeting minutes less frequently. The board applied for and received a federal level one establishment grant of \$39.4 million in August 2011, which is being used for overall business and operational planning, research and analysis, and implementation of an information technology system.

Stakeholder working groups have been formed on individual and employer enrollment, but have met only a few times, mostly by phone, to discuss various issues without yet reaching any formal recommendations. These workgroups appear to function as consultative feedback mechanisms, providing information to exchange staff about various issues. In place of advisory committees with defined membership and reporting responsibilities, California has sought broad stakeholder input through a series of public meetings across the state.

The focus of initial California board meetings was on adopting a mission statement and strategic vision and on how best to integrate the exchange with Medicaid and the Children's Health Insurance Program. The discussion of the mission statement and strategic vision occupied substantial amounts of board meeting time over four months in 2011, resulting in adoption of a document with sweeping aspirations. Rather than committing itself to a particular strategic model or operational approach, the board embraced many aspects of the various possible values and aims of an exchange. This indicates that many tough trade-offs still lie ahead among inevitably competing objectives (e.g., quality/cost, choice/simplicity, transparency/agility, etc.).

Integration of enrollment and eligibility determinations with public programs has also occupied substantial discussion. This issue is complicated in every state, but more so in California because of the variety of its public programs and health plans, which include county health plans and several types of Medicaid managed care plans. Also, decision-making has been slowed by consideration of the Affordable Care Act's basic health plan option, which permits states to offer a public plan to people with incomes up to 200 percent of the federal poverty level. Medicaid and county health plans in California have backed a state legislative proposal that would adopt this model. Although the bill was not adopted in the most recent term, observers believe the bill is still viable. If enacted, it would reduce individual enrollment in the exchange by roughly half and rework the boundary between public plans and exchange enrollment. The lack of resolution

about the basic health plan option has been a bottleneck in terms of implementing some operational details for the exchange.

Regarding the commercial insurance market, the state's exchange legislation determined some of the key issues, such as limiting initial group size to firms with no more than 50 workers and keeping the individual and small-group markets separate until at least 2018. The law also requires participating insurers to offer each of the Affordable Care Act's four "metal" levels (i.e., platinum, gold, silver, bronze) and to offer those products outside the exchange as well, if they sell coverage outside the exchange.

It is significant that California's statute adopted an "active purchaser" model for the exchange, requiring it to engage in selective contracting to maximize consumer value and to drive delivery system change. California has one of the least concentrated and most competitive individual markets in the country, and active purchaser models are generally favored when a market is not very competitive. The point of the active purchasing is to force greater competition among insurers so the purchaser obtains better value in terms of lower price and/or higher quality. In spite of specifying an active purchaser model in the law, neither the legislature nor the board has yet made any of the major decisions needed to implement this authority, including standardization of benefits and minimum qualifications for participating insurers.

Given the geographic size of California and the fact that many health plans offer policies only in some parts of the state, determining the minimum qualifications for participating insurers may not be simple. Accordingly, insurers are so far taking a "wait-and-see" stance toward the exchange. According to informed observers, some insurers, such as Kaiser Permanente and Blue Shield, are more likely to participate while others, such as Wellpoint and HealthNet, are not. Participation cannot be taken for granted and some of the plans on the sidelines might choose to bid, depending on the terms of participation and other key operational factors.

Insurance agents are even more cautious than the health plans. They complained vocally at one point that the exchange would freeze them out of selling through the exchange. Efforts have been taken to reassure them that their participation is welcome, especially for the employers' Small Business Health Options Program (SHOP) exchange, recognizing that most employers rely on agents to help them choose insurance. However, the compensation and role of agents remain to be determined. Employers' engagement with the exchange is also undetermined, with questions remaining about whether employers must provide employees with a choice of plans and whether contributions will be calculated based on the group's average age or instead based on each worker's age.

Overall, although California's legislature was the first to create an exchange, the state made only modest progress on key operational decisions in 2011. However, the pace of implementation picked up noticeably in 2012 once an executive director was in place and core staff positions were filled. Many difficult choices still must be made in the full light of public scrutiny. As the board chair commented recently, "We've got the foundation laid and the rafters up, but we need to get the Sheetrock in place."

### **Colorado: Forward Progress**

Colorado's Health Benefit Exchange (COHBE) was created by legislation adopted in May 2011 with bipartisan support (i.e., Democratic governor, Republican House, and Democratic Senate). According to one reporter, the law "was nearly torpedoed by local Tea Party members—and other conservative Republican lawmakers—who believe that the Affordable Care Act is actually a Trojan horse for creating a single-payer system. Ultimately, SB 200 was saved by an unusual alliance of Democratic state legislators and five Colorado business groups: the Denver Chamber of Commerce; the Colorado Association of Commerce and Industry; the Colorado Competitive Council; the Colorado chapter of the National Federation of Independent Business; and Colorado Concern, a

group of executives advocating for a better business climate.”<sup>14</sup>

The exchange is a newly created quasi-governmental entity—a nonprofit corporation governed by a board appointed by the governor (five members) and legislative leaders (four members). Members of the Colorado exchange board must demonstrate expertise in at least one of several specified areas of relevance, such as health care insurance, finance, administration, health care provision or purchasing, economics, or information technology. A majority of the board must be unaffiliated with the insurance industry, and none may be state employees, although three key agency heads serve as nonvoting members.

Initial appointees include heads or managers of three of the state’s largest insurers: Anthem, United, and Rocky Mountain Health Plan. The chair is director of the Colorado Coalition for the Medically Underserved. Insurance brokers are not represented on the board. Two members are affiliated with providers and the remaining three are affiliated with payroll accounting, information technology, and small business management. Industry affiliates, public interest advocates, and other interested parties participate in the advisory working groups established by the board.

The Colorado board’s authority is limited to developing an initial operating and financial plan for the exchange, applying for grants, and making recommendations for key decisions. These plans, grants, and recommendations are to be reviewed by a legislative committee established to guide implementation of the exchange. The committee may also introduce legislation needed for further implementation. It comprises 10 members from the General Assembly and is appointed by its majority and minority leaders.

The Colorado exchange board and its advisory working groups have been meeting regularly since July 2011. All major market participants and stakeholders appear to be participating actively and constructively. State planners vowed from the beginning to build the exchange “from the inside out,” with substantial stakeholder involvement. It is hoped this will result in an exchange structure and operations that most insurers,

employers, and brokers will embrace, or, at least, not actively oppose. Key informants report this stakeholder structure has not produced deliberations that are excessively adversarial or contentious. However, this level of active stakeholder engagement requires considerable amounts of staff effort to prepare technical issues for discussion.

The active involvement of the Legislative Review Committee is a significant difference from the other two states. This separate layer of political oversight appears to have resulted in at least modest delays in hiring an executive director and applying for additional federal grant support. In September 2011, the board prepared an application to file for a federal level one planning grant of \$22 million but was not able to file it until December 2011 because the committee could not initially agree on the application. Key informants commented that active legislative involvement should help in advancing legislative measures needed to implement exchange structures and market rules.

The exchange’s implementing legislation firmly rejects an active purchaser model, declaring that all qualified insurers may be eligible to participate. Other major decisions regarding exchange structure and market dynamics have either been made or recommended. These include:

- maintaining a SHOP exchange with a separate Web portal;
- initially limiting the exchange to firms with 50 or fewer workers;
- not merging the individual and small-group markets;
- having the same market rules in and out of the exchange; and
- not requiring insurers to offer the same plans in and out of the exchange.

In addition, the following issues have yet to be addressed by the working groups or board, but are still on their agendas:

- how to classify “groups of one;”

- whether to allow employers to select only a single plan;
- whether to permit a “defined contribution” model for the small business exchanges;
- how to collect and distribute premiums;
- the extent to which benefit structures might be standardized;
- how the exchange will be funded and how administrative costs will be assessed; and
- determining how brokers will be compensated.

Some of these issues were initially deferred because greater resolution was expected from federal regulations. Also, some of these issues are expected to be more contentious and therefore difficult to resolve among stakeholders and interest groups. Exchange leaders decided to emphasize building trust and cooperative attitudes among participants and constituencies before taking on the more difficult issues, especially in the highly charged political environment that surrounds issues relating to the Affordable Care Act.

### **Maryland: Off to the Races**

Maryland has been on a fast track since spring 2011 to implement the state’s health insurance exchange. On April 12, 2011, the governor signed into law the Maryland Health Benefit Exchange Act of 2011, and within five weeks he announced the first appointments to the nine-member board of the Maryland Health Benefit Exchange. Since its first meeting in June, the board has maintained a demanding schedule, meeting almost twice a month to deliver a report in December to the legislature with recommendations for further legislative actions in the 2012 session. Between June and December, the board hired the executive director for the exchange, applied for and was awarded a \$27 million establishment grant from the federal government, created four advisory committees, issued request for proposals (RFPs) for quick turnaround reports to assist the advisory committees in creating the report to the legislature, and issued three other RFPs for analyses to assist the board in 2012.

Maryland’s legislation required the board to create committees to provide advice and assistance and specifically required the committees to conduct a series of studies on key issues. Four committees were established by the beginning of September 2011 to focus on: operating model and insurance rules; SHOP; navigator and enrollment; and finance and sustainability.

The advisory committees and the consultants contracted to provide them with information and data analyses maintained a demanding schedule, meeting 22 times between early September and mid-November. Each of the committees received their respective consultants’ reports and submitted their preliminary recommendations to the board by mid-November. The finance and sustainability advisory committee was continued into 2012 and three new advisory committees were established by May 2012: navigator program, continuation of care, and plan management. Each of the three new committees has 20 members representing various stakeholders in the state.

Maryland’s ability to sustain rapid progress in setting up its exchange is due in part to its long history of health care reform activity. In 2006–2007, the Maryland Health Care Commission developed a proposal that promoted an exchange that would offer uninsured people a choice of health plans, provide subsidies, and include a risk-adjustment mechanism to mitigate adverse selection in the individual and small-group markets. The proposal also called for penalties to be levied against people who did not obtain coverage if it were affordable. The proposal was under consideration in the Maryland legislature when President Obama was elected. The state then opted to defer action while waiting to see what might emerge from Congress. On March 24, 2010, the day after the Affordable Care Act was signed into law, Governor Martin O’Malley issued an executive order creating the Maryland Health Care Reform Coordinating Council to immediately provide advice on implementing the reforms called for in the law.<sup>15</sup> The Council had eight meetings between June and December 2010 and applied for the state’s initial federal planning grant. Most important, the Council submitted



recommendations in December 2010 that were the basis for the Maryland Health Benefit Exchange Act. The Act established the exchange as a public corporation and an independent unit of the state government.

The Act stipulates that insurers participating in the exchange must offer at least bronze, silver, and gold levels of coverage inside the exchange, and at least one silver and one gold plan outside the exchange. The requirement to offer these richer plans outside the exchange could help counteract possible adverse selection against the exchange, since sicker people tend to seek out more comprehensive coverage. Because the issue was not raised during discussions before the Act was passed, the Act's stipulation saved the board from having to spend time during the fall of 2011 deliberating which actuarial level health plans would be offered through the exchanges.

A second contributing factor to Maryland's fast pace was its ability to quickly assemble an impressive and large number of state residents who have experience relevant to establishing the exchange. In addition to the people on the Health Care Reform Coordinating Council, nine people were appointed to the exchange board, which is chaired by Department of Health and Mental Hygiene (DHMH) secretary Joshua Sharfstein. The board includes two academics, from Johns Hopkins University's Bloomberg School of Public Health and the University of Maryland's School of Public Policy, and a researcher/administrator at AcademyHealth with extensive experience working with states.<sup>16</sup> As noted, the four original advisory committees to the board had at least 17 members each. The three new advisory committees have 60 members total, so that as of July 2012, almost 150 people with extensive health backgrounds and representing a broad swath of stakeholders have been involved in the initial stages of setting up Maryland's exchange.<sup>17</sup> Finally, the state was one of 10, along with Colorado, that are receiving technical assistance from the Robert Wood Johnson Foundation on matters related to implementing reforms called for in the Affordable Care Act. In addition, planning for coordination between the exchange and Medicaid is greatly facilitated by the fact

that Dr. Sharfstein, as Secretary of DHMH, administers the state's Medicaid program.

In December 2011, the board submitted its recommendations in a report to the Governor and the legislature on December 23, 2011. The board agreed to a set of seven ambitious guiding principles in making its policy decisions and provided recommendations on 27 specific points.<sup>18</sup> The more significant recommendations are described in the following paragraphs.

The board recommended that there should be two separate exchanges—one for individuals and one for small groups. Further, the exchanges should have flexibility in setting minimum standards for qualified health plans. That is, the board does not want to engage in active selective contracting initially, and is using the minimum threshold size to set minimum standards for qualified plans.

With the December 2011 announcement by the federal Department of Health and Human Services that each state must determine what constitutes essential health benefits,<sup>19</sup> the board further recommended that the choice of a benchmark plan for making this determination be made no later than September 30, 2012. The board also recommended that insurers above a minimum threshold size be required to offer plans through the exchange, with thresholds of \$20 million in annual premium revenue for the small-group market and \$10 million for the individual market. If an insurer offers a catastrophic plan, as defined by the Affordable Care Act, outside the exchanges, it also must participate in the exchanges.

Although the board recommended that the individual and small-group markets should initially remain separate, it called for a reassessment of the option of merging the two markets in 2016.<sup>20</sup> The board also recommended that at least until 2016, the small-group market should be limited to firms with 50 or fewer employees; employers with 51 to 100 employees will have to obtain coverage in the larger-group market. In addition to honoring the federal requirement that small employers be allowed to offer their workers a choice of plans, the board also recommended that small employers be allowed to continue to offer only

one insurer with one or more qualified health plans. These options will be reevaluated in 2016.

The board did not recommend specific options for financing the operations of the exchange. Instead, the report states that there are “significant benefits” for all Maryland residents in having the exchange and therefore the funding should come from a “broad-based assessment” with some additional funding coming from “transaction fees” tied to enrollment in the exchange.<sup>21</sup> The board urged that the financing decision be made by early 2013, which gave the legislature a year to consider financing options.

## IMPLICATIONS

California, Colorado, and Maryland continue to be leaders among the states in establishing the health insurance exchanges called for in the Affordable Care Act. The different paths they have taken reflect the political and financial circumstances in each state, as well as the current health insurance markets for small firms and individuals. While this group may be too small to draw conclusions about what might work best in other states, several implications emerge from this issue brief.

There is no one right or best formula for the composition and size of the exchange board. More important is the board’s ability to act expeditiously in making key and often controversial operational decisions.

Working groups or advisory committees composed of state residents with relevant expertise can be a very effective way of obtaining information that states have not usually collected in a short time. Moreover, by bringing together representatives of different stakeholder groups, the advisory committees may achieve consensus about decisions that the legislature might fail to make.

Creating advisory committees with substantial stakeholder participation can contribute to greater public understanding of the choices being made to implement the exchanges. Given many of the arcane technical issues inherent in insurance, greater transparency in decision-making and discussions of

the complexities behind decisions appears to ease the public’s worries about what the exchanges will do and how they will impact their lives. Similarly, with more stakeholder participation, the executive and legislative branches of the state government have more assurance that decisions will be vetted.

The three states outlined in this brief are taking a prudent evolutionary, rather than a radical revolutionary, approach to improving their health insurance markets. None have decided to expand small employer rules initially beyond groups of 50 and none have merged their individual and small-group markets. They differ somewhat in whether they favor the “active purchaser” or “any willing insurer” models of determining which insurers and health plans may participate in their exchanges. Other key differences are likely to emerge as these states decide in the coming year whether insurers must offer the same products inside and outside the exchanges, the standardization of benefits plans, and other critical issues.

The decisions made by California, Colorado, and Maryland in 2011 and early 2012 indicate strong collective determination to make the most of the opportunities afforded by the Affordable Care Act to improve market conditions for individuals and small employers so they can obtain health insurance. These states are providing valuable models by showing other states how to think through issues connected to decisions required to set up exchanges. These states recognize the need to keep working through issues that require decisions by the end of 2012 or early 2013. These include choosing vendors to construct an IT infrastructure that will allow speedy determination of eligibility for Medicaid or tax credit subsidies to use in the exchange, deciding how to finance the exchanges so they will be self-sustaining by 2015, adopting a risk-adjustment mechanism to compensate insurers for people likely to have high medical expenses, and deciding how to coordinate care for people who may have to change health plans when their incomes change. These decisions will require a lot of effort in the coming year and other states are watching to see how they choose to tackle them.

## Reader Resources

U.S. Census Bureau, "Table H106: Health Insurance Coverage Status by State for All People: 2010," available at: <http://www.census.gov/hhes/www/cpstables/032011/health/toc.htm>.

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<http://www.getcoveredco.org/Resources/Board-Meeting-Activities>

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See <http://dhmh.maryland.gov/exchange/SitePages/meetings.aspx> and related documents for the meetings, including consultants and contractors' reports to the Advisory Committees.

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## NOTES

- <sup>1</sup> Massachusetts and Utah had established insurance exchanges prior to the passage of the Affordable Care Act.
- <sup>2</sup> Technically, each state will have two exchanges, one for individuals and another for small employers. But because both will be governed by the same board, for simplicity we refer to only a single exchange in each state.
- <sup>3</sup> The review committee has 10 members who are appointed by the majority and minority leaders.
- <sup>4</sup> Under the “any willing insurer” model, so long as an insurer or health plan meets minimum qualification criteria (e.g., sufficient financial reserves) then the state will permit it to sell whichever of the platinum, gold, silver, and bronze actuarial plans the state has decided should be offered in its exchanges. In contrast, an active purchaser exchange will be operating like many large employers that use selective contracting, competitive bidding, and price negotiations to obtain better value for the individuals and small firms that will be purchasing plans in the exchanges.
- <sup>5</sup> The board’s choice of words—“setting minimum standards”—to refer to selective contracting may be a matter of diplomatic semantics.
- <sup>6</sup> These thresholds will prevent only one insurer from participating in the exchange.
- <sup>7</sup> Kaiser Family Foundation, “How Competitive Are State Insurance Markets?” (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Oct. 2011), available at <http://www.kff.org/healthreform/upload/8242.pdf>.
- <sup>8</sup> Ibid.
- <sup>9</sup> Ibid.
- <sup>10</sup> U.S. Census Bureau, “Table H106: Health Insurance Coverage Status by State for All People: 2010,” available at: <http://www.census.gov/hhes/www/cpstables/032011/health/toc.htm>.
- <sup>11</sup> California HealthCare Foundation, Briefing for the California Health Benefit Exchange, Oct. 21, 2010, available at <http://www.chcf.org/events/2010/briefing-california-health-benefit-exchange>.
- <sup>12</sup> J. Gruber, “Background Research to Support the Development of the Colorado Health Benefit Exchange,” (Jan. 2012), available at <http://www.getcoveredco.org/COHBE/media/COHBE/PDFs/DAWG/Gruber-modeling-report-narrative-january-2012.docx>.
- <sup>13</sup> Maryland Health Benefit Exchange, “Recommendations for a Successful Maryland Health Benefit Exchange: A Report to the Governor and Maryland General Assembly, December 23, 2011,” available at [http://dhmh.maryland.gov/exchange/pdf/HB0166\\_MHBE-Report\\_of\\_2of2\\_12-23-11\\_OGA\\_1204.pdf](http://dhmh.maryland.gov/exchange/pdf/HB0166_MHBE-Report_of_2of2_12-23-11_OGA_1204.pdf).
- <sup>14</sup> T. R. Goldman, “Colorado’s Health Insurance Exchange: How One State Has So Far Forged a Bipartisan Path Through the Partisan Wilderness,” *Health Affairs*, Feb. 2012 31(2):332–39.
- <sup>15</sup> The Council was cochaired by the lieutenant governor, Anthony Brown, and the secretary of the department of Health and Mental Hygiene, Joshua Sharfstein, and included the chair of the Maryland Health Care Commission, Marilyn Moon, as well as the commissioner of the Maryland Insurance Administration, the attorney general, the chair of the Health Services Cost Commission, and six members of the General Assembly.
- <sup>16</sup> The commissioner of Maryland’s Insurance Administration, the executive director of the American Public Health Association, the former president of the Maryland Retailers’ Association, and the acting executive director of the Maryland Health Care Commission round out the members of the board.
- <sup>17</sup> Of the 66 people who served on the advisory committees, one-third represented health insurers, one-sixth were either health care providers or from provider associations, one-fifth were community members and advocates, and the remaining were academics (12%), business owners (9%), consultants (3%), and local government officials (3%) (Report to the Legislature, Dec. 23, 2011).

- <sup>18</sup> Some decisions to be made in 2012 were not in the recommendations to the legislature. These include: the exchange may become a not-for-profit entity in the future; although Navigator functions may be contracted out, it is likely that IT functions related to determining eligibility will be provided by exchange staff; there is support for creating a faster, more nimble IT computer system that allows for more frequent updates of income or family structure changes during the year. In February 2012, the board awarded a contract for IT to support the core functions needed to coordinate eligibility and enrollment between the Maryland's exchange and Medicaid program. The \$76 million contract is with the Noridian, which will design, develop, and implement Phase 1A of the IT plan. (See the materials for the Feb. 14, 2012, board meeting, available at <http://dhmh.maryland.gov/healthreform/exchange/SitePages/meetings.aspx>.)
- <sup>19</sup> The Bulletin is available at: [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf).
- <sup>20</sup> The rationale for this decision is that current rate setting for the two markets is quite different and there was concern that if the markets were merged, small firms might drop employee coverage if premiums rose substantially.
- <sup>21</sup> One news media column reported that consultants had estimated the costs to run the exchanges as starting at \$30 million in 2014 (Herald-Mail.com, Jan. 11, 2012). However, the board's report to the legislature states that "the early years of the exchange will be uncertain, and it will be difficult to properly estimated fixed and variable costs."

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