Making the Grade

A Scorecard for State Health Insurance Exchanges

NJPIRG
Law & Policy Center

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Executive Summary

When it comes to health care, there are few magic-bullet solutions for the many problems consumers face in the marketplace: insurers don't compete for their business, leading to higher prices and lower quality. Important information about coverage is buried in the fine print, making it hard to know what's really covered or which plan is right. And costs are continuing their unsustainable rise.

Yet there are policy solutions that can make a difference and give consumers a better deal on health care. One of the most important of these is the creation of new state-based health insurance marketplaces, called exchanges. These exchanges, authorized by 2010's health reform law, offer the states the chance to address the twin problems of cost and quality, and help consumers get a fair shake when buying insurance.

Exchanges give individuals and small businesses the same advantages that large businesses generally enjoy when it comes to buying health insurance. Large businesses have strong negotiating power, allowing them to get a lower rate for coverage as insurers compete for their business. They also benefit from economies of scale that lower administrative costs, and have sophisticated human resources departments and brokers at their disposal, making it easier for employees to understand their options and decide which plan is right for them.

In much the same way, exchanges give individuals and small businesses the ability to band together and gain the same benefits of size, negotiating power, and information. By providing better options and better information, and negotiating on behalf of its enrollees, the exchange can level the playing field for consumers.

States thus have an important opportunity to improve their health care marketplaces through the creation of an exchange. And the health reform law gives the states substantial leeway to define critical aspects of the exchange, including who is eligible to buy coverage through it, how aggressively it will set standards and negotiate with insurers, and who will run it. A weak exchange could wind up taking its cues from the insurance industry, not consumers, and do

little to shift the fundamental problems in most states' health care markets. A strong exchange, though, can be just the tool states need to revolutionize their health care systems and improve quality while lowering costs.

As of this writing, several states have already taken this opportunity and established their exchanges. But not all exchanges are created equal, and many states have yet to commit to establishing one. This report assesses the progress that the states have made, and for the states that have begun to set up their exchange, evaluates them on the myriad policies and criteria that will determine whether it is ultimately successful in improving health care for consumers.

Grading the Exchanges

Our scorecard breaks exchanges down into four major areas: first, the governance and overall structure of the exchange; second, the ability of the exchange to negotiate on behalf of consumers and drive lower rates and higher quality; third, the overall consumer experience and ease of use when searching for and buying coverage on the exchange; and fourth, the stability of the exchange and its protections against the risk of adverse selection.

Within governance, key policies include:

- **Exchange structure**: the exchange should be an independent public agency, to maximize its flexibility and accountability.
- **Board makeup**: the board should be run by consumers and their representatives, not the insurance industry.
- **Conflicts of interest**: board members should not make decisions that implicate their personal or financial interests.
- **Size of the exchange**: the exchange should be open to larger businesses so more consumers can see its benefits.
- **Stakeholder input**: consumers should be consulted as the exchange forms its policies.

For negotiating power and driving value, our criteria are:

- **Active purchasing**: the exchange must have the power to negotiate with insurers and push them to deliver higher-value care.
- **Delivery and payment reforms**: by promoting innovations like emphasizing primary care and paying for quality rather than quantity, the exchange can reduce premiums and improve value.
- **Rate review**: the exchange should be integrated into the state's rate review system.
- **Standardization of products**: to help make consumers' choices more understandable, the exchange should be able to standardize plan offerings.

Important points for the consumer experience include:

- **Navigators**: exchange Navigators will help consumers choose and enroll in coverage; they should have strong relationships with communities with a high number of potential enrollees, and the program should not be limited to brokers.
- **Rating tools**: the exchange website

should provide robust tools to allow consumers to make apples to apples comparisons and pick the plan that's right for them.

- **Eligibility and enrollment systems**: applicants to the exchange should experience a seamless eligibility determination process, and if they're eligible for other public programs, they should be automatically enrolled in them instead.

- **Privacy protections**: the exchange must safeguard the personal information of enrollees.

- **Language access**: exchange materials must be available in the primary languages spoken by enrollees.

To ensure the exchange remains stable, states must take these actions:

- **Ongoing monitoring**: to protect the exchange from adverse selection, which would make the exchange's risk pool sicker and more expensive than the outside market, the exchange must monitor the danger and recommend legislation if necessary.

- **Prohibitions on steering**: to prevent insurers or brokers from segregating high-risk enrollees onto the exchange, the state should prevent steering.

- **Restrictions on off-exchange plans**: limiting the availability of high-deductible "catastrophic" plans off the exchange, and requiring high-benefit products to be offered both on and off the exchange, allows the state to mitigate the risk of adverse selection.

- **Financing**: ensuring that fees apply to all insurance plans in the state will

Table 1. State Exchange Scorecard.

State	Governance and Structure	Negotiating Power and Driving Value	Consumer Experience	Stability	Total Score	Percentage of Available Points	Final Grade
California	21 of 25	13 of 30	12 of 25	8 of 15	54 of 95	57%	B+
Colorado	9 of 22	3 of 15	N/S	N/S	12 of 37	32%	C *
Connecticut	21 of 22	13 of 30	12 of 25	5 of 15	51 of 92	55%	B+
Hawaii	5 of 22	3 of 15	7 of 10	1 of 2	16 of 49	41%	C
Maryland	21 of 22	3 of 5	4 of 10	1 of 2	29 of 39	74%	A *
Massachusetts	13 of 25	16 of 20	15 of 20	N/S	44 of 65	68%	A-
Nevada	8 of 25	N/S	N/S	N/S	8 of 25	32%	C *
Oregon	15 of 25	14 of 30	11 of 25	2 of 15	42 of 95	44%	B-
Rhode Island	14 of 25	24 of 30	5 of 25	2 of 15	45 of 95	47%	B
Vermont	5 of 9	23 of 30	12 of 25	0 of 8	40 of 72	56%	B+
Washington	17 of 22	3 of 5	N/S	N/S	20 of 27	74%	A *
West Virginia	11 of 25	3 of 5	N/S	N/S	14 of 30	47%	B *

States with asterisks next to their grades have been assessed on criteria worth half or less of all available scorecard points. Typically, this is because their legislation sets up governance and structure only, and contemplates future state action; we have accordingly not rated them on criteria their laws do not address. Thus, their grades should be considered highly provisional.

mean neither insurers nor consumers will have an incentive to avoid the exchange.

Twelve states have so far established exchanges with sufficient detail to allow us to score them using these criteria. Table One details our findings—different states have pursued different models, each with their own strengths and weaknesses, and states that have yet to take action have a variety of examples to look to in crafting an exchange that will work best for them.

Getting an Incomplete

Beyond these twelve, many other states have yet to take action to create their exchange, giving them an Incomplete on our scorecard—they have not yet made the decisions necessary to judge whether or not their exchange will be pro-consumer—or, indeed, whether the state itself will run the exchange, or if the federal government will step in to establish it.

In general, most states are pursuing the creation of their own exchange, or at least are exploring the tradeoffs of running it themselves as against leaving its operation to the federal government. Only two states appear to have entirely rejected the idea of creating an exchange—Louisiana and Florida—while twelve other states have officially expressed their intent to create a state exchange, or created a formal study committee to weigh their options.

There will be many policy decisions that must be made, and much infrastructure that must be created, to ensure that the exchange is open and ready to do business in 2014. With the states that have already taken action providing a guide to the remaining states, it's past time for those that have yet to set up their exchange to get the ball rolling.

I. Introduction

When it comes to health care, there are few magic-bullet solutions for the many problems consumers face in the marketplace: insurers don't compete for their business, leading to higher prices and lower quality. Important information about coverage is buried in the fine print, making it hard to know what's really covered or which plan is right. And costs are continuing their unsustainable rise, with premiums for employer-sponsored coverage rising between 8 and 9 percent over the course of 2010.[1] Nationally, the great majority of individual-market policyholders— 77% —saw a premium increase from early 2009 to early 2010, with an average rate hike of 20%.[2]

Yet there are policy solutions that can make a difference and give consumers a better deal on health care. One of the most important of these is the creation of new state-based health insurance marketplaces, called exchanges. These exchanges, authorized by 2010's health reform law, offer the states the chance to address the twin problems of cost and quality, and help consumers get a fair shake when buying insurance.

In principle, exchanges are a simple idea: they give individuals and small businesses the same advantages that large businesses generally enjoy when it comes to buying health insurance. Large businesses have strong negotiating power, allowing them to get a lower rate for coverage as insurers compete for their business. They also benefit from economies of scale that lower administrative costs, and have sophisticated human resources departments and brokers at their disposal, to make it easier for employees to understand their options and decide which plan is right for them.

In much the same way, exchanges give individuals and small businesses the ability to band together and gain the same benefits of size, negotiating power, and information. By providing better options and better information, and negotiating on behalf of its enrollees, the exchange can level the playing field for consumers.

States thus have an important opportunity to improve their health care marketplaces through the creation of an exchange. And the health reform law gives the states substantial leeway to define critical aspects

of the exchange, including who is eligible to buy coverage through it, how aggressively it will set standards and negotiate with insurers, and who will run it. The details of these decisions matter, and will determine whether the exchange fully lives up to its promise. A weak exchange could wind up taking its cues from the insurance industry, not consumers, and do little to shift the fundamental problems in most states' health care markets. A strong exchange, though, can be just the tool states need to revolutionize their health care systems and improve quality while lowering costs.

Under the health reform law, state exchanges will be open for business starting in 2014. Before then, states will need to create their own exchanges—and if a state is not on track to do so by 2013, the federal Department of Health and Human Services will step in to operate one for the state.

As of this writing, several states have already taken this opportunity and established their exchanges. But not all exchanges are created equal, and many states have yet to commit to establishing one. This report assesses the current state of play, examining the progress that the states have made, and for the states that have taken the step of setting up their exchange, evaluating them on the myriad policies and criteria that will determine whether their exchange is ultimately successful in improving health care for consumers.

The remainder of this Introduction elaborates on what the federal law requires the states to do when they set up an exchange. The immediately following section explains in detail the scoring criteria we used to grade the state exchanges. The third section presents a report card for each of the states that have so far taken action on their exchange. Finally, the report concludes with a short analysis of where the remaining states are in terms of creating their exchange.

The fact that a majority of states have yet to formally establish their exchanges should not obscure the progress that has been made—in almost all states, study committees and stakeholder processes are examining options, looking to the examples of other states, and preparing to act. And several pathbreaking states are showing the way for others, even as they grapple with the increasingly detailed questions of implementation.

We hope that policymakers and advocates in the states where an exchange has been established will be able to use this report to identify the strengths and weaknesses of their state's exchange; even in California and Massachusetts, which have made the most progress towards setting up their exchanges, much work remains to implement the fine details of the new marketplace. For states that have yet to take action, the scorecards included in this report provide examples of which states have adopted best practices in specific areas of exchange implementation, allowing them to pick and choose the approaches that will work best for their unique health insurance markets.

The findings in this report are only a snapshot. As of this writing, many states continue their deliberations, and more may still take action before the end of the year. In the future, we plan to revisit these issues in later editions of this scorecard as more state exchanges become established, and early-adopter states bring their exchanges closer to being operational.

Exchange Requirements

States have a large amount of flexibility to adapt the exchange to their particular goals and the state's market and policy environ-

ment, but the federal law does provide some important guidelines and requirements, including:

Timeline: Federal reform gives states the responsibility to establish exchanges for individuals and small businesses by 2014. If states do not establish an exchange by 2014, the federal government will establish one for them.[3]

Funding: States can apply for federal grants to help set up exchanges. By 2015, however, exchanges must be self-sustaining.[4]

Eligibility: Individuals without group coverage will be able to use the exchange, as will small businesses of up to 100 employees, once the law's full provisions go into effect in 2014. States that currently define a small business as one with 50 or fewer employees may first open the exchange to these smaller businesses and then expand to businesses with up to 100 workers by 2016. Further, states are explicitly authorized to open the exchanges to larger employers starting in 2017. The state may run separate exchanges for individuals and businesses, or combine them.[5]

How consumers connect to the exchange: The federal government will make a template internet portal available to states.[6] States are required to create a website to help consumers compare plans, and operate a toll-free hotline to answer questions.[7]

Helping consumers compare plans and sign up: The law directs the federal government to develop ranking systems on cost and quality, as well as an enrollee satisfaction survey tool, for states to use to help consumers compare plans in the exchange.[8] It also requires states to use a standardized format to present health plan options, help applicants eligible for Medicaid or another public program enroll into that program, and offer an electronic calculator to allow consumers to evaluate their expected premiums after any tax credits or other benefits are factored in.[9]

Benefit package: The federal government will establish an essential health benefits package and four tiers of coverage, including bronze (the lowest level), silver, gold, and platinum (the highest), with a fifth "catastrophic" plan only available to people under 30 or who are exempt from the requirement to have coverage.[10] States can require additional benefits, but must assume the cost for any subsidies for the additional benefits.[11]

Subsidies: Consumers that make too much to qualify for Medicaid but cannot afford coverage are eligible for sliding scale assistance to pay for premiums, and limits on out-of-pocket costs. These subsidies are only available on, and will be delivered through, the exchange.[12]

Criteria for health plans: The law directs the federal government to set criteria for an insurance plan to be a "qualified health plan" and allowed into the exchange. Criteria will include having sufficient choice of providers and implementing a quality improvement program. The law delegates the enforcement of the certification of qualified health plans to the state exchange.[13] Aside from some narrow exceptions, states may develop and enforce additional criteria for qualified health plans, to better serve the interests of enrollees. For example, the state can empower the exchange to set additional quality standards, negotiate on costs, and engage in selective contracting. The exchange may also exclude plans with premium increases that are unjustified.[14]

Reinsurance and Risk Adjustment: The law directs states to establish a

reinsurance mechanism by 2014, to protect insurers in the individual and small group markets from having to raise rates because too many of their enrollees are sicker than average. For similar reasons, it also provides for risk corridor and risk adjustment programs.[15]

Process: The law requires state exchanges to consult with a range of interests in setting up their exchanges, and requires the exchange to be transparent regarding its costs.[16]

Outside of these fairly limited provisions, states can make their own decisions about what their exchange should look like and who should run it.

II. Explaining the Scorecards

This section explains the scores used to grade each state's exchange. Our scorecard breaks exchanges down into four major areas, issuing subtotal grades for each: first, the governance and overall structure of the exchange; second, the ability of the exchange to negotiate on behalf of consumers and drive lower rates and higher quality; third, the overall experience and ease of use the consumer will experience when searching for and buying coverage on the exchange; and fourth, the stability of the exchange and its protections against the risk of adverse selection.

The policies and issues we use to grade the state exchanges are in large measure drawn from the best practices identified in our previous report, *Building a Better Health Care Marketplace*. For more detail on these policies, please consult that report.[17]

This scorecard does not set out a one-size-fits-all model for an exchange. Different states have very different health care marketplaces and population health needs, and will justifiably take different approaches in creating their exchange. The criteria that follow primarily look to a few basic, building-block protections that will benefit consumers in all states, and at whether the exchange is given the flexibility and power it needs to meet enrollees' needs. Two exchanges that both have the power to set standards for plans to participate, or to recommend legislation to protect against adverse selection, may well make very different decisions about how best to exercise those powers—but regardless of the content of those decisions, they will both provide a better marketplace for consumers than an exchange that lacks those powers entirely.

As of this writing, the federal Department of Health and Human Services is soliciting comments on draft regulations governing state exchanges. Many of those regulations pertain to the issues discussed below. However, since the regulations have yet to be finalized, we do not include their requirements in our grading.

Table 2. Model Scorecard

Governance and Overall Structure		Negotiating Power and Driving Value	
Exchange Structure	5 points	Active Purchaser	10 points
Board Makeup	8 points	Delivery/Payment Reforms	10 points
Conflicts of Interest	5 points		
Transparency	2 points	Rate Review	5 points
Size of Exchange	3 points	Standardization of Products	5 points
Stakeholder Input	2 points		
TOTAL	**25 points**	**TOTAL**	**30 points**
Consumer Experience		**Stability**	
Navigators	5 points	Ongoing Monitoring	3 points
Rating Tools	5 points	Prohibitions on Steering	5 points
Eligibility and Enrollment Systems	5 points	Restrictions on Off-Exchange Plans	5 points
Privacy Protections	5 points		
Language Access	5 points	Financing	2 points
TOTAL	**25 points**	**TOTAL**	**15 points**
TOTAL SCORE: 95 points			

Governance and Overall Structure

The basic structure and governance of the exchange are absolutely critical to making the new marketplace a success. The exchange must be transparent and accountable to the individual and small business consumers who will buy their coverage through it. If it is dominated by industry interests or opaque in its operations, it will not win consumers' trust and will have a hard time attracting enrollees. And because the broader the exchange's eligibility rules are, the more consumers will be able to benefit, it is important to cast as wide a net as possible.

This series of criteria are worth 25 points in total.

Exchange Structure: states have three primary options for how to set up their exchange: as an independent public agency with its own governing board; as an ordinary part of its administrative agencies; or as a private not-for-profit corporation.

Accountability can best be insured by creating the exchange as a strong, independent public agency, with a governing board. Having the exchange be a private non-profit runs the danger of making it unaccountable to the public. At the same time, the exchange will need to have some degree of independence from the state's government; otherwise it will not have the agility and power it will need to be an effective advocate for consumers, and consumers and insurers might fear that practical business decisions would be influenced by political considerations.

This criterion is worth up to five points; we assign the full five if the exchange is an independent public agency with its own board, two if it is an ordinary part of a state administrative agency, and zero if it is a private nonprofit.

Board makeup: the board of the exchange will be charged with making many decisions that will have profound implications for the state's health care and insurance markets. For it to serve the interest of enrollees when it confronts these decisions, consumers should play the leading role, and it must be free of industry influence.

Consumers need the exchange to deliver high quality, affordable coverage—when it comes to negotiating for a better deal, their interests are at odds with those of the insurers. Because brokers are usually paid by insurers on commission for the policies they sell, they face a similar conflict of interest. So do providers, because pressure on insurers to lower costs might translate to cost pressure on providers. As a result, representatives of these industry interests should not serve on the exchange board (though exceptions could be made for health care providers who do not have an ownership interest in a health care facility or hospital or who do not currently practice, as the impact of exchange decisions on their financial affairs would be very limited). Representatives of associations of such industries, or of businesses a majority of whose clients are in such industries, likewise should be excluded from service.

This criterion is worth up to eight points. We assign the full credit if all industry representatives are barred from serving on the board, and there is a majority of consumer representatives; seven points if all industry representatives are barred but there is no guarantee of a consumer majority (due to the presence, for example, of state government officials serving *ex officio*). Where some, but not all industry representatives are barred but there is a consumer majority, we assign five points. If a state does not specifically bar industry representatives but prevents anyone with a financial conflict of interest from serving on the board, or if some industry representatives are allowed but they are specifically prohibited from constituting a majority, we assign four points.

If some but not all industry representatives are barred, but there is no requirement of a consumer majority and nothing to stop industry from receiving a majority of the board, we assign two points. If no industry interests at all are barred, and they may be able to establish a voting majority, we assign one point; if the exchange board is stipulated to consist of a majority of industry representatives, we award zero points.

Finally, where a state has chosen to set up its exchange as part of a state agency, this criterion is inapplicable and we do not include it in calculating the state's score.

Conflict of interest protections: keeping industry representatives from serving on the exchange board is an important step, but by itself will not guarantee that the board's decision-making is free of conflicts of interest. Board members might face a conflict when particular decisions implicate specific financial or personal interests. In such cases, the conflict of interest should be disclosed, and board members should recuse themselves from both discussion of and voting on the issue.

This criterion is worth five pints; states receive full credit if board members with a conflict must recuse themselves from both discussion and voting; three points if they must be recused from voting but may otherwise participate in discussion about the decision; and zero points if there are no conflict of interest protections.

As above, where a state has chosen to set up its exchange as part of a state agency we do not consider this criterion.

Transparency: the public needs to know that the exchange is working efficiently to promote their interests. The state will also need to know the details of its operations, to inform their oversight and deliberations about possible further reforms. As result, transparency and public reporting are critical to allowing the exchange to build the trust it needs to do its job.

That means the exchange's yearly budget and details of its spending and revenue, including any contract agreements it reaches with insurers or outside vendors, should be made available to the public. Transcripts of hearings and other public proceedings should also be public and easily accessible.

However, some records and information, in particular those involving specific negotiations with health insurers, will need to remain confidential in order to protect the exchange's ability to drive a good bargain on behalf of consumers. Such materials should ordinarily not be open to public disclosure.

This criterion is worth two points. A state receives full credit if the state's open meetings and public records laws apply to all exchange activities except the sensitive contract-related issues discussed above, and if the exchange's budget and final contracts are open to public inspection. We assign one point if less comprehensive or less specific transparency measures apply, and zero points if there are no specific guarantees of transparency.

Size of the exchange: the exchange will be most effective if it is open to as many consumers as possible. Greater enrollment means greater negotiating power, greater stability, and greater economies of scale, as well as providing the exchange's benefits to even more of a state's residents.

Under the federal law, states must open their exchanges to individuals and small businesses with up to fifty employees starting in 2014, and to small businesses with up to 100 employees in 2016. They have the option of including all businesses up to 100 employees immediately in 2014, and likewise of opening the exchange to large businesses with more than 100 employees in 2017.

This criterion is worth three points. The full three points are awarded if small businesses up to 100 employees are eligible in 2014, and large businesses are allowed into the exchange in 2017; two points are awarded if small businesses up to 100 employees are on the exchange in 2014 but no action is taken on large businesses. A single point is given where large businesses are allowed in starting in 2017, but businesses between 51 and 100 employees only get exchange access in 2016. Zero points are assigned if the state only abides by the federal minimums.

Stakeholder input: the exchange's decisions will be better if they're informed by representatives of important stakeholder groups, including an array of consumer representatives who can best communicate the unique needs of particular constituencies. Of course, industry participation in such stakeholder processes is also important.

This criterion is worth two points, which are given if the exchange is specifically instructed to consult with stakeholders including consumer representatives. If there is no such instruction (including if there is a stakeholder process in which consumers are not specifically named), zero points are assigned.

Negotiating Power and Driving Value

If the exchange is simply a website that offers the same plans that are currently available on the market, it will have missed much of its potential. A well-made state exchange can help deliver lower costs for individuals and small businesses. Just as big businesses negotiate with insurers, using the bargaining power of their employees to push for lower premiums, so too can exchange enrollees benefit from a muscular exchange that negotiates on their behalf for better choices and lower costs.

The exchange will need to do more than simply take all insurers who want to sell their products to its enrollees. It will have to take a close look at the benefits being offered, and the premiums and cost-sharing being charged, to assess whether they provide a good value. And in addition to negotiating on cost, it should also push insurers to adopt groundbreaking payment and delivery reforms, like bundled payments and reimbursement for better primary care through medical homes, which can lower costs while improving quality.

Another way the exchange can facilitate lower costs and higher value is by standardizing insurers' products so consumers have apples to apples choices of plans, which will foster competition on price and quality rather than confusing fine print. And because insurers' premium increases will be reviewed to determine whether they're unreasonable, the exchange should also engage with that process to make sure enrollees are receiving a fair deal.

This set of criteria are collectively worth thirty points.

Active purchaser authority: empowering the exchange to negotiate will provide consumers and small businesses with an exchange that is not only a transparent and fair marketplace, but also a much-needed advocate standing up for their interests. A negotiating exchange will deliver concrete value for enrollees, with the potential to save consumers millions of dollars.

There are two primary ways the exchange can leverage the bargaining power of its enrollees: first, by engaging in individual negotiation, or "selective contracting," with insurers, deciding on a case by case basis whether a particular product will deliver a high value option for enrollees, and second, by setting overall plan criteria in addition to the federal minimums. Ideally, exchanges will be empowered to use both tools.

This criterion is worth up to ten points. A full score is awarded where the exchange has the power to set certification standards above the federal minimums, with an explicit direction to include cost or value as one of the criteria, and is also directed to negotiate individually with insurers and/or engage in selective contracting. Eight points are given where the exchange can set standards but cost or value are not specifically listed, and the exchange has selective contracting or individual negotiation authority.

Five points are given if the exchange can only set standards for certification, but cannot engage in individual negotiation or selective contracting. If the state does not explicitly address the question of the exchange's ability to act as an active purchaser, we award two points. And if the state specifically requires the exchange to take all comers or bars it from saying no to a plan, we assign zero points.

Delivery and payment reforms: too much of our current health care spending does not yield improved health. Instead, as

much as a third of all health care spending goes to treatments that at best are ineffective, and at worst can pose a danger to patient health.[18] The widely used fee-for-service payment approach, which rewards providers for the number and complexity of tests and procedures that can be billed, not the quality of care provided or whether the patient gets healthy, is one root of this problem.

Fortunately, research and the experience of innovative providers across the country have charted a path toward medical care which can better rein in costs and improve patient's health. Primary care physicians need to be able to work as a part of a team coordinating with a patients' other health professionals so that patients get all the care they need while avoiding unnecessary, duplicative, or harmful tests and procedures.[19]

The exchange, in its negotiations with insurers, can drive them to adopt these proven strategies, which will improve enrollees' health and lower overall health care costs. It should have a variety of mechanisms at its disposal in accomplishing these goals. If the exchange requires plans to submit competitive bids to participate, the extent and quality of cost-saving reforms should be a required element of every insurer's bid. Insurers participating in the exchange could be required to pay providers via bundled payments where appropriate, or reimburse primary care doctors for leading a medical home team.

The impact of the exchange's efforts in this area will be magnified if it coordinates with other payers in the state, including state employee benefit plans and large employers.

This criterion is worth ten points. The full value is assigned if the state directs the exchange to require plans to adopt a robust suite of delivery and payment reforms, including medical homes and better primary care, and also to align its payment policies with those of other large payers. Eight points are given if there is no instruction to align incentives with other payers, but the exchange can require insurers to adopt reforms.

Five points are given if the exchange can encourage reforms, but is not specifically allowed to require these reforms of participating plans. If the state gives the exchange the ability to label certain plans as high-performing on these reforms, so that consumers can take this into account when choosing coverage, we assign three points. If no mention is made of these reforms, we assign zero points.

This criterion is interactive with the previous one; if an exchange must take all comers, its ability to drive change in the marketplace will also necessarily be limited.

Incorporation of rate review: the exchange can play a role in protecting consumers from unreasonable rate increases. In many states, regulators review insurers' proposed rate increases to ensure that they are justified, and the new law sets up a similar procedure at the federal level for states that do not currently review rates. In determining whether a premium increase is justified, regulators weigh some considerations that are similar to those the exchange should use in its negotiations, including whether the benefits offered are reasonable given the premium being charged. However, rate review also looks to broader issues, including the impact of the rate increase on insurers' solvency and ability to pay future claims.

Because the exchange, unlike a regulator, is concerned first and foremost with the interests of consumers, rate review is no

substitute for an exchange with the power to negotiate. But states should take steps to harmonize the exchange's negotiations with their regulatory rate review processes, increasing the exchange's effectiveness and efficiency. In particular, the exchange should be directed to decertify plans with a history of unreasonable rate increases, and should participate in the rate review process by submitting comments to the appropriate authority, to ensure that the review takes account of the exchange's perspective and priorities.

This criterion is worth five points in total. All five are given where the state exchange is directed to refuse plans with a history of unreasonable rate increases (in states where regulators have prior approval over both the individual and small group markets, we assume that this criterion is met), and the exchange is instructed to submit comments or otherwise engage in the rate review process; we assign three points where one or the other of these criteria are met; and where neither is included, we assign zero points.

Standardization of products: one important way the exchange can help improve cost and quality is by empowering consumers to make more informed decisions about their coverage. In particular, by standardizing the products insurers offer, it can help foster healthy competition: if insurers' ability to come up with dozens of products with slight benefit variations is limited, consumers will have an easier time comparison shopping on cost and quality.

The experience of Massachusetts's state exchange, the Connector, has been that consumers prefer to have fewer, more significantly different options, rather than a vast array of slightly-varied products whose differences are not immediately clear.[20] Exchanges can respond to this desire and further drive competition by standardizing products to weed out unnecessary variation and allow for better comparison-shopping.

States may earn up to five points under this criterion. Five are awarded if insurance products both on and off the exchange are standardized; three are given where exchange products only are standardized; one point is given if some, but not all, plans either on or off the exchange are standardized; zero points are assigned if there is no power to standardize plan offerings.

The Consumer Experience

Perhaps the ultimate test of the exchange's effectiveness will be whether it becomes an attractive, consumer-friendly marketplace. For all the attention that must be paid to getting the behind-the-scenes aspects of the exchange to work, the front end is just as important. When a consumer goes to the exchange to buy coverage, it should be a simple, easy process, unencumbered by needless red tape.

There should be comparison tools that make the task of picking a plan intuitive and clear, and informed exchange employees who can help guide consumers through the process. Consumers' personal information should be protected, the linguistic and cultural diversity of the state should be taken into account, and if someone who is eligible for a public program like Medicaid applies to the exchange, they should be seamlessly enrolled in that program without having to jump through additional bureaucratic hoops.

Even if the state ensures that its exchange is fair and effective, if it is not easy to use and trusted by consumers, eligible enrollees won't materialize. And

if consumers lack the ability to understand their options and make informed decisions, the power of the exchange to drive competition and quality will be undermined.

In total, states may earn up to 25 points under the criteria in this area.

Navigators: the federal law requires state exchanges to run a Navigator program, through which the exchange will contract with individuals and organizations to provide information and help eligible consumers enroll in the exchange.

Insurance brokers and agents may be a natural choice to help with some aspects of the Navigator program, but while many brokers possess significant expertise about private coverage, and have deep relationships with some small businesses, in many states they may not have the required knowledge about public programs, or the language or cultural skills needed to perform effective outreach to underserved communities.

As a result, in designing their outreach efforts, states should make sure that they have all their bases covered—in some communities, brokers can be an effective information source, but a strong Navigator program should also include a wider array of organizations, particularly those with longstanding ties to underserved communities and constituencies.

There are five points available under this criterion. All five are awarded where the exchange is directed to partner with community and/or consumer groups as part of its Navigator program, and there's no restriction requiring Navigators to be licensed as brokers; three are given if there is no requirement that Navigators be brokers, but there is no direction given on community or consumer group participation; and no points are given where the state requires all Navigators to be licensed as insurance brokers or agents.

Rating and ranking tools: consumers must be able to understand their options and easily determine what coverage is right for them, in order to maximize the benefits of the exchange as a competitive health care marketplace. To get past this confusing status quo and provide a consumer-friendly shopping experience, the exchange must do several things.

First, it must help consumers make apples to apples comparisons of plans, making it easy for a consumer to compare the important aspects of two different coverage options at a glance, so they can focus in on important differences as they narrow down the list of options. This should also include ratings that allow for a clear understanding of when one plan is better than another, rather than simply just different.

It must also make it easy to find products that meet a consumer's needs. The consumer should be able to prioritize different criteria, such as whether they care more about price, specific categories of benefits, location and breadth of provider networks, customer service, quality of care, history of premium increases, and so on—and then run a customized search to find plans that meet those particular needs.

We give up to five points under this criterion. Full credit is awarded if the exchange is instructed to provide consumer tools allowing for consumers to make easy, apples-to-apples comparisons on cost, benefits, and provider networks, and both rankings and ratings are incorporated into these tools. Two points are given if the exchange is empowered to develop such tools but without the specificity of incorporating rankings or easy comparisons on each of the above areas. Zero points are assigned if there are no specific directions on this point.

Eligibility and enrollment: under the federal law, exchanges must use a single, streamlined application for coverage, helping to make enrollment and eligibility determinations much simpler and less administratively complex. However, there is a major potential challenge the exchange's eligibility and enrollment systems must confront: some of those who try to buy coverage through the exchange will inevitably be eligible for a public program, such as Medicaid or CHIP.

In order to meet this challenge in an efficient, cost-effective way, the exchange must make it simple for consumers to enroll in the program that is appropriate for them. This means it must coordinate its eligibility systems with those of the state's public programs, to catch whether an applicant is eligible for one of them instead. If so, the exchange should forward the application to the relevant agency, which can then process the paperwork and enroll the applicant, without requiring the applicant to submit duplicate forms or visit another office.

Creating this streamlined no-wrong-door enrollment system will be important to ensuring that consumers are able to easily sign up for coverage. Not only will this benefit those consumers, it will also be important for ensuring that the exchange has a stable risk pool—the larger the number of enrollees, the more stable the exchange will be, and the applicants most likely to be turned off by a complex application process will be those who are healthy and least in need of coverage.

This criterion is worth up to five points. Five are assigned if the exchange is instructed to create a no-wrong-door enrollment system that automatically enrolls applicants into whatever coverage program they are eligible for; two points are given if the exchange is required to coordinate with the agencies responsible for other public programs, but could still require consumers to manually resubmit or revise their applications; and zero points are assigned if there are no instructions above the federal minimum.

Privacy protections: if consumers are not confident that the exchange will keep their personal data safe, they will be hesitant to enter the exchange or give it the personal and financial information needed to make accurate eligibility and enrollment decisions. Thus, the exchange must develop and implement a plan to ensure that identifiable personal information is not shared, internally or externally, with those who do not have an immediate, legitimate need for it, for example in order to make eligibility determinations or process payments.

In particular, it should be barred from selling any personal data, even in the aggregate or de-identified, or share it with others for commercial use. Protections must be adopted to prevent data breaches or unauthorized access, and in the event that such breaches do occur, the exchange must speedily inform consumers and take strong action to minimize the harm.

We award up to five points for this area, with full credit going to states that specifically prohibit the sale or commercial use of any personal data, and specifically require consumers to be notified in the event of a data breach. Three points are awarded if one but not both of these protections are in place; zero points are assigned otherwise.

Language access: in performing outreach and helping consumers to enroll in coverage, the state must take account of the diverse language and cultural needs of potential enrollees and lay out a plan to meet them—simply offering a Spanish version of the web portal, for example, is a good start but in most states will likely not be enough to guarantee that all consumers

are able to use the exchange effectively. A good rule of thumb is that all written materials should be translated into any language spoken by at least 5% of potential enrollees, assessed on a per-county or per-city level, and provision should be made for enrollees speaking other languages that fall below this threshold.

States can earn up to five points for these issues. All five are given if the exchange's written materials must all be translated into languages spoken by at least 5% of the eligible population, on a per-county and/or per-city basis, and specific provision is made for translators for other languages that fall below this threshold; we give two points if the exchange is simply instructed to address linguistic and cultural competency issues in developing its materials and outreach; zero points otherwise.

Stability and Protection From Adverse Selection

In the past, many states have experimented with creating purchasing pools like exchanges, and their experience has shown that safeguarding the stability of the exchange must be a high priority. Many such pools have been failures, forced to close their doors by upwardly-spiraling premiums and downwardly-spiraling enrollment.[21] These failures can often be traced to a single dynamic: sicker enrollees congregated within the purchasing pools, with healthier enrollees remaining outside. Because sicker enrollees cost more to insure, this drives up premiums, leading more healthy people to drop coverage and secure less expensive coverage on their own, which in turn sends premiums within the pool up again. This phenomenon, called adverse selection, can lead to a vicious cycle that only ends with the destruction of the purchasing pool.

States must ensure that the exchange does not become a dumping-ground for less-healthy patients, with healthier enrollees purchasing coverage outside of it. This is critical both to protect consumers and to instill confidence in insurers—if they are worried that adverse selection might undermine the exchange, they will be significantly less likely to participate.

Fortunately, the federal law guards against the worst risks of adverse selection by preventing insurers both on and off the exchange from directly discriminating against the sick, and it also contains specific provisions aimed at balancing risk on and off the exchange. But to complement these policies, states must adopt additional measures to ensure that adverse selection does not undermine the viability of their insurance market.

Fifteen points in total are assigned for these issues.

Ongoing monitoring: one of the simplest, yet most important, things a state can do to prevent adverse selection is to monitor the stability of its exchange. If the exchange, or a state regulatory body, is instructed to closely measure the risk profile of enrollees on and off the exchange, it can take quick action to prevent or mitigate problems as they arise. In many cases, this may require further state legislation to stabilize the market outside the exchange, so the entity monitoring for stability should have the power to recommend legislative action if needed.

Three points are assigned for this criterion: all three are given if the state sets up an authority to watchdog adverse selection, and empowers the watchdog to recommend legislative action or otherwise take needed

action to correct problems; one point is given if the state requires monitoring of the exchange's stability but does not provide specific powers to correct any imbalances; we assign zero points if the risk of adverse selection is not addressed.

Prohibition on steering: one way that less-healthy people can wind up in the exchange is if insurers or brokers put them there. Because many insurers might wish to keep their non-exchange risk-pool as healthy as possible, they may have an incentive to direct less-healthy applicants into the exchange.

To guard against this possibility, states should protect the exchange by prohibiting insurers or brokers from steering people either onto or off of the exchange, through setting different broker commissions, adopting targeted marketing strategies, or by any other method. This prohibition should be policed via the state insurance regulator, as well as the licensing authority for brokers.

Five points may be given for this criterion. Full credit is assigned if both brokers and insurers are prevented from steering enrollees either on or off the exchange, including requirements that all products be fairly and affirmatively marketed to all potential enrollees. Three points are given if there are general steering prohibitions that do not go into specific detail, or that prohibit steering only for exchange-participating plans. Otherwise, we assign zero points.

Restrictions on plans offered outside exchange: If certain kinds of products are primarily available either on the exchange or off of it, consumers who want those kinds of products will be drawn to that marketplace. That means that if products that appeal most to healthy consumers are primarily available outside the exchange, or if products that sicker consumers will want to buy are primarily available on the exchange, this could create a risk of adverse selection.

A state can reduce this risk by requiring insurers to offer "mirror" versions of all their products, such that they sell identical exchange and non-exchange products. If that approach is not possible, states could ensure that at least some products are available both inside and outside the exchange. The federal law already requires that exchange-participating insurers offer both at least one silver and one gold product inside of the exchange, so one place to start would be requiring insurers to offer those products outside the exchange as well as on the exchange, or go even further.

High-deductible catastrophic plans, which can be offered only to young adults and those who have no other affordable coverage options, pose the greatest adverse selection risk, since they will be most attractive to the healthiest enrollees. States can mitigate this risk by requiring such plans to be offered only on the exchange, or requiring insurers who offer such products off the exchange to also sell an identical version on the exchange.

States may earn up to five points on this criterion. All five are given if insurers must offer an identical array of products both on and off the exchange; four are assigned if insurers must offer high-benefit plans (including at least one gold plan) off of the exchange (or must offer all exchange plans in the outside market), and the sale of catastrophic plans is limited outside the exchange in the ways described above. If the state only includes one of the previous two protections, we give it two points; if no attempt is made to reduce adverse selection by limiting plans available off the exchange, we give out zero points.

Financing: the primary way most exchanges will be funded is through a fee assessed on insurers. But whether the fee is assessed on all insurance plans, or just those sold through the exchange, will have important implications for the exchange's stability.

Assessing a fee solely on exchange plans should be avoided, regardless of whether the assessment is paid primarily by the insurer, or passed on to the consumer. In the former case, insurers will have a positive incentive to steer enrollees into non-exchange plans to avoid the assessment; in the latter, consumers would face slightly higher prices on the exchange, and would be more likely to go to the outside market. In both cases, the effect is likely to be strongest for the healthiest enrollees, who will be most sensitive to small differences in premium, and who would therefore be more likely to avoid the exchange, threatening its stability. Assessing the fee on all insurers would eliminate this danger.

The assessment should be shared by everyone in the market because the exchange benefits all the market players. The outreach and engagement generated by the exchange will increase participation inside and outside the exchange, increasing the number of customers. The exchange website will allow for plan comparisons that people getting coverage outside the exchange might use as well (just as many consumers may browse for products through online shopping portals, then go out and buy them at a brick and mortar store). The exchange will also likely administer risk adjustment programs that will help keep risk pools stable across the entire state.

This final criterion is worth up to two points. Both are given if the exchange's fee is placed on all plans, not just those sold on the exchange; one point is given if the exchange is not prohibited from assessing a broad fee on all insurance plans; and we assign zero points if the fee is specifically required to be placed only on exchange-participating plans.

State Scorecards

Twelve states have defined their exchanges sufficiently for us to analyze them using the scorecard laid out in the previous section.

Our analysis looks only to provisions specifically included in state exchange legislation or executive orders, or closely-related legislation passed at the same time. In future editions of this report, we will also include regulations and operating rules of established exchanges as they come online.

Where there is ambiguity about whether a state law of general applicability pertains to the exchange—for example, where a state has a general rule about conflicts of interest, but does not specifically cite them in creating its exchange board—we will not count them as applying, to encourage states to explicitly address the key policy questions we identify, so that consumers and businesses will know exactly what the rules of the road are.

As discussed in more detail in the specific scorecards, some states have decided to take a piecemeal approach to their exchanges, in some cases defining only the governance and overall structure of their exchange in initial legislation or executive action. And in some cases, they have explicitly reserved judgment on important policy questions, such as the eventual size of the exchange and whether it will act as an active purchaser, asking the exchange board or some other entity to develop recommendations or options for later state action.

Where action on an issue is specifically reserved, we exclude that criterion from the final grade a state receives, as it is clear that the state is aware of the issue but has not yet made a final determination (in such cases we use the mark "N/S", for "not scored"). Similarly, where a state clearly is deferring action on entire categories of exchange operations, we do not assign grades for those categories. If, however, the state's action simply does not address a particular question, we do include that criterion in the final grade, because that suggests the exchange may have to meet the issue without a specific grant of power or guidance.

Some of the criteria we use to rate

exchanges are fairly specific, and to make sure that consumers actually benefit from promised protections, in several cases we assign fewer points to a vague declaration of an exchange's goal than to specific, operational commitments. Where ambiguous legislative language leaves it less than clear that a particular policy will apply, we err against assigning additional points, if nothing else because consumers and enrollees should have perfect clarity on what the exchange will do. This is not to undermine the importance of legislative intent, or to suggest that the exchange would later be prohibited from taking action to win full points. For example, if a statute instructs the exchange to assist applicants in enrolling in public programs such as Medicaid, but does not explicitly require that they be automatically enrolled rather than being referred to some other agency, we award only partial credit even though the legislative intent might be to adopt a no-wrong-door model and the exchange might later create such a system.

Finally, in interpreting our rankings, it is important to keep in mind that even in

Table 3. Scoring Curve

Percent of Available Points Earned	Grade
85-100	A+
70-85	A
60-70	A-
50-60	B+
45-50	B
40-45	B-
35-40	C+
30-35	C
20-30	C-
10-25	D
0-10	F

Table 4. State Exchange Scorecard.

State	Governance and Structure	Negotiating Power and Driving Value	Consumer Experience	Stability	Total Score	Percentage of Available Points	Final Grade
California	21 of 25	13 of 30	12 of 25	8 of 15	54 of 95	57%	B+
Colorado	9 of 22	3 of 15	N/S	N/S	12 of 37	32%	C *
Connecticut	21 of 22	13 of 30	12 of 25	5 of 15	51 of 92	55%	B+
Hawaii	5 of 22	3 of 15	7 of 10	1 of 2	16 of 49	41%	C
Maryland	21 of 22	3 of 5	4 of 10	1 of 2	29 of 39	74%	A *
Massachusetts	13 of 25	16 of 20	15 of 20	N/S	44 of 65	68%	A-
Nevada	8 of 25	N/S	N/S	N/S	8 of 25	32%	C *
Oregon	15 of 25	14 of 30	11 of 25	2 of 15	42 of 95	44%	B-
Rhode Island	14 of 25	24 of 30	5 of 25	2 of 15	45 of 95	47%	B
Vermont	5 of 9	23 of 30	12 of 25	0 of 8	40 of 72	56%	B+
Washington	17 of 22	3 of 5	N/S	N/S	20 of 27	74%	A *
West Virginia	11 of 25	3 of 5	N/S	N/S	14 of 30	47%	B *

States with asterisks next to their grades have been assessed on criteria worth half or less of all available scorecard points. Typically, this is because their legislation sets up governance and structure only, and contemplates future state action; we have accordingly not rated them on criteria their laws do not address. Thus, their grades should be considered highly provisional.

states like California and Massachusetts, who have had the most time to set up their exchanges, they remain a work in progress. In many states, further legislation or official state action may occur in the next year or two, and newly-established exchanges will further define their operations through regulations and operating rules.

That means that as a result of our methodological decisions, it is very unlikely that any initial piece of legislation or executive order establishing the exchange could have sufficient detail and comprehensiveness to ensure that any state achieves a perfect score. As a result, while we list the raw points scored by each state, we use a grading curve to assign letter grades, as shown in Chart Three. Because we expect states to make progress over time, future editions of this report will employ a different ranking scheme.

California

California was the first state to take action to create an exchange after the passage of federal health reform, with then-Governor Schwarzenegger signing SB 900 and AB 1602 in September of 2010.[22] In the year since, a full complement of members have been named to the exchange's board, and it has held monthly meetings, engaging with stakeholders and applying for additional federal grants.

As its scorecard indicates, California's exchange is quite strong across the board, offering an appealing model for other states. The major area where the exchange could be improved is in its ability to drive payment and delivery reforms. While the exchange was constituted with strong active purchaser authority, with a mandate to engage in selective contracting to promote

Table 5. California Scorecard

Governance and Overall Structure		**Negotiating Power and Driving Value**	
Exchange Structure	5 of 5	Active Purchaser	10 of 10
Board Makeup	7 of 8	Delivery/Payment Reforms	0 of 10
Conflicts of Interest	5 of 5		
Transparency	2 of 2	Rate Review	0 of 5
Size of Exchange	0 of 3	Standardization of Products	3 of 5
Stakeholder Input	2 of 2		
TOTAL	**21 of 25**	**TOTAL**	**13 of 30**
Consumer Experience		**Stability**	
Navigators	3 of 5	Ongoing Monitoring	0 of 3
Rating Tools	2 of 5	Prohibitions on Steering	3 of 5
Eligibility and Enrollment Systems	5 of 5		
		Restrictions on Off-Exchange Plans	4 of 5
Privacy Protections	0 of 5		
Language Access	2 of 5	Financing	1 of 2
TOTAL	**12 of 25**	**TOTAL**	**8 of 15**
TOTAL SCORE: B+ (54 of 95)			

high-value coverage, the establishing legislation does not explicitly direct the exchange to use this power to advance delivery and payment reforms that can lower costs while improving quality. With that said, the exchange's recent hiring of an executive director with particular expertise in developing such reforms is an encouraging sign, suggesting that it does intend to pursue these approaches.[23]

As a final note, California's approach to standardization of products is somewhat unique. The exchange by statute has the power to standardize the products it offers, and if it does so, then insurers offering coverage outside of the exchange must offer a standardized product at each of the four tiers of value (bronze, silver, gold, and platinum). Because not all products off of the exchange will be standardized, even if the exchange exercises this power, we award three points for this criterion.[24]

Colorado

Colorado enacted Senate Bill 11-200 in the summer of 2011, with the legislature approving it on a bipartisan basis.[25] The law is fairly short, and is primarily concerned with setting out the governance and structure of the exchange. It appears to contemplate further legislative action, as it also creates a legislative oversight committee that is authorized to report legislation in support of the exchange, and which must review the exchange's financial and operational plans. As a result, we have scored it only in that area (not scoring the question of what size businesses will

Table 6. Colorado Scorecard

Governance and Overall Structure		**Negotiating Power and Driving Value**	
Exchange Structure	5 of 5	Active Purchaser	0 of 10
Board Makeup	1 of 8	Delivery/Payment Reforms	N/S
Conflicts of Interest	3 of 5		
Transparency	0 of 2	Rate Review	3 of 5
Size of Exchange	N/S	Standardization of Products	N/S
Stakeholder Input	0 of 2		
TOTAL	**9 of 22**	**TOTAL**	**3 of 15**
Consumer Experience		**Stability**	
Navigators	N/S	Ongoing Monitoring	N/S
Rating Tools	N/S	Prohibitions on Steering	N/S
Eligibility and Enrollment Systems	N/S	Restrictions on Off-Exchange Plans	N/S
Privacy Protections	N/S		
Language Access	N/S	Financing	N/S
TOTAL	**N/S**	**TOTAL**	**N/S**
TOTAL SCORE: C (12 of 37)			

Table 7. Connecticut Scorecard

Governance and Overall Structure		Negotiating Power and Driving Value	
Exchange Structure	5 of 5	Active Purchaser	10 of 10
Board Makeup	7 of 8	Delivery/Payment Reforms	0 of 10
Conflicts of Interest	5 of 5		
Transparency	2 of 2	Rate Review	3 of 5
Size of Exchange	N/S	Standardization of Products	0 of 5
Stakeholder Input	2 of 2		
TOTAL	**21 of 22**	**TOTAL**	**13 of 30**
Consumer Experience		**Stability**	
Navigators	3 of 5	Ongoing Monitoring	3 of 3
Rating Tools	2 of 5	Prohibitions on Steering	0 of 5
Eligibility and Enrollment Systems	5 of 5	Restrictions on Off-Exchange Plans	0 of 5
Privacy Protections	0 of 5		
Language Access	2 of 5	Financing	2 of 2
TOTAL	**12 of 25**	**TOTAL**	**5 of 15**
TOTAL SCORE: B+ (51 of 92)			

be eligible for the exchange, as the bill requires the exchange to study and issue a report on that question), and on the active purchasing criterion, as the law specifically says the exchange shall not "solicit bids or engage in the active purchasing of insurance."[26]

Unfortunately, even on these limited criteria, Colorado ranks low. In addition to the prohibition on the exchange leveraging the negotiating power of its enrollees through active purchasing, the other major weakness of the exchange is that industry representatives are allowed to serve on the board. The only protection is that a majority of the board cannot be "directly affiliated with the insurance industry," but insurers are allowed to be represented, and could combine with other industry interests to form a majority bloc. As a result, there is a real risk that Colorado's exchange could be co-opted by those with a financial stake in its decisions, and be unaccountable to its enrollees, consumers generally, and the public.

Connecticut

Connecticut's SB 921, enacted over the summer of 2011, sets out a comprehensive framework for its state's exchange.[27] In many respects it is similar to California's exchange, and likewise offers a strong model for other states to consider following. It bans a comprehensive array of industry representatives from serving on the board, and has strong active purchaser authority. However, again much like California, Connecticut did not specifically direct its exchange to use that power to promote delivery and payment reforms.

An additional area where Connecticut could consider doing more is around adverse selection; on a positive note, the exchange is required to monitor the risk of adverse selection, and can make legislative recommendations, but the law does not impose any bans on insurer or broker steering, nor are there limits on the plans that may be offered outside of the exchange. The Connecticut exchange may wish to consider recommending such legislation under the monitoring provision, to ensure the stability of its risk pool.

The law requires the exchange to report on whether to allow businesses above 50 employees to participate, and so that criterion is not scored. While the exchange does have the power to limit the number of products offered on the exchange, it is not clear that this provision would allow the exchange to standardize products, so we have not awarded points for that criterion.

Hawaii

Much like Colorado, Hawaii passed legislation in the early summer of 2011 (SB 1348) to establish the governance and basic structure of its exchange, while leaving most operational details for later implementation.[28] The law establishes an interim exchange board that will recommend such implementing legislation in 2012. Accordingly, we have not scored most areas outside of the governance and overall structure criteria, except where the law makes a specific reference to another criterion.

Hawaii is so far unique in that it is the only state that has decided to create its exchange as a private non-profit corporation. As discussed in greater detail in the previous section, an exchange structured in this way may not be appropriately accountable to the public. This concern is exacerbated by the fact that industry representatives

Table 8. Hawaii Scorecard

Governance and Overall Structure		**Negotiating Power and Driving Value**	
Exchange Structure	0 of 5	Active Purchaser	0 of 10
Board Makeup	1 of 8	Delivery/Payment Reforms	N/S
Conflicts of Interest	3 of 5		
Transparency	1 of 2	Rate Review	3 of 5
Size of Exchange	N/S	Standardization of Products	N/S
Stakeholder Input	0 of 2		
TOTAL	**5 of 22**	**TOTAL**	**3 of 15**
Consumer Experience		**Stability**	
Navigators	N/S	Ongoing Monitoring	N/S
Rating Tools	N/S	Prohibitions on Steering	N/S
Eligibility and Enrollment Systems	5 of 5	Restrictions on Off-Exchange Plans	N/S
Privacy Protections	N/S		
Language Access	2 of 5	Financing	1 of 2
TOTAL	**7 of 10**	**TOTAL**	**1 of 2**
TOTAL SCORE: B- (16 of 49)			

Table 9. Maryland Scorecard

Governance and Overall Structure		Negotiating Power and Driving Value	
Exchange Structure	5 of 5	Active Purchaser	N/S
Board Makeup	7 of 8	Delivery/Payment Reforms	N/S
Conflicts of Interest	5 of 5		
Transparency	2 of 2	Rate Review	3 of 5
Size of Exchange	N/S	Standardization of Products	N/S
Stakeholder Input	2 of 2		
TOTAL	**21 of 22**	**TOTAL**	**3 of 5**
Consumer Experience		**Stability**	
Navigators	N/S	Ongoing Monitoring	N/S
Rating Tools	2 of 5	Prohibitions on Steering	N/S
Eligibility and Enrollment Systems	2 of 5	Restrictions on Off-Exchange Plans	N/S
Privacy Protections	N/S		
Language Access	N/S	Financing	1 of 2
TOTAL	**4 of 10**	**TOTAL**	**1 of 2**
TOTAL SCORE: A (29 of 39)			

may serve on both the interim and final boards of the exchange (indeed, there are seats reserved for insurers and providers on the interim board), with no protections ensuring that they cannot constitute a majority.

Further, like Colorado Hawaii prohibits its exchange from being an active purchaser. While the unique characteristics of Hawaii's insurance market and its geographic isolation may have led policymakers to conclude that the ability of the state's exchange to negotiate with insurers from a position of strength was limited, their denial of active purchasing authority means that even in future years, when the state's market dynamics may have shifted, the exchange's hands will still be tied absent further legislative action.

Maryland

Maryland's Senate Bill 182 established its state exchange, passing in mid-2011, and as of this writing its board has already conducted several meetings.[29] While the law is more comprehensive than the governance-only legislation pursued by several other states, it is also charged with making many different recommendations for later legislative or regulatory action, and the statute even specifically allows for the possibility that the exchange will later be reorganized into a private nonprofit. Accordingly, many areas are not scored for purposes of our ratings.

With that said, the governance structure laid out in the statute is quite strong, and the fact that Maryland's exchange is closely studying so many important issues,

including whether to use selective contracting to drive payment and delivery reforms and how best to set rules for which plans may be offered on and off the exchange to protect against adverse selection, suggests that it may become a leading pro-consumer exchange once final action is taken on these recommendations.

Massachusetts

Massachusetts enacted its own comprehensive health care reform in 2006, which included many of the elements of the later federal reform, including its own state exchange, called the Connector.[30] The Connector has been operational and selling insurance to enrollees since 2007. While it has initiated a transition process, including stakeholder involvement, to plan changes needed to bring it fully into compliance with the new federal law, the Connector served in large measure as the template for the exchanges contemplated by the federal reform, and it is thus possible to rank it on the same criteria we use for other states.[31]

The Connector board has seats allocated to specific interests, including a broker, but industry cannot command a majority, so we assign four points on the board makeup criterion. Insurers and their representatives may not serve on the board, but there are no specific conflict-of-interest provisions beyond this.

There are two coverage programs run by the Connector: Commonwealth Care, for individual enrollees whose income qualifies them for state subsidies, and Commonwealth Choice for those not eligible

Table 10. Massachusetts Scorecard

Governance and Overall Structure		**Negotiating Power and Driving Value**	
Exchange Structure	5 of 5	Active Purchaser	10 of 10
Board Makeup	4 of 8	Delivery/Payment Reforms	N/S
Conflicts of Interest	0 of 5		
Transparency	2 of 2	Rate Review	3 of 5
Size of Exchange	0 of 3	Standardization of Products	3 of 5
Stakeholder Input	2 of 2		
TOTAL	**13 of 25**	**TOTAL**	**16 of 20**
Consumer Experience		**Stability**	
Navigators	N/S	Ongoing Monitoring	N/S
Rating Tools	5 of 5	Prohibitions on Steering	N/S
Eligibility and Enrollment Systems	5 of 5	Restrictions on Off-Exchange Plans	N/S
Privacy Protections	3 of 5		
Language Access	2 of 5	Financing	N/S
TOTAL	**15 of 20**	**TOTAL**	**N/S**
TOTAL SCORE: A- (44 of 65)			

for subsidies and small businesses. Both engage in active purchasing activities, though Commonwealth Care has generally followed a selective contracting model of soliciting bids from participating insurers to meet specific statutory requirements, while Commonwealth Choice has followed a less formal model of standard-setting and individual back-and-forth. For purposes of the scorecard, we assign ten points, as the Connector explicitly considers value as a part of its activities.[32]

The Connector has recently moved to standardize the products it offers, so we assign three points for this criterion (products sold on the outside market remain non-standardized).[33]

The privacy policy posted on the Connector's website notes that it prohibits sale of personal information, or use of it for any purpose except those required for Connector purposes; as such, we award three points.[34]

Massachusetts is currently engaging in an effort to institute large-scale payment reform across all state payers. Presumably the Connector will play a role in those plans, but until they are enacted, we do not assign a score for this criterion.

The Connector legislation does not contain any provisions aimed at addressing the risk of adverse selection. This is partly an artifact of the state's unique situation—prior to the passage of its 2006 reform, it had required insurers to offer coverage on a guaranteed issue basis, even to patients with pre-existing conditions. Thus, its individual market risk pool was skewed towards less healthy, more expensive enrollees. The state's individual mandate requirement, which went into effect in 2007, was thus one of the most important

Table 11. Nevada Scorecard

Governance and Overall Structure		**Negotiating Power and Driving Value**	
Exchange Structure	5 of 5	Active Purchaser	N/S
Board Makeup	2 of 8	Delivery/Payment Reforms	N/S
Conflicts of Interest	0 of 5		
Transparency	1 of 2	Rate Review	N/S
Size of Exchange	0 of 3	Standardization of Products	N/S
Stakeholder Input	0 of 2		
TOTAL	**8 of 25**	**TOTAL**	**N/S**
Consumer Experience		**Stability**	
Navigators	N/S	Ongoing Monitoring	N/S
Rating Tools	N/S	Prohibitions on Steering	N/S
Eligibility and Enrollment Systems	N/S		
		Restrictions on Off-Exchange Plans	N/S
Privacy Protections	N/S		
Language Access	N/S	Financing	N/S
TOTAL	**N/S**	**TOTAL**	**N/S**
TOTAL SCORE: C (8 of 25)			

measures to mitigate adverse selection across the entire marketplace.[35] Because of these considerations, we do not assign a score for the Stability category, though with the passage of the federal reform, Massachusetts policymakers may wish to consider whether additional policies in this area are needed.

Nevada

Nevada's SB 440 is a short statute that primarily concerns itself with creating the exchange's governance; the exchange board will submit a plan for full implementation to the legislature by the end of 2011.[36] As such, we have not evaluated the Nevada exchange on criteria outside the governance and structure area.

Representatives of the health insurance industry are barred from serving on the exchange board, but other industry interests, such as brokers or providers, may do so. Further, there are no specific conflict of interest protections included in the law, which may pose difficulties if industry representatives are appointed to the board. As currently established, the governance of Nevada's exchange risks being unaccountable to consumer interests, thus its low grade.

Notably, unlike several other states that have pursued the governance-only route, SB 440 is silent on the question of whether Nevada's exchange shall ultimately be permitted to exercise its negotiating power as an active purchaser.

Oregon

Oregon's exchange legislation, SB 99 of 2011, was the result of a multi-year initiative to reform the state's health care system.[37] The statute is comprehensive, addressing many aspects of the state's exchange, though it is not the final word: the exchange must develop a formal business plan and submit it for legislative approval before it may open its doors.

The governing board of the exchange is open to industry representatives, including insurers, but they are limited to holding at most two seats on the nine-member board; two seats are also reserved for consumer representatives. Thus, we assign four points on this criterion—Oregon's score would be improved if industry representatives were barred, and if the conflict of interest protections in the law required board members with a conflict of interest to recuse themselves from discussion as well as voting.

The extent of active purchasing authority granted under the Oregon law remains somewhat unclear. The exchange does have the power to limit the number of plans offered on the exchange, so long as that limit is applied uniformly to all insurers; similarly, it may set additional standards and criteria for participating plans, which also must be uniform. This legislative language appears to make it more difficult for the state exchange to engage in individual negotiation or selective contracting with insurers, and so we assign five points. Along similar lines, the exchange is directed to "encourage" new delivery and payment reforms, but not explicitly to require them, again meaning that we assign five points. Oregon's exchange would be stronger if these two provisions were broadened.

There is little in the statute that addresses the danger of adverse selection, meaning that Oregon policymakers should carefully consider whether additional action is necessary in this area. And beyond their impact on adverse selection, the financing provisions of the statute may

Table 12.Oregon Scorecard

Governance and Overall Structure		Negotiating Power and Driving Value	
Exchange Structure	5 of 5	Active Purchaser	5 of 10
Board Makeup	4 of 8	Delivery/Payment Reforms	5 of 10
Conflicts of Interest	3 of 5		
Transparency	1 of 2	Rate Review	3 of 5
Size of Exchange	0 of 3	Standardization of Products	1 of 5
Stakeholder Input	2 of 2		
TOTAL	**15 of 25**	**TOTAL**	**14 of 30**
Consumer Experience		**Stability**	
Navigators	5 of 5	Ongoing Monitoring	0 of 3
Rating Tools	2 of 5	Prohibitions on Steering	0 of 5
Eligibility and Enrollment Systems	2 of 5		
		Restrictions on Off-Exchange Plans	2 of 5
Privacy Protections	0 of 5		
Language Access	2 of 5	Financing	0 of 2
TOTAL	**11 of 25**	**TOTAL**	**2 of 15**
TOTAL SCORE: B- (42 of 95)			

prove problematic; not only is the exchange barred from assessing a fee on insurers that do not participate in the exchange, but the law also imposes caps on the fees the exchange is permitted to collect. This limitation may ultimately make it more difficult for the exchange to be financially stable and self-supporting.

Finally, our ratings include two other bills passed in Oregon's 2011 legislative session that will have a bearing on the state exchange. SB 91 requires insurers doing business in the state to offer bronze and silver plans in any market in which they do businesses, and also requires all catastrophic plans to be sold on the exchange rather than the outside market.[38] As a result, we assign two points for the limitations on plans sold off of the exchange criterion. Similarly, SB 89 establishes a standardized bronze-level health benefit plan, so we award a single point for the standardization criterion.[39]

Rhode Island

Rhode Island was the first state to establish its exchange via executive order, in the fall of 2011.[40] As of this writing, board members had recently been appointed. While the executive order is brief, it is reasonably comprehensive in the issues that it addresses, and thus we score it on each of our criteria.

The governance of the Rhode Island exchange is generally strong. The significant weak point is that while industry interests are barred from serving on the board,

Table 13. Rhode Island Scorecard

Governance and Overall Structure		Negotiating Power and Driving Value	
Exchange Structure	5 of 5	Active Purchaser	10 of 10
Board Makeup	7 of 8	Delivery/Payment Reforms	8 of 10
Conflicts of Interest	0 of 5		
Transparency	2 of 2	Rate Review	3 of 5
Size of Exchange	0 of 3	Standardization of Products	3 of 5
Stakeholder Input	0 of 2		
TOTAL	**14 of 25**	**TOTAL**	**24 of 130**
Consumer Experience		**Stability**	
Navigators	3 of 5	Ongoing Monitoring	1 of 3
Rating Tools	0 of 5	Prohibitions on Steering	0 of 5
Eligibility and Enrollment Systems	2 of 5	Restrictions on Off-Exchange Plans	0 of 5
Privacy Protections	0 of 5		
Language Access	0 of 5	Financing	1 of 2
TOTAL	**5 of 25**	**TOTAL**	**2 of 15**
TOTAL SCORE: B (45 of 95)			

there are no specific conflict of interest protections in the event that a member does have a personal interest implicated in a particular decision. On negotiation, the picture is also strong, as the executive order empowers the exchange to engage in selective contracting, charges it to pursue payment reforms aligned with efforts of other payers in the state, and allows it to standardize products.

The Rhode Island exchange is comparatively weak on criteria having to do with the consumer experience and stability and protection against adverse selection. This may be because some of the required changes, especially around adverse selection, would have to be instituted via statute rather than executive order. Rhode Island's policymakers should closely examine whether legislation should be pursued in these areas, so that its exchange can match in these areas its high performance on governance and negotiating power.

Vermont

The bill creating Vermont's exchange, 2011's HB 202, has to do with much more than simply the state's new exchange.[41] It is the first step in a comprehensive plan to reform the state's health care system, which is planned to ultimately integrate all state payers into a single-payer system. As a result, Vermont's exchange is unique on many levels; it will be run by the existing state government agencies (albeit with input from an advisory committee of stakeholders), and it will be used as the foundation for the eventual single-payer

system. With that said, it is not difficult to compare Vermont's exchange with those established in other states, as there are only a few places where its unique approach renders our methodology inapplicable.

One place where our usual rating approach does not work is when it comes to board composition and conflict of interest rules; as the exchange will be run as part of a state agency, we do not score these criteria. Several issues, such as what size employers will buy coverage through the exchange, are explicitly reserved for future decision, and so we do not score them either.

All told, Vermont's exchange plan is quite strong; while its governance score is comparatively low, in large measure this reflects the fact that its exchange is an integrated part of a comprehensive state reform plan. While this means the exchange will not be independent of state policy decisions, in the context of a broad transition to a single-payer system, such independence could be a double-edged sword. The incorporation of delivery and payment reforms into the active-purchasing exchange means that Vermont exchange enrollees will see their negotiating power put to good use. More could be done to guard the exchange against adverse selection, however, especially as limitations on steering and monitoring the risk pool could be important to the overall success of a single-payer plan.

Table 14. Vermont Scorecard

Governance and Overall Structure		**Negotiating Power and Driving Value**	
Exchange Structure	2 of 5	Active Purchaser	10 of 10
Board Makeup	N/S	Delivery/Payment Reforms	10 of 10
Conflicts of Interest	N/S		
Transparency	1 of 2	Rate Review	3 of 5
Size of Exchange	N/S	Standardization of Products	0 of 5
Stakeholder Input	2 of 2		
TOTAL	**5 of 9**	**TOTAL**	**23 of 30**
Consumer Experience		**Stability**	
Navigators	3 of 5	Ongoing Monitoring	0 of 3
Rating Tools	2 of 5	Prohibitions on Steering	0 of 5
Eligibility and Enrollment Systems	5 of 5	Restrictions on Off-Exchange Plans	N/S
Privacy Protections	0 of 5		
Language Access	2 of 5	Financing	N/S
TOTAL	**12 of 25**	**TOTAL**	**0 of 8**
TOTAL SCORE: B+ (40 of 72)			

Washington

The Washington legislation creating its exchange, SB 5445, is primarily concerned with governance and structure.[42] Similar to other states, Washington has charged its exchange with making recommendations for further state action in several areas, including whether to have the exchange act as an active purchaser, whether all Navigators should be brokers, whether it should participate in delivery and payment reform efforts, and how to structure the exchange's financing. Therefore, we follow our practice of primarily judging it on governance criteria, and not scoring areas where future state action is anticipated.

On these limited selection of policies, Washington's exchange appears strongly pro-consumer. No person with a conflict of interest may serve on the exchange board, and in the event such a conflict of interest does arise, they must immediately be dismissed. As of yet, however, it is unclear whether this provision will ultimately be used to disqualify all potential members with an industry affiliation, or simply those directly employed by insurers.

Hopefully, Washington will maintain its current high rating once it takes action on the numerous questions deferred by SB 5445 for future action.

West Virginia

The final state to act so far to create its exchange is West Virginia, which did so via SB 408, passed into law in the spring of 2011.[43] The statute is a clear "governance-only" law, and does not address issues

Table 15. Washington Scorecard

Governance and Overall Structure		**Negotiating Power and Driving Value**	
Exchange Structure	5 of 5	Active Purchaser	N/S
Board Makeup	4 of 8	Delivery/Payment Reforms	N/S
Conflicts of Interest	5 of 5		
Transparency	1 of 2	Rate Review	3 of 5
Size of Exchange	N/S	Standardization of Products	N/S
Stakeholder Input	2 of 2		
TOTAL	**17 of 22**	**TOTAL**	**3 of 5**
Consumer Experience		**Stability**	
Navigators	N/S	Ongoing Monitoring	N/S
Rating Tools	N/S	Prohibitions on Steering	N/S
Eligibility and Enrollment Systems	N/S	Restrictions on Off-Exchange Plans	N/S
Privacy Protections	N/S		
Language Access	N/S	Financing	N/S
TOTAL	**N/S**	**TOTAL**	**N/S**
TOTAL SCORE: A (20 of 27)			

Table 16. West Virginia Scorecard

Governance and Overall Structure		Negotiating Power and Driving Value	
Exchange Structure	5 of 5	Active Purchaser	N/S
Board Makeup	4 of 8	Delivery/Payment Reforms	N/S
Conflicts of Interest	0 of 5		
Transparency	0 of 2	Rate Review	3 of 5
Size of Exchange	0 of 3	Standardization of Products	N/S
Stakeholder Input	2 of 2		
TOTAL	**11 of 25**	**TOTAL**	**3 of 5**
Consumer Experience		**Stability**	
Navigators	N/S	Ongoing Monitoring	N/S
Rating Tools	N/S	Prohibitions on Steering	N/S
Eligibility and Enrollment Systems	N/S		
		Restrictions on Off-Exchange Plans	N/S
Privacy Protections	N/S		
Language Access	N/S	Financing	N/S
TOTAL	**N/S**	**TOTAL**	**N/S**
TOTAL SCORE: B (14 of 30)			

outside of the structure of the exchange's board and a few details of its financing. The board will include one representative of insurance producers, one of providers, and one of payers. Individual consumers, small businesses, and organized labor are also represented, with the remaining slots on the board filled by state officials.

The question of whether the West Virginia exchange will be an active purchaser appears to be left unaddressed by SB 408. There is a provision prohibiting the exchange from entering into contracts with health insurers that would make it difficult for the exchange to engage in selective contracting, but as it is not yet clear whether the exchange would be allowed to set certification standards or otherwise be an active purchaser, we have not scored this criterion.

While a reasonable start, much more work will need to be done to fully establish and operationalize West Virginia's exchange.

IV. Incompletes

In contrast to the states examined in the previous chapter, many other states have yet to take action to create their exchange. Rather than giving them letter grades, their status must be marked as Incomplete, as they have not yet made the decisions necessary to judge whether or not their exchange will be pro-consumer—or, indeed, whether the state itself will run the exchange, or if the federal government will step in to establish it. This section briefly summarizes the status of exchange creation efforts in the remaining states. [44]

In general, most states are pursuing the creation of their own exchange, or at least are exploring the tradeoffs of running it themselves as against leaving its operation to the federal government. Only two states appear to have entirely rejected the idea of creating an exchange—Louisiana and Florida. This is a positive trend, but at the same time, the fact that so many states have yet to make significant progress on their exchange is cause for some concern.

There will be many policy decisions that must be made, and much infrastructure that must be created, to ensure that the exchange is open and ready to do business in 2014. With the states that have already taken action providing a guide to the choices states have available to them, it's past time for those states that have yet to set up their exchange to get the ball rolling.

Study Committees or Official Intent

A number of states have not formally established an exchange, but have taken some action to begin the process: either they have convened legislative or administrative study committees to make formal recommendations for government action, or they have officially established their intent to create a state level exchange.

These states include Alabama, Georgia, Indiana,[45] and South Carolina, all of which have proceeded via executive order. States that have passed intent or study committee legislation include Illinois, Maine, Mississippi, Montana, North Dakota, Utah,

Virginia, and Wyoming, for a combined twelve states in total.

Not all of these states are in the same place. Utah, for example, created its own small business exchange before the passage of the federal law. The study legislation the state passed this year will begin the process of reforming that existing exchange to bring it into compliance with the federal law's requirements.[46] With an existing foundation to build on, hopefully the state will find it easy to quickly set up its exchange. Similarly, as of this writing Illinois' study committee has just issued its report to the legislature, and some leaders are pressing for legislative action this year.

Other states in this category have more work to do. But they have made a start on establishing their own exchanges, and we look forward to evaluating the resulting proposals in a future edition of this report.

Table 17. "Incomplete": States Yet to Take Action to Create an Exchange

Alaska	New Hampshire
Arizona	New Jersey
Arkansas	New Mexico
Delaware	New York
Florida *	North Carolina
Idaho	Ohio
Iowa	Oklahoma
Kansas	Pennsylvania
Kentucky	South Dakota
Louisiana *	Tennessee
Michigan	Texas
Minnesota	Washington, D.C.
Missouri	Wisconsin
Nebraska	

States with asterisks have indicated that they will not create a state exchange.

States Not Pursuing an Exchange

As discussed above, only two states appear to have definitively disclaimed their intent to create a state exchange. In Louisiana, Governor Jindal has stated that they will allow the federal government to run their state's exchange. In Florida, Governor Scott has persistently opposed the health reform law, and his administration has expressed its intent to return the federal planning grant they received to help establish their exchange (though as of this writing, they had not yet returned the money). As such, it is likely that a federally-facilitated exchange will be set up in each of these states.

Action Pending

In twenty-four additional states, and the District of Columbia, action on a state exchange is pending. All of these states, save Alaska,[47] have applied for and received planning grants to assist in this process.

As with states that have passed study committees or officially committed to creating an exchange, these states are at widely different places in the process. For example, as of this writing, leaders in New Jersey are still considering exchange legislation, which may pass this year. In New Mexico, Governor Martinez vetoed legislation that would have created a state exchange, but has endorsed the idea of the state running its own. Exchange legislation failed in Arizona this year, but the state's executive branch is pursuing the creation of an exchange, potentially without legislative action.

In other states, there are only vague stakeholder information-gathering

processes in place, and state leaders may have gone on the record as opposing the creation of the exchange. Similarly, meeting the timetable of establishing an exchange that can be operational by 2014 will be made more difficult in some states due to the fact that their legislatures will not meet in 2012, meaning that a special legislative session or unilateral executive branch action will be needed to create a state exchange.

Still, in most of these states, the legislature has introduced and considered bills establishing an exchange. And as this report demonstrates, the quick action of other states means that those that have yet to act have at their disposal several credible models and pieces of actual legislation. With sufficient political will, all of these states should be able to quickly erase the "Incomplete" from their transcript and set up an exchange.

Endnotes

1 Kaiser Family Foundation, *Employer Health Benefits 2011 Survey*, Sept. 27, 2011, *available at* http://ehbs.kff.org/.

2 Julie Appleby and Jaclyn Schiff, *New Survey: Consumers Who Buy Their Own Health Insurance Report Big Rate Increase Requests*, Kaiser Health News, June 21, 2010, *at* http://www.kaiserhealthnews.org/Stories/2010/June/21/Consumers-Who-Buy-Their-Own-Health-Insurance-Report-Big-Rate-Increase-Requests.aspx.

3 H.R. 3590, the Patient Protection and Affordable Care Act of 2010 (hereafter "ACA"), § 1311(b), § 1321(c).

4 ACA § 1311(a), (d)(5).

5 ACA § 1311(b)(2), § 1312(f)(2).

6 ACA § 1311(c)(5).

7 ACA § 1311(c)(5), (d)(4).

8 ACA § 1311(c)(3), (c)(4).

9 ACA § 1311(d)(4).

10 ACA § 1302(e).

11 ACA § 1311(d)(3).

12 ACA § 1401, § 1402.

13 ACA § 1311(c)(1), (d).

14 ACA § 1311(e).

15 ACA § 1341, § 1342, § 1343.

16 ACA § 1311(d)(6), (7).

17 The report is available online at http://www.uspirg.org/home/reports/report-archives/health-care/health-care/building-a-better-health-care-marketplace.

18 *See* Statement of Peter R. Orszag, Director, Congressional Budget Office, *Opportunities to Increase Efficiency in Health Care*, Health Reform Summit of the Committee on Finance, United States Senate, June 16, 2008, *at* http://www.cbo.gov/ftpdocs/93xx/doc9384/06-16-HealthSummit.pdf.

19 Our *Building a Better Health Care Marketplace* report, cited in note 17, discusses these policies in more detail.

20 *See* Connector Board of Directors PowerPoint presentation, June 23, 2009, *available at* http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/Current/Connector%2520Board%2520Meeting%2520June%252023%252C%25202009/SoA%2520recommendation%2520to%2520Board%25206_23_2009%2520FINAL.ppt.

21 *See* Timothy Stoltzfus Jost for the Commonwealth Fund, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, July 2010, *at* http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.

22 *Available at* http://www.leginfo.

ca.gov/cgi-bin/postquery?bill_number=sb_900&sess=0910&house=S, http://leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.pdf.

23 California Health Benefit Exchange, *Peter V. Lee Named First Executive Director of the California Health Benefit Exchange*, Aug. 25, 2011, *at* http://www.healthexchange.ca.gov/Documents/HBEXPeterLeeRelease.pdf.

24 *See* A.B. 1602, Section 8(c); Section 15(e); Section 16(e).

25 *Available at* http://www.leg.state.co.us/CLICS/CLICS2011A/csl.nsf/fsbillcont3/733327000DC9A078725780100604CC4?Open&file=200_enr.pdf.

26 See SB 11-200, Section 10-22-104.

27 *Available at* http://www.cga.ct.gov/2011/ACT/Pa/pdf/2011PA-00053-R00SB-00921-PA.pdf.

28 *Available at* http://www.capitol.hawaii.gov/session2011/bills/SB1348_CD1_.pdf.

29 *Available at* http://mlis.state.md.us/2011rs/bills/sb/sb0182t.pdf.

30 The legislation creating the Connector is available at http://www.malegislature.gov/laws/generallaws/parti/titlexxii/chapter176q.

31 *See* Kaiser Family Foundation, *Implementing Health Insurance Exchanges: Massachusetts*, *at*, http://www.kff.org/healthreform/upload/8223-MA.pdf.

32 Sabrina Corlette et. al., *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned*, Georgetown University Health Policy Institute, Mar. 30, 2011, *available at* http://www.rwjf.org/coverage/product.jsp?id=72105.

33 *Id.*

34 *See* Massachusetts Connector website *at* https://www.mahealthconnector.org/ , follow link to Site Policies and then Privacy Policy.

35 Amitabh Chandra, Jonathan Gruber, and Robin McKnight, *The Importance of the Individual Mandate—Evidence from Massachusetts*, New England Journal of Medicine, Jan. 27, 2011, *at* http://www.nejm.org/doi/full/10.1056/NEJMp1013067.

36 *Available at* http://www.leg.state.nv.us/Session/76th2011/Bills/SB/SB440_EN.pdf.

37 *Available at* http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0099.en.pdf .

38 *Available at* http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0091.en.pdf.

39 *Available at* http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0089.en.pdf.

40 *Available at* http://www.governor.ri.gov/documents/executiveorders/2011/Executive_Order_11-09.pdf .

41 *Available at* http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf .

42 *Available at* http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Session%20Law%202011/5445-S.SL.pdf .

43 *Available at* http://www.legis.state.wv.us/bill_status/bills_text.cfm?billdoc=SB408%20SUB2%20ENR.htm&yr=2011&sesstype=RS&i=408.

44 The information in this section is largely drawn from a series of state-specific fact sheets created by the Kaiser Family Foundation. These are available at http://www.kff.org/healthreform/8223.cfm.

45 Indiana's executive order says it "conditionally" establishes the exchange, subject to further federal guidance and state analysis, and provides no details of implementation save that the exchange will be a private nonprofit corporation; as such, we treat it as a statement of intent, rather than an operative creation of an exchange. *See* http://www.in.gov/gov/files/Executive%20orders/EO_11-01.pdf.

46 While much like Massachusetts, Utah does currently administer an exchange, the Utah exchange is currently much more limited in scope than the federal reform law requires. As a result, rather than issue a premature scorecard assessing the Utah exchange against a standard it was never intended to meet, we include the state in the list of those still planning for how to comply with federal exchange requirements, though its existing exchange means that it is significantly ahead of many other states.

47 Despite not applying for a planning grant, Alaskan leaders have said they will pursue an exchange entirely with state funding. *See* Kaiser Family Foundation, *Implementing Health Insurance Exchanges: Alaska*, *at* http://www.kff.org/healthreform/upload/Implementing-Health-Insurance-Exchanges-Alaska.pdf.