AN ARIZONA POLICY PRIMER

A Closer Look at Proposals to Create an Arizona Health Insurance Exchange

ARIZONA HEALTH FUTURES

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Policy Primers: *a nonpartisan guide to a better understanding of key terms and issues in the Arizona health policy landscape.*

A Closer Look at Proposals to Create an Arizona Health Insurance Exchange

This issue brief is focused on appraising Arizona's first two health insurance exchange legislative bills and the state's progress toward establishing a state-based exchange within the context of other states' actions and federal guidance. While neither of these bills passed this legislative session, they are likely to be reintroduced in some form in January 2012.

The Affordable Care Act (ACA) includes many opportunities for states to innovate and tailor health reform to their local context and conditions. One of the more significant opportunities allows states to establish one or more of their own health insurance exchanges where individuals and small employers can comparatively shop and purchase healthcare coverage. It is estimated that 746,000 Arizonans will participate in the health insurance exchanges once they are established.[1]

Arizona's option to exert control is time-bound: state exchanges meeting set criteria need to be in place by January 2014 and plans to implement state-based exchanges have to be in place one year earlier. In the absence of a state-controlled exchange, Arizona would defer administration of its Exchange to the federal government. Both the federal and state-based options have their pros and cons. However, pursuit of a state-based exchange is worthy of consideration.

St. Luke's Health Initiatives
A Catalyst for Community Health

To date, Arizona's legislature has responded with two bills – HB 2666 and SB 1564 – that provide competing visions on key dimensions of: structure, governance, authority, roles, management of adverse risk, financing and cooperation among state agencies. The bills are fundamentally different. Understanding their differences and respective strengths and weaknesses is a key objective of this report. Hopefully, information contained in this report can help inform dialog and change moving forward.

Some efforts are underway to address exchange-related technology, but the complexity and breadth of Exchange technology requirements call for full-speed, non-stop planning, building, implementing and testing from now until January 2014.

The timeline for action is very tight. To date, the state has not fully engaged stakeholders or modified the insurance market in accordance with federal requirements. In addition, the federal government has yet to provide some needed guidance. Some efforts are underway to address exchange-related technology, but the complexity and breadth of Exchange technology requirements call for full-speed, non-stop planning, building, implementing and testing from now until January 2014.

Time is indeed of the essence. Stakeholders and interested parties can start by engaging with findings of this brief.

Major Features of Proposed Exchange Legislation

The two bills authorizing the creation of Arizona's Health Insurance Exchange differ considerably in their assumed structure and in the ways the proposed Exchange would interact with the state's insurance market. Both bills establish a single Arizona Exchange housed within the state's Department of Insurance (DOI), with its own governing board and would function largely as a quasi-governmental organization or public authority, though inside the DOI. HB 2666 requires that the Small Business Health Option Program (SHOP) and individual components operate separately, while SB 1524 allows the Exchange to operate the SHOP separately if necessary.

Governance

Under HB 2666, the Governor appoints nine voting members to a board heavily dominated by the insurance industry and brokers. The directors of DOI and Arizona Health Care Cost Containment System (AHCCCS) are non-voting members, leaving the decision-making largely in the insurance industry's control. Conflict of interest provisions are minimal, but prohibit members from taking any action in which the member or entity he/she represents has a conflict of interest. If enforced, most of the board's decisions will require abstention by most members, which will render the board unable to carry out its work.

Under SB 1524, the governor and majority and minority caucuses of the House and Senate share in the appointment of seven voting members who may not be employed by or consulting to, serving on a board of, affiliated with, or a representative of a healthcare insurer, an insurance agent or broker, a healthcare provider, facility or clinic. Members also may not be a member of, board member, or employee of a trade association representing healthcare insurers, heathcare facilities, clinics or providers. This configuration may not provide the expertise needed to launch and operate an effective Exchange.

Authority

HB 2666 does not give the Exchange governing board authority to make rules. As such, the Exchange must rely on the DOI, legislature and Governor to achieve its objectives. SB 1524 allows the board to promulgate rules, which must be published by the Secretary of State with a 30-day period for comments. SB 1524 also exempts the Exchange from state procurement

and employment rules. The Exchange under SB 1524 is far more flexible and empowered than under HB 2666.

Exchange Role in the Insurance Market

Under HB 2666, the Exchange operates solely as a distribution channel for insurance. It cannot impose any criteria for Exchange participation beyond what the federal government requires, and cannot require that carriers participate on or off the Exchange. SB 1524 provides the Exchange with some flexibility to determine the minimum requirements of a qualified health plan, and the standards and criteria for selecting qualified health plans to be offered through the Exchange. It also requires that the Board seek choices that offer the optimal combination of choice, value, quality and service.

These approaches are fundamentally different, and early experience has already clearly demonstrated that completely open access to sell on the Exchange results in more choices than consumers want or can reasonably discern between. The Utah Exchange has almost 150 plans available, and more than half of small businesses electing not to use the Exchange cite the process to select plans as the reason.

An effective Exchange must balance the insurance industry's objectives with the need to provide consumers with a usable environment that allows plans to be compared on quality and cost. The Arizona Exchange would be best served by legislation that allows it to limit the number of plans in response to consumer needs.

Managing Adverse Risk Selection

The federal government will issue a methodology to adjust for adverse risk selection against Exchanges. However, risk adjustment science and practice are imperfect, and there are additional strategies that Exchanges can use to further mitigate against adverse risk. Such strategies level the playing field on and off the Exchange to reduce opportunities for carriers to structure products in a manner that draws healthier populations away from the Exchange.

Neither HB 2666 nor SB 1564 addresses strategies to level the on- and off-Exchange playing fields in Arizona. Such measures should be seriously considered.

Financing the Exchange

Both HB 2666 and SB 1524 allow the Exchange to levy user fees to finance Exchange operation and administration. HB 2666 does not allow fee collection to begin until 2015. HB 2666 allows fees charged to carriers selling on the Exchange. SB 1524 allows fees to small business and individuals buying coverage on the Exchange.

Though different, both have the same effect of creating a financial disincentive to Exchange participation. If the Exchange levies fees to the entire insurance market, on and off the Exchange, the disincentives are mitigated and the playing field is made far more uniform. This is a key feature in establishing an environment in which the Exchange can operate as intended and with the desired effect of creating a more competitive environment.

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Assuring the Cooperation of Other State Agencies

Neither HB 2666 nor SB 1524 requires the cooperation or participation of other state agencies such as AHCCCS, Treasury, Secretary of State, Vital Records and others. Because of the enormous time constraints and complexities in establishing an operational Exchange by January 2014, it is highly advisable to address this matter in an Exchange's authorizing legislation.

Introduction

Among the provisions of federal health reform (the Patient Protection and Affordable Care Act, or ACA), one of the most significant opportunities for states is the design of Health Insurance Exchanges that will make health coverage more affordable and available. The ACA gave states considerable latitude in how they can structure their Exchanges. Arizona now has the opportunity to create an Exchange that is uniquely designed to work in the best possible way for the people and businesses in the state.

As a marketplace for consumers, an Exchange is expected to be a distribution channel for commercial insurance for both individuals and small businesses.

In the past legislative session, two bills were introduced – HB 2666 and SB 1524 – to enable the creation of an Arizona Health Insurance Exchange. The purpose of this Issue Brief is to compare and contrast the manner in which the two bills address the key elements of a Health Insurance Exchange, the requirements in the ACA, and other options and choices reserved for the states.

The analysis focuses on the following elements and criteria:

- Exchange Structure and Governance
  - The organizational structure and operation of the Exchange
  - The governance model proposed
- Consumer Outreach and Enrollment
- Certifying Carriers and Plans to Participate in the Exchange
  - Providing consumer choice
  - The number and types of plans that could participate in the Exchange
  - Addressing geographic access and choice
  - Incentivizing cost control and/or quality
- Managing the Exchange Risk Pool
  - Merging or separating the small business and individual markets
  - Addressing potential adverse selection in the exchange
- Ensuring the Exchange's financial self-sufficiency

In addition, the analysis also:

- Evaluates additional similarities and differences between the bills
- Compares[2] the bills to model legislation created by the National Association of Insurance Commissioners (NAIC)[3] and by the National Academy of Social Insurance (NASI)[4]
- Assesses how each bill would integrate with AHCCCS (Medicaid) and with Arizona's existing insurance market.
- Compares the bills with Exchange approaches developing in CA, NM, TX, OR, IL, NV and RI

Overview: Health Insurance Exchanges

The Affordable Care Act establishes American Health Benefit Exchanges (serving individuals) and SHOP Exchanges serving small employer groups, to be operated by states that elect to establish Exchanges for individuals and employer groups through which they can buy qualified health plans. The Secretary of Health and Human Services (HHS) has provided the following definition of a Health Insurance Exchange.

A mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers.[5]

As a marketplace for consumers, an Exchange is expected to be a distribution channel for commercial insurance for both individuals and small businesses. It is expected to work with small employers to aid them in offering coverage, and to interact with health plans that participate on the Exchange to ensure compliance with state and federal standards for reporting, marketing and plan benefit design. These functions will occur almost exclusively in the private sector.

The ACA also obligates Exchanges to perform many functions that are intertwined with new and existing public health programs. For example, Exchanges will determine eligibility for federal tax subsidies available to lower-income people buying coverage through the Exchange. This function must be closely coordinated with Medicaid eligibility and enrollment processes, especially since over time many individuals will move between the Exchange-based subsidized market and Medicaid and Children's Health Insurance Program (CHIP) programs. An Exchange is also expected to seamlessly interface with state Medicaid and CHIP programs.

Other functions of the Exchange, such as determining exemptions from the individual mandate and providing information to the IRS to support tax credits, vouchers and other financial exceptions are more like traditional government functions than commercial activities, but they require less integration with existing state programs.

The ACA lays out the duties and functions an Exchange must perform. A complete list is included as Attachment D. The majority of Exchange functions can be organized as follows.

Insurance Carriers and Plans

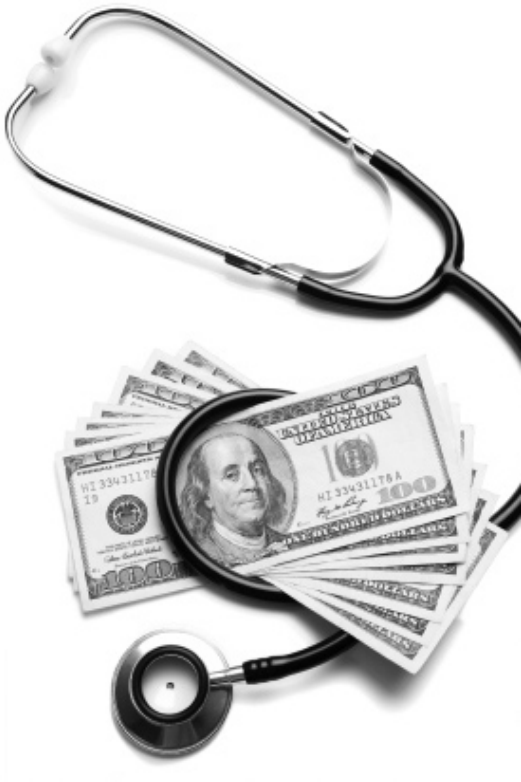
- Certify, recertify and decertify health insurance carriers and their plans to sell on the Exchange
- Administer a quality rating system that allows plans to be compared
- Conduct risk adjustment and transitional reinsurance functions

Conduct Eligibility Determinations For:

- Exchange participation
- Medicaid, CHIP and other state-based programs
- Advance payment of premium tax credits and cost-sharing reductions
- Free Choice Vouchers

Provide Seamless Enrollment Into:

- Medicaid and CHIP
- Subsidized individual products
- Unsubsidized individual products
- Employer-sponsored products (small business)



Consumer and Small Business Services

- Conduct consumer and small business outreach and education
- Operate an Exchange website through which consumers and businesses can compare, select and enroll in insurance plans
- Operate a call center for consumers
- Operate a Navigator program to assist consumers
- Adjudicate appeals of eligibility determinations
- Render individual responsibility determinations

Financial/Tax Functions

- Provide a premium tax credit and cost-sharing reduction calculator
- Calculate premium tax credits and cost-sharing reductions
- Report information to IRS and enrollees

By January 1, 2013, the Secretary of HHS will certify that the state has taken the necessary steps to establish an Exchange and reform its insurance laws as required under the Act. If the Secretary determines that a state has not sufficiently prepared for implementation of an Exchange, the Secretary must establish and operate an Exchange. States also may elect not to establish Exchanges and defer to HHS to establish and operate an Exchange.

Exchange Structure

Background

Each state has a tiered series of questions to answer to decide which of the many options allowed under the ACA are the most desirable and feasible for that state.

Because Exchange functions include both traditional commercial and public activities, the structure and governing body of an Exchange should be configured to address both with proficiency. Given the large number of new functions Exchanges must perform and the operational complexity of these functions, state implementation will proceed under extremely challenging time constraints and in an evolving regulatory environment. As a result, implementation structures that promote informed and transparent public input, prompt decision-making and flexibility to adapt quickly to shifting market conditions will be valuable to states.

In deciding on an organizational model for an Exchange, each state has a tiered series of questions to answer to decide which of the many options allowed under the ACA are the most desirable and feasible for that state. The questions, in order, are:

1. Should the state operate an Exchange, or defer to the federal government?
2. If the state decides to operate an Exchange,
   a. Should the Exchange be state-based or multi-state?
   b. Should there be regional Exchanges within the state?
   c. Should the individual market and the SHOP Exchanges be separate?
3. What should be the legal structure of the Exchange?

Exchange Structural Options: Federal/State, Multi-State, Regional

The following tables illustrate the pros and cons of state decisions about the basic structure of an Exchange and decisions that have been made by states thus far.

STATE-BASED EXCHANGE

(Instead of Federally Operated Exchange)

ADVANTAGES	DISADVANTAGES	STATE EXCHANGE DECISIONS
Preserves state self-determination on a range of issues, including role the Exchange plays in insurance markets, interplay between the Exchange and non-Exchange markets and coordination of the Exchange with Medicaid Avoids the difficulty of joint federal and state regulation of insurance markets—state insurance agency would regulate Exchange and non-Exchange markets	Creates obligation on the state to pass laws and regulations to establish the Exchange Obligates state support of the Exchange if it is not self-sustaining by 2015	Approaches in CA, IL, OR, NV and RI all create state based Exchanges. Governors in TX and NM have refused to pass legislation introduced to create state-based Exchanges

MULTI-STATE EXCHANGE

(Instead of Single-State Exchange)

ADVANTAGES	DISADVANTAGES	STATE EXCHANGE DECISIONS
Creates potential efficiencies from combining Exchange operations across states and assembling an enrollment base large enough to sustain the Exchange's operations and spread risk May increase consumer choice in markets without robust competition	Requires extensive cooperation with multiple governors, regulatory agencies and legislatures Requires a more complicated governing structure Requires reconciling insurance market differences across states	Of the states reviewed, none have proposed a multi-state Exchange

STATEWIDE EXCHANGE

(Instead of Regional Exchanges Within a State)

ADVANTAGES	DISADVANTAGES	STATE EXCHANGE DECISIONS
Greater efficiency by avoiding duplication of Exchange governance and operations Could more easily facilitate regulation of the commercial market and coordination with Medicaid Could increase options and competition in some regions. Could spread promising initiatives developed in one region throughout the state	May be less responsive to unique regional markets Regional variations in plan prices may be easier to address through regional Exchanges	Of the states reviewed, all propose statewide Exchanges

REGIONAL EXCHANGES

(Instead of State-Based Exchange)

ADVANTAGES	DISADVANTAGES	STATE EXCHANGE DECISIONS
Creates the opportunity to tap local expertise to create smaller Exchanges more responsive to unique local market conditions, including tribal populations	Adds overall cost through duplicative governance and administrative functions Could present difficulties for small employers with employees in multiple regions Could hamper regulation of the commercial market and coordination with Medicaid Could limit competition in some regions Smaller risk pool may lead to higher cost	Of the states reviewed, none have proposed regional Exchanges, though NM would require an Advisory Committee of Native Americans

Both HB 2666 and SB 1524 enable an Arizona-based exchange, and thereby elect not to require the federal government to operate Arizona's Exchange. Both bills also opt out of a multi-state Exchange. Both bills establish a single, statewide Exchange and preclude the operation of regional Exchanges in Arizona, though in neither bill is a single statewide Exchange prevented from allowing regional pricing, regional service offices or other regional functions. The features of HB 2666 and SB 1524 provide Arizona with maximum self-determination, simplicity in regulation of the insurance market and efficiency in the cost to govern and operate Exchange functions.

Exchange Structural Options: SHOP and Individual Exchanges

The next decision facing a state Exchange is whether there should be separate Exchanges for SHOP and the individual market. An important consideration is that a single Exchange can opt to operate separate risk pools for individual and SHOP functions.

COMBINED INDIVIDUAL AND SHOP EXCHANGE

ADVANTAGES	DISADVANTAGES	STATE EXCHANGE DECISIONS
May offer enrollees more choices if insurers were required to participate in both markets Could have one Exchange (governance and operations) with separate risk pools for individuals and small businesses Combining functions such as certification and rating of qualified health plans could be cost effective and could produce economies of scale Could ease transition of individuals moving between individual and employer-based coverage	May add administrative complexity because some operations, such as billing and enrollment processes, are different for employer groups and individuals	Massachusetts – (begun pre-ACA) *Commonwealth Choice* offers coverage to unsubsidized individuals and small business; *Commonwealth Care* offers coverage to subsidized individuals. Both operate under a single Exchange.

SEPARATE INDIVIDUAL AND SHOP EXCHANGE

ADVANTAGES	DISADVANTAGES	STATE EXCHANGE DECISIONS
Separate Exchanges could specialize in servicing the unique needs of individuals and small businesses, respectively, including billing and enrollment.	Two Exchanges would create administrative duplication, as each would have to determine eligibility for Medicaid, CHIP and premium subsidies.	It appears that in most legislation, the issue of a single or combined SHOP and Individual Exchanges is not explicitly addressed, leaving the question to the Exchange itself.

HB 2666 explicitly states, "The individual and small group markets shall remain separate." SB 1524 establishes a SHOP Exchange "if the Exchange does not have adequate resources to assist qualified individuals in a unified Exchange." Both bills imply that SHOP and individual Exchanges operate under a single governance and organizational structure. Both bills could be more explicit in articulating how and when SHOP and individual market operations integrate and separate.

Finally, HB 2666 specifies that the Exchange "shall not be the sole marketplace for individual and small group health insurance in the state" and articulates an off-Exchange market. SB 1524 does not explicitly state the existence of an off-Exchange market, but it is clearly implied where the bill addresses pricing and other features of off-Exchange activities.

Exchange Structural Options: Organizational Model

The ACA allows three options for an Exchange's organizational model.

1. The Exchange can be located within state government, either in a new state agency, in an existing state agency, or in a new cabinet-level executive agency. Options for placing an Exchange within an existing agency include a state's insurance, human services, budget or health agencies.
2. The Exchange can be located in an independent, quasi-governmental executive branch agency with an appointed governing board or commission.
3. The Exchange can be located in a government sponsored nonprofit organization. The nonprofit must be created by the state for the Exchange; an Exchange cannot be placed into an existing nonprofit organization.

States can also create Exchanges that combine features of the above. The table below illustrates the key advantages and disadvantages of these options.

ORGANIZATIONAL OPTIONS

	ADVANTAGES	DISADVANTAGES	STATE DECISIONS
Any State Agency Option	May allow some shared infrastructure Direct ability to coordinate with other state agencies Can require governing board	May duplicate existing capacity Restricted to state procurement practices Restricted to state hiring practices, including freezes Decision making and operations politicized	NA
New Cabinet-Level Agency	May promote important interagency collaboration	Requires start-up of human and other resources	No state reviewed chose this option
New State Agency	Single focus, avoids conflicting priorities and objectives within agency	Requires start-up of human and other resources May not be influential with other agencies whose cooperation is required	No state reviewed chose this option
Existing Agency in State Government	Enables use of existing staff and skills, administrative systems and procedures	Objectives may overwhelm or conflict with existing functions or objectives of host agency	No state reviewed places the Exchange in an existing agency
New Quasi-Governmental Authority or Independent Public Agency	Less politicized Flexibility to use or not use state procurement and personnel rules for any or all purchasing or hiring Maintains public accountability	Requires governing board May be difficult to obtain cooperation of Medicaid and other state agencies May be less transparent	CA, RI, OR and NM place the Exchange in a quasi-governmental organization
New Nonprofit Organization	Less politicized More flexible in hiring and procurement practices More independent and flexible	Requires governing board No access to government purchasing or hiring advantages or processes Less public accountability and transparency Little ability to influence or gain coordination of state agencies Some Exchange functions are inherently governmental and likely cannot be delegated to the private sector	Of the states reviewed, none place the Exchange in a nonprofit organization

Both HB 2666 and SB 1524 place the Arizona Exchange within the state DOI by adding Chapter 22 to the Title 20 of the Arizona Revised Statutes. Of the states reviewed by Health Management Associates (HMA), no Exchange legislation places it within an existing state agency.

Both also call for a separate Governing Board, thereby creating an Exchange that is within a state agency but functions somewhat like a quasi-governmental organization. HB 2666 delegates the important functions of assigning quality ratings and determining whether to allow large groups to participate on the Exchange to the DOI Director, while SB 1524 assigns them to the Governing Board.

In summary, SB 1524 affords the Exchange more flexibility to adapt to shifting market conditions and more nimble decision making and operations than HB 2666.

The Exchange proposed by either bill assures close cooperation with the Arizona DOI, and likely creates close links with AHCCCS. It can use existing staff, skills, administrative systems and procedures, which provide efficiencies. It also affords transparency to the public, through open meetings, lobbying restrictions and more.

The Exchange proposed by HB 2666 restricts procurement and hiring practices to those used by the state, while SB 1524 allows exemptions from state procurement and hiring rules. Goods and services procured by the Exchange will attract much interest, making the public procurement process desirable for its equity and transparency. However, the Exchange also needs to be very nimble, and will be hampered by adherence to the complex state procurement processes for all of its transactions.

Similarly, state hiring practices can be slow and wages may not be competitive. Under HB 2666, Exchange staffing may be subject to hiring or wage freezes, furloughs and other state employment practices. All of these can have a negative effect on Exchange operations.

Placing the Exchange in state government also subjects the Exchange to political influence, especially when administrations change. This can create a real or perceived instability, risk or weakness in the eyes of the public, health insurers, the legislature and other government agencies.

Finally, placing the Exchange within the DOI creates a tension between the DOI's current regulatory obligations to license insurance carriers, monitor their solvency and ensure compliance with state law and rules, and the Exchange's operational duties to create a platform for the efficient, transparent sale of insurance plans to many thousands of Arizona citizens, and to integrate operational systems with AHCCCS.

In summary, SB 1524 affords the Exchange more flexibility to adapt to shifting market conditions and more nimble decision making and operations than HB 2666. The Exchange under SB 1524 is more likely to successfully navigate the demands and complexities of the January 2014 launch.

Exchange Governance

Background

Because the duties of an Exchange encompass public and private sector functions, its governing board should have working knowledge of and experience in both sectors. The NAIC draft merely notes that a state bill will establish the appointment process, powers, duties and other responsibilities of the board and other committees or entities that will have day-to-day Exchange responsibilities. The NASI draft explicitly addresses the board appointment

process, powers, duties, responsibilities and staggering of terms. Both require a statement to address potential conflict of interest, and HHS' January 19, 2011 Funding Opportunity Announcement requires a state establishing its own Exchange to develop standards for preventing conflicts of interest. The NASI draft also recommends an advisory committee to allow for stakeholder involvement. Of the state Exchange legislation HMA reviewed, none places all appointment rights under the Governor.

Governing Board

Appointments

HB 2666 calls for an 11-member board, nine with voting rights. The governor makes all appointments. Members must represent the two largest individual market health carriers, the two largest small group carriers (excluding those individual market representatives), a limited-scope dental plan, one producer selling individual plans, one producer selling small group plans, a small business or chamber or association representing small business and an individual consumer. The two non-voting members direct the DOI and AHCCCS.

SB 1524 calls for a seven-member board, all with voting rights. Two are the directors of the DOI and AHCCCS. Of the other seven members, the governor appoints four, and one must be a patient advocate. Each of the senate and house majority and minority caucuses appoint one member. Each of the seven appointed members must have skills in at least two of the following areas: individual coverage, small business coverage, benefits administration, healthcare finance, delivery system administration, purchaser, patient advocate and actuarial science.

HB 2666 is far more politicized in its appointment process and strongly favors the insurance industry in its makeup; only one member can be expected to directly represent consumers. Key state agencies involved in Exchange activities do not have voting rights. SB 1524 spreads the appointment process across both parties and seeks members with skills rather than direct representation of healthcare sectors and interests. It allows the key state agencies voting rights.

Conflict of Interest

HB 2666 prohibits board members from taking any action in which the member or entity he/she represents has a conflict of interest. Members are not required to declare conflicts, and no enforcement provisions are noted.

SB 1524 prohibits board members from being employed by or consulting to, serving on a board of, affiliated with, or a representative of a healthcare insurer, an insurance agent or broker, a healthcare provider, facility or clinic. Members also may not be a member of, board member, or employee of a trade association representing heath care insurers, healthcare facilities, clinics or providers. No enforcement provisions are noted.

The voting members of the board under HB 2666 almost exclusively represent the health insurance industry. If the conflict of interest rules were enforced, there would be few items that come before the board on which a quorum could vote. This is untenable and will preclude the work of the Exchange. Board members under SB 1524 cannot work for or affiliate with insurance or providers, nor may they belong to affiliated trade associations. These restrictions may force appointments in the academic arena and/or among retirees, and pose challenges to seating a well-equipped board.

Because the duties of an Exchange encompass public and private sector functions, its governing board should have working knowledge of and experience in both sectors.

An approach that blends the two bills would produce a more productive board and assure that the Exchange can fairly and impartially execute its obligation to foster a more competitive insurance market in Arizona. The language from NASI may serve this purpose:

> *No board member may be employed by, a consultant to, serve on a board of, represent, or lobby for an entity in the business of, or potentially in the business of, selling items or services of significant value to the Exchange.*

In addition, Arizona may wish to consider additional language similar to the California Exchange's which does not allow board members to

> *receive and accept gifts, grants, or donations of moneys from any agency of the United States, any agency of the state, any municipality, county, or other political subdivision of the state, or receive and accept gifts, grants or donations from individuals, associations, private foundations, or corporations, in compliance with the conflict of interest provisions to be adopted by the board at a public meeting.*

The primary differences in the bills relate to authority and accountability.

Board Duties

HB 2666 calls for the board to hire an executive director, oversee operation of the Exchange, prepare requests for proposals, award contracts, set performance standards for contractors and ensure compliance with standards. The board may not promulgate rules.

SB 1524 calls for the board to hire an executive director, determine the structure of and develop the Exchange, ensure that the Exchange is developed and certified by HHS no later than January 1, 2013, ensure that the Exchange is available for open enrollment no later than July 1, 2013 and adopt all necessary rules for operation of the Exchange. It also requires the Exchange to consult with AHCCCS and CHIP on interoperable enrollment requirements and to contract with DOI for premium review. The Exchange may also enter into contracts and information sharing agreements with federal and state agencies and other Exchanges, and retain legal counsel.

The primary differences in the bills relate to authority and accountability. HB 2666 prohibits rule making, which leaves the Exchange powerless in fulfilling its duties and heavily reliant on the legislative process and/or the governor. It also does not obligate the Exchange to important federally mandated timelines for readiness and operation. SB 1524 equips the Exchange with rulemaking authority and other powers, and commits the Exchange to readiness by 2013 and implementation even earlier than required (which will be nearly impossible to achieve).

Exchange Operations

Similarities

The ACA poses a long list of functions and obligations the Exchange must carry out. Both Arizona bills address many of these functions and make appropriate reference to the federal act. Neither bill addresses all the mandatory Exchange functions, nor must they.

Differences

There are substantive differences in the Exchange operations posed by the two bills. HB 2666 calls for the Director of the Department of Insurance to assign quality ratings to Qualified

Health Plans. The Director is also charged to review changes in premiums inside and outside of the Exchange in order to recommend whether to limit access to the Exchange to small employers or open it up. Under SB 1524 these functions fall to the Exchange itself.

HB 2666 calls for the Exchange to "contract with an eligible entity for the non-regulatory functions of the Exchange." This implies a minimal staff, especially when considered with the statement that the Executive Director "may hire additional staff if needed." It also implies a single contractor to carry out many disparate functions of education and outreach, website development and operation, enrollment and more. Presumably, the single contractor will issue its own subcontracts for these functions. Given the complexities and time constraints, the Exchange may not find a contractor's subcontractors sufficiently responsive and accountable. SB 1524 allows the Exchange to issue contracts but does not address which functions would or should be contracted.

HB 2666 also requires the Exchange to pay a producer/broker a commission using a schedule established by the board and commensurate with the average commission or fee outside of the Exchange. This has significant implications relating to adverse selection, which is discussed elsewhere. SB 1524 does not address this matter.

SB 1524 specifically exempts the Exchange from state procurement requirements, state hiring practices and many state rulemaking requirements. Rules will be published by the Secretary of State and the process includes a 30-day period for public comment.

Both bills require the Exchange to consult with stakeholders in carrying out activities, which is a requirement of the federal act. However, neither bill addresses important and mandatory consultation with federally recognized Native American tribes, which is important in Arizona.

Public transparency is required of an Exchange, and the NASI bill draft recommends an Exchange be subject to open meeting laws, Freedom of Information Act (FOIA) inquiries, and relevant administrative and ethics laws. Because both bills place the Exchange within a government agency, these transparency requirements are de facto.

In summary, HB 2666 establishes a bare bones Exchange that relies heavily on the DOI for its functions and contracts for most of the services. SB 1524 establishes a more flexible, staffed Exchange that is not obligated to use state procurement or hiring processes, though it may. Given the hiring and procurement constraints under HB 2666 and its reliance on a single contractor, the Exchange it proposes is less likely to achieve the many complex tasks required by 2014.

Public transparency is required of an Exchange, and the NASI bill draft recommends an Exchange be subject to open meeting laws, Freedom of Information Act (FOIA) inquiries, and relevant administrative and ethics laws.

Consumer Outreach and Enrollment

Education and outreach are fundamental to enrolling adequate numbers of individuals and small businesses in an Exchange to create robust risk pools and reduce the numbers of uninsured. Exchanges are expected to conduct consumer and small business education and outreach, and to coordinate with Medicaid and CHIP education and outreach, but education and outreach are not explicitly addressed in the federal act. Neither the NAIC nor NASI drafts address consumer outreach or enrollment. Neither Arizona bill addresses them either. Outreach and education are functions of the Exchange that do not require legislative authorization or definition.

Certifying Carriers and Plans to Participate in the Exchange

Access and Consumer Choice

Neither the NAIC nor NASI model bills address consumer choice or geographic considerations in plan options, though these considerations are implicit in the concept of a statewide Exchange open to all individuals and small businesses. SB 1524 includes, "consider geographic accessibility to the Qualified Health Plans participating in the Exchange when determining which qualified health plans may participate in the Exchange." HB 2666 makes no mention of geographic access or consumer choice.

Minimum Requirements

The Exchange "determines that making the plan available on the Exchange is in the interest of qualified individuals and qualified employers in the state."

The ACA sets forth minimum requirements for carriers selling on an Exchange and for plans sold there. Carriers must be licensed and in good standing in the state, and must offer at least one silver and one gold level plan in the Exchange(s) in which it participates. Carriers must charge the same premium regardless of whether a plan is sold on the Exchange or outside of it, and whether or not a producer/broker is involved. Carriers and plans must comply with requirements not yet issued by HHS regarding network, marketing, essential community providers, accreditation, quality improvement, uniform enrollment forms, descriptions of coverage and quality measures. Plans must meet actuarial values set forth in the ACA. Finally, the Exchange "determines that making the plan available on the Exchange is in the interest of qualified individuals and qualified employers in the state."

Role of the Exchange in the Insurance Market

The ACA allows each Exchange to determine its role in the market place. Options include:

- Market Organizer/Distribution Channel, in which the Exchange allows all eligible carriers and plans that meet federal requirements access to the Exchange.
- Selective Contractor, in which the Exchange applies additional criteria or incentives to advance quality, pricing, health policy or access objectives. There are many options in this continuum.
- Active Purchaser, in which the Exchange functions like an employer or Medicaid agency, selecting certain carriers or plans on behalf of the purchasers. This option is only feasible where all or nearly all small group or individual insurance is purchased through an Exchange. Note that neither Arizona bill explicitly states that off-Exchange markets for small business and individuals will be available, though it is clearly implied. Accordingly, the Arizona Exchange cannot operate as an active purchaser.

Experiences in Massachusetts and Utah have illustrated interesting outcomes regarding an Exchange's role in the market. The Utah Exchange deliberately formed as a distribution channel, allowing any qualified carrier and plan access to the Exchange. In 2010, 146 plans were offered. More than half of the businesses that opted not to participate in the Utah Exchange cited the process for choosing a health plan as the reason; the Exchange did not "organize the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality" as intended.[6] In Massachusetts, in response to individual

market consumer complaints about the complexity of deciding among just 27 plans, the Massachusetts Exchange opted to significantly reduce the number of plans in its second year, offering just nine. Clearly, an Exchange offering unlimited number of plans does not simplify the process of shopping for health insurance.

The NAIC model bill notes that states should evaluate whether or not to include carrier or plan certification standards above the minimum, and consider factors such as consumer choice and additional costs in doing so. The NASI model bill notes that a state may want to empower the Exchange more specifically with respect to transparency, service area designation and achievement of health outcomes. It also suggests that a state explicitly authorize the Exchange to standardize benefits and cost sharing and selectively admit qualified health plans as a means of encouraging competition. Proposed Exchange legislation from Rhode Island, Nevada and Texas appears to prohibit the Exchange from a role in selective contracting. The California Exchange will create criteria to stimulate competition, and the bill introduced in Oregon will allow the Exchange to limit the number of plans by tier.

HB 2666 stipulates that a plan that satisfies the minimum requirements put forth by HHS is deemed to be in the best interests of qualified individuals and qualified small employers. The bill also "does not permit the Exchange or Director to impose premium controls on health carriers."

HB 2666 further states that the Exchange shall not require a plan to meet more than the minimum standards, and shall not be required to cover state-mandated health benefits that are not included in the essential benefits specified by HHS. SB 5124 does not address mandated benefits. Where states require mandated benefits that are additive to the federally specified benefits, federal law specifies that the state must pay for the cost of those benefits through some mechanism.

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SB 1524 enables the Exchange Board to determine the minimum requirements of a qualified health plan, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interest of qualified individuals and qualified employers. It calls on the board to uniformly apply all health plan standards, and requires that the Board seek choices that offer the optimal combination of choice, value, quality and service. SB 1524 also calls on the Director of DOI to certify health benefit plans that comply with the ACA requirements.

Both bills require that state licensure and solvency requirements be uniformly applied to all carriers seeking access to the Exchange. However, earlier in the bill, SB 1524 deems an unlicensed health plan that is participating in AHCCCS and meets alternative licensure criteria set forth by HHS as eligible for participation on the Exchange. This provision is necessary if the goal is to allow all current AHCCCS health plans to participate in the Exchange without meeting the additional requirements that would be necessary to achieve licensure. This provision is a distinct difference between the bills, and also may conflict with SB 1524's later provision for uniformity. The objectives that must be weighed against each other are:

1. Ease of participation in the Exchange for current AHCCCS plans, a situation that would also make it easier for enrollees to transition between Medicaid-funded coverage and Exchange coverage without changing plans, and
2. Development of uniform standards for all Medicaid and Exchange plans, which would require that all AHCCCS health plans achieve licensure.

This is not a simple issue since the AHCCCS plans may incur significant costs to achieve HMO licensure, including the need for additional capital to meet reserve requirements for licensed plans. Alternatively, a licensure requirement provides additional assurance about the solvency of the health plans and the quality of care provided.

SB 1524 allows the Exchange board to require that all carriers participating on the Exchange sell at least one plan in each of the mandatory benefit tiers (gold, silver, bronze). HB 2666 does not allow the Exchange to apply such a requirement.

HB 2666 allows full participation in the Exchange by all carriers offering qualified health plans, with no options for the Exchange to impose incentives to control cost, improve quality or provide an array of plans among which a consumer could reasonably be expected to differentiate. SB 1524 allows but does not require additional plan certification standards that could advance cost and/or quality objectives and/or manage the number of consumer choices.

It is almost certain that with no additional standards, the Arizona Exchange's first year will offer more choices than consumers could easily process, and the simplification intended by the ACA will not occur.

It is almost certain that with no additional standards, the Arizona Exchange's first year will offer more choices than consumers could easily process, and the simplification intended by the ACA will not occur. Under SB 1524, the Exchange is authorized to address this issue, and can also incentivize quality and cost. Under HB 2666, the Exchange enabling law would need revision to provide this flexibility.

Managing the Exchange Risk Pool

It is paramount that Exchanges be authorized to maximize their opportunities for success in their main objectives to provide affordable coverage to individuals and small business, and to provide a simple means to compare, select and enroll in insurance plans. Managing the Exchange's risk pool(s) is inextricably tied to success in providing affordable coverage.

The people who choose to join a health plan combine to form the group's risk pool, over which the cost of the group's care is spread. Adverse risk selection can occur when people with like characteristics make similar choices, concentrating similar risk in specific market segments. Unrestrained adverse risk selection can produce an unstable marketplace. If sicker people congregate inside the Exchange and healthier people seek care outside the Exchange, the same coverage inside the Exchange costs more than outside. Therefore, a key challenge for an Exchange is achieving a balance between choice and potential adverse selection. The ACA puts forth a number of provisions designed to mitigate adverse selection in an Exchange, for which the regulatory details are still under development. Nevertheless, because risk adjustment in practice is far from perfect, states can consider additional strategies to further mitigate the risk of adverse selection.

One key choice that neither Arizona bill addresses is whether the risk pools for the individual and SHOP exchanges should be managed separately or combined. HB 2666 states that "the individual and small group markets shall remain separate," but does not clarify whether this applies to the risk pools. SB 1524 calls for a single Exchange unless the SHOP functions cannot be provided in that manner, but also does not mention how the risk pools would be managed. By omission, it appears that the intent of both bills is to combine the two risk pools. The markets, members and motivators are fundamentally different between small business and individuals, making it easy to assume that their risk pools are also quite different, with the individual pool presenting far sicker people who may buy insurance only when

they become ill. However, there is little data to support this assumption. Regardless, most Exchanges are opting to separate the risk pools, or at least reserve the option to separate them.

Another choice that is likely to reduce the potential for adverse risk selection is to limit the size of small businesses eligible for the SHOP exchange to 50 employees, rather than 100. This option is available until 2016. Some groups of 100 may elect to self-fund, leaving sicker groups to join the Exchange and affect the risk pool. Both Arizona bills require that small business size be limited to 50 employees or fewer in the first two years, which will likely reduce adverse selection.

The concept of a level playing field between products in the Exchange and outside it offers another important means to minimize adverse selection against the Exchange. If carriers and plans operate under the same rules in both markets, the opportunity for adverse selection is reduced. The ACA includes several rules to address this concern. For example, carriers must pool all their members in individual products as a single risk pool, whether on or off the Exchange. Even with this and many other features, there are structural issues that can bias selection. For example:

- There is no requirement that a carrier offer the same plans on and off the exchange. A carrier could offer the requisite silver and gold plan on the Exchange, and just bronze or catastrophic plans off the Exchange, thereby attracting healthier people to its off-Exchange products.
- There is no requirement that carriers operating outside the Exchange must also sell on the Exchange. A carrier can sell plans very similar but not identical to Exchange plans outside the Exchange. Because they are not subject to the same certification requirements, they may be less expensive and attract healthier people.

SB 1524 allows the Exchange board to require that all carriers participating on the Exchange sell at least one plan in each of the precious metal tiers, which may slightly mitigate adverse selection. HB 2666 specifies that a carrier is free to sell plans on or off the Exchange, or both, which can clearly contribute to adverse selection. As such, neither Arizona bill can level the playing field sufficiently to mitigate adverse selection. It would be in the Exchange's interest to at least make this possible through the enabling legislation.

Another source for selection bias against the Exchange is the manner in which brokers/producers are compensated in the two markets. HB 2666 calls for commissions and fees to be similar inside and outside the Exchange. SB 1524 does not address commissions or fees.

To mitigate the risk of adverse selection against the Exchange, enabling legislation could:

- Extend some or all of the qualified health plan requirements to the outside market. Requirements address member satisfaction measures, accreditation, quality measurements and others. Since most of the requirements are at the level of the carrier and all carriers should want to participate on the Exchange, there is little administrative burden to this provision. *This option has the most potential for reducing adverse risk in a state that wishes to minimize the Exchange's market influence.*
- Require carriers to participate on the Exchange in order to sell individual or small group plans in Arizona. This would protect against insurers targeting a healthy risk off the Exchange and benefitting from imperfect risk adjustment. It would also prevent a

It is paramount that Exchanges be authorized to maximize their opportunities for success in their main objectives to provide affordable coverage to individuals and small business, and to provide a simple means to compare, select and enroll in insurance plans.

carrier developing a subsidiary to avoid the requirement that products be priced the same on and off the Exchange, which is a likely strategy.

- Require carriers selling off the Exchange to offer products at all precious metal tiers. This reduces the likelihood of adverse selection to the Exchange where a carrier targets only low risk members off the Exchange with bronze or catastrophic plans.

Ensuring the Exchange's Financial Self-Sufficiency

Exchanges must be self-sufficient by 2015.

Exchanges must be self-sufficient by 2015. The NAIC and NASI model acts allow the Exchange to charge assessments or use fees to health carriers or otherwise generate funding necessary to operate the Exchange. Note that neither limits fees to carriers selling on the Exchange.

HB 2666 states that starting in January 2015, the Exchange may charge assessments or user fees to carriers selling on the Exchange to support its operations. It specifies that fees be separate from the premiums charged. By limiting assessments to January 2015, HB 2666 may "cost" the Exchange a year of operating revenue.

SB 1524 states, under duties of the governing board, that the board may require qualified health plans participating in the exchange to charge a premium surcharge to qualified individuals and qualified employers purchasing plans on the exchange.

Both approaches restrict fees to users of the Exchange. Under HB 2666, the carriers selling on the Exchange bear the cost, which can skew carriers to sell off the Exchange, or to sell off-Exchange plans only slightly different than those on the Exchange, and price them lower. Under SB 1524 employers and individuals using the Exchange bear its costs, which is a financial disincentive to participation in the Exchange. Both bills serve to skew selection to lower cost off-Exchange alternatives, which contributes to the adverse risk selection considered earlier. Arizona should consider spreading the cost of the Exchange across all carriers in the state, regardless of their independent business decisions to sell on and/or off the Exchange.

The NAIC model also calls for the Exchange to publish the average cost of licensing, regulatory fees, any other payments required and the Exchange's administrative costs, on an Internet Web site to educate consumers on such cost. Costs reported are to include monies lost to fraud, abuse and waste. The NASI model act further calls for the Exchange to report its reserves, and to provide an annual report to the legislature that would allow analysis of its financial performance. Both Arizona bills require that Exchange costs be published to the public. Only HB 2666 requires an annual report of costs to the legislature.

Both bills establish an Exchange fund into which planning grant monies, premium assessments and other fees will be placed and made available to the board for operation and administration of the Exchange. Both also call for the monies to be continuously appropriated and exempt from the state's lapsing appropriation provisions. HB 2666 goes further to state that on notice from the Exchange board, the state treasurer can invest and divest monies from the Exchange fund, and that investment earnings will be credited to the Exchange fund. It also provides that the Exchange may "accept and spend federal monies, private gifts, contributions, and devises to assist in carrying out the purposes."

Other Differences Between Arizona Bills

Dental Benefits

The ACA allows for freestanding limited-scope dental plan on the Exchange and speaks to the manner in which mandatory dental benefits for children would be addressed by plans. Both bills address these ACA requirements. HB 2666 also allocates one board seat to a limited-scope dental plan and provides more content related to dental services. HB 1524 does not allocate a board seat to a dental plan.

SHOP Exchange

SB 1524 provides that if a SHOP Exchange is formed, "the Board shall adopt rules to reconcile eligibility criteria based on domicile versus place of employment." HB 2666 does not address this matter.

Annual Review of Exchange Performance

SB 1524 requires that the board conduct an annual review of the Exchange and report findings to the banking and insurance committees of the house and senate. HB 2666 has no requirement for a performance review of the Exchange.

Repeal

HB 2666 allows the Exchange legislation to be repealed in the event that the ACA is ruled unconstitutional or is repealed by Congress. SB 1524 does not address repeal of the Exchange legislation.

Issues Not Addressed in the Bills

Producer Rules

Both the NAIC and NASI model bills call for an analysis of whether the Exchange should be exempt from the State's producer or consultant licensing requirements or whether the Exchange or its employees need to obtain such licensure. It is not clear whether this issue was considered in the drafting of the bill.

Interface with Medicaid, CHIP and Other State Agencies

The ability of an Exchange to conduct its many functions is completely dependent on the timely and efficient cooperation of other state entities. Both the NAIC and NASI model bills note that language should be included to specify the responsibilities and obligations of other state agencies in coordinating with the Exchange. They also recommend Memoranda of Understanding or other means to obligate cooperation. Agencies would include AHCCCS (Medicaid, CHIP) and agencies that provide unemployment benefits, capture payroll data, operate data warehouses, determine eligibility for government programs, collect state taxes, monitor childcare payments and perhaps others. Neither Arizona bill addresses cooperation or obligation of state agencies with the Exchange.

The ability of an Exchange to conduct its many functions is completely dependent on the timely and efficient cooperation of other state entities. Neither Arizona bill addresses cooperation or obligation of state agencies with the Exchange.

Integration with Arizona's Existing Insurance Market and State Purchasing

As Exchanges take shape, each state must carefully consider how its Exchange will interact with the unique state insurance market overall and with the large state purchasers of health care, including prisons and state employee and retiree plans.

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Both Arizona bills seem to create an Exchange that operates independent of, rather than in concert with, the larger non-Exchange insurance market. Neither requires carriers to sell both on and off the Exchange, and both assess fees only on carriers, employers or individuals using the Exchange. This may serve to disadvantage the Exchange and undermine its intent of creating an efficient and competitive market for individuals and small businesses.

As the Exchange operates, especially in its first years, the state should carefully watch any effect on the illustrative rates and administrative fees charged by carriers serving state employees and retirees, and the state department of corrections if applicable. Typically, these mega-purchasers have leveraged significant discounts, and carriers may reconsider them in light of the new market rules and the Exchange itself.

Integration with AHCCCS (Medicaid) and KidsCare (CHIP)

The ACA requires significant changes in the way in which many consumers will access the Medicaid and CHIP programs. With the exception of the elderly and some disabled individuals, most low-income individuals (including all adults in families with incomes under 133 percent of the federal poverty level [FPL]) will be able to complete a very simple application for Medicaid. There will not be any asset test and in general income will be verified through electronic data matches with sources such as the IRS.

ACA also requires integration of eligibility and enrollment functions between Medicaid and the Exchange. In particular, there must be a common web-based application for Medicaid, CHIP and tax credits to purchase subsidized coverage in the Exchange. Even for individuals specifically applying for tax credit subsidies in the Exchange, the Exchange must screen for Medicaid or CHIP eligibility, and the state Medicaid and CHIP programs must accept these enrollments without further review. As part of a one-stop shopping approach to health coverage, ACA also requires that individuals eligible for Medicaid must be able to choose their Medicaid health plan through the Exchange. For individuals that apply for Medicaid or CHIP outside of the Exchange who are determined ineligible due to factors such as excess income or status as a legal non-citizen with less than five years of US residency, the Medicaid/CHIP agencies must refer these individuals to the Exchange.

Over time many people will move back and forth from Medicaid/CHIP to Exchange subsidy. The ACA requires that states develop seamless systems for this movement so that individuals do not lose coverage when income moves above and below the 133 percent of FPL level.

These and other ACA requirements for an integrated approach to coverage dictate that there must be a close working relationship and integrated systems between AHCCCS and

the Exchange. The two entities will need to be able to use the same web-based application for their programs and to share or coordinate collection of data from the IRS and other federal and state sources to confirm income and citizenship status of applicants for Medicaid and tax subsidies. In addition, they will need interoperable information technology systems to enroll individuals in Medicaid and enroll them in a particular health plan when the Exchange determines that they are Medicaid eligible.

Conclusion

Arizona's option to create and operate its own Health Insurance Exchange is time-bound: state Exchanges meeting explicit criteria must be in place by January 2014, and the federal government must certify state-based Exchange plans by January 2013. In the absence of a state-controlled exchange, Arizona would defer administration of its Exchange to the federal government. HB 2666 and SB 1524, though significantly different, provide Arizona with the means to combine the strengths of both approaches and quickly move forward with the essential Exchange legislative framework.

Enabling legislation is just the first of many steps in Exchange development and implementation. To date, Arizona has not fully engaged stakeholders or modified its insurance market in accordance with federal requirements. Some efforts are underway to address exchange-related technology, but the complexity and breadth of Exchange technology requirements call for full-speed, non-stop planning, building, implementing and testing from now until January 2014.

In order to operate an Arizona Health Insurance Exchange, the legislature must act swiftly and many other parties must begin a long list of tasks. Time is, indeed, of the essence.

In order to operate an Arizona Health Insurance Exchange, the legislature must act swiftly and many other parties must begin a long list of tasks. Time is, indeed, of the essence.

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2 Appendix A provides a table comparing many features of the Arizona bills to model acts.

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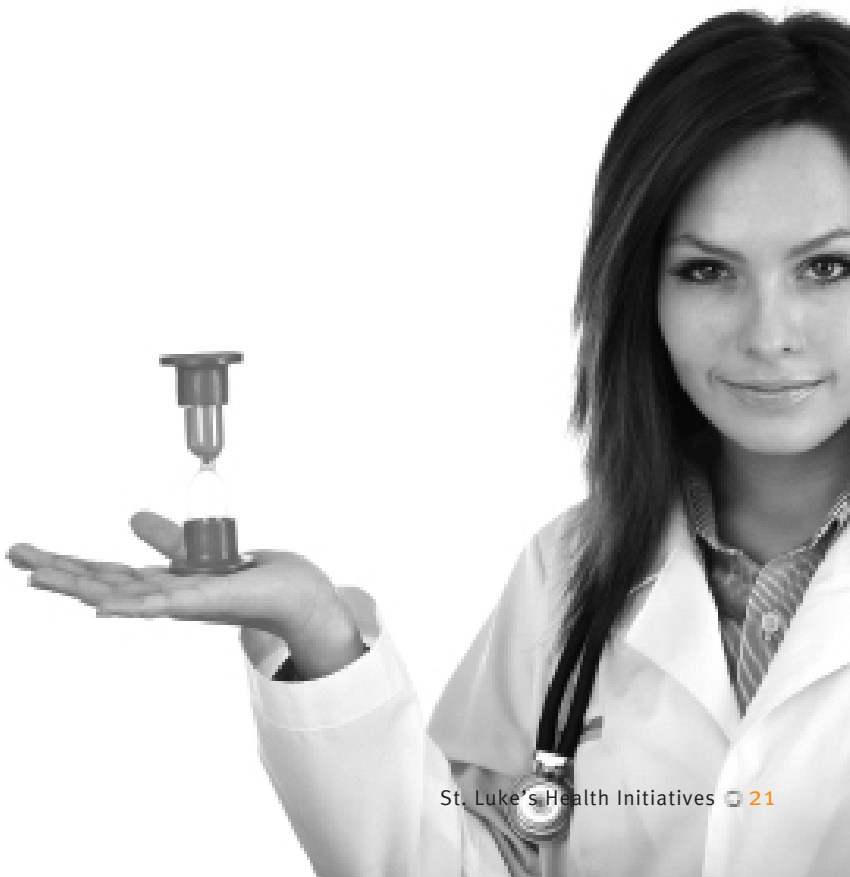

APPENDIX A: COMPARISON: ARIZONA EXCHANGE BILLS AND NATIONAL MODEL ACTS

	NAIC/NASI MODEL ACTS
ORGANIZATIONAL STRUCTURE	1. Within government as: • cabinet-level new agency • new agency • within existing agency • Notes that location with department of insurance will create explicit conflicts and tensions 2. Quasi-governmental agency or public authority 3. New nonprofit agency
GOVERNING BOARD SIZE	Not specified
GOVERNING BOARD APPOINTMENT	Not specified
GOVERNING BOARD MEMBERSHIP	Expertise in at least one area: individual market, small employer market, benefits administration, healthcare finance and economics, actuarial science, healthcare delivery (private or public), healthcare purchasing. Members represent the interests of consumers, small businesses and other purchasers
ADVISORY BOARD	Yes
AUTHORITY	Both expect Exchange will have rule-making authority, unless it is located in a nonprofit, in which case an executive branch agency must be specified to engage in necessary rulemaking
DUTIES	Appoints Executive Director Appoint advisory committee
TERMS	Staggered, no more than two consecutive
CONFLICT OF INTEREST	No board member may be employed by, a consultant to, serve on a board of, represent, or lobby for an entity in the business of, or potentially in the business of, selling items or services of significant value to the Exchange
BOARD COMPENSATION	Not addressed
HIRING EXCHANGE STAFF	
TRANSPARENCY	Subject to open meeting laws, FIOA, relevant administrative and ethics laws
PROCUREMENT	
HIRING	
FINANCIAL INTEGRITY REQUIREMENTS	In addition to ACA requirements, an annual report to legislature of all costs, including fund balance and cost loss to waste, fraud and abuse
FUNDING STRATEGIES	Exchange may access fees to carriers or otherwise generate funds to operate and administer the Exchange

HB 2666	SB 1524
Within the Arizona Department of Insurance, with separate governing board	Within the Arizona Department of Insurance, with separate governing board
11, including 2 non-voting	9 voting members
Governor appoints all board members	Governor: 3 (1 is a patient advocate) House Majority: 1 House Minority: 1 Senate Majority: 1 Senate Minority: 1
2 largest individual market health carriers 2 largest small group carriers, excluding appointed individual market carriers 1 limited scope dental plan 1 producer selling individual plans 1 producer selling small group plans Small business OR chamber or association representing small business Individual consumer Director, Dept. of Insurance (non-voting) Director, AHCCCS (non-voting)	Director, DOI Director, AHCCCS Others must each have at least two skills, and mix must represent all skills: Individual coverage, small business coverage, benefits administration, healthcare finance, delivery system administration, purchaser, patient advocate, actuarial science
No	No
Has no rule making authority	May promulgate rules, which are exempt from public requirements except that the Secretary of State must publish with 30 day public comment period
Hire Executive Director, oversee operation of exchange, prepare requests for proposals, award contracts, set performance standards for contractors, ensure compliance with standards	Hire Executive Director Determine structure and develop Exchange Ensure certification by 1/1/13 Ensure open enrollment by 7/7/13 Adopt all necessary rules
Staggered, preference to health insurers on longer initial terms Eventually three-year terms No term limits	Staggered, eventually four-year terms No term limits
Member shall not take any action in which member or entity he represents has a conflict of interest	No board or staff member may be employed by, consultant to, member of board, affiliated with, or representative of insurer, agent or broker, provider, facility or clinic, or a board or staff member of trade association representing insurers, facilities, clinics or providers
None	Expenses to attend meetings may be reimbursed
Employees of Exchange are employees of DOI	Exchange employees are exempt from state hiring practices
Subject to all state rules	Not addressed in cohesive manner
Procurement would be subject to all state rules	Exempt from Title 41 chapter 23 AZ procurement code
Allows ED to hire additional staff if necessary, staff would be subject to state hiring practices	Exempt from Titles 41 chapter 4 articles 5 and 6 Personnel administration and personnel board
In addition to ACA requirements, an annual performance review and report to Legislature on fund	ACA requirements
Exchange may levy fees on carriers participating in the Exchange	Exchange may require plans participating on Exchange to charge premium surcharge to individuals and small businesses using the Exchange

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