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State Exchange Enacted Legislation and Executive Orders as of August 31, 2011

State	Source	Policy Goals	Type of Entity	Scope of Authority	Composition of the Board/ Advisory Committee	Conflict of Interest	Additional Duties	Relationship between Individual and SHOP Exchanges	Stakeholder Engagement
Alabama	Executive Order 17 (2011)	Alabama aims to present consumers with broader choices and more individualized options by fostering a consumer-centric health insurance market. Exec. Order No. 17 ¶ 3	A study commission will make recommendations on whether to create the Alabama Exchange within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity. Exec. Order No. 17 ¶ 6(i)	A commission is established to study and make recommendations on the structure, governance, and functions of the Exchange. Exec. Order No. 17 ¶ 4; ¶ 6	The study commission will make recommendations on the make-up of the governing board. The study commission consists of 13 members, including the chairs of the House and Senate health committees, Commissioner of Medicaid, Commissioner of Insurance, Finance Director, two members appointed by the governor, four members appointed by the legislature, and three members appointed by the Medical Association, Nursing Association, and Hospital Association. Members appointed by elected officials represent the interests of insurers, insurance agents, or the business community. Exec. Order No. 17 ¶ 4, ¶ 7	Not addressed.	The commission must make recommendations on the establishment of the Exchange by December 1, 2011. Exec. Order No. 17 ¶ 7	Not addressed.	The commission may create advisory committees consisting of stakeholders. Exec. Order No. 17 ¶ 5
California	Legislation: AB 1602 (2010); SB 900 (2010)	California aims to reduce the number of uninsured by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available federal tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act; strengthen the health care delivery system, guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers; require that health care service plans and health insurers issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, not on risk selection; and meet the requirements of the federal act and all applicable federal guidance and regulations. SB 1602 Sec. 2	California establishes its Exchange as an independent state agency (public entity). SB 900 Sec. 2(a)	California creates the Exchange and governing board. The board has authority to make rules, including criteria for plan inclusion in the Exchange. SB 900 Sec. 2(a); SB 1602 Sec. 7(c)	The Exchange is governed by a five-member board. The Secretary of California Health and Human Services serves as a voting, ex officio member. Two members are appointed by the governor and two are appointed by the legislature. Each member must have expertise in two of six categories: individual or small employer coverage issues, plan administration, health care finance, delivery system administration, and purchasing. The law encourages a diversity of experience and reflection of the cultural, ethnic, and geographical diversity of the state. SB 900 Sec. 2(a), (c)(1), (e)	Members of the board and staff may not be affiliated with a carrier, agent or broker, health care facility, or trade association of carriers, health care facilities, health clinics, or providers. Providers may be board members only if they receive no compensation as a provider and do not have ownership in a practice. SB 900 Sec. 2(f)	The Exchange must annually assess the impact of the Exchange on other publically funded health programs, including cost shifting or increases that may be due to Exchange policies or operations. SB 1602 Sec. 14(e)	The SHOP Exchange is separate from the activities of the individual Exchange; however, the board will report to the legislature by December 1, 2018 on whether to merge the individual and small employer markets. SB 1602 Sec. 6(m); Sec. 7(v)	California requires stakeholder engagement with the same requirements as the federal law. SB 1602 Sec. 7(t)

State	Interaction with Brokers	Adverse Selection	Relationship with Qualified Health Plans	Coordination with Other Programs and Agencies	Fees and Other Revenue	Relationship with Other Laws	Eligibility and Enrollment	Navigators and Customer Assistance Programs	Transparency
Alabama	Not addressed.	Not addressed.	Not addressed.	The commission will study and make recommendations on the interactions between the Exchange, Medicaid, and other health programs. Exec. Order No. 17 ¶ 7(v)	The commission will study and make recommendations on the resources needed to operate the Exchange. Exec. Order No. 17 ¶ 7(iii)	Not addressed.	Not addressed.	Not addressed.	Not addressed.
California	California prohibits brokers from serving on the board or as employees. It does not prohibit the use of brokers as Navigators, but requires the Exchange to set standards for Navigators. SB 900 Sec. 2(f); SB 1602 Sec. 7(l)	If a carrier sells products both inside and outside of the Exchange, it must make all of its plans available in the Exchange also available outside of the Exchange. As of January 1, 2014, a health plan that does not participate in the Exchange may only sell platinum, gold, silver, and bronze level plans; the non-participating plan must also offer at least one standardized product at each of the four levels. SB 1602 Sec. 7(f); Sec. 15(c)-(e), Sec. 16(c)-(e)	The Exchange will determine the minimum requirements for a participating carrier that optimize choice, value, quality, and service. Each region of the state must have a choice of plans at each of the five levels of coverage in the ACA and carriers must offer at least one product within each of the five levels. The board may require carriers to offer additional products. The Exchange will determine and approve cost-sharing provisions, establish uniform billing and payment policies, and require a carrier notify the Exchange when an individual is enrolled or disenrolled from any qualified plan. With respect to the SHOP program, the Exchange will collect premiums and administer all other necessary and related tasks, including enrollment and plan payment in order to simplify the offering of plan choice. SB 1602 Sec. 7(c)-(f), (i)-(j), (w) (x); Sec. 15(b)-(e); Sec. 16(b)-(h)	The Exchange must coordinate eligibility determinations and enrollment processes with other government entities, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and counties. The Exchange must coordinate with Medi-Cal and the Healthy Families Program on processes for case transfer, referral, and enrollment in the Exchange. SB 1602 Sec. 7(a)-(b)	The board may assess charges on qualified health plans; however, the charges cannot affect the requirement that carriers charge the same premiums inside or outside the Exchange. The Authority may provide a working capital loan up to $5 million if the federal planning and establishment grants are insufficient to meet the necessary federal requirements. SB 1602 Sec. 3(s); Sec. 7(n)	The legislature finds that, although SB 1602 imposes a limitation on the public's right of access within the meaning of the California constitution, the limitations are necessary for the Exchange to exercise its fiduciary powers and obligations to the public. SB 1602 Sec. 17	The Exchange must collaborate with the Department of Health Care Services and the Managed Risk Medical Insurance board to allow an individual the option to remain enrolled with the individual's existing carrier and provider network if the individual loses eligibility for premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits. SB 1602 Sec. 8(a)(7)	The Exchange will select and set performance standards and compensation for Navigators. The Director of the Department of Managed Health Care and the Insurance Commissioner will review the Internet portal developed by HHS. If the portal does not adequately market all individual and small employer health plan products, they will jointly develop and maintain an electronic clearinghouse of coverage available. Carriers must regularly update an electronic directory of contracting health care providers so individuals may search by name to determine whether a provider is in-network. The board may also require the carrier to include information as to whether the provider is accepting new patients. The Exchange will provide oral interpretation services in any language, a toll-free telephone number for the hearing and speech impaired, and written information in a plainly worded format in prevalent languages. SB 1602 Sec. 7(l), (y); Sec. 8(a)(9); SB 900 Sec. 3-4	The board is subject to the Bagley-Keene Open Meeting Act, which allows closed sessions when considering matters related to litigation, personnel, contracting, and rates. Records of contract negotiations and work products are exempt from disclosure under the California Public Records Act; however, contracts are open to inspection one year after their effective dates. The Exchange must annually prepare a written report on the implementation and performance of the Exchange functions for the legislature, governor and public through the Exchange website. SB 900 Sec. 2(j); SB 1602 Sec. 7(q); Sec 12(a)-(b)

State	Source	Policy Goals	Type of Entity	Scope of Authority	Composition of the Board/ Advisory Committee	Conflict of Interest	Additional Duties	Relationship between Individual and SHOP Exchanges	Stakeholder Engagement
Colorado	Legislation: SB 11-200 (2011)	Colorado aims to create an Exchange to fit the unique needs of Colorado, seek Colorado-specific solutions, and explore the maximum number of options available; facilitate the access to and enrollment in health plans in the individual market and include a small business health options program to assist small employers in facilitating the enrollment of their employees; and increase access, affordability, and choice for individuals and small employers purchasing health insurance. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-102)	Colorado establishes its Exchange as a nonprofit unincorporated public entity. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-104)	The board is given the authority to make an operational plan and apply for federal grants; however, both are subject to approval by the Legislative Health Benefit Exchange Implementation Review Committee. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-106(1)(b)-(c))	The board consists of 12 members. The Executive Director of the Department of Health Care Policy and Financing, the Insurance Commissioner, and the Director of the Office of Economic Development and International Trade serve as nonvoting, ex-officio members. The governor appoints five members and the legislature appoints four. A majority of the appointees must be business representatives, but not directly affiliated with the insurance industry and none may be state employees. Each appointed member must have demonstrated knowledge in at least one, but preferably two, areas of health care expertise. The Legislative Health Benefit Exchange Implementation Review Committee is comprised of ten legislators. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-105)(1)(a)-(c); §10-22-107(2)(a)-(d))	Board members may not take any action that may have a direct effect on the member's financial interests. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-105(3)(b))	The board must assess a number of issues including the appropriate size of the small employer market; rural Coloradans' needs in regard to access, affordability, and choice; and affordability and cost in the context of quality care and increased access. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-106(1)(f), (h)-(j))	The two markets are separate, but the board is to consider the desirability of combining the individual and SHOP Exchanges. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-106(1)(g))	The board must create technical and advisory groups as needed, which will meet regularly and make recommendations to the board. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-106(1)(d))
Connecticut	Legislation: SB 921 (2011)	Connecticut aims to reduce the number of individuals without health insurance and assist individuals and small employers in the procurement of health insurance. SB 921 Sec. 5(b)	Connecticut establishes its Exchange as a public non-profit corporation. SB 921 Sec.2(a)	Connecticut creates the Exchange and governing board. The board has authority to develop policies and procedures, operate the Exchange, and develop and use selective criteria for plan inclusion. Some additional functions, such as offering the essential health benefits package and efforts to mitigate adverse selection, require recommendations to the legislature. SB 921 Sec. 3(1), Sec. 5(c)(16); Sec. 6(25)	The board consists of 11 voting members. The Commissioner of Social Services, the Special Advisor to the Governor on Healthcare Reform, and the Secretary of the Office of Policy and Management serve as ex-officio, voting members. The Insurance Commissioner, the Commissioner of Public Health, and the Healthcare Advocate serve as ex-officio, non-voting members. The governor appoints two members and the legislature appoints six. The appointees must have expertise in coverage issues, finance and economics, plan administration, or delivery systems. SB 921 Sec. 2(a)-(b)	No board member may be affiliated with an insurer, producer or broker, provider, or health care facility. No board member or employee may be a provider, unless the provider is not compensated for their services and has no ownership in a practice, or affiliated with a trade association of an insurer, producer or broker, provider, or health care facility. There is not a conflict of interest when a board member has a financial interest in an entity subject to the board 's authority provided the member abstains from deliberation, action, or vote affecting that entity. Board members and employees may not accept employment with a carrier participating in the Exchange within one year of service to the Exchange. SB 921 Sec. 2(b)(2), (c)(7), (c)(9), (e)(1)-(4)	The Exchange must annually report on, among other issues, whether to revise the definition of "small employer" to not more than 100 employees and whether to include large employers in the Exchange. SB 921 Sec. 12 (a)	The Exchange will report to the legislature and governor on whether to establish two separate Exchanges and whether to merge the individual and small group markets. SB 921 Sec. 12(a)(1)-(2)	In addition to federal requirements, the board shall consult with the Department of Social Services as well as individuals with knowledge about the health care system; informed decision-making on health, medical and scientific matters; and enrollees in qualified health plans. SB 921 Sec. 6(22)(A)-(E)
Georgia	Executive Order No. 06.02.11.01	Georgia will assess whether to establish an Exchange and how to develop it such that it reflects a free market, conservative approach to expanding coverage and incentivizing affordable healthcare. Exec. Order No. 06.02.11.01 ¶ 8	Not addressed.	The Order creates the Georgia Health Insurance Exchange Advisory Committee to study whether Georgia should create a state-based Exchange Exec. Order No. 06.02.11.01 ¶ 10	Members of the advisory committee include legislators, health plans, underwriters, insurance brokers, political representatives, employers, business representatives, trade organizations, providers, insurance consultants, consumer advocates, and academics. Exec. Order No. 06.02.11.01 ¶11	Not addressed.	The committee will assess whether the state should create a state-based Exchange and, if so, provide legislative recommendations and a businesses plan focusing on free market principles for making coverage more affordable, providing more choices to individuals, and making the Exchange sustainable. The committee must provide its preliminary recommendations by September 15, 2011, and its final recommendations by December 15, 2011. Exec. Order No. 06.02.11.01 ¶ 10	Not addressed.	Stakeholders including health plans, underwriters, insurance brokers, political representatives, employers, business representatives, trade organizations, providers, insurance consultants, consumer advocates, and academics are represented on the advisory committee. Exec. Order No. 06.02.11.01 ¶ 11

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Colorado	Not addressed.	Not addressed.	The Exchange cannot not solicit bids or engage in active purchasing, nor replace the Commissioner's duties in regard to rate approval except as directed in the federal law. All carriers that meet federal requirements and are authorized to conduct business in Colorado may be eligible to participate in the Exchange. SB 11-200 Sec. 2	Not addressed.	The general fund may not be used to implement the Exchange except to compensate members of the legislative committee and no money is appropriated. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-108); Sec. 3	The legislative review committee may report up to five bills a year. Individual committee members are exempt from any applicable bill limit. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-107(5))	Not addressed.	The board will review the federal internet portal as to whether the model template could be used to assist consumers in enrolling and making informed choices. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-106(1)(f))	The Exchange must provide an annual report to the governor and legislature on Exchange operations. Five years after the act becomes law, the legislative services agencies will conduct a post-enactment review. SB 11-200 Sec. 1 (Colo. Rev. Stat. §10-22-106(1)(e)); Sec. 2
Connecticut	Connecticut prohibits brokers from serving as board members and Exchange employees who sell, solicit, or negotiate insurance to individuals and small employers must be licensed as producers. Brokers may be awarded Navigator grants and the Exchange must report to the governor and legislature on a plan for the relationship between the Exchange and producers. SB 921 Sec. 2(b)(2)(ii), (e)(1), (e)(4); Sec.	The Exchange must annually report on adverse selection issues including ensuring similar regulation of insurers and plans offered inside and outside of the Exchange. SB 921 Sec. 6(25)	The Exchange may use selective criteria to determine which plans to offer and certify a plan if the premium rates and contract language have been approved by the commissioner. It must seek to include the most comprehensive plans that offer high quality benefits at the most affordable price. The board, Office of Health Reform and Innovation, and legislative committees must prepare a cost analysis of the essential health benefits package and recommendations on whether to require additional benefits. The Exchange may also study the feasibility of a basic health program option. SB 921 Sec.5(c)(16)-(17); Sec. 6(24); Sec. 8(a)(2); Sec. 14(a)	The Exchange must collaborate with the Department of Social Services to allow an enrollee who loses premium tax credit eligibility and is eligible for HUSKY Plan, Part A or any other state or local public program, to remain enrolled in a qualified health plan. SB 921 Sec. 6(11)	The Exchange will annually report on ways to ensure financial sustainability that are not limited to assessments and user fees on carriers. SB 921 Sec. 12(9)	Not addressed.	The Exchange will establish a program for small employers to specify a level of coverage for their employees and allow employees to enroll in any qualified plan at that level. The Exchange will offer enrollees and small employers the option of having the Exchange collect and administer premiums, including through allocation of premiums among the various insurers and qualified health plans chosen by individual employers. SB 921 Sec. 6(13) -(14)	The Exchange will set standards and requirements for Navigators and may award Navigator grants to a trade, industry or professional association, community and consumer-focused non-profit, chamber of commerce, labor union, small business development center, or licensed producer or broker. Navigators may not be insurers or receive any benefit from an insurer for enrollment. SB 921 Sec. 9(b), (e)	The Exchange may make contracts that are not subject to approval by any other state department, office, or agency provided copies are made public records. Consumer information and information exchanged between the Exchange and any state agency is not subject to FOIA. The Exchange must solicit proposals for professional services at least once every 3 years and is subject to audits. The Exchange must annually report to the governor and legislature on its financial activities and operational plan. SB 921 Sec. 3(4); Sec. 5(c)(13); Sec. 12(a)-(b); Sec. 13(b)(3)
Georgia	The advisory committee includes an insurance broker. Exec. Order No.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.

State	Source	Policy Goals	Type of Entity	Scope of Authority	Composition of the Board/ Advisory Committee	Conflict of Interest	Additional Duties	Relationship between Individual and SHOP Exchanges	Stakeholder Engagement
Hawaii	Legislation: SB 1348 (2011)	Hawaii intends to reduce the number of uninsured, provide a transparent marketplace, conduct consumer education, and assist individuals in gaining access to assistance programs, premium assistance tax credits, and cost-sharing reductions. SB 1348 Sec. 2	Hawaii establishes its Exchange as a private non-profit. SB 1348 Sec. 3(2)(a)	Hawaii establishes its Exchange, called the Connector, and a board that commences activities on July 1, 2012. An interim board will make legislative recommendations and take actions to comply with the ACA requirements in the meantime. SB 1348 Sec. 3 (§2(a), §4(a))	The board will be comprised of 15 members. The Director of Commerce and Consumer Affairs, the Director of Health, the Director of Human Services, and the Director of Labor and Industrial Relations will serve as ex-officio, voting members. The remaining members must include consumers, employers, insurers, and dental benefit providers. An interim board is created to make legislative recommendations on initial operations of the Connector. Interim members are appointed by the governor and must include the Director of Health, Director of Human Services, Director of Labor and Industrial Relations, Director of Commerce and Consumer Affairs, and representatives of insurers, providers, a health information exchange, and a hospital trade association. SB 1348 Sec. 3 (§4(a)-(b)); Sec. 4(a)	The board will adopt policies and procedures regarding conflicts of interest and recusal, including financial involvement prior to service on the board. SB 1348 Sec. 3 (§4(d))	The interim board will make legislative recommendations prior to the 2012 session on financing mechanisms, transparency, insurer inclusion, continuity of care for consumers transitioning between carriers, opportunity for public participation, conflict of interest policies, and use of electronic media. SB 1348 Sec. 4(b)(1)-(11), Sec. 4(f)	Not addressed.	The interim board includes stakeholder representatives including insurers, providers, and a hospital trade association. The governing board will include representatives of consumers, employers, insurers, and dental benefit providers. SB 1348 Sec. 3 (§4(b)); Sec. 4(a)
Illinois	Legislation: SB 1555 (2011)	Illinois seeks to avoid having the federal government set up its Exchange, provide an implementation process that provides for broad stakeholder representation, foster a robust competitive marketplace inside and outside the Exchange, and provide a broad-based approach to the fiscal solvency of the Exchange. The Exchange is designed to supplement, not supplant, any existing insurance markets for individuals and small employers. SB 1555 (§5-3; §5-5)	Not addressed.	Illinois conveys its intent to create an Exchange, but does not establish an entity. The Department of Insurance and the Commission on Governmental Forecasting and Accountability are authorized to apply for federal money and use that money to meet the federal requirements and coordinate with other state agencies as necessary. A legislative study committee is established to make recommendations to the legislature. SB 1555 (§5-10)	The legislative study committee is comprised of 12 legislators. SB 1555 (§5-15(b))	Not addressed.	The study committee is required to produce a report by September 30, 2011 on the recommended governance, structure, operating model, financial sustainability, stakeholder engagement, coverage pools for individuals and businesses, standards for the coverage of full-time and part-time employees, and legislative oversight. SB 1555 (§5-20(1)-(3), (A)-(D))	The Exchange will have separate coverage pools for individuals and small employers. SB 1555 (§5-5)	The study committee will include stakeholder engagement in its report. SB 1555 (§5-20(3))
Indiana	Executive Order No. 11-01	Indiana seeks to maintain the existing free market, assure coverage choices, coordinate with all appropriate stakeholders, and utilize resources efficiently and effectively. Exec. Order No. 11-01 Preamble ¶ 9	Indiana intends to establish its Exchange as a non-profit. Exec. Order No. 11-01(2)	The Indiana Family and Social Services Administration will work with agencies, including the Department of Insurance, to conditionally establish and operate an Exchange. The governing board will not be appointed until the federal government approves the Exchange. Exec. Order No. 11-01(1), (4)	The board will include representatives of state agencies and the Indiana General Assembly. Exec. Order No. 11-01(5)	Not addressed.	Not addressed.	Not addressed.	Standing committees will be appointed to represent stakeholders including consumers, providers, and actuaries. Exec. Order No. 11-01(5)
Maine	Legislation: LD 1582 (2011)	Not addressed. LD 1582 Preamble ¶ 2-4	The Advisory Committee on Maine's Health Insurance Exchange must make recommendations on the governance of the Exchange, but LD 1582 does not specify the type of entity. LD 1582 Sec. 1	The advisory committee must provide the legislature and governor with suggested enabling legislation and a report with recommendations on background research; stakeholder consultation; legislative and regulatory action; governance; program integration; exchange information technology systems; financial management; oversight and program integrity; health insurance market reforms; providing assistance to individuals and small businesses, coverage appeals and complaints; and business operation. LD 1582 Sec. 1; Preamble ¶ 2	The advisory committee consists of no more than nine members appointed by the governor after consultation with the legislature and nominations from statewide stakeholder associations. The members must include representatives of health care providers, insurers, health insurance producers, consumers, employers with more than 50 employees, employers with 50 or fewer employees, and the Board of Trustees of Dirigo Health. LD 1582 Sec. 2	Not addressed.	The advisory committee must submit a report to the legislature and governor by September 1, 2011 with recommendations on core federal Exchange requirements and suggested legislation. The advisory committee must review and consider the recommendations issued by the 124th Legislature's Joint Select Committee on Health Care Reform, consider federal rules issued subsequent to the ACA, review other state exchange establishment activities, establish technical committees, and seek input from the legislative leadership, the Joint Standing Committee on Insurance and Financial Services, and the governor's office. The advisory committee must also report regularly to the legislature and governor's office. LD 1582 Sec. 4; Sec. 8	Not addressed.	The governor will seek nominations for the advisory committee from statewide associations representing the interests of stakeholders and must appoint members that represent stakeholders, including health care providers, insurers, health insurance producers, consumers, employers with more than 50 employees, employers with 50 or fewer employees, and the Board of Trustees of Dirigo Health. LD 1582 Sec. 2

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Hawaii	Not addressed.	Not addressed.	The Insurance Commissioner determines eligibility and retains full regulatory power over insurers and qualified plans. All qualified plans that apply must be included in the Connector. SB 1348 Sec. 3 (§6-8)	The Insurance Commissioner determines individual eligibility for Medicaid and other public programs, and will verify eligibility for the Connector. SB 1348 Sec.3 (§7)	As required by the ACA, the Connector must be self-sustaining and may generate funding. However, Exchange funds will not be put into the state treasury and the State is not responsible for the Connector's financial operations or solvency. SB 1348 Sec. 3 (§3)	The Connector will work in tandem with the Hawaii Prepaid Health Care Act and nothing in SB 1348 limits the consumer protections contained that Act. SB 1348 Sec. 2; Sec. 3 (§9)	The Department of Human Services retains the authority to make eligibility determinations for Medicaid and CHIP and will verify eligibility for the Connector. SB 1348 Sec. 3 (§7)	The interim board will recommend policies and procedures to ensure continuity of care for consumers transitioning between carriers, plans, and public programs. SB 1348 Sec. 4(b)(5)	The Connector is not subject to rulemaking, public employment, or public procurement policies. The board must maintain transparency including posting of board minutes on the Connector's website. The Exchange is subject to an annual audit that must be submitted to the legislature along with an annual report from the board of directors. SB 1348 Sec. 2(d)-(e); Sec. 3 (§2(a); §4(f))
Illinois	Not addressed.	Not addressed.	Not addressed.	Not addressed.	The study committee must include financial sustainability in its report. SB 1555 (§5-20(2))	The act creating the Exchange will become null and void if the ACA is repealed or replaced. SB 1555 (§5-25)	The study committee must include the development of standards for covering full-time and part-time employees and their dependents in its report. SB 1555 (§5-20(D))	Not addressed.	Not addressed.
Indiana	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.
Maine	The advisory committee must include representatives of insurance producers. LD 1582 Sec. 2	The advisory committee must include recommendations on health insurance market reforms in its report to the governor and legislature. LD 1582 Sec. 1;	The advisory committee must include recommendations on health insurance market reforms in its report to the governor and legislature. LD 1582 Sec. 1; Preamble ¶ 2	Dirigo Health shall provide staffing services to the advisory committee. The Department of Professional and Financial Regulation, Bureau of Insurance; the Department of Administrative and Financial Services, Office of Information Technology; the Department of Health and Human Services; and the State Coordinator for Health Information Technology shall also provide staffing assistance as necessary. The advisory committee must include recommendations on program integration in its report to the governor and legislature. LD 1582 Sec. 7; Sec. 1; Preamble	The advisory committee must include recommendations on financial management in its report to the governor and legislature. LD 1582 Sec. 1; Preamble ¶ 2	The advisory committee must include recommendation on legislative and regulatory action in its report to the governor and legislature. LD 1582 Sec. 1; Preamble ¶ 2	Not addressed.	The advisory committee must include recommendation on providing assistance to individuals and small businesses in its report to the governor and legislature. LD 1582 Sec. 1; Preamble ¶ 2	The advisory committee must submit a report to the legislature and governor, including recommendations on oversight and program integrity. LD 1582 Sec. 8; Sec. 1; Preamble ¶ 2

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Maryland	Legislation: HB 166 (2011)	Maryland seeks to reduce the number of uninsured, facilitate enrollment in the individual market and small group market, assist individuals in access public programs, tax credits, and cost sharing reductions, and supplement the individual and small group markets outside the Exchange. The Exchange must be administered to prevent discrimination, maximize efficiency, and promote financial integrity. HB 166 Sec. 1 (Md. Insurance Code §31-102(c); §31-111(a)(1)-(4))	Maryland establishes its Exchange as a public corporation; however, the board must make recommendations on whether the Exchange should remain so or become a nongovernmental non-profit. The board may not take any action that would limit such a transformation. HB 166 Sec. 1 (Md. Insurance Code §31-102(b)); Sec. 6; Sec. 8	The board must report findings and recommendations but await statutory authorization before certifying plans, making qualified plans available, assigning ratings, establishing a SHOP Exchange, establishing a navigator program, providing customer assistance, promoting the Exchange, or assessing fees. HB 166 Sec. 3	The board consists of nine members including the Secretary of Health and Mental Hygiene, the Insurance Commissioner, the Executive Director of the Maryland Health Care Commission, and six members appointed by the governor. The appointees must represent employers or individuals, or have expertise in public health, coverage and enrollment issues, plan administration, finance, or delivery systems. The governor should appoint members with knowledge of minority–owned employers and individual consumers who come from lower–income and minority communities, have chronic conditions, or belong to other special populations. HB 166 Sec. 1 (Md. Insurance Code §31-104(b)); Sec. 4	Board members may not have a financial interest or affiliation with a carrier, producer, third-party administrator, managed care organization, any other entity in a position to contract directly with the Exchange, or any trade organization thereof. In addition to required financial disclosures, board members must disclose any potential conflicts of interest and steps to avoid the conflict. HB 166 Sec. 1 (Md. Insurance Code §31-104(d), (n))	The board must report findings and recommendations on Exchange operations before December 23, 2011 and produce an annual report on plan participation, quality measures, financial integrity, and disparities. HB 166 Sec. 1 (Md. Insurance Code §31-111(c)); Sec 5(2)	The board will make recommendations on whether the small group market should be merged with the individual market. HB 166 Sec. 5(1)(iv)(2)	The board must consult with advisory committees comprised of insurers, nonprofit health service plans, producers, third–party administrators, providers, managed care organizations, employers, unions, researchers and experts, and consumers including those who reside in lower–income and minority communities, have chronic diseases, or belong to other special populations. HB 166 Sec. 1 (Md. Insurance Code §31-106(g)(1)-(2))
Mississippi	Legislation: SB 2554 (2010); HB 377 (2011)	Not addressed.	Not addressed.	Mississippi establishes the Health Insurance Exchange Study Committee to study and make recommendations on Exchange implementation. HB 377 Sec. 1(1)-(4)	The study committee is comprised of thirteen members. The governor appoints two insurer representatives; the Lieutenant Governor and Speaker of the House each appoint two legislators. Trade associations name two underwriters, two business owners, and one insurance agent. The Division of Medicaid names one member. The Commissioner of Insurance also serves on the study committee. HB 377 Sec. 1 (1)(a)-(i)	Not addressed.	The study committee is charged with conducting an extensive study of health insurance exchanges and presenting recommendations to the governor and legislature during the 2011 regular session. The study must include the necessity of duplicate costs from dual regulations of health insurance plans; other states' successes and failures including implementation of similar plans; the ability to reduce the number of uninsured; emergency room utilization by the uninsured; and analysis of the uninsured population including high income individuals who choose not to purchase coverage, those with access to group coverage but choose not to participate, those eligible but not enrolled in government programs, and those that are below poverty level and cannot afford coverage. HB 377 Sec. 1(4)(a),(e)-(g),(l)-(n)	Not addressed.	Insurers, underwriters, business owners, and insurance agents are represented on the study committee. HB 377 Sec. 1(1)(a)-(e)
Nevada	Legislation: SB 440 (2011)	Nevada aims to facilitate the purchase and sale of qualified plans in the individual market, assist qualified small employers in facilitating the enrollment, reduce the number of uninsured persons, provide a transparent marketplace, provide consumer education, and assist residents with access to programs, premium assistance, tax credits, and cost-sharing reductions. SB 440 Sec. 13(1)-(5)	Nevada creates a state-based Exchange, but SB 440 does not specify the type of entity. SB 440 Sec. 14(1)(a)	Nevada establishes the Exchange and governing board and gives them the authority to operate, adopt regulations, and make plans available. SB 440 Sec. 14(1)-(2); Sec. 22(2)	The board consists of seven voting members and three ex-officio members. The Director of the Department of Health and Human Services, the Director of the Department of Business and Industry, and the Director of the Department of Administration serve as non-voting ex-officio members. The governor appoints five members and the legislature appoints two members. Appointees must have expertise in insurance markets, health care administration, financing, or health IT, delivery systems, or consumer issues. The board should collectively represent a diversity of skills, knowledge, experience, and geographic and stakeholder perspectives. SB 440 Sec. 15(1)-(4)	A voting member may not hold elected office nor be affiliated with a health insurer. SB 440 Sec. 15(5)-(6)	The board must provide a plan for implementation and operation of the Exchange by December 31, 2011. SB 440 Sec. 30	Not addressed.	The board may appoint subcommittees or advisory committees. Such committees should represent the various geographic and ethnic groups of the state. SB 440 Sec. 20(2)

State	Interaction with Brokers	Adverse Selection	Relationship with Qualified Health Plans	Coordination with Other Programs and Agencies	Fees and Other Revenue	Relationship with Other Laws	Eligibility and Enrollment	Navigators and Customer Assistance Programs	Transparency
Maryland	Board members may not be producers or have any affiliation with producers, but may have expertise about the role of producers in enrollment. The board may contract with and form advisory committees of producers and must make recommendations on the role of producers in the Navigator program. HB 166 Sec. 1 (Md. Insurance Code §31-104(b)(4)(ii)(6), (d)(2);	Carriers participating in the Exchange must offer at least one plan at the silver level and one at the gold level outside of the Exchange. Additionally, the Exchange must study and make recommendations on the feasibility and desirability of selective contracting, regulation of plans outside the Exchange, and additional rules to mitigate adverse selection. HB 166 Sec. 1 (Md. Insurance Code §31-109(b)(5)(ii)-(iii)); Sec.	In order to be certified, a plan must obtain prior approval of premium rates and contract language from the Commissioner and provide the essential benefits package as determined by the Commissioner. Carriers jointly may offer a comprehensive plan provided that the health and dental plans are priced and made available separately. The board must report findings and recommendations before December 23, 2011 on selective or regional contracting and adding required benefits. HB 166 Sec. 1 (Md. Insurance Code §31–109(b)(1)-(2), (b)(8), (g)(4)); Sec. 5(1)(i)-(ii)	The board may contract with the Maryland Assistance Program and the Family Investment Unit of the Department of Human Resources. HB 166 Sec. 1 (Md. Insurance Code §31-106(d))	The Exchange may not impose fees that would provide a competitive disadvantage to plans operating outside the Exchange. To the maximum extent possible, fees must be assessed in a transparent and broad-based manner. HB 166 Sec. 1 (Md. Insurance Code §31–110(b), (e))	Members of the board are subject to state ethics laws. HB 166 Sec. 1 (Md. Insurance Code §31–104(n)(1)(i))	The Exchange will make eligibility determinations for and facilitate enrollment in Medicaid and CHIP. A small employer may enroll its employees through the Exchange if its principal place of business is in Maryland, even if those employees are not employed in the state; or if the employees are principally employed in Maryland, even if the employer's principal place of business is not in the state. HB 166 Sec. 1 (Md. Insurance Code §31–101(J)(1)-(2); §31–108(b)(9)-(10))	The board must report findings and recommendations before December 23, 2011 on the role of the private sector in the Navigator program. HB 166 Sec. 5(1)(iii)	The board will adopt procurement policies that are open and transparent, promote public confidence, foster appropriate competition, provide safeguards, promote economic efficiency, achieve maximum purchasing power of the Exchange, and provide clarity and simplicity. In addition to the annual report to the Secretary of HHS, the Exchange must annually report to the governor and legislature on health plan participation, ratings, coverage, price, quality improvement measures and benefits; consumer choice, participation, and satisfaction; financial integrity, fee assessments, and status of the fund; and data on disparities. HB 166 Sec. 1 (Md. Insurance Code §31-106(f); §31-111(c)(1)-(2))
Mississippi	The study committee must study the role and compensation of insurance agents in the Exchange. HB 377 Sec. 1(4)(d)	The study committee must study the pool of eligible individuals to mitigate any selection effects on the small group market and the effect of adverse selection. HB 377 Sec. 1(4)(b),	The study committee will make recommendations on the participation of carriers in the Exchange, benefits offered, insurance product standards, and rating standards. HB 377 Sec. 1(4)(a)	Not addressed.	The study committee must study the funding requirements and fiscal notes of the Exchange, the projected fees paid by employees and employers, and the methodology used to project those fees. HB 377 Sec. 1(4)(i)-(k)	The study committee must study the review of all applicable ERISA, HIPAA and COBRA laws to ensure plans meet the requirements for rating, guarantee issue, imposition of preexisting condition exclusions and continuation of coverage, and potential liability of carriers if the exchange is negligent in applying the laws. HB 377 Sec. 1(4)(c)	Not addressed.	Not addressed.	Not addressed.
Nevada	Not addressed.	Not addressed.	Not addressed.	The Exchange will coordinate with Medicaid, CHIP, and any other applicable state or local public programs to create a single point of entry for users of the Exchange who are eligible for such programs to promote continuity of coverage and care. SB 440 Sec. 24(1)	The Exchange may request an advance from the general fund if other funds are delayed; however, the advance may not exceed 25% of expected revenue from non-legislatively appropriated sources. SB 440 Sec. 26(1), (4)	If the federal act is repealed or held invalid, the Exchange must define "qualified health plan" for the purposes of operating the Exchange. Nothing in SB 440 may be construed to preempt or supersede the authority of the Commissioner to regulate insurance. SB 440 Sec. 22(1)(f); Sec. 27	A small employer may enroll its employees through the Exchange if its principal place of business is in Nevada, even if those employees are not employed in the state; or if the employees are principally employed in Nevada, even if the employer's principal place of business is not in the state. SB 440 Sec. 11(1)-(2)	Not addressed.	The Exchange must submit an annual report and be subject to an annual audit. SB 440 Sec. 22(1)(c)-(d)

State	Source	Policy Goals	Type of Entity	Scope of Authority	Composition of the Board/ Advisory Committee	Conflict of Interest	Additional Duties	Relationship between Individual and SHOP Exchanges	Stakeholder Engagement
North Dakota	Legislation: HB 1126 (2011)	Not addressed.	The Commissioner and Department of Human Services are directed to plan for the implementation of an Exchange, but HB 1126 does not specify the type of entity. HB 1126 Sec. 1 (N.D. Cent. Code 26.1 -54-01)	The Insurance Commissioner and Department of Human Services must plan for an individual and small group Exchange that meets federal requirements and collaborate with the IT Department. However, they must collectively submit proposed legislation prior to implementing any federal requirements, applying for federal funds, or contracting to implement the Exchange. HB 1126 Sec. 1 (N.D. Cent. Code 26.1-54-01)(1)-(5)); Sec. 3	Not addressed.	Not addressed.	The Insurance Commissioner and the Department of Human Services must submit proposed legislation if the state is required to take action by January 1, 2014. HB 1126 Sec. 3	The legislative assembly may consider establishing one Exchange for both individuals and small employers. HB 1126 Sec. 1 (N.D. Cent. Code 26.1 -54-01(1))	Not addressed.
Oregon	Legislation: SB 99 (2011)	Oregon aims to improve the lifelong health of its residents; increase the quality, reliability and availability of health insurance; make insurance affordable for everyone; administer an Exchange for the benefit of the people and businesses that obtain health insurance coverage for themselves, their families and their employees through the Exchange; empower Oregonians by giving them the information and tools they need to make health insurance choices that meet their needs and values; improve health care quality and public health; mitigate health disparities linked to race, ethnicity, primary language, and similar factors; control costs and ensure access to affordable equitable, and high quality health care; be accountable to the public; and encourage the development of new health insurance products that offer innovative healthcare delivery systems and payment mechanisms. SB 99 Sec. 2(2)	Oregon establishes its Exchange as a public corporation. SB 99 Sec. 2(1)	Oregon establishes the Exchange and governing board. The Exchange may administer federal grants but must receive legislative approval of its business plan prior to operating the Exchange. SB 99 Sec. 2(1); Sec. 4(1); Sec. 27(1)	The Exchange is governed by a nine-member board. The Director of the Oregon Health Authority and the Director of the Department of Consumer and Business Services serve as ex-officio, voting members. The governor appoints seven members who must collectively offer expertise in consumer issues, health plans, purchasing, business, administration, and use of an Exchange. They must represent the geographic, ethnic, gender, racial, and economic diversity of the state. No more than two appointees may be affiliated with an insurer, producer, provider, or trade association thereof. At least two members must be consumer members. A legislative committee comprised of four legislators provides legislative oversight during implementation. SB 99 Sec. 4(1)-(6); Sec. 5(5)	A board member must declare any affiliation with an entity that may receive a pecuniary benefit and abstain from voting on issues affecting that entity. No employee may be affiliated with an insurer, producer, health care facility, provider, or trade association thereof. SB 99 Sec. 4(5); Sec. 6(4); Sec. 9(4)	The Exchange must develop a business plan and regularly report to the Legislative Fiscal Office on the implementation of an IT system. SB 99 Sec. 4(7); Sec. 5(6)	Not addressed.	The board will establish an Individual and Employer Consumer Advisory Committee which must be representative of individuals and employers, individuals who receive medical assistance, racial and ethnic minorities, all geographic regions, and organizations that help individuals enroll in plans through the Exchange. SB 99 Sec. 7(1)
Vermont	Legislation: HB 202 (2011)	The Exchange will facilitate the purchase of affordable qualified health benefit plans in the individual and group markets in order to reduce the number of uninsured and underinsured; reduce disruption when individuals lose employer-based insurance; reduce administrative costs in the insurance market; contain costs; promote health, prevention, and healthy lifestyles by individuals; and improve the quality of health care. HB 202 Sec. 4 (33 V.S.A. § 1801(a)-(b))	Vermont establishes its Exchange as a division within the Department of Vermont Health Access. HB 202 Sec. 4 (33 V.S.A. § 1803(a)(2))	The Exchange is established within the Department of Vermont Health Access, which has authority to carry out the duties of the Exchange. Vermont is seeking a waiver to implement the Green Mountain Care single-payer system and the Exchange will serve as the platform for that system. The Green Mountain Care board will have oversight over the minimum benefits to be provided and any payment reforms implemented through the Exchange. HB 202 Sec. 2(a)(2)(A); HB 202 Sec. 4 (33 V.S.A. §1803; §1805-1806)	The Exchange is administered by the Department of Vermont Health Access in consultation with the Medicaid and Exchange Advisory Committee, an advisory committee appointed by the Commissioner of the Department of Vermont Health Access. The Medicaid and Exchange Advisory Committee consists of 22 members and must include one insurer representative and the Commissioner of Health. The remaining members must be beneficiaries of Medicaid, individuals or small businesses, advocates for consumer organizations, or healthcare professionals. Members whose participation is not supported through their employment or association shall receive a per diem and reimbursement of travel expenses. The Green Mountain Care board consists of five members, a Chair, and four others. HB 202 Sec. 4 (33 V.S.A. §1803(a)(2); §402(a)-(b); §9390(a)-(b))	The Medicaid and Exchange Advisory Committee does not have separate conflict of interest language, but does limit membership (See Composition of the Board). HB 202 Sec. 3 (18 V.S.A. §9374(c)(1)-(2), (4); §402(a)-(b))	Vermont requires its Exchange to carry out the same duties as required by the federal law. HB 202 Sec. 4 (33 V.S.A. §1805(1)-(16))	Not addressed.	The Medicaid and Exchange Advisory Committee must include one insurer representative. The remaining members must be beneficiaries of Medicaid, individuals or small businesses, advocates for consumer organizations, or healthcare professionals. HB 202 Sec. 3 (18 V.S.A. §9378); Sec. 7 (33 V.S.A. §402(a)-(b))

State	Interaction with Brokers	Adverse Selection	Relationship with Qualified Health Plans	Coordination with Other Programs and Agencies	Fees and Other Revenue	Relationship with Other Laws	Eligibility and Enrollment	Navigators and Customer Assistance Programs	Transparency
North Dakota	Not addressed.	Not addressed.	Not addressed.	The Commissioner and Department of Human Services must plan for an Exchange that coordinates with Medicaid and CHIP. State agencies must cooperate with the Commissioner and the Department of Human Services to ensure the success of the exchange. HB 1126 Sec. 1 (N.D. Cent. Code 26.1 -54-01(1); 26.1-54-03)	$1 million is appropriated from federal funds to plan the Exchange. HB 1126 Sec. 2	Not addressed.	Not addressed.	Not addressed.	The Insurance Commissioner and the Department of Human Services must provide regular updates to the legislative management during the 2011-12 interim. HB 1126 Sec. 3
Oregon	A producer may be appointed to the board. The board may seek assistance from producers and will establish a process for certifying producers. The board must provide an annual report on, among other things, the role of insurance producers in the Exchange. SB 99 Sec. 4(5)(a)(B); Sec. 8(1); Sec. 11(8);	The corporation, in collaboration with the appropriate state authorities, may establish risk mediation programs within the Exchange.	The Exchange may limit the number of plans offered provided the same limitations apply to all insurers and that multiple plans are certified to promote competition. The Exchange may also establish risk mediation programs. Prepaid managed care health services organizations that do not have a certificate of authority to transact insurance may serve only medical assistance recipients through the Exchange and may not offer qualified health plans. SB 99 Sec. 3(1)(f); Sec. 11(3)-(4), (7)	The Oregon Health Authority will provide staff and resources necessary to comply with the ACA. The Exchange must also establish one streamlined and seamless application and enrollment process for both the Exchange and the state medical assistance programs. SB 99 Sec. 10(1); Sec. 11(6)	The Exchange will establish fees on insurers and state programs ranging from 3-5% of the premium for each enrollee, depending on the total number of enrollees in the plan. If there is a surplus exceeding the amount of six months' operational expenses, the money will be applied to reduce fees. SB 99 Sec. 17(1)-(3)	To the extent that there is any conflict between SB 99 and the ACA, the federal law controls. When there is a conflict or inconsistency with federal requirements and federally granted funds are involved, the federal requirements govern. SB 99 Sec. 13(1)-(2)	The board, along with other cooperating agencies, must provide an annual report recommending additional groups eligible for participation in the Exchange. SB 99 Sec. 22(2)(d)	Mirrors federal requirements. SB 99 Sec. 3(1)	The Exchange is subject to an annual audit and the Exchange must submit a report with any necessary corrective actions. Complaints made to the Exchange regarding a health plan remain confidential and may only be used by the Exchange to prosecute violations; however, the Exchange must establish a annual statistical report on complaints for the public. SB 99 Sec. 21(2)-(3), (9); Sec. 23(1)-(3)
Vermont	Not addressed.	By 2017, large employers will be part of the Exchange. The Exchange will review the rate of premium growth both inside and outside the Exchange. HB 202 Sec. 2(a)(3); Sec. 4 (33 V.S.A. §	Qualified plans must offer at least the silver level of coverage. The Secretary of Human Services may require qualified plans to provide additional benefits or impose additional cost sharing requirements. Qualified plans must meet minimum prevention, quality, and wellness requirements in addition to the ACA requirements. In determining the best interests of consumers, the Commissioner must consider affordability, access, promotion of high-quality care, prevention and wellness, and participation in the state's health care reform efforts. HB 202 Sec. 4 (33 V.S.A. §1803(b)(2); §1806(a)-(c))	Green Mountain care will seek a waiver to include Medicaid, CHIP, Medicare, and other health programs in the Exchange. The Secretary of Administration will create an integration plan for including Medicaid, Medicare, private insurance, associations, state employees, and municipal employees in the Exchange. HB 202 Sec. 2(a)(1); Sec. 8(a)(1)	HB 202 calls for broad payment reforms to Vermont's entire health care system beyond the sections applicable to the Exchange. HB 202 Sec. 3 (18 V.S.A. Chapter 220)	If the ACA is modified, the director of health care reform will continue operations and adjust as appropriate. HB 202 Sec. 2(a)(1)	The Exchange may offer health benefits to populations in addition to those eligible under the ACA. Upon implementation of Green Mountain Care, all Vermont residents are eligible to participate in the Exchange. HB 202 Sec. 4 (33 V.S.A. §1803(b)(2); §1824(a)(1))	The Exchange will select individuals and entities to serve as Navigators. Navigators must provide assistance in a manner that complies with the Americans with Disabilities Act. HB 202 Sec. 4 (33 V.S.A. §1807(a)(1)-(2))	In regard to the sections applicable to Vermont's Exchange, HB 202 mirrors federal requirements. HB 202 Sec. 4 (33 V.S.A. Chapter 18)

State	Source	Policy Goals	Type of Entity	Scope of Authority	Composition of the Board/ Advisory Committee	Conflict of Interest	Additional Duties	Relationship between Individual and SHOP Exchanges	Stakeholder Engagement
Virginia	Legislation: HB 2434 (2011)	Virginia seeks to preserve and enhance competition in the health insurance market, facilitate the purchase and sale of qualified plans in the individual market, and assist qualified small employers in facilitating enrollment of employees in qualified plans in the small group market. HB 2434 1. Sec. 1	The Department of Health and Human Resources and the State Corporation Commission must make legislative recommendations on whether to create the Exchange within an existing agency, as a new agency, or as a non-profit by October 1, 2011. HB 2434 1. Sec. 2(i)	Virginia conveys its intent to create an Exchange and requires legislative recommendations on the structure and operations for the 2012 legislative session. HB 2434 1. Sec. 1; Sec. 2	The Department of Health and Human Resources and the State Corporation Commission must make legislative recommendations on the make-up of the governing board by October 1, 2011. HB 2434 1. Sec. 2(ii)	Not addressed.	In conjunction with the Department of Health and Human Resources and the State Corporation Commission, the governor must make legislative recommendations on the structure and specific functions of the Exchange by October 1, 2011. HB 2434 1. Sec. 2(i)-(v)	Not addressed.	The Secretary of Health and Human Resources and State Corporation Commission's Bureau of Insurance must work with the legislature, relevant experts, and stakeholders generally to provide legislative recommendations on the structure and governance of the Exchange by October 1, 2011. HB 2434 1. Sec. 2
Washington	Legislation: SSB 5445 (2011)	Washington aims to increase access to coverage; reduce the number of uninsured residents; increase private coverage to individuals and small employers; provide consumer choice and portability regardless of employment status; create an organized, transparent, and accountable marketplace; claim available federal tax credits and subsidies; meet the federal requirements for minimum coverage; promote consumer literacy and empower consumers; administer health care subsidies and determination of eligibility; create a market that competes on price, quality, service, and other innovative efforts; operate compatibly with efforts to improve quality, costs, and innovation; preserve markets outside of the Exchange; and retain the authority of the insurance commissioner to regulate the market inside and outside of the Exchange. SSB 5445 Sec. 1(2)	Washington establishes its Exchange as a non-governmental, public-private partnership. The Exchange will provide recommendations on whether to create a regional Exchange. SSB 5445 Sec. 5(a)(iii); Sec. 3(1)	Until March 15, 2012 the board may only apply for grants, establish IT infrastructure, and undertake administrative functions necessary to begin Exchange operations by 2014. It must create a comprehensive report by January 1, 2012 on options for carrying out the duties of the Exchange and begin operations after March 15, 2012. SSB 5445 Sec. 4(2); Sec. 5(5)	The board consists of nine voting members. The Insurance Commissioner and Administrator of the Health Care Authority serve as nonvoting, ex officio members. The governor appoints eight legislatively nominated members including at least one employee benefits specialist, health economist or actuary, representative of small business, and consumer advocate. Members must have expertise in coverage issues, health benefits plan administration, health care finance and economics, actuarial science, or delivery systems. SSB 5445 Sec. 3(1)(a)-(d)	Board members may not have a personal financial interest or represent an entity with a financial interest in a matter governed by the board. A board member who develops a conflict of interest must resign or be removed. SSB 5445 Sec. 3(4)	In collaboration with legislative committees, the board must develop a report by 2012 with recommendations on the operations and administration of the Exchange. The Exchange will create a work plan based on its report and begin operations on March 15, 2012. SSB 5445 Sec. 5(2)(a)-(l), (3), (5)	The board must make recommendations on whether to create a single Exchange for both the individual and small group markets. It must also make recommendations on merging the risk pool with the private health insurance markets. SSB 5445 Sec. 5(2)(a)(ii),	The Health Care Authority and Exchange board will consult with representatives of healthcare facilities, providers, publicly subsidized health care programs, and the American Academy of Actuaries. SSB 5445 Sec. 5(4)
West Virginia	Legislation: SB 408 (2011)	West Virginia aims to facilitate the purchase and sale of qualified health plans in the individual market and assist small employers by facilitating the enrollment of their employees in qualified health plans. SB 408 (W. Va. Code § 33-16G-1)	West Virginia's Exchange is housed within the Office of the Insurance Commissioner. SB 408 (W. Va. Code § 33-16G-3(a))	West Virginia creates the Exchange and board and authorizes the board to pursue federal funding and promulgate rules necessary for federal recognition. SB 408 (W. Va. Code § 33-16G-3(a)-(b))	The West Virginia Exchange is governed by a ten-member board. The Insurance Commissioner, Commissioner of the Bureau for Medical Services, CHIP Director, and chair of the Health Care Authority serve as ex-officio members. The governor appoints four members each representing individual health care consumers, small employers, organized labor, or insurance producers. One member is selected by an advisory group of ten carriers to represent payors; however, that member may not be an employee of a carrier. One member is selected by an advisory board of provider associations to represent providers. SB 408 (W. Va. Code § 33-16G-5(b)(1)-(4))	Board members will receive governmental ethics training within six months of appointment and every two years thereafter. SB 408 (W. Va. Code § 33-16G-6(j))	The Exchange may contract with other states to perform administrative functions. SB 408 (W. Va. Code § 33-16G-3(c))	The Small Business Health Options Program is within the West Virginia Health Benefit Exchange. SB 408 (W. Va. Code § 33-16G-1)	The board will consult with consumers, carriers, producers, and providers. The board may establish advisory committees of other stakeholders. SB 408 (W. Va. Code § 33-16G-4(a)(1); § 33-16G-5(g))

State	Interaction with Brokers	Adverse Selection	Relationship with Qualified Health Plans	Coordination with Other Programs and Agencies	Fees and Other Revenue	Relationship with Other Laws	Eligibility and Enrollment	Navigators and Customer Assistance Programs	Transparency
Virginia	Not addressed.	Not addressed.	No qualified health plan that is sold or offered through the Exchange may provide coverage for abortions, regardless of whether it is provided through the plan or offered as a separate optional rider. HB 2434 1. Sec. 1 (ii)	The Department of Health and Human Resources and the State Corporation Commission must make legislative recommendations regarding the potential effects of the Exchange on relevant health programs, including Medicaid by October 1, 2011. HB 2434 1. Sec. 2(v)	The Department of Health and Human Resources and the State Corporation Commission must make legislative recommendations addressing the resource needs and sustainability of the Exchange by October 1, 2011. HB 2434 1. Sec. 2(iii)	Nothing in HB 2434 may be construed or implied to recognize the constitutionality of the ACA. HB 2434 3.	Not addressed.	Not addressed.	Not addressed.
Washington	The board must make recommendations on the role and services to be provided by producers and brokers, including brokers as Navigators. SSB 5445 Sec. 5(2)(f)	The Exchange will include risk management methods in its legislative recommendations and work plan. SSB 5445 Sec. 5(2)(g)	In collaboration with legislative committees, the board must develop a report by 2012 on, among other issues, adoption of a federal basic health plan option, market impacts, cost containment methods, and offering spiritual care services. SSB 5445 Sec. 5(2)(a)-(c), (h), (k)	The Exchange will make recommendations on the continuing role of the Washington State Health Insurance Pool. The board must consult with the American Indian Health Commission. SSB 5445 Sec. 3(9); Sec. 5(2)(g)	Appropriation is not required for expenditures. The board's report must include recommendations for promoting participation by carriers and enrollees in the Exchange so that the Exchange is financially sustainable. SSB 5445 Sec. 7; Sec. 5(2)(d)	Any conflict with federal conditions to the allocation of federal funds renders the provision inoperative; however, all provisions are severable from the remainder of the Act. SSB 5445 Sec. 9	Mirrors federal requirements.	The Exchange will include the role of Navigators in its legislative recommendations and work plan. SSB 5445 Sec. 5(2)(f)	The Exchange and the board are subject only to The Open Public Meetings Act and The Public Records Act, which allows the board to hold executive sessions to consider proprietary or confidential non-published information. Beginning in 2012 the Health Care Authority, in collaboration with the Joint Select Committee on Health Reform Implementation and Exchange board, must report on an ongoing basis to the governor and legislature on a broad range of options and recommendations for operating the Exchange. SSB 5445 Sec. 3(6); Sec. 5(2)
West Virginia	One of the governor's appointees must represent the interests of insurance producers and the board must consult with producers as stakeholders. SB 408 (W. Va. Code § 33-16G-5(b)(2); § 33-	Not addressed.	Not addressed.	Not addressed.	The board may assess fees on carriers, including plans sold outside the Exchange, which will be based on premium volume of qualified plans. SB 408 (W. Va. Code § 33-16G-6(a))	If the ACA is invalidated in any respect, the board will issue a bulletin on its legal opinion of the effect of such action and recommendations for amendments to the legislature. Nothing in the bill preempts or supersedes the authority of the commissioner to regulate insurance. SB 408 (W. Va. Code § 33-16G-4(b)(2); §33-16G-8)	Not addressed.	Not addressed.	The board must annually report to the governor and legislature on the activities of the Exchange. SB 408 (W. Va. Code § 33-16G-6(h))

State	Source	Policy Goals	Type of Entity	Scope of Authority	Composition of the Board/ Advisory Committee	Conflict of Interest	Additional Duties	Relationship between Individual and SHOP Exchanges	Stakeholder Engagement
Wyoming	Legislation: HB 0050 (2011)	Not addressed.	Not addressed.	Wyoming creates a steering committee to study whether to create or participate in an Exchange and, if so, how to develop its Exchange. HB 0050 Sec. 1(a), (e)	The steering committee consists of four legislators and thirteen gubernatorial appointees. The governor appoints two business representatives, two insurance representatives, a producer, a provider, a hospital representative, and a consumer representative. The governor also appoints at least five members from affected state agencies. Steering committee members are paid a salary, per diem, and travel expenses. HB 0050 Sec. 1(c)(i)-(ix), (h)	Not addressed.	The steering committee must conduct a study and make recommendations to the legislature by October 1, 2011. The study must include whether to develop an Exchange or join a regional Exchange; how the Exchange will help people comparison shop and reduce marketing costs and what work is needed to facilitate these goals; what options are being used by other states; and whether the Exchange should offer a full or limited scope of services. If the committee recommends Wyoming establish an Exchange it must develop a work plan and make legislative recommendations. HB 0050 Sec. 1(e)(i)-(vi)	Not addressed.	Stakeholders, including businesses, insurers, producers, providers, hospitals, and consumers, are represented on the steering committee. HB 0050 Sec. 1(c)(iii)-(viii)

State	Interaction with Brokers	Adverse Selection	Relationship with Qualified Health Plans	Coordination with Other Programs and Agencies	Fees and Other Revenue	Relationship with Other Laws	Eligibility and Enrollment	Navigators and Customer Assistance Programs	Transparency
Wyoming	The governor appoints one producer to serve on the steering committee. HB 0050 Sec. 1(c)(v)	Not addressed.	The committee will evaluate whether the Exchange can be used to facilitate the sale of health plans across state lines. It must also consider whether opting out of Medicaid or other provisions of the ACA would affect the ability of other states to join Wyoming in the sale of insurance across state lines. HB 0050 Sec. 1(e)(ix)-(x)	Not addressed.	The study is to be paid for by a federal grant; however, Wyoming appropriates $145,000 from the general fund for any portions of the study not paid for by the federal grant. HB 0050 Sec. 1(b), (g)	The steering committee is to recommend whether Wyoming should proceed with the development of an Exchange if the ACA is repealed. The committee will also evaluate whether there is reasonable opportunity for successful litigation to prevent the federal government from establishing an Exchange if Wyoming decides not to establish an Exchange or if its Exchange does not meet the minimum federal requirements. HB 0050 Sec. 1(e)(vii)-(viii)	Not addressed.	Not addressed.	Not addressed.