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HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT: GOVERNANCE OPTIONS AND ISSUES

I. INTRODUCTION

The federal Patient Protection and Affordable Care Act (the "Affordable Care Act," or ACA) provides for the establishment of American Health Benefit Exchanges ("Exchanges") to facilitate the purchase of health insurance by individuals and employers.[i] Under the Affordable Care Act, for States electing to establish an Exchange, the Exchange must be established and meet certain minimum requirements by Jan. 1, 2014.[ii] In States that do not establish a qualifying Exchange, the ACA requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish and operate an Exchange for the residents of that State.[iii]

While the ACA provides broad guidelines, the States retain discretion in the establishment and operation of the Exchange. As a State explores whether to establish an Exchange and how it should be implemented, one of the first—and, perhaps, most important—questions to be considered is that of governance. Where should the Exchange be located in relation to State insurance regulators and other State agencies? What legal structure should it take? How should the Exchange be operated? To whom should the Exchange be accountable? How will the Exchange governing board be structured such that it includes members with the necessary experience and expertise to implement and operate the Exchange? This paper—one in a series of white papers to be published by the NAIC for the benefit of State policymakers and interested parties—will examine these and other questions of Exchange governance. The paper focuses strictly on governance; other important questions that the States must resolve are, or will be, addressed in other papers.

II. ACA REQUIREMENTS AND FEDERAL GUIDANCE

The Affordable Care Act contains few explicit requirements related to the governance of an Exchange. According to the ACA, a State Exchange "shall be a governmental agency or nonprofit entity that is established by a State."[iv] Section 1311(d) of the Act enumerates additional requirements an Exchange must meet, including a requirement to "consult with stakeholders relevant to carrying out" the activities required of an Exchange, and a requirement that Exchanges be financially self-sustaining beginning Jan. 1, 2015.

Section 1321(a) requires the HHS Secretary to issue regulations providing minimum standards for the establishment and operation of Exchanges. According to HHS, the first Notice of Proposed Rulemaking is scheduled for publication in the spring of 2011, with additional regulations planned for release later in 2011 and in 2012. HHS has indicated its intent to provide a series of "guidance documents" to assist States in the planning and development of Exchanges.[v] The first such document, titled *Initial Guidance to States on Exchanges*, identifies "organizational form" as one of the issues the States need to consider in establishing an Exchange:

> **Section 1311(d) gives States the option to establish the Exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the Exchange could be housed within an existing State office, as it is in Utah, or it could be an independent public authority, as it is in Massachusetts. Regardless of its organizational form, the Exchange must be publicly accountable, transparent, and have technically competent leadership, with the capacity and authority to take all actions necessary to meet federal standards, including the discretion to determine whether health plans offered through the Exchange are "in the interests of qualified individuals and qualified employers" as Section 1311(e)(1) requires. The Exchange also must have security procedures that meet the data and privacy standards necessary to receive tax data and other sensitive information needed for enrollment. The type of organization may affect the federal tax treatment of an Exchange, including potential income taxation (depending upon whether a nonprofit organization qualifies as a tax-exempt organization), annual filing requirements, the availability of tax-exempt bond financing, and FICA liability for employees.**

III. EXISTING STATE MODELS

As mentioned in HHS' initial guidance, models for the ACA Exchanges can be found in existing State insurance Exchanges. A comparison of the Massachusetts and Utah Exchanges, in particular, can be instructive as the States explore the range of governance and organizational structures allowed under the ACA.

A. *Massachusetts*. The Massachusetts Health Connector (the "Connector") is perhaps the best known of the existing State Exchanges. In terms of governance and organizational structure, the Connector is a "quasi-governmental agency" or an "independent public entity." It is established and operated under State law and is subject to some of the laws and requirements governing State agencies, but is explicitly "not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency, or political subdivision of the [State]."[vi] The Connector is run by a governing board consisting of 10 members: four ex officio members who are public officials, three members appointed by the governor, and three appointed by the attorney general. The ex officio members represent relevant State agencies—the State Medicaid agency, the Division of Insurance, the Executive Office of Administration and Finance, and the Group Insurance Commission—while the appointed members represent relevant stakeholders (e.g., small businesses, organized labor and individuals) and bring necessary skill sets (e.g., actuaries, health economists and benefit specialists).

B. *Utah*. Utah's Health Insurance Exchange (the "Utah Exchange") presents an alternative to the "quasi-public" structure of the Connector. The Utah Exchange is located within and operated by an existing State agency (the Office of Economic Development, within the Governor's Office). Utah established a separate advisory board to "advise the exchange concerning the operation of the exchange and transparency issues."[vii] The eight-person advisory board consists of insurance company and insurance agent representatives, consumers and representatives from the State's Insurance Department and Department of Health. In addition, there is a separate board within the Utah Insurance Department with responsibility over implementation of the risk adjuster program in the State. The Risk Adjustor Board consists of representatives from health insurers, employers and consumers. It also includes a voting member with actuarial experience from the State Public Employees Plan and the Utah Insurance Commissioner or a representative of the Commissioner with actuarial experience.

C. *Other States*.

1. Of the existing State insurance Exchanges, a directly analogous model does not exist for the third type of governance and organizational structure contemplated by the ACA: "a nonprofit entity that is established by a State." One such example, however, can be found in Minnesota Gov. Tim Pawlenty's 2007 proposal to establish a non-profit health insurance Exchange in that State or, more recently, in Indiana Gov. Mitch Daniels' Executive Order conditionally establishing the "Indiana Insurance Market, Inc." as that State's ACA Exchange.[viii] Additionally, the Connecticut Business and Industry Association, while not established by the State, has successfully operated a non-profit "Health Connections Exchange" for small employers since 1995.[ix]

2. California enacted a law in 2011 establishing an Exchange as "an independent public entity not affiliated with an agency or department."[x] A 2011 Maryland law established an Exchange as a "public corporation and a unit of state government," while prohibiting the Exchange from taking any action that "would inhibit the potential transformation of the Exchange into a nongovernmental, nonprofit entity or a quasi-governmental entity."[xi] West Virginia enacted a law establishing an Exchange within that State's Office of the Insurance Commissioner as a "governmental entity of the state."[xii]

D. *State-based Analogies*. Other types of entities, beyond proposed or existing State insurance Exchanges, can serve as models for the possible governance and organizational forms of the ACA Exchanges. For example, 35 States operate high-risk pools that provide coverage to individuals with preexisting conditions.[xiii] Most State high-risk pools are quasi-public bodies established by State law, but operated and supervised by an independent governing board. The Illinois Comprehensive Health Insurance Plan, as one representative example, was established by State law to:

> **[O]perate subject to the supervision and control of the board. The board is created as a political subdivision and body politic and corporate and, as such, is not a State agency. The board shall consist of 10 public members, appointed by the Governor with the advice and consent of the Senate.**[xiv]

IV. STATE-BASED GOVERNANCE ISSUES

The successful establishment and operation of an Exchange will require thousands of decisions of varying complexity and magnitude. State policymakers will necessarily have to delegate some decision-making authority to the Exchange. It is crucial, therefore, that each State determine the Exchange governance structure that reflects that particular State's comfort with the delegation of decision-making authority. While legislative and executive branch involvement in (and guidance for) the Exchange is essential, most legislatures and existing State agencies lack the resources and time needed to collect data, analyze data, evaluate policy options and implement the selected policy option, particularly when the actual number of considerations and decisions will require a full-time commitment. Listed below are some of the most important questions and considerations for policymakers evaluating whether and how to establish and structure an Exchange.

A. *Location and Legal Structure of the Exchange*

States can choose from three options:

- An existing executive branch agency or a newly-created executive branch agency (the Utah model).
- An independent public entity or quasi-governmental agency (the Massachusetts model).
- A non-profit entity established by the State.

These three alternatives present different sets of advantages and disadvantages that should be evaluated in light of each State's goals, policy priorities, legal and political environments, and other factors. Qualities that are deemed advantages in one State might be seen as disadvantages in another.

The Exchange model law adopted by the NAIC summarizes some of the primary advantages and disadvantages of each approach; there are others, as well:[xv]

Model	**Advantages**	**Disadvantages**
State Agency	• Direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the insurance department. • Potential for more direct accountability to policymakers, stakeholders and the public. • Less potential for regulatory duplication, conflict and confusion.	• Risk of the Exchange's decision-making and operations being politicized. • Possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most of the States' personnel and procurement rules. • Possible State budgetary considerations.
Independent Public Entity	• Possible exemption from State personnel and procurement laws. • More independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized.	• Possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency, the insurance department and relevant State employees (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the governor). • Potential for regulatory duplication, conflict and confusion. • Possible expense to establish entity.
Non-profit Entity	• Flexibility in decision-making. • Less likely for decisions to be politicized.	• Isolation from State policymakers and key State agency staff. • Potential for decreased accountability. • Potential for regulatory duplication, conflict and confusion. • Possible expense to establish entity.

1. *Flexibility vs. Accountability.* An important trade-off the States will encounter in evaluating these alternatives is the balance between flexibility and accountability. As Professor Timothy Stoltzfus Jost explained in his September 2010 report, an Exchange located in a State agency would be subject to many State administrative and government operations laws.[xvi] Laws limiting civil service salaries, for example, could make it difficult to attract the talent necessary to effectively run the Exchange; procurement and administrative procedure laws could impede the ability of the Exchange to react quickly to changes in insurance markets. Other laws that could apply include laws on administrative review, open meetings, freedom of information and privacy.[xvii]

An independent public entity or non-profit Exchange might be exempt from such laws and, thus, be able to operate more flexibly than an Exchange located in a State agency. However, as Professor Jost pointed out, State laws governing administrative agencies generally exist to ensure transparency, accountability and public participation in the governance of such agencies, as well as to limit corruption and patronage. Those States choosing to establish an Exchange as an independent public entity or non-profit should carefully consider which administrative and government operations laws should, or should not, apply to the Exchange.

In addition to the Massachusetts model discussed above, such States might also wish to examine the decisions made by California State policymakers in the recently enacted law establishing a California Health Benefit Exchange.[xviii] The California law, for example, exempts certain Exchange employees from State civil service laws, thus allowing the Exchange to set salaries that are "reasonably necessary to attract and retain individuals of superior qualifications."[xix] The California law also authorizes the Exchange board to establish its own competitive process for selecting insurance companies and other contractors, and exempts such contracts from certain provisions of California's Public Contract Code.[xx]

2. *Viability.* In addition to the advantages and disadvantages highlighted within the NAIC model law, the States will need to consider other factors when deciding where the Exchange should be located. For example, a successful Exchange must be able to rely upon a steady funding source and a consistent, long-term business plan. An Exchange located within a State agency, however, would be subject to political and economic cycles (assuming the agency is funded by appropriations from the State's general revenue fund), which can undermine the desired stability. The location and legal structure of the Exchange can also have important tax-related implications that policymakers must consider, including whether the Exchange is subject to Social Security and Medicare taxes and whether the Exchange can use tax-exempt bond proceeds.[xxi]

B. Board Structure

An Exchange established as an independent public entity or a nonprofit entity will likely have a governing board to set policy and provide strategic direction, and an executive director (or similar position) to manage staff and oversee the Exchange's operations. The size and composition of the governing board, and the process by which board members are selected, will vary from one State to another.

While State policymakers might be tempted to establish a board large enough to accommodate the full range of stakeholder perspectives and/or technical skill sets desired, the governing board must be of a manageable size. A survey of the various State models described above—including the existing Exchanges and State high-risk pools, as well as Exchange legislation that was introduced in other States during the spring of 2011—reveal that State policymakers generally prefer a board ranging in size from five to 10 members.

C. Stakeholder Board Participation

One way to ensure broad stakeholder representation and sufficient technical expertise without expanding the size of the Exchange governing board is through the use of auxiliary or advisory boards, or nonvoting members on the governing board. The Utah Exchange relies upon an eight-person advisory board, as described above. Based on a review of proposals, other States appear to contemplate similar advisory boards.

D. Board Expertise

The Exchange boards in Massachusetts, Utah and California all include at least one ex officio member who is a representative of a relevant State agency(s), such as the insurance department or Medicaid agency. Other board members are generally appointed, either by the governor or legislative leaders, to serve a term of three to five years. Board members may be selected based on their experience or expertise—health economists, actuaries or health care administrators, for example—or based on their membership in, or advocacy on behalf of, a specific stakeholder group (e.g., a small business owner, a health care provider or an individual with a chronic disease or disability).

E. *Conflicts of Interest*

Regardless of the board's size, composition and appointment process, it is important to protect against possible conflicts of interest among board members. According to HHS' *Initial Guidance to States on Exchanges*:

> **Successful Exchanges must ensure public accountability in areas such as objective information on the performance of plans; availability of automated comparison functions to inform consumer choice; fair and impartial treatment of consumers, plans and other partners; and *prohibitions on conflicts of interest.***[xxii] (emphasis added)

One approach to addressing conflicts of interest is to prohibit Exchange boards from including health industry representatives. For example, the California Exchange legislation generally prohibits anyone currently affiliated with any insurance company, insurance agent or broker, or health care provider from serving on the board or staff of the Exchange.[xxiii] The Massachusetts Connector, meanwhile, prohibits current employees of health insurance companies from being appointed to the board.[xxiv] In contrast, for example, West Virginia's Exchange legislation provides for the appointment of members to its Exchange board that represent the interests of insurance producers, health care providers and health insurers. The legislation provides, however, that the member to be appointed to represent the interests of health insurers cannot be an employee of an insurer or an affiliate of an insurer eligible to select such member.

As another approach for addressing conflicts of interest, the States might wish to consider implementing a conflict of interest policy for Exchange board members. The States should consider including in such a conflict of interest policy clear and transparent disclosure and recusal processes. Under such processes, board members could be required to report any potential or actual conflicts of interest concerning any vote or issue before the board and recuse themselves accordingly from discussion and voting.

The States might also wish to consider "revolving door" provisions; i.e., prohibiting Exchange managers or board members from moving directly to or from the insurance industry or other entities potentially impacted by Exchange operations. In deciding upon the appropriate scope and strength of conflict of interest provisions for a State Exchange, State policymakers must balance the need for integrity and impartiality of key Exchange personnel against the desire to leverage existing and relevant experience and expertise.

CONCLUSION

The ACA provides the States with flexibility in the establishment of an Exchange that meets the unique needs of each State and its residents. Governance of the Exchange comprises one area in which the States exercise such discretion. State policymakers must consider the questions explored within this paper and others, including questions related to financing, Exchange operating model, the role of producers and Navigators, access to larger employers, benefit mandates, coordination with public programs and other important policy areas. Given the hundreds, if not thousands, of structural and operational issues, the States should carefully reflect upon the Exchange governance structure and whether that structure enables the State to realize its vision for a successful Exchange.

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[i] Pub. L. 111-148 (ACA).
[ii] ACA Sec. 1311(b)
[iii] ACA Sec. 1321 (c)
[iv] ACA Sec. 1311(d)(1)
[v] U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, *Initial Guidance to States on Exchanges* (November 18, 2010), available at http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html
[vi] Mass. Gen Laws Ann. 176Q, § 2.
[vii] Utah Code § 63M-1-2506(1)(a)(iv).
[viii] Executive Order 11-01, available at http://www.in.gov/gov/files/Executive%20orders/EO_11-01.pdf.
[ix] State Health Access Data Assistance Center, *Health Insurance Exchanges: Implementation and Data Considerations for States and Existing Models for Comparison* (Robert Wood Johnson Foundation, October 2010).
[x] AB 1602 (2011), SB 900 (2011).
[xi] SB 182 (2011).
[xii] SB 408 (2011).
[xiii] National Association of State Comprehensive Health Insurance Plans, available at www.naschip.org/states_pools.htm (accessed Jan. 4, 2011).

[xiv] 215 ILCS 105/3
[xv] National Association of Insurance Commissioners, *American Health Benefit Exchange Model Act*, available at www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.
[xvi] T.S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues* (New York: The Commonwealth Fund, September 2010).
[xvii] Ibid.
[xviii] AB 1602; SB 900
[xix] AB 1602, §100503(m)
[xx] AB 1602, §100505
[xxi] U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, *Initial Guidance to States on Exchanges* (Nov. 18, 2010), available at http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html.
[xxii] Ibid.
[xxiii] SB 900, § 100500(f).
[xxiv] Mass. Gen Laws Ann. 176Q, § 2(b)