An Analysis of State-Based Health Insurance Exchange Proposals After the Passage of the Affordable Care Act

Charles Greenberg, JD
MPH Candidate

Capstone Advisor: Brad Herring, PhD

Executive Summary

The passage of the Affordable Care Act on March 23, 2010 was marked with, depending on your opinion, fanfare or derision. The ACA accomplishes many goals including a reorganization of the insurance markets and a mandate that all U.S. citizens maintain health insurance. One of the methods by which the Act attempts to accomplish these feats is through the creation of state-based health insurance exchanges.

States have the option to create and govern their own exchange or they may elect to have the federal government operate one in their stead. While there are important ACA-based requirements on the exchanges, states still have a great deal of flexibility in their creation. This flexibility includes aspects related to the exchange's governance and design, such as the ability to require benefits beyond those mandated by the ACA, and the choice of a wide-open or a more closed marketplace. This paper documents the status, as of May 1, 2011, of state legislative proposals creating health insurance exchanges. It both identifies where each state is in the legislative process and examines different facets of the legislation related to governance and exchange/insurance design.

To this point, state adoption of health insurance exchanges is anemic, as only six states have enacted legislation creating the structure of an exchange or the legal authority to create such an exchange. Currently, a third of all states have no legislative activity that would create an exchange. Tracking these developments is important because on January 1, 2013 states will be judged by the Department of Health and Human Services as being ready or not to operate an exchange. If a state is deemed unready, the federal government will operate the exchange in place of the state.

There is a great deal of variation across the state's legislative proposals with respect to these governance and design aspects. The form of exchange being pursued by states varies between governmental, nonprofit, and a quasi-public form and is roughly split evenly between the three. The vast majority of exchange boards of directors have regulatory authority but there is variation in terms of insurance company representation on the boards.

Most states have not chosen to create restrictions on the minimum or maximum number of plans an insurance carrier may offer. Nor have states explicitly granted additional benefits or restricted benefits to those enumerated in the ACA. About half of the states are pursuing abortion coverage restrictions yet many of these states do not have active legislative proposals creating an exchange.

I. Introduction

In March of 2010, the United States government passed the most important health care legislation in a generation, the Affordable Care Act.[1] The ACA has a multitude of requirements that change the landscape of health care for the whole country. There are new government programs, adjustments to already existing programs, new rules for insurers, and new options for states - most of which were created in an attempt to eliminate the number of uninsured individuals in the country or reduce the growth in health care spending.

However, one of the main criticisms leveled against the ACA is the alleged overreach of the federal government into the domain of the states. Traditionally, regulation of health insurance has been a state issue. One compromise made in an attempt to allay concerns about federal overreach allowed states to implement one of the key provisions of the ACA: health insurance exchanges. These exchanges will be new marketplaces for health insurance coverage in the individual and small group markets and are considered to be central to the success or failure of the ACA as a whole. Given the high stakes and controversy involved, the activity in the states in regard to these exchanges must be followed. The U.S. Department of Health and Human Services is required to determine a state exchange's feasibility by January 1, 2013. Thus, it is imperative that states not dawdle in creating the exchanges.

This paper examines the various proposals currently circulating in the states. First, this paper examines the activity in the states regarding the decision to create the health insurance exchanges or, alternatively, to allow the federal government to instead operate the exchanges. Second, this paper examines the various legislative

proposals for different key aspects of governance including: form of exchange entity, regulatory authority, and insurance representation on the board of directors. Third, this paper reviews differences in exchange and insurance design parameters including: maximum or minimum number of plans, allowance of extra benefit mandates, and the abortion opt-out.

II. Health Insurance Exchanges and the ACA

As imagined through the ACA, each state will create an American Health Benefit Exchange that acts as a marketplace for those trying to find health care coverage.[2] In fact, states are required to allow two different groups into the exchange at the outset: individuals and small businesses. States have the option of creating two separate exchanges, one dedicated to each of those two markets, or states can combine the two into a single exchange.[3] Those without employer sponsored coverage and those who do not qualify for Medicaid or Medicare have the option of utilizing the exchange or purchasing coverage elsewhere. Under the ACA, individuals will receive a tax credit to put towards premiums for qualified health plans offered on the health insurance exchange if the individual is between 133% and 400% of the federal poverty level (FPL).[4] Likewise, small businesses (businesses with 25 or fewer full time employees) will receive premium tax credits for qualified health plans in the exchange.[5]

The Congressional Budget Office estimates that 24 million individuals will purchase insurance through the exchanges.[6] Recently, the Kaiser Family Foundation estimated that of those 24 million, 65% would transition from uninsured status to

an exchange-based health plan.[7] Thus, according to these estimates, 15.6 million formerly uninsured individuals would find insurance through the exchanges.

Two states, Massachusetts and Utah, had exchanges in service prior to the passage of the ACA, but they are popularly viewed as approaching the programs differently.[8] Massachusetts, as part of its health care overhaul in 2006, created the Health Connector as its exchange.[9] The Connector negotiates with insurance carriers as to which plans will be offered. By contrast, the Utah Health Exchange, while still determining minimum benefits to be offered, allows any carrier to enter the market at any price they choose.[10] The two states are viewed as representing the opposite ends of the spectrum in formulating exchanges in that one attempts to protect consumers by behaving as an active purchaser in a market while the other allows the consumers to choose freely.

There are both explicit restrictions on flexibility and grants of flexibility provided to the states in the ACA. The Act is written so that states have the option to implement their own exchanges like Massachusetts, Utah, or in different ways from either state. The following sections will examine key restrictions and policy choices states face in constructing an exchange.

II.A. Restrictions on States Creating Health Insurance Exchanges

The ACA places certain minimum requirements on states in the creation and operation of the exchanges. First and foremost, the plans offered in the exchanges must be "qualified health plans" (QHP). [11] A QHP is defined as a health plan that is certified by the exchange, offered by a health insurance issuer that meets certain requirements, and provides the essential health benefits package.[12] The essential

health benefits package is a set of benefits that must be offered in every plan, such as emergency services, hospitalizations, and prescription drugs.[13] Only when the regulations meant to illuminate the contours of the required minimum benefits are released will state exchanges know the exact benefits that must be offered by QHPs. These federally mandated health benefit minimums have caused a good deal of consternation as opponents charge they could lead to more expensive plans that consumers might not want.

The essential health benefits package contains a multitude of other restrictions that states must honor. The package must include limits on cost sharing.[14] Also, the package must provide one of bronze, silver, gold, or platinum levels of coverage.[15] The different levels signify differing levels of coverage "designed to provide benefits that are actuarially equivalent to" 60% to 90% "of the full actuarial value of the benefits." However, if a plan is a catastrophic plan, it can only be offered in the individual market and must be restricted to a certain subset of qualified individuals.[16] The demand that only QHPs be offered on the state exchanges is the main federal requirement affecting consumer choice within the exchanges.

II.B. State Flexibility in Creation and Regulation of Health Insurance Exchanges

Although there are important requirements on the state-based exchanges, Congress granted states a great deal of latitude in the implementation and operation of these new entities. The first, and most important, choice states must make is whether or not to elect to have their own exchange. By January 1, 2013, should a state elect not to have an exchange, or if the Secretary of Health and Human Services

determines that an exchange will not be operational by January 1, 2014, the federal government will operate an exchange in the state.[17] Thus, states that dither in creating the exchange might lose the ultimate authority to craft an exchange as they would like.

While the quality and level of health benefits to individuals and small businesses in the exchange is partially determined by benefit mandates in the ACA, states can go beyond those mandates. For example, federal law allows a state to mandate QHPs to offer benefits beyond those required in the minimum benefits package discussed in the previous section.[18] However, any state that chooses to require a greater benefits package must assume the incremental costs of the premium subsidy associated with those greater benefits.[19] Another example of state flexibility is that there is no federally mandated minimum or maximum number of plans that a carrier must offer on the exchanges. The quality, choice, and cost of health plans available to consumers would vary dramatically between states depending on how an exchange implements such restrictions.

Whether or not a state chooses to implement certain exchange and insurance design parameters will be determined by two entities. At the outset, states themselves must create the form of the exchanges and the restrictions under which the exchanges must operate. This is largely determined through the legislative process though certain states are operating under the belief that already existing entities have the legal authority to create exchanges. Once the exchange is formed and operational, the entity in charge of governing the exchange will have most of the authority in making such decisions. Thus, the strictures placed on the exchanges by

the legislatures and the governing structure of the exchanges are the logical starting points in examining the flexibility states will give exchanges.

Based on this discussion, the following six factors may or may not be addressed in state legislation creating exchanges but they are all important in determining the flexibility given to the exchanges:

1. Governance:

    A. States may choose the form of the exchange either as a government agency, non-profit entity, or some combination of the two.[20]

    B. The board of directors for the exchange may or may not have regulatory authority.

    C. The board of directors for the several exchanges may or may not contain representatives of the insurance industry.

2. Exchange and Insurance Design Parameters:

    D. Legislative limits on the number of health plans a carrier may offer.

    E. Various legislative limits on the services health plans must offer.

    F. The ability of health plans in the exchange to offer abortion coverage to individuals receiving federally subsidized premium support.

Of course, these policy choices are only relevant if a state elects to create its own health insurance exchange. The remainder of this paper summarizes a comprehensive search of the relevant legislative proposals and characterizes them by 1) state and location in the particular states' legislative process, 2) governance, and 3) exchange and insurance design parameters.

III. Methods

There were multiple methods by which this data was collected. In total, 53 separate website were regularly utilized to gather the necessary information. All of these following websites were necessary, as no single source would offer complete information as to which states actually put forward health insurance exchange legislation. First, the National Council of State Legislatures tracks exchange related legislation in all of the states. However, the tracking system does not interpret the individual pieces of legislation and sometimes includes legislation that does not fit the parameters of this review. Second, keyword searches were conducted on the Lexis/Nexis State Capitol search engine. Keywords included: health insurance exchange, insurance exchange, exchange, connector, and abortion. Third, a daily Google News Alert was created to search for all instances of the term "health insurance exchange." Fourth, all 50 state legislative websites were searched with the same keywords listed for Lexis/Nexis. The following three sections present the cumulative results from these internet-based searches, as of May 1, 2011.

IV. Results for Whether States Are Actively Pursuing Exchanges

Given that by January 1, 2013, HHS must determine if an exchange will be operational in a state by the 2014 start date, states must move quickly to create the legal structure of the exchanges. Time pressure could be more acute depending on a particular state's legislative system. For example, the State of Texas utilizes a bi-annual legislature that meets for 140 days in odd years.[21] Thus, absent a special session called by the Governor, 2011 is the last opportunity for Texas to pass a law creating its own state-run exchange, thereby necessitating a federally-run exchange.

In fact, an author of one of Texas' exchange proposals fears that a federally-run exchange is inevitable as the Governor has apparently shown little interest in creating or approving the creation of an exchange.[22]

Texas is not the only state that could fail to elect to operate an exchange by the necessary point. Montana, Nevada, and North Dakota also convene biennial regular sessions and these sessions only meet in odd-numbered years.[23] Thus, just like Texas, these states will not have the option of legislatively creating a state-based exchange absent a special session called according to their respective state constitutions.

Some states are actively pursuing exchanges while others are not, and still others already have laws creating exchanges in place. For purposes of this review, states are considered to be "actively pursuing" an exchange if a legislative proposal is currently being considered in a current legislative session, or has completed the legislative process and is approved by the state's Governor. For a proposal to be considered current, there must not have been a final majority vote against it, the proposal's sponsorship not have been withdrawn, nor should it have been vetoed. If any of these events occur, the bill is considered "inactive." If an inactive bill was the only one being pursued by the state, then this review does not consider that state to be actively pursuing the creation of an exchange. Additionally, if a legislative body has passed one bill and sent it for approval to the Governor, any other bill creating an exchange that has not been officially voted down is considered inactive. Lastly, bills simply calling for a state to examine the possibility of creating an exchange are not considered active because the legislative intent to actually create an exchange is

not present, only the intent to study the possibility of creating an exchange is present (Wyoming, for example).[24]

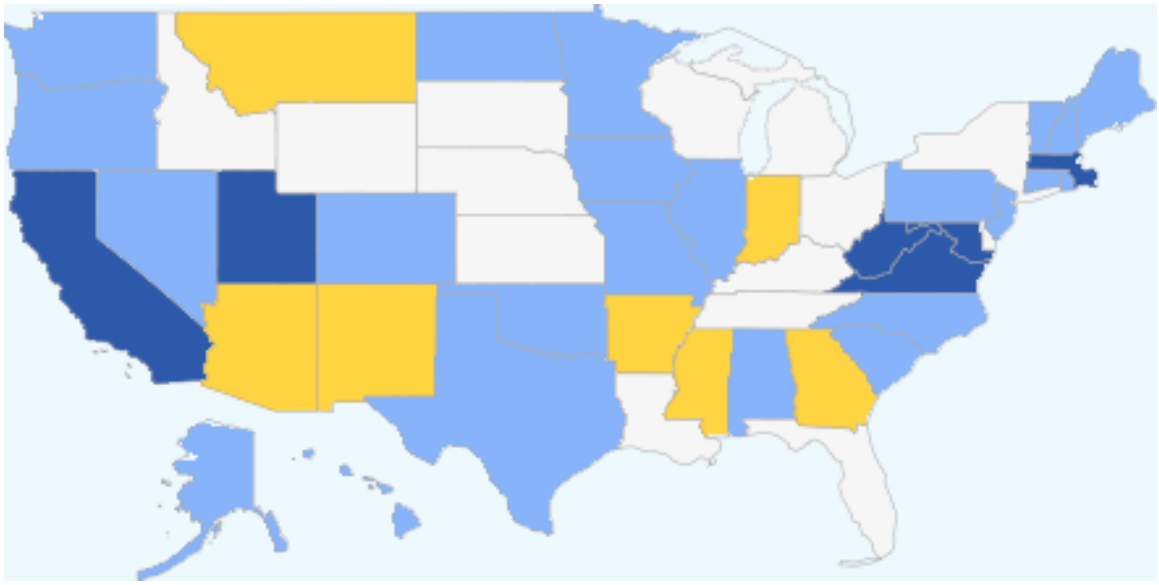
At this point, it is important to explain what this review does not attempt. This review does not take into account attempts to create an exchange outside of the legislative process. Some states have, or believe they have, the authority to create exchanges without any action by the legislature. For example, even though Alaska is considering exchange legislation, certain state officials have stated that the legislation is unnecessary to create an exchange.[25] Also, Indiana has issued an executive order commanding state officials to meet to determine the structure and operations of the exchange.[26]

Currently, 24 states are actively pursuing the creation of an exchange while six states have already passed the necessary legislation. As stated previously, Massachusetts and Utah had exchanges in place prior to the passage of the ACA. Since the passage of the ACA, the following states have passed legislation creating an exchange: California[27,28] (9/30/2010), West Virginia[29] (3/12/2011), and Maryland[30] (4/12/2011). Virginia (4/6/2011) enacted legislation that establishes that the state will create an exchange, however, it does not contain any other specifications concerning the exchange.[31]

Some of the states actively pursuing exchanges have multiple active proposals. However, 20 states, or just over a third of the states, are not actively pursuing the creation of exchanges at the time of publication. Some states were once active but are now inactive for a variety of reasons. Georgia had been active but has since seen its lone exchange proposal withdrawn from consideration and its

legislature has since adjourned.[32] Arizona[33,34], Arkansas[35,36], Indiana[37], Mississippi[38,39,40,41], and Montana[42,43] had multiple legislative proposals but their legislative sessions adjourned without passage and none of the states have carryover. New Mexico succeeded in passing insurance exchange legislation but the governor vetoed it.[44] Figure 1 is a map indicating whether or not a state is active, inactive, or has enacted a health insurance exchange.

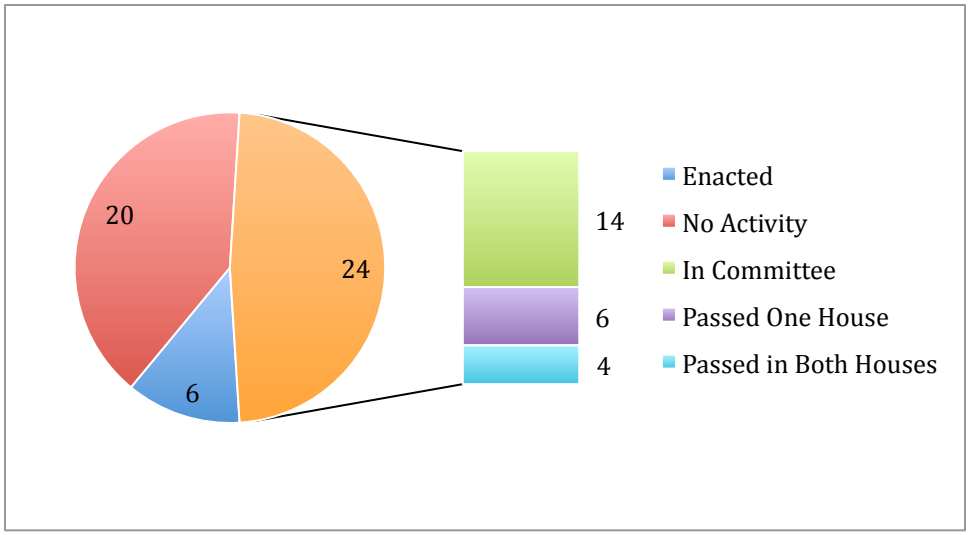
Figure 1
Map showing states with enacted exchange legislation (dark blue), active and pending legislation (light blue), complete inactivity (white), and inactivity after failed legislative attempts (orange).



The 24 states actively pursuing legislation have proposals at various stages in the legislative process. A plurality of the states has active legislation (14) that is currently in committee. Four state legislatures have approved exchanges in both halves of their respective legislatures (Hawaii[45], North Dakota[46], Vermont[47], and Washington[48]), but their governors have not signed these bills into law. Six other proposals have been favorably voted on in one half of bicameral legislatures and sent to their counterparts: Colorado[49], Illinois[50], Missouri[51], Oklahoma[52], Oregon[53],

and Rhode Island[54]. Figure 2 shows the number of states in each stage of legislative activity.

Figure 2
Extent to which exchange legislative proposals have progressed.



V. Results for Governance

As of May 1, 2011, there are a total of 53 legislative proposals across the 24 states actively pursuing legislation, and six states with legislation enacted. Each piece of legislation among these 30 states is different in multiple respects, including governance of the future health insurance exchanges. The aspects affecting the governance of the exchanges reviewed here are form of exchange, regulatory authority, and the presence of insurance representation on the board of directors. The following set of results shift from summarizing the status of the 30 different states (i.e., six states with enacted legislation and 24 states actively pursuing legislation) to the status of the 53 different proposals across these 30 states. Some states only have one proposal, while other states have multiple proposals.

V.A. Forms of Health Insurance Exchanges

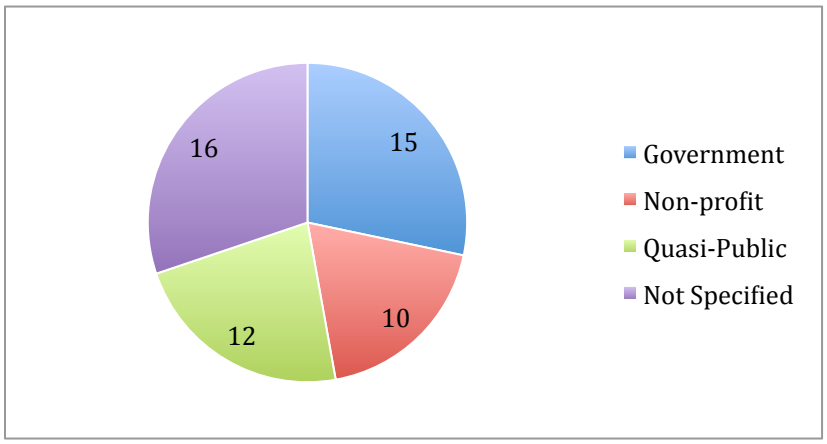
There is a great deal of variation among the active legislative proposals regarding the form of the exchanges. Fifteen active bills would establish the state

exchange as a governmental agency or as an arm of an already existing agency. Ten actives bills would establish the exchange as a nonprofit entity. Sixteen states do not specify the form of exchange entity. However, of the unspecified category, six of the proposals originate in Texas and four others simply elect to create an exchange while not legislatively creating any other exchange characteristics.

However, 12 separate proposals opt for a quasi-public approach. This third category is difficult to define. Essentially, the exchange would be established with both governmental and private elements. For example, in Connecticut, the statutory definition of "quasi-public" is only a list of entities set up without any further explanation.[55] A legislative report, however, lists certain key characteristics about quasi-public agencies in Connecticut.[56] These agencies operate outside the normal state government structure, thus exempting them from certain personnel and spending controls typically required of Executive agencies. Additionally, there are no Legislative or Executive controls over the quasi-public agency's budget. Theoretically, this allows a quasi-public agency to respond to both problems and opportunities more quickly than a traditional government agency. However, quasi-public agencies must still comply with "good government" laws such as freedom of information and ethics laws. Such a description can be generalized to additional quasi-public or public/private partnership formations when discussing the state-based health insurance exchanges. A good number of legislatures have made the policy choice to grant the exchanges more operating flexibility so that the exchanges could act more as a private entity while maintaining the public character states

require of government agencies. Figure 3 shows the number of active proposals with each form of governing structure

Figure 3
Distribution of forms of exchanges in active legislation.



V.B. Variation in the Boards of Directors

An integral part of the establishment of an exchange is the establishment of a board of directors to oversee its implementation and operation. Two facets of the board could affect the forms of the health plans ultimately offered on the exchange: 1) whether or not the board has regulatory authority and 2) allowing representatives of insurance companies onto the boards.

American political institutions follow a typical flow of grants of authority. The authority for state governments flows from a state constitution that creates the branches of a particular government. One of the branches created, the legislative branch, can write laws that affect the citizenry. When the legislature creates new entities, such as a health insurance exchange, the legislature can grant that new entity the authority to write regulations that affect the conduct of its business. In the case of the exchanges, an exchange with regulatory authority might, for example, have the ability to determine that certain added health benefits must be included in

a health plan beyond that which is provided for in the ACA. Absent such a legislative grant of regulatory authority, however, the exchange could not undertake such an action.

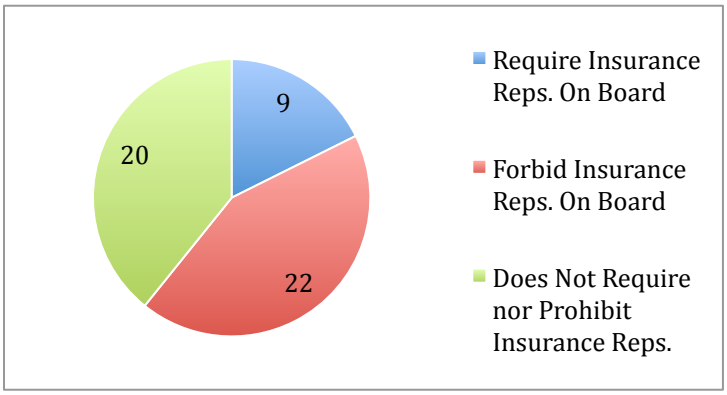
A large majority (41) of the 53 legislative proposals across these 30 states contain regulatory authority for the exchange board of directors while only one active proposal, Colorado SB11-200[57], specifically withholds a grant of regulatory authority. Two states, Texas[58] and North Carolina[59], have active pieces of legislation that do not vest regulatory authority with the board itself but one of the board members has such authority. Seven proposals do not specify whether or not the exchange board has regulatory authority. Utah and Vermont do not appear to utilize boards of directors in their systems.

The ACA does not contain requirements on the makeup of boards of directors, thus states have maximum flexibility in making such determinations. Inclusion of representatives from insurance companies on exchange boards breaks down into three categories depending on which legislative proposal one reads. Twenty-two of the 53 proposals completely forbid individuals with insurance carrier affiliations from participating on exchange boards. Twenty of the 53 proposals do not include any language requiring nor prohibiting insurance carrier representation. Nine of the 53 proposals require representatives of carriers to participate on the board.[i] Six of the nine proposals that require insurance carrier

[i] South Carolina proposal H. 3738 is inconsistent on this one issue. At one point the bill requires that three members of the board represent the health insurance industry. But in the same section the bill states that no individual can be appointed to the board if they are "employed by, a consultant to, on the board of, or a lobbyist or other representative for an entity in the business of, or potentially in the

representation require more than one such representative. Again, Utah and Vermont do not utilize boards of directors and are not considered in this part of the analysis. Figure 4 shows the number of active proposals in each of the three categories described above.

Figure 4
Distribution of insurance company representation on exchange boards of directors among the various state proposals.



VI. Results for Exchange and Insurance Design Parameters

Beyond the governance structure of the exchanges, legislatures may choose to grant or restrict the specific powers of the exchange or limit the type of health plans offered.

VI.A. Limits on the Number of QHPs Offered by a Carrier

Eight proposals across five states have provisions expressly affecting the number of health plans an insurance carrier may offer on the exchange. California[60] and two of New Jersey's proposals[61,62] require carriers to offer at least one QHP in each of the five levels of coverage (bronze, etc.) as a condition of participation in the exchange. Five other bills allow for or require a limit on the number of plans a carrier can offer in each level of coverage.

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business of, selling products or services of significant value to the exchange…includ[ing] insurance carriers."

VI.B. Limiting the Ability to Exceed the Minimum Coverage and Certification Standards of the ACA

Only one active legislative proposal contains explicit restrictions on the ability of exchanges to go beyond the ACA. Texas H.B. 636[63] specifically forbids the exchange from requiring prospective health plans to meet standards beyond those established by the ACA and related federal regulations. Three of Iowa's proposals direct the exchange to request a five year waiver from HHS so that it may offer health plans without the benefit mandates in the ACA.[64,65,66]

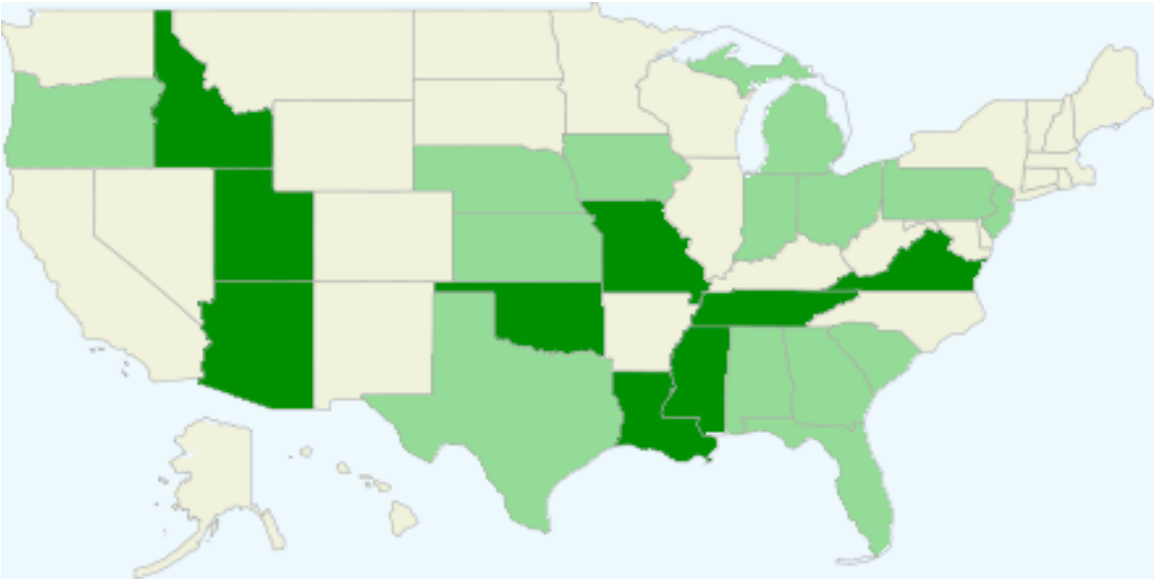
VI.C. States Opting Out of Abortion Coverage

One of the more controversial aspects of the health care reform debates was coverage for abortions. Abortion opponents worried that when individuals receiving premium assistance from the federal government would purchase insurance on the exchanges that contained abortion coverage, it would be as though the federal government were subsidizing abortions. Eventually, a compromise was found. The default rule is that QHPs would be allowed to offer abortion coverage in the exchanges, but a state could affirmatively opt-out of that rule and prohibit QHPs from offering abortion coverage.[67] Should a state not opt-out of abortion coverage, individuals who choose to enroll in a QHP that has abortion coverage must send two separate payments: one for the insurance coverage itself and another for the abortion coverage.

Many, but not most, states are actively pursuing the abortion opt-out. To this point, there have been many legislative proposals from about half of the states. Currently, there are 31 active legislative proposals across 23 states (See Figure 5).

Nine states have passed opt-out legislation: Arizona, Idaho, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, Utah, and Virginia. Eight of the states actively pursuing an opt-out from abortion coverage do not have active legislation creating a state-based exchange. Of those nine states that have enacted opt-out legislation, five are not actively pursuing exchanges.

Figure 5
Map showing states with complete abortion opt-out legislation (dark green), active and pending legislation (light green), and no legislation (tan).



VII. Conclusion

Although states have a deadline by which they must demonstrate the capability to operate their own health insurance exchange, a third of all states are not actively engaged in the process of creating such exchanges, at least not legislatively. The forms of the exchanges are fairly evenly split between government, nonprofit, and quasi-public. There is tremendous variation between the states regarding the presence of insurance company representation on the exchange boards of directors with a plurality of states forbidding such appointments. Of the

active states, relatively few are limiting the ability of the exchanges to create requirements beyond those stated in the ACA. Such limitations can be made by explicitly prohibiting the exchange from requiring benefits above those created by the essential health benefits package or by refusing to grant the exchange regulatory authority. Half of all states are pursuing the abortion opt-out, and some of those states are not actively pursuing exchange legislation.

States have until January 1, 2013 to demonstrate their exchange operational capabilities or risk losing authority to implement the exchange to the federal government. In order to implement all of the required regulations and operations, states must accelerate their legislative activity.

Appendix

STATE	BILL	EXCHANGE FORM	INSURANCE REPRESENTATION	REGULATORY AUTHORITY	MAXIMUM/MINIMUM PLANS
Alabama	HB 401	NP	Require	Yes	No Restriction
Alaska	SB 70	Q/P	Require	Yes	No Restriction
California	AB 1602/SB 900	G	Forbid	Yes	Minimum
Colorado	SB11-200	NP	Neither	No	No Restriction
Connecticut	SB 921	Q/P	Require	Yes	No Restriction
Connecticut	HB 6323	Q/P	Forbid	Yes	Maximum
Connecticut	SB 1204	Q/P	Forbid	Yes	Maximum
Hawaii	SB 1348	NP	Neither	Yes	No Restriction
Illinois	SB 1549	Unspecified	Unspecified	Unspecified	No Restriction
Illinois	HB 1577	Unspecified	Unspecified	Unspecified	No Restriction
Iowa	SF 235	Unspecified	Unspecified	Unspecified	No Restriction
Iowa	SF 348	NP	Forbid	Yes	No Restriction
Iowa	SF 391	Unspecified	Unspecified	Unspecified	No Restriction
Iowa	HF 559	Unspecified	Unspecified	Unspecified	No Restriction
Maryland	HB 166/SB 182	Q/P	Forbid	Yes	No Restriction
Massachusetts	Mass Gen Laws 176Q	G	Forbid	Yes	No Restriction
Minnesota	HF 497	NP	Neither	Yes	Maximum
Minnesota	HF 1204	G	Forbid	Yes	No Restriction
Minnesota	SF 917	G	Forbid	Yes	No Restriction
Missouri	HB 609	Q/P	Require	Yes	No Restriction
Nevada	SB 440	Unspecified	Forbid	Yes	No Restriction
New Hampshire	SB 163	Q/P	Require	Yes	No Restriction
New Jersey	A 3733	NP	Forbid	Yes	Minimum
New Jersey	S 2597	NP	Forbid	Yes	Minimum
New Jersey	S 1288	G	Forbid	Yes	No Restriction
New Jersey	A 1930	G	Forbid	Yes	No Restriction
New Jersey	S 2553	G	Forbid	Yes	No Restriction
New Jersey	A 3561	G	Forbid	Yes	No Restriction
North Carolina	HB 115	NP	Require	Yes	No Restriction
North Carolina	HB 126	NP	Forbid	Yes	No Restriction
North Carolina	SB 418	NP	Forbid	Yes	No Restriction
North Dakota	HB 1126	Unspecified	Unspecified	No	No Restriction
Oklahoma	HB 2130	G	Require	Yes	No Restriction
Oregon	SB 99	Q/P	Neither	Yes	Maximum
Oregon	HB 3137	Q/P	Neither	Yes	Maximum
Pennsylvania	HB 627	Unspecified	Neither	Yes	No Restriction

Pennsylvania	SB 940	Unspecified	Neither	Yes	No Restriction
Rhode Island	S 87	Q/P	Forbid	Yes	No Restriction
Rhode Island	H 5498	Q/P	Forbid	Yes	No Restriction
South Carolina	H 3738	G		Yes	No Restriction
Texas	HB 636	Unspecified	Neither	Yes	No Restriction
Texas	SB 1510	Unspecified	Neither	No	No Restriction
Texas	SB 1586	Unspecified	Neither	Yes	No Restriction
Texas	SB 1782	Unspecified	Forbid	Yes	No Restriction
Texas	HB 3402	Unspecified	Forbid	Yes	No Restriction
Texas	HB 3419	Unspecified	Neither	Yes	No Restriction
Utah	HB 133 (2008), HB 188 (2009)	G	Neither	Yes	No Restriction
Vermont	H 202	G	No Board	No Board	No Restriction
Virginia	HB 2434	Unspecified	Neither	Unspecified	No Restriction
Washington	SB 5445	Q/P	Neither	Yes	No Restriction
West Virginia	SB 408	G	Neither	Yes	No Restriction
Key: G- Government Agency NP- Non-Profit Entity Q/P- Quasi Public Entity					

Notes

[1] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119.
[2] § 1311(b).
[3] § 1311(b)(2).
[4] § 1401.
[5] § 1421.
[6] *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 Before the House Subcomm. on Health, Comm. on Energy and Commerce*, 112th Cong. (2011) (statement of Douglas W. Elmendorf, Director, Congressional Budget Office).
[7] A Profile of Health Insurance Exchange Enrollees. (2011). Retrieved March 31, 2011, from http://www.kff.org/healthreform/upload/8147.pdf.
[8] Pear, R. (2010). Health Care Overhaul Depends On States ' Insurance Exchanges. *The New York Times*, 1-4.
[9] MASS. GEN. LAWS ch. 176Q (2010).
[10] Corlette, S., Alker, J., Touschner, J., & Volk, J. (2011). *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned*. *Emerging infectious diseases* (Vol. 17, pp. 1-16). Retrieved May 6, 2011, from http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf publications/health reform/exchanges.pdf.
[11] ACA § 1311(d)(2)(B)(i).
[12] § 1301(a).
[13] § 1302.
[14] § 1302(c).
[15] § 1302(d).
[16] § 1302(e).
[17] § 1321(c).
[18] § 1321(d)(3).
[19] § 1321(d)(3)(b)(ii).
[20] § 1311(d)(1).
[21] TEX. CONST. art. III, § 5.
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