



JULY 2012

Issue Brief

State Health Insurance Exchange Laws: The First Generation

SARA ROSENBAUM, NANCY LOPEZ, TAYLOR BURKE,
AND MARK DORLEY

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor of
Health Law and Policy
School of Public Health and
Health Services
The George Washington University
srosenbaum@law.gwu.edu

To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts.

Commonwealth Fund pub. 1616
Vol. 19

ABSTRACT: Health insurance exchanges are the centerpiece of the private health insurance reforms included in the Patient Protection and Affordable Care Act. As of May 2012, 13 states, together with the District of Columbia, had taken legal action to establish exchanges, through legislation or executive order. State implementing laws are essential to the translation of broad federal policies into specific state and market practices. Overall, the laws in the 14 jurisdictions vary, but they tend to show a common approach of according exchanges much flexibility in how they will operate and what standards they will apply to the insurance products sold. In all states, these “threshold policies” will be followed by policy decisions, expressed through regulations, guidelines, and health plan contracting and performance standards.

★ ★ ★ ★ ★

OVERVIEW

Health insurance exchanges, the centerpiece of the private health insurance reforms included in the Patient Protection and Affordable Care Act (Affordable Care Act), will create a marketplace through which qualified individuals and small employers will be able to buy affordable, comprehensive health coverage that meets or exceeds a set of minimum benefit standards.^{1,2,3} The law affords the states the option of fully operating their own exchange or offering their residents an exchange administered in partnership with the federal government.⁴ Final regulations for implementing the exchange provisions were issued in March 2012, and states electing to operate their own exchanges must demonstrate a degree of operational readiness by January 2013.^{5,6}

This analysis of state exchange laws offers a glimpse into the choices being made by the 13 states that, together with the District of Columbia, as of May 2012 had begun the process of establishing an exchange, either through legislation or executive order.⁷ In this brief, we focus on how these

states—California, Colorado, Connecticut, Hawaii, Illinois, Maryland, Nevada, New York, Oregon, Rhode Island, Vermont, Washington, and West Virginia—and the District of Columbia have approached certain choices allowed under federal law, including the legal structure of the exchange itself and the degree to which, in their initial laws, states are expressing key policy preferences.

The Affordable Care Act creates the policy backbone for state exchanges. The law depends on a series of crucial choices that states must make regarding the structure and operation of their exchange, as well as the structure and performance of qualified health plans (QHPs)—which must meet certain benefit and quality standards—sold in the exchange. State implementing laws are essential to the translation of broad federal policies into specific state and market practices. The initial implementation laws may simply create a framework, or they may be detailed. In all states, these “threshold policies” will be followed by policy decisions, expressed through regulations, guidelines, and QHP contracting and performance standards.

Our study finds that while the states implementing exchanges vary in their approach, all tend to take a broad approach to structure, duties, and powers, leaving many important decisions to later policy implementation through regulations, guidance, and contracts. This initial decision to write broad policies reflects the complexity of not only establishing a new health insurance market but also integrating that market with other forms of coverage. It also reflects the still-evolving nature of federal policies. Among the specific findings:

- Twelve states and the District of Columbia have established exchanges as some form of public entity, whether an agency or a public corporation. Illinois has not yet determined its exchange structure.
- Ten states and the District specify governance by boards. Vermont utilizes its Health Access Authority, supplemented by advisory committees. Ten states and the District seek to prevent conflicts-of-interest among board members, such as by

prohibiting board members from having any financial association with health insurers or health care facilities. Illinois, New York, and Vermont laws are silent on this issue.

- Four states request a study on the merger of the individual and small-group markets, while the District gives its exchange direct authority to merge the two markets.
- Four states and the District consider their option under the law of limiting, through 2015, enrollment in their exchanges to small businesses with 50 or fewer workers, rather than firms with 100 or fewer workers. Of those states, only Oregon decided to make enrollment available to employers with 100 or fewer employees.
- Nine states and the District have authorized their exchange to either accept all qualified health plans for certification or use a selective bidding process to determine which plans will be sold through the exchange.
- Five states and the District are taking steps beyond the provisions in the Affordable Care Act that protect exchanges and insurance markets from adverse selection—that is, attracting large numbers of people with high health risks. California requires health insurers selling in the exchange to sell plans at all levels of coverage specified in the law both inside and outside the exchange.
- Eight states and the District address the issue of coordinating eligibility and enrollment into Medicaid, with five states authorizing their exchanges to coordinate with Medicaid and the Children’s Health Insurance Program (CHIP) to ensure continuity of care.
- Eight states and the District expressly address how they will ensure the financial sustainability of their exchanges, such as assessing fees on participating health plans.
- Eleven states and the District give their exchanges the authority to contract core functions.

- Four states and the District explicitly direct their exchanges to establish network adequacy standards to ensure a sufficient choice of providers, and three consider the Affordable Care Act requirement to include essential community providers in networks.
- Three states and the District specifically address the issue of whether to maintain existing state health benefit requirements that extend beyond the scope of the new federal essential health benefits standards. Connecticut and the District require their exchanges to study this issue.
- Five states and the District explicitly assign a role to their exchanges in reviewing premium rate increases for QHPs.
- Three states and the District include in their laws QHP performance monitoring mechanisms, while four states and the District have outlined QHP information submission requirements.
- Two states have identified the establishment of the appeals process as a specific exchange duty.
- The laws of five states and the District address the so-called Navigator program, through which the exchanges will contract with organizations to raise public awareness of the availability of the QHPs and premium subsidies, as well as facilitate enrollment and use of coverage. One state defines the role of brokers and agents in the program.⁸

ESTABLISHING INSURANCE EXCHANGES: FEDERAL AND STATE ROLES

Federal law creates a framework for the state health insurance exchanges. First, the Affordable Care Act and its implementing regulations set minimum structural and operational standards that state exchanges will be required to meet.⁹ These federal minimum standards are intended to ensure: sound and ethical exchange governance, free of conflict of interest; financial stability; ready access to qualified health plans (QHPs) for eligible individuals and groups; and an appropriate array of health insurance products offering

access to high-quality care. Second, because it rests on a state-regulated insurance system, the health reform law gives states numerous choices in the design and operation of their exchange.

In states that elect to operate their own exchange, the first step is to establish laws authorizing the exchange to begin functioning. Technically speaking, a state's law might be no more than one or two sentences in length, in which case most of the state exchange's actual operating policies would derive from subsequently issued interpretive regulations and guidelines, memoranda of understanding and agreements with other state agencies (e.g., the insurance department or Medicaid office), and service agreements between an exchange and its private-market participants, including QHPs and other contractors that will assist in operating the exchange, such as contractors overseeing information, consumer support, appeals, quality performance oversight, or measurement.

This devolutionary process mirrors the implementation of federal laws generally; that is, in participating in a federal program, states typically have the choice of writing detailed statutory standards or, instead, writing broad terms into state statute while leaving many of the implementation specifics to oversight agencies. Thus, as is true with state law generally, state exchange laws may be lengthy and nuanced; alternatively, states' laws may be broad and succinct, leaving much discretion to implementing exchanges and other implementing entities (e.g., state Medicaid agencies or departments of health insurance) to interpret and apply the law. Broad discretion may be especially appealing when, as here, implementing a law will involve not only the agency directly charged with implementation but also other state agencies with which the implementing agency must have a coordinated relationship. A state's approach to lawmaking also is a reflection of the constitutional framework under which the state legislative and regulatory processes operate, as well as lawmakers' policy, cultural, and political preferences. In some states, legislation may be detailed, because legislators wish to have a more directive role in agency implementation; in other

states, lawmakers may give their agencies broad running room. State exchange laws are no different.

State insurance exchange laws are important to understand, even in their initial stages. After all, much is at stake: the Affordable Care Act creates an entirely new market for health insurance, especially for individuals in need of affordable health care coverage. Furthermore, the federal legislation and regulations frequently speak in broad terms, and state implementing laws, as they are put into place, hold the key to the translation of broad federal standards into an operational exchange; for example, it will be up to states whether multistate exchange markets develop.

To a large extent, the Affordable Care Act depends on a series of crucial state choices: whether to directly operate an exchange or instead to select an approach that functions as a state/federal partnership; whether to operate subsidiary exchanges; whether to provide separate exchanges in the individual and group markets; and which, if any, state benefit mandates, beyond those falling within the health reform law's "essential health benefit" coverage categories, will be included in QHPs' benefit packages.¹⁰ The law tends to set minimum, rather than maximum, standards. For example, certain classes of providers are defined as "essential community providers" and, as a matter of federal law, QHPs are required to include such providers in their networks. A state might decide, however, to go beyond this federal minimum standard and, through statute, regulation, or contract term, designate additional types of community health care providers as essential for purposes of QHP certification.

States whose laws are drafted broadly and with limited detail essentially opt to implement their exchange operations through greater use of "downstream" policymaking tools, such as regulations, guidelines, contracts, and other mechanisms. States whose initial laws are more detailed in scope can be thought of as already having initiated the difficult job of policy translation, providing state implementers with more specific legislative guidance. Regardless of whether state laws are drafted broadly or with detail, state exchange operations will be guided by the federal requirements that apply to all state exchanges.

FINDINGS IN GENERAL

As of May 2012, 13 states, along with the District of Columbia, had either enacted legislation establishing an exchange or created one through an executive order signed by the governor. Eleven states (California, Colorado, Connecticut, Hawaii, Illinois, Maryland, Nevada, Oregon, Vermont, Washington, and West Virginia) and the District of Columbia had passed exchange laws, and two (Rhode Island and New York State) had moved forward through executive order. Overall, the 14 jurisdictions vary in how they specify exchange structure and governance, as well as in how closely they adhere to the minimum standards set under federal law.

Still, all of the states that have taken action tend to share a common approach when it comes to the flexibility accorded exchanges: as a general matter, state exchanges are granted broad running room in how they will operate and the specific standards they will apply to the insurance products sold.

There are, however, notable exceptions to this flexible approach. For example, as discussed below, a number of states appear to have made a choice regarding whether their exchanges are to be active purchasers of health care rather than more passive certifiers of all QHPs that seek to enter the exchange market. At the same time, states' initial post-health reform exchange laws suggest a willingness to grant their exchanges broad discretion to adjust their standards and operations to meet market conditions and population needs. Part of this willingness to grant broad decision-making powers to exchanges themselves may reflect the still-evolving nature of the underlying federal policies on which state exchanges ultimately rest. For example, as of mid-May 2012, federal regulations implementing the Affordable Care Act's essential health benefit provisions had not yet been proposed, although early guidance was available.¹¹ In this sense, it is not surprising that important dimensions of exchange operations remain sufficiently open as a means of accommodating the ultimate direction of federal policy.

In numerous instances, state laws are completely silent on certain matters. Silence, however, does not mean that the state's exchange will not operate in

conformance with applicable federal law, which always sets the default standard against which exchange operations will be measured. For example, a state law might be silent on the question of how an exchange will avoid injurious financial consequences, such as adverse selection. However, under federal principles the Affordable Care Act establishes broad standards for ensuring a level, competitive marketplace in all states, regardless of whether the state directly operates its own exchange or opts for a partnership with the federal government.

As exchange implementation proceeds, all states can be expected to issue implementing guidance. This is particularly true in states whose initial laws are silent on major implementation matters. In both cases, however, states will establish implementing regulations, guidelines, and other downstream policies. The need for further state clarification is essential to all stakeholders: the consumers who will purchase health insurance products; the insurers that plan to sell QHP products in the exchange; the health care providers that participate in QHP networks; and the broad array of state agencies that will relate to the exchange on an ongoing basis.

FINDINGS: SELECTED ISSUES

Exchange Structure and Governance

The Affordable Care Act permits states to establish exchanges either as nonprofit entities—public or private corporations operating under a formal agreement with a state—or as independent public agencies or agencies within the government’s executive branch.^{12,13} Exchanges may operate as unified entities, with individual and small-employer services merged under one exchange, or states may maintain such exchange services separately.¹⁴ In addition, a state may establish subsidiary exchanges (more than one exchange within a state) or participate in regional and interstate exchanges, with a single exchange covering more than one state.¹⁵ In their operations, exchanges are required to consult with a range of stakeholders.¹⁶ Thus, each state has many decisions to make concerning just the issue of exchange structure and governance.

The 13 states that, along with the District of Columbia, have established exchanges through legislation or executive order generally have all created public entities, either divisions within larger governmental agencies or independent agencies (Exhibit 1).

Exhibit 1. Insurance Exchange Structure, May 2012

State	Structure of Exchange
California	Independent public entity not affiliated with an existing state agency or department
Colorado	Independent public entity that is an instrumentality of the state, except with regard to debts and liabilities
Connecticut	Public nonprofit corporation not to be construed as a department, institution, or agency of the state
District of Columbia	Independent public agency
Hawaii	Publicly established nonprofit corporation subject to state oversight
Illinois	Undetermined—study committee to recommend structure
Maryland	Public corporation that is a unit of state government
Nevada	Independent public agency
New York	Government agency within department of health
Oregon	Public corporation
Rhode Island	Government agency established as division of the executive department
Vermont	Government agency established as a division within the Department of Vermont Health Access.
Washington	Legislatively chartered authority operating in collaboration with the Joint Committee on Health Reform Implementation
West Virginia	Government agency established within the Office of the Insurance Commissioner

Source: George Washington University analysis of state exchange legislation and executive orders.

Board Composition, Appointments, Governance, and Conflict of Interest

The Affordable Care Act does not directly address governance or conflict of interest, but final federal regulations issued in March 2012 do address these matters, as do states.¹⁷ Again, existing state laws show that, in some instances, the state has reiterated the federal standard, gone beyond the federal standard by passing a more strict state provision, or remained silent on the issue. In general, nearly all the states specify governance by boards (10 states and the District of Columbia), although Vermont's law establishes governance by the Vermont Health Access Authority, supported by advisory committees, and Illinois specifies a study of governance. State laws typically call for selection of board members by the governor and legislature and give governance powers. In six states, the law specifies that consumers must be part of the governance structure, rather than playing merely a consultative role.¹⁸

In the case of conflict of interest, all states (except Vermont and New York) and the District of Columbia address the issue. Connecticut and the District's laws represent the most extensive conflict-of-interest standard among the 14 jurisdictions with established exchanges. By contrast, Oregon takes a less extensive specification approach to conflicts (Exhibit 2).

Separate vs. Single Exchange to Oversee Individual and Small-Group Markets

The Affordable Care Act permits states that have adequate resources to establish a single exchange for both the individual and Small Business Health Options Program (SHOP) markets, as well as allowing states the option to merge the individual and small-business markets into one risk pool. States that have addressed the scope of exchange authority (eight states and the District of Columbia) tend to establish exchanges that are empowered to oversee both the individual and small-employer group markets. Washington's law calls for study of whether a single state exchange should administer both markets.

Less likely to be addressed is whether to merge the individual and small-group risk pools. Four states and the District of Columbia have spoken on the issue; all direct their exchange to study the issue of merger of risk pools, with only the District directly giving the exchange authority to merge risk pools if it determines that the merger is in the District's best interest (Exhibit 3).

Active vs. Passive Purchasing

Under the Affordable Care Act and implementing regulations, exchanges may act as passive certifiers of all qualified health plans or as active purchasers that select among competing plans based on such considerations as quality, price, and value.¹⁹ Nine states and the District of Columbia address the question of whether exchanges have the power to engage in active purchasing and selection among QHPs. Among these states, there is considerable variation. For example, five states and the District specify that their exchanges be active purchasers, two states obligate exchanges to permit participation by all QHPs, and two states identify the issue of active versus passive purchasing as a matter for further study (Exhibit 4).

Oversight of Exchange and Nonexchange Markets to Mitigate Adverse Selection

A central issue in federal exchange policy is mitigating the potential for adverse risk selection against the exchange (i.e., enrollment of individuals and small groups with higher health risks) through policies that ensure a more level playing field in terms of the products that the exchange offers. For example, adverse risk selection occurs when an insurer, in a bid to attract younger, healthier enrollees, offers more limited provider networks in the plans it sells outside the exchange, thus allowing plans to reduce the cost of coverage below what it might be for a higher-risk population in poorer health. In this way, the insurer is able to attract younger and healthier purchasers to the nonexchange market, leaving a less-healthy risk pool in the exchange. In its basic structure, the Affordable Care Act seeks to mitigate such adverse selection through regulation of the insurance marketplace—for example,

Exhibit 2. Conflict-of-Interest Provisions, May 2012

State	Conflict-of-Interest Provision
California	No board member or exchange staff member may work for organizations that pose an obvious conflict of interest, such as insurance industry organizations or health care providers. Board members are prohibited from engaging in activities that financially benefit themselves or their family.
Colorado	Board members are barred from engaging in activities that financially benefit themselves or their family. A majority of voting board members may not be state employees or directly associated with the insurance industry.
Connecticut	No board member or exchange staff member may work for organizations that pose an obvious conflict of interest, such as insurance industry organizations or health care providers. Board members cannot be compensated, except for necessary expenses. Individual board members may not deliberate or vote on matters in which a family member has a financial interest. Board members and employees may not work for any QHP issuer for a period of one year after leaving the board.
District of Columbia	No board member or exchange staff can be affiliated with a health carrier, agent, broker, health care facility, or trade association of health carriers or be a compensated health professional. Board members cannot participate in any decisions that would result in a financial effect on the member or their family. Board members and staff members are not permitted to work for a QHP issuer that offers QHPs in the exchange for one year after ending their service or employment with the exchange.
Hawaii	The board shall adopt policies prohibiting conflicts of interest and procedures for recusal, including policies that prohibit members from taking part in any action in which the member had a financial involvement or interest prior to service on the board. Board members may not be state employees.
Illinois	Study committee to make recommendations on exchange structure and governance.
Maryland	No board member or exchange staff member may work for or represent organizations that pose an obvious conflict of interest, such as insurance industry organizations or health care providers. Board members are prohibited from engaging in activities that financially benefit themselves or their family members. Board members must strictly adhere to all state ethics and conflict-of-interest laws.
Nevada	Board members may not in any way be affiliated with health insurers, including serving on boards of health insurers, being a consultant to a health insurer, or having any ownership interest in a health insurer.
Oregon	A board member with a conflict of interest must declare the conflict; the conflict will be recorded and the member can participate in the discussion but cannot vote on the issue posing the conflict. A conflict of interest exists if the issue would result in financial benefit to members or their family. No more than two governor-appointed board members may have an affiliation with an insurance industry organization or be a compensated health care provider.
Rhode Island	No board member or exchange staff member may work for organizations that pose an obvious conflict of interest, such as insurance industry organizations or health care providers. Board members are also prohibited from engaging in activities that are financially beneficial to themselves or their family members.
Washington	No board member will be appointed if the act of participating in the decisions of the board would benefit financial interests of the nominee or any entity he or she represents. If such a conflict of interest develops during a board member's tenure, the member shall resign or be removed.
West Virginia	Board members must receive governmental ethics training within the first six months of appointment, and at least every two years thereafter.

Source: George Washington University analysis of state exchange legislation and executive orders.

by providing tax credits only for plans sold within the exchange, barring exclusions for preexisting conditions inside and outside the exchange, prohibiting the use of discriminatory pricing, defining the broad contours of minimum coverage for plans sold both in the individual and small-group markets and in the exchange, and establishing a risk-adjustment mechanism that will

compensate plans with above-average health risks. States can supplement these broad standards through laws aimed at curbing other product-design strategies that insurers might employ to lure healthier people into the nonexchange markets.

Five states and the District of Columbia have taken steps to define the role of exchanges, either

Exhibit 3. Separate vs. Single Exchange, May 2012

State	Merger of Small-Group and Individual Markets
California	Exchange must report to the legislature by December 1, 2018, on whether to merge the individual and small-group markets.
Connecticut	The exchange will report to the legislature and governor by January 1, 2012, and annually thereafter until January 1, 2014, on whether to merge the individual and small-employer markets.
District of Columbia	The board may merge the individual and SHOP exchanges if a merger is considered to be in the best interest of the District. The board is required to study whether the current individual and small-group markets should be merged.
Maryland	The board is required to study and make recommendations on the design and function of the SHOP exchange, including whether the current individual and small-group markets should be merged.
Washington	The Washington State Health Care Authority must collaborate with the board and the Joint Select Committee on Health Reform Implementation to develop and make recommendations to the governor on the creation of a single state-administered exchange, with merged individual and small-group markets, by January 1, 2014.

Source: George Washington University analysis of state exchange legislation and executive orders.

alone or in consultation with other state agencies, in mitigating adverse risk selection against the exchange market, with some simply restating the federal standard and others using more comprehensive language than federal law requires. For example, Oregon specifies that as a condition of doing business with a state, an insurer must offer both bronze and silver plans both inside and outside the exchange and expressly authorizes the exchange, in collaboration with other state agencies, to establish risk mediation programs within the exchange.²⁰ Similarly, the laws in Vermont and

the District of Columbia require carriers to charge the same rate for qualified health plan products, regardless of whether the products offered are sold inside or outside the exchange. Washington's exchange is required to make recommendations regarding effective implementation of risk management methods, including reinsurance (a transitional means of stabilizing premiums in the individual market), risk corridors (a temporary, federally administered program to protect QHP issuers by limiting gains and losses of QHPs), and risk adjustment (a permanent program to spread the financial

Exhibit 4. Exchanges as Active vs. Passive Purchasers of QHPs, May 2012

State	Provision Related to Active or Passive Purchasing
California	The exchange is authorized to act as a selective purchaser of QHPs in both the individual and small-group markets through a competitive process.
Colorado	Specifies that the exchange is barred from soliciting bids or actively purchasing and must include all QHPs meeting federal requirements.
Connecticut	The exchange is empowered to limit the number of participating plans, provided that there is an adequate number and selection of QHPs.
District of Columbia	The board may limit the number of plans offered in the exchanges, using selective criteria or contracting, provided that individuals and employers have an adequate number and selection of choices.
Hawaii	The insurance commissioner determines if plans are qualified health plans, and the exchange must allow the sale of all QHPs.
Maryland	Directs the exchange to study the feasibility of selective contracting based on price and quality.
Oregon	Authorizes the exchange to limit participation by QHPs, as long as the limit applies to all insurers.
Rhode Island	Exchange may selectively contract based on price, quality, cost containment, standardization, and the best interests of qualified individuals and employers.
Vermont	Authorizes the exchange to selectively contract based on price, quality, coverage of preventive services, access, participation in health reform, and other criteria deemed appropriate by the commissioner.
Washington	Directs the exchange to make recommendations on standards for qualified health plan certification and selection.

Source: George Washington University analysis of state exchange legislation and executive orders.

risk among insurers in the individual and small-group markets).

To mitigate adverse risk selection and encourage exchange participation, Maryland and the District of Columbia specify that the exchange board must make recommendations regarding the sale of plans inside and outside the exchange. California requires its exchange to establish as a condition of QHP participation a requirement that carriers selling products in the exchange “fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.” The state imposes comparable requirements on the QHP market (Exhibit 5).

Coordination with Medicaid and CHIP

A requirement of all exchanges is to coordinate among all health insurance affordability programs, including advance premium tax credits available through the exchange, Medicaid, CHIP, and state-established Basic Health Programs (where they exist).²¹ The Affordable Care Act explicitly requires coordination in determining applicants’ eligibility for these programs.²² Other potential areas of collaboration include facilitation of plan enrollment, alignment of QHP and Medicaid managed care purchasing practices, transitions among

“insurance affordability programs” (the term used in federal regulations to refer to Medicaid, CHIP, premium tax credits, and any other form of state financial assistance) when people’s income changes, and addressing short-term lapses in coverage as individuals move among different sources of insurance. In general, states are addressing Medicaid coordination with their exchanges broadly, choosing to focus chiefly on coordination around eligibility determination and enrollment into insurance affordability programs.

Eight states and the District of Columbia address the issues of eligibility and enrollment into Medicaid. No state specifically addresses alignment of QHP and Medicaid markets, although Oregon bars prepaid managed care organizations not authorized to engage in insurance transactions from offering QHPs, in recognition of the requirement that QHPs must be licensed insurers. Five states specifically authorize their exchanges to collaborate with other states agencies to address situations in which individuals may experience disruption in coverage and care as a result of shifting between insurance affordability programs or assistance (e.g., premium tax credits or cost-sharing reductions). California, Connecticut, Hawaii, Nevada, and Vermont specifically direct their exchanges to develop policies aimed at stabilizing plan enrollment

Exhibit 5. Mitigation of Adverse Risk Selection, May 2012

State	Adverse Selection Mitigation Provision
California	As a condition of participation in the individual and SHOP exchanges, all insurers must sell a plan meeting each of the four coverage levels, plus a catastrophic plan, both inside and outside the exchange.
Connecticut	A health insurer offering a QHP must charge the same premium rate inside and outside the exchange and without regard to whether the plan is offered directly from the carrier or through an insurance agent. Exchange QHPs are also subject to the same state licensure and reserve requirements as other health insurance plans. The exchange must report to the General Assembly annually the effects of adverse selection on exchange operations.
District of Columbia	To be certified as a QHP, a health carrier must charge the same premium rate for each QHP, whether offered inside or outside the exchange and without regard to whether the plan is offered directly or through an insurance producer or agent.
Maryland	Exchange user fees cannot create a competitive disadvantage to plans operating outside the exchange. A QHP must be offered at the silver and gold levels outside the exchange if the same QHP is sold inside the exchange. QHP premiums must be the same for identical plans sold inside and outside the exchange. In consultation with the advisory committee, the board must study and make recommendations on the rules under which plans should be offered inside and outside the exchange in order to mitigate adverse selection and encourage enrollment in the exchange.
Oregon	As a condition of transacting business within the state, insurers must offer at least one QHP at the silver and gold levels outside the exchange, in the individual or small-group market, if the carrier also sells plans inside the individual or SHOP exchange.
Vermont	A health insurer offering a QHP must charge the same premium rate inside and outside the exchange and without regard to whether the plan is offered directly from the carrier or through an insurance agent.

Source: George Washington University analysis of state exchange legislation and executive orders.

Exhibit 6. Exchange Coordination with Medicaid and CHIP, May 2012

State	Coordination with Medicaid and Children's Health Insurance Program (CHIP)
California	The board must coordinate with county entities that administer eligibility for Medicaid and other state programs to develop processes for case transfer, referral, and enrollment in the exchange of individuals applying for assistance to those entities. The board may collaborate with the state agencies to allow an individual the option to remain enrolled with his or her carrier and provider network if the individual experiences a loss of eligibility of premium tax credits and becomes eligible for Medicaid or other state programs or vice versa.
Connecticut	The exchange must collaborate with the department of social services to that ensure any enrollee who loses premium tax credit eligibility and is eligible for Medicaid any other state or local public program can remain enrolled in their QHP. The exchange must inform individuals of eligibility requirements for the Medicaid program, CHIP, or any applicable state or local public program, and enroll them in such program if the individual is eligible.
District of Columbia	The exchange must conduct eligibility determinations in accordance with Section 1413 of the Act for the Medicaid and CHIP programs or any other applicable District program pursuant to the policies established by the department of health care finance.
Hawaii	The department of human services is responsible for determining eligibility for subsidized exchange plans and for Medicaid and CHIP. The interim board is to recommend policies and procedures to ensure continuity of care for consumers transitioning between carriers or coverage.
Maryland	The exchange must provide information and make determinations regarding eligibility for Medicaid, CHIP, and any other applicable public health insurance program, as well as facilitate the enrollment in those programs.
Nevada	The board and the state department of health and human services shall ensure proper coordination of the exchange with Medicaid and CHIP, in order to create a single point of entry for consumers and to ensure continuity of care.
New York	The department of health must work in conjunction with state agencies to effectuate the exchange and expedite its ability to perform those functions necessary to carry out the requirements and goals of the Affordable Care Act.
Oregon	The exchange must provide information to consumers regarding the eligibility requirements for state medical assistance programs and assist eligible consumers and families in applying for and enrolling in the programs.
Vermont	The exchange must ensure that individuals who transfer between QHP coverage and other sources of coverage do so as seamlessly as possible.

Source: George Washington University analysis of state exchange legislation and executive orders.

and continuity of care in the event of a shift in the source of insurance affordability assistance, whereas the District of Columbia and New York merely reiterate the obligation to follow the Affordable Care Act's eligibility determination requirements (Exhibit 6).

Funding the Exchange

The Affordable Care Act provides financial assistance to the states to help “stand up” the exchanges in the form of both planning and establishment grants, but the law also bars federal exchange grant support awards after January 1, 2015.²³ To this end, the health reform law permits the state exchanges to charge user or assessment fees to exchange-participating health insurance issuers.²⁴

Eight states and the District of Columbia have taken steps to ensure the financial sustainability of their exchanges. California directs its exchange to assess a charge on all QHPs sold through the exchange, while simultaneously clarifying that the charge does

not affect the requirement that the premium rates for carrier products be the same regardless of whether the product is sold inside or outside the exchange. Similarly, Connecticut, Hawaii, Oregon, and West Virginia authorize their exchanges to charge insurers with which they do business. The District of Columbia goes a step further, authorizing its exchange to assess a charge on all QHPs, including those sold outside the exchange.

By contrast, Maryland authorizes its exchange to develop a broad policy on licensing fees, user fees, and other regulatory fees and assessments. Nevada and Hawaii expressly authorize their exchanges to seek grants, contributions, fees, or gifts. Nine states and the District of Columbia require ongoing studies and reports related to financial sustainability. New York merely reiterates the federal law by mentioning that its exchange needs to be self-sustaining by January 2015, but provides no direction on how that is to be accomplished (Exhibit 7).

Authority to Contract

The Affordable Care Act permits exchanges to contract their functions.²⁵ Eleven states and the District of Columbia specify the authority of exchanges to contract for core functions as a matter of state law; these are California, Colorado, Connecticut, Hawaii, Maryland, Nevada, New York, Oregon, Vermont, Washington, and West Virginia.

Essential Community Provider and Network Adequacy Standards

The Affordable Care Act requires qualified health plans to provide essential community providers where available to serve mainly low-income, medically underserved individuals and to provide a sufficient network of providers. Three states and the District of Columbia expressly reference essential community providers as an area that their exchanges will be expected to address in developing standards, while four states and the District specifically direct their exchanges to establish network adequacy standards (i.e., ensuring a sufficient

choice of providers). California, rather than specifically directing the development of network adequacy standards, authorizes its exchange to require QHPs to make available and regularly update network directories.

Connecticut specifies that its exchange must develop network adequacy standards, while Maryland and the District specify that QHPs must meet minimum federal standards regarding network adequacy and take a similar approach to essential community providers, requiring plans to meet the federal law requirements.^{26,27}

Vermont takes an approach similar to Maryland's, while also leaving open the express possibility of exceeding the standards established by the Affordable Care Act.

Specifying Essential Health Benefits and Treatment of State Benefit Mandates

Federal policy related to the definition of essential health benefits—the minimum package of health care benefits that must be included in any QHP—and the treatment of state mandates related to essential health

Exhibit 7. Ensuring Exchange Financial Sustainability, May 2012

State	Financing
California	The exchange board must charge all the QHPs offered an amount that is reasonable and necessary to support “prudent” exchange operations. The law creates the California Health Trust Fund, which is funded through state appropriations. The California Health Facilities Financing Authority is permitted to provide a working capital loan of up to \$5 million to assist in the establishment and operation of the exchange.
Connecticut	The exchange can charge fees on QHPs to generate necessary exchange funding. The CEO will submit an annual report to the governor and General Assembly beginning Jan. 1, 2012, and ending Jan. 1, 2014, to address such issues as how to ensure the exchange is financially sustainable by 2015.
District of Columbia	The exchange can charge fees on all QHPs or qualified dental plans sold in the District as long as these fees do not exceed reasonable projections to support operations of the exchange. All revenues shall be deposited in the D.C. Exchange Fund. The board must prepare a plan that identifies how the exchange will be financially self-sustaining by January 1, 2015.
Hawaii	The exchange may receive multiple sources of financial contribution, that is, grants or QHP fees, for the purposes of carrying out exchange operations; \$750,000 has been allotted for fiscal year 2011–12 to support the interim board.
Maryland	The exchange may charge reasonable fees that support exchange operations and must adopt regulations that lay out the rules of such fees. The law creates the Maryland Health Benefit Exchange Fund, which is to be funded through multiple sources, including but not limited to fees.
Nevada	The exchange executive director may request an advance not to exceed 25 percent of expected revenues from the state if expenses exceed available funds.
New York	The exchange is required to become financially self-sustaining by January 1, 2015.
Oregon	Fees for the Oregon Health Insurance Exchange Fund will be collected from all insurers (including fees to cover insurance producers' commissions) and state programs participating in the exchange, in an amount ranging from 3 percent to 5 percent of the premium for each enrollee, depending on the number of enrollees. There is a cap on the amount of fees that may be collected.
West Virginia	Beginning July 1, 2011, the board is authorized to assess fees on carriers selling QHPs or qualified dental plans—including those sold outside the exchange—based on premium volume. The law creates the West Virginia Health Benefits Exchange Fund, administered by the board and used to pay all proper costs incurred in implementing the provisions of the exchange law.

Source: George Washington University analysis of state exchange legislation and executive orders.

benefits is still developing. Reflecting this, state laws are either silent on this matter or defer to the coming standards. Among the jurisdictions that address this issue (Connecticut, Maryland, Oregon, Vermont, and the District of Columbia), Vermont offers the most specific direction, requiring QHPs to cover the essential health benefits package defined by the U.S. Department of Health and Human Services (HHS),²⁸ as well as any additional benefits required under state standards. The District of Columbia requires its exchange board to study whether any additional state benefits beyond the federal law should be required of QHPs.

Rate Review Information and QHP Certification

The Affordable Care Act requires that a health insurer seeking certification for a product as a QHP must justify to the exchange any premium rate increase and allow the exchange to take a plan's history of rate increases into consideration when determining whether it can participate in the exchange. Five states (California, Connecticut, Hawaii, Maryland, and Vermont) and the District of Columbia specify an exchange role in reviewing insurance premium rates charged by QHPs; of these, California, Connecticut, and the District specify that a plan's rate information not only must be furnished to the exchange but also may be used by the exchange in the selection of QHPs. In the case of California and the District, the exchange is directed to take rates into account when selecting participating QHPs. Connecticut's law, meanwhile, authorizes the exchange to take rates into account in certifying QHPs.

Quality Performance Evaluation of Qualified Health Plans

Although the Affordable Care Act requires QHPs to include a quality improvement strategy, as with essential health benefits, the federal government has not yet issued comprehensive implementing QHP quality performance standards. Similarly, only a small proportion of states specify exchange obligations where quality

performance monitoring is concerned. Three states (Connecticut, Maryland, and Vermont) and the District of Columbia specify the monitoring of QHP quality performance as an exchange duty. Vermont reserves the right to establish quality standards that exceed federal requirements, while Connecticut directs its exchange to develop written standards for quality improvement and quality measures for plan performance.

Submission of Information

The Affordable Care Act requires health plans seeking certification as QHPs to submit certain information, such as claims payments and enrollment, in plain, understandable language. Four states (California, Connecticut, Maryland, and Vermont) and the District of Columbia require QHPs to submit information on claims payment and denials, rating, enrollment and disenrollment, cost-sharing, and other coverage and payment practices. Maryland and the District's information requirements also include information about enrollee rights and standardized information about costs that consumers would incur under particular plans.

Appeals Procedures

The Affordable Care Act requires the secretaries of the HHS, Homeland Security, and Treasury departments to establish an appeals process for disputes related to eligibility for participation in a QHP and requires exchanges to establish and notify enrollees of such an appeals process. Two states lay out the duties of their exchange in this area. Both California and Vermont direct their exchanges to develop appeals procedures for when an insured individual is denied coverage by a QHP for a particular service. The state directives are broad and do not address either the federal requirements under the federal law or additional state requirements beyond these federal standards.²⁹ Vermont requires its exchange to ensure that individuals receive assistance from the state ombudsman in pursuing and managing their appeals.

Employer Eligibility

The Affordable Care Act specifies that a small employer is a firm with one to 100 employees but

allows states, for plan years beginning before January 2016, to define small employer as a firm with one to 50 workers. States vary in their approaches to small-employer eligibility to participate in the SHOP exchange. Connecticut, Illinois, and the District of Columbia direct their exchanges to submit studies regarding employer size limits in relation to exchange participation. Oregon fixes its employer participation rules at 100 employees. Vermont specifies that its exchange be opened to large employers no later than November 2015. By and large, however, the issue of employer size in relation to participation is not addressed.

Navigators

Under the Affordable Care Act, each state exchange is to operate a Navigator program, which will provide eligible organizations with grants so they can raise awareness of the availability of qualified health plans and facilitate the enrollment of individuals and employees of small businesses in QHPs.³⁰ Navigators, which may include organizations such as trade associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, and chambers of commerce, will be trained by state exchanges. The information they provide must be delivered in a manner that is culturally and linguistically appropriate to the needs of the population they serve. Unlike health insurance agents and brokers, however, Navigators cannot receive any financial compensation or other form of payment, either directly or indirectly, from any health insurance issuer in connection with the enrollment of any qualified individuals, or employees of a qualified employer, in a QHP. Because they do not have any incentive to steer potential customers to specific plans for a commission, Navigators can be relied upon to provide impartial information.

In general, state laws do not specify Navigator roles, duties, or standards. California, Connecticut, Maryland, Oregon, Vermont, and the District of Columbia require that their exchanges establish Navigator programs and contract with Navigators. No

state sets out detailed criteria for Navigators, although Connecticut, in addressing the role of agents and brokers, specifies that both agents and brokers can serve as Navigators. In describing Navigator functions, California, Connecticut, Oregon, Vermont, and the District set forth duties that parallel those found in the health reform law. Maryland and the District direct their exchanges to undertake a study of the Navigator program's functions and an assessment of its sustainability, the availability of private resources, training and expertise requirements, Navigator retention and compensation, and procedures and standards for ensuring cultural competency.

Role of Brokers and Agents

Final federal regulations permit state exchanges to utilize brokers and agents to assist qualified individuals and employers in enrolling in QHPs.³¹ No state directly addresses the role of brokers and agents. Connecticut permits brokers and agents to carry out Navigator functions. Oregon specifies that its exchange must establish a specific certification process for insurance producers (i.e., agents and brokers) who seek to do business in the exchange.

DISCUSSION

With federal policymaking still evolving, state legislators and officials have tended to use broad brushstrokes in painting their health insurance exchanges. The variation in states' approaches is also consistent with differences in the legal frameworks under which state lawmaking happens, as well as policymaking traditions among the states. As more states set up exchanges, the trend toward variation is expected to continue, particularly in light of the broad flexibility given to states in the final exchange regulations.

Together, the laws analyzed in this brief essentially stand up the state exchanges, specifying the initial pathway to implementation, structure, operation, and policy. The silence of initial state laws on a particular issue signals a state's desire to address the issue more fully downstream, in the form of regulations, contracts, and guidelines that interpret and apply

federal law in the context of state population health needs and insurance market conditions. Regardless of whether state lawmaking is detailed or more broadly sweeping, the Affordable Care Act's provisions offer the minimum standards against which the operation of all state laws will be measured. Still, the federal law itself is highly deferential to the state-governed insurance market and to state policy choices, making how states interpret the federal standards a matter of great importance for both policy oversight and research on the impact that divergent state approaches have on health care access, cost, and quality, and ultimately, health outcomes.

Despite their differences, states that have begun the process of establishing an exchange share a common vision in one key area: the creation of a publicly accountable entity. In the state laws reviewed here, the exchange is publicly established, as an agency or public corporation, with direct accountability to lawmakers, rather than contracted out to and governed by a private entity. The exchanges appear to be contemplated as independent agencies, public corporations, or operational units of larger, established regulatory agencies. Importantly, the early legislation suggests

that in most states, exchanges are envisioned as high-level policymaking and market-shaping entities, rather than as governmental units with limited authority and power. Even where an exchange is a certifier of health plans rather than an active purchaser, its authority to bring rigor to the certification review process does not appear to be limited, at least not in the early laws.

Finally, states appear ready to delegate powers broadly to their exchanges to oversee the full implementation process. Exchanges possess contracting authority, the power to conceptualize product design and performance consistent with federal law, and the power to enter into working relationships with other agencies. In measuring the implementation of exchange policy, it will be important to examine not only regulatory policy as it unfolds, but other methods of policy expression, such as informal guidance, requests for proposals from issuers that seek to sell QHPs, memoranda of understanding between exchanges and other state agencies, letters, circulars, and other informal policy guidance, and other means of policy communication that together will enable each exchange to take shape over time as intended by both state and federal policymakers.

NOTES

- ¹ T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010) (accessed May 9, 2012).
- ² Qualified individuals are persons who are state residents, are not excluded because they are incarcerated, and who are legally present in the U.S. 42 U.S.C. §18032(f)(1) added by ACA §1312; 45 C.F.R. §155.305(a). The term “qualified employer” means small employers that elect to make one or more full-time employees eligible for group coverage. 42 U.S.C. §18032(f)(2); 45 C.F.R. §155.710(b); 42 U.S.C. §18031, added by PPACA §1311.
- ³ 42 U.S.C. §18021, added by PPACA §1301.
- ⁴ D. Bachrach and P. Boozang, *Federally-Facilitated Exchanges and the Continuum of State Options* (Washington, D.C.: National Academy of Social Insurance, Dec. 2011), available at http://www.nasi.org/sites/default/files/research/Federally_Facilitated_exchanges_and_the_Continuum_of_State_Options.pdf (accessed March 15, 2012, pp. 12–29).
- ⁵ 77 Fed. Reg. 18310 (March 27, 2012).
- ⁶ 45 C.F.R. §155.105.
- ⁷ The Governor of Kentucky issued an executive order to establish an exchange in July 2012.
- ⁸ 42 U.S.C. §18031, added by PPACA §1311. Through grants from the exchange, eligible entities will serve as Navigators and carry out the required functions including conducting outreach to raise awareness of the exchange and QHPs; facilitate enrollment into QHPs; and distribute impartial information about enrollment.
- ⁹ The ACA, 42 U.S.C. §18031(d)(4); 45 C.F.R. §§ 155.200 and 155.205, requires exchanges to carry out certain core functions: certification of QHPs financial oversight; support for consumers and purchasers through a Web site showing standardized comparative information about the relative price and quality of QHPs; provision of a cost calculator; monitoring plans for adverse selection; informing consumers about, determining eligibility for, and enrolling individuals in Medicaid, CHIP, premium assistance and other insurance affordability programs; qualified health plan enrollment; certification of individuals’ exemptions from penalties in connection with the Act’s minimum essential coverage requirements; provision of information to federal agencies including the IRS; data exchange; and establishment of a Navigator program.
- ¹⁰ 42 U.S.C. §18022, added by PPACA §1302.
- ¹¹ Center for Consumer Information and Insurance Oversight (CCIIO), *Essential Health Benefits Bulletin* (Dec. 2011); Centers for Medicare and Medicaid Services (CMS), *Frequently Asked Questions on Essential Health Benefits Bulletin* (Feb. 2012).
- ¹² 42 U.S.C. §18031(d)(1); 45 C.F.R. §155.100(b).
- ¹³ 42 U.S.C. § 18031(d)(1); Preamble 76 Fed. Reg. at 41870; 45 C.F.R. §155.100.
- ¹⁴ 42 U.S.C. §18031(b)(2); 45 C.F.R. §155.110(e).
- ¹⁵ 42 U.S.C. §18031(f)(1) and (2); 45 C.F.R. §155.140.
- ¹⁶ 42 U.S.C. §18031(d)(6); 45 C.F.R. §155.130.
- ¹⁷ Final exchange regulations published on March 12, 2012 require exchanges to establish governance principles including ethical standards, disclosure of financial interests, and conflict of interest policies. 45 C.F.R. §155.110(d).
- ¹⁸ Final regulations specify that exchanges must include at least one voting consumer member. 45 C.F.R. §155.10(c)(3)(i) (March 12, 2012).
- ¹⁹ 42 U.S.C. §13031(d)(4)(A); 45 C.F.R. §155.1000(c).

- ²⁰ In the insurance exchanges, consumers can choose among plans that vary by four distinct levels of cost-sharing: bronze, silver, gold, and platinum. The plans with the highest cost-sharing are bronze plans, which cover a minimum of 60 percent of health expenses; platinum plans must cover 90 percent of expenses.
- ²¹ 42 U.S.C. § 18031(d)(4)(F); 45 C.F.R. §155.302(d).
- ²² *Ibid.*
- ²³ 42 U.S.C. § 18031 (a)(4)(B); 45 C.F.R. §155.160(b)(2).
- ²⁴ 42 U.S.C. § 18031(d)(5); 45 C.F.R. §155.160(b)(1).
- ²⁵ 42 U.S.C. §18031(f)(3); 45 C.F.R. § 155.110(a).
- ²⁶ 42 U.S.C. §18031(c); 45 C.F.R. §156.230.
- ²⁷ The Act requires that QHPs have provider networks which include essential community providers, where available, that “serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 U.S.C. 1396r-8(c)(1)(D)(i)(IV)]....” 42 U.S.C. §18031(c)(1)(C); 45 C.F.R. §156.235.
- ²⁸ Guidance issued by HHS, Center for Consumer Information and Insurance Oversight in 2011 delegates to states the responsibility of defining essential health benefits in relation to one of several possible benchmarks. CCIIO, Essential Health Benefits Bulletin (Dec. 16, 2011), available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf (accessed March 15, 2012).
- ²⁹ Final exchange regulations note [at Preamble 77 Fed. Reg. at 18324] that the content and manner of appeals of eligibility determinations for individuals will be addressed in future rulemaking and thus HHS removed appeals from the list of exchange minimum functions. Exchange notices, however, are still required to include and explanation of appeal rights (45 C.F.R. §155.230).
- ³⁰ 45 C.F.R. § 155.210.
- ³¹ 45 C.F.R. § 155.220.

ABOUT THIS STUDY

To conduct this research, state laws were accessed through readily available legal search engines including Lexis and Westlaw, as well as through onsite access to state legislative and executive branch Web sites and consultation with exchange experts and analysts regarding state activities. Legal researchers with knowledge of the Affordable Care Act and implementing regulations and with substantial experience in legal analysis then carried out a content analysis of the state laws. This analysis was carried out using 13 key dimensions of analysis that were developed for the review project and applied to the legal review. These dimensions were built by identifying the key elements of the exchange provisions of the Act, as well as proposed regulations issued by the United States Department of Health and Human Services in 2011, a review of early exchange literature and analyses, examination of the National Association of Insurance Commissioners (NAIC) Model Exchange Act for its minimum essential elements,ⁱ and consultation with persons knowledgeable about state exchange implementation.

The 13 principal domains of analysis contain numerous subdomains. Using the domains and subdomains that were developed, researchers examined the exchange laws in 14 states (12 legislative enactments and two executive orders) that were adopted following the enactment of the Affordable Care Act; the laws of these 14 states were considered to contain sufficient content to lend themselves to an analysis of their provisions.

The analysis was conducted at two levels. First, for each issue represented in the domains and subdomains, state laws were examined to determine whether they specifically addressed a particular issue at all or, alternatively, were silent on the issue. Silence was coded as “not addressed in legislation;” where a state law did address an issue, the terms of the law were captured on a spreadsheet covering the 14 states addressed in this analysis.

The second step in the analysis was to compare state approaches to specific issues captured in the domains and subdomains. Thus, for example, one issue is the question of whether state law specifies that an exchange is to be an active or passive purchaser of qualified health plans (QHPs); that is, whether the exchange uses a selective contracting process to allow the exchange to only accept those QHPs deemed high in quality, low in price, etc. (active) or allows any qualified health plan to be sold in the exchange (passive). The state laws were examined to determine whether they addressed this issue. Then the state laws that did address the issue were compared to identify similarities and differences in approach. Illustrative examples showing the variable ways in which states elect to approach any particular issue are presented in this analysis. Future analyses will offer particular snapshots of the different approaches states are taking to particular aspects of exchange implementation.

ⁱ http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf (accessed March 15, 2012).

ABOUT THE AUTHORS

Sara Rosenbaum, J.D., is the Harold and Jane Hirsh Professor of Health Law and Policy at The George Washington University School of Public Health and Health Services and Founding Chair of the Department of Health Policy, George Washington University School of Public Health and Health Services. She has devoted her professional career to issues of health justice for populations that are medically underserved as a result of race, poverty, disability, or cultural exclusion. An honored teacher and scholar, a highly popular speaker, and a widely read writer on many aspects of health law and policy, Rosenbaum has emphasized public engagement as a core element of her professional life, providing public service to six presidential administrations and 15 Congresses since 1977. She is best known for her work on the expansion of Medicaid, the expansion of community health centers, patients' rights in managed care, civil rights and health care, and national health reform. Rosenbaum also regularly advises state governments on health policy matters and has served as a testifying expert in legal actions involving the rights of children under Medicaid.

Nancy Lopez, J.D., M.P.H., is a senior research scientist and professorial lecturer in the Department of Health Policy at The George Washington University School of Public Health and Health Services. She specializes in legal and policy matters related to health insurance exchanges, Medicaid, private health insurance, health reform implementation, and health care fraud. Her research has been used to produce analyses and papers regarding Medicare coverage determinations; health care volunteer and entity liability; nonemergency medical transportation; privacy rules related to Medicare claims data; health care fraud; and reimbursement policies of state Medicaid programs and private insurance for obesity treatment or prevention. Lopez is also part of the legal rulemaking record project for federal regulations relating to implementation of health insurance exchanges.

Taylor Burke, J.D., L.L.M., is associate professor of health policy at The George Washington University School of Public Health and Health Services, Department of Health Policy. He specializes in legal and policy issues as they relate to health information technology (HIT), health insurance exchanges, private health insurance, managed care, Medicare, Medicaid, and the application of antitrust law to health care payment reform. Burke currently serves as the coprincipal investigator on a federal contract for the creation of the legal rulemaking record for federal regulations implementing the planning and establishment of state-level insurance exchanges, and serves as project director for the multiyear Legal Barriers to Health Information Project, funded by the Robert Wood Johnson Foundation.

Mark Dorley, M.P.H., is a research associate in the Department of Health Policy at The George Washington University School of Public Health and Health Services, where he works on and supports multiple projects related to health reform implementation. He also serves as the content manager for the Web site HealthReformGPS.org. Dorley is particularly interested in Medicaid policy, health insurance coverage, health care fraud and abuse, and the intersection of health policy and the law. Previously, Dorley was an emergency room intake clerk in a level 1 trauma center, where he had significant exposure to both the clinical and business aspects of hospital emergency department operations.

Editorial support was provided by Chris Hollander.



www.commonwealthfund.org