WISCONSIN LEGISLATIVE COUNCIL
STAFF MEMORANDUM

Memo No. 1

TO: MEMBERS OF THE SPECIAL COMMITTEE ON HEALTH CARE REFORM IMPLEMENTATION

FROM: Laura Rose, Deputy Director, and Heidi Frechette, Staff Attorney

RE: Health Benefits Exchanges in Selected States and Under Federal Health Care Reform

DATE: September 14, 2010

This Memo provides information requested by members of the Special Committee on Health Care Reform Implementation at the August 19, 2010 meeting. The Memo presents information on the following items:

- The requirements placed upon states by the federal Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act, with regard to the establishment of health insurance exchanges.

- The components of the grant application submitted by the Wisconsin Department of Health Services on September 1, 2010, for exchange planning grants.

- Information on exchanges established in Massachusetts, Utah, Washington, Florida, and California.

- Issues relating to establishing a governance structure for a Wisconsin health insurance exchange.

PART I: FEDERAL REQUIREMENTS FOR ESTABLISHING STATE HEALTH INSURANCE EXCHANGES

The PPACA, P.L. 111-148, requires the establishment of health insurance exchanges in order to expand access to health insurance. The PPACA provides each state the opportunity to establish an exchange. The Secretary of Health and Human Services is responsible for establishing and operating

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exchanges where states choose not to establish an exchange or for states the Secretary determines will not have an exchange operable by January 1, 2014.

The U.S. Department of Health and Human Services (DHHS) is currently soliciting public comment to aid the agency in developing standards for the establishment and operation of the exchanges. Enclosure 1 sets forth the Federal Register notice for comments. It also includes the Wisconsin Office of Health Care Reform (OHCR) outline of questions from the Federal Register notice. Comments are due October 4, 2010.

General Requirements for Exchange

The PPACA requires that either a governmental agency or a nonprofit entity established by a state run the exchange. Exchanges are required to make qualified health plans available to eligible individuals and employers and must consult with various stakeholders in carrying out their responsibilities. States must submit an annual report to the Secretary on the exchange's activities and on receipts and expenditures, and must publish pertinent information about the average costs of licensing, regulatory fees, administrative costs and moneys lost to waste, fraud, and abuse.

Additionally, the exchange must do all of the following:

- Implement procedures for certification, recertification, and decertification of qualified health plans.
- Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.
- Maintain an Internet website containing comparative information on qualified health plans.
- Assign ratings to each qualified health plan offered through the exchange on the basis of relative quality and price, in accordance with criteria as defined by the Secretary.
- Present plan options (bronze, silver, gold, platinum, and a catastrophic plan for young adults) in a standard format.
- Inform individuals of eligibility requirements for the Medicaid program and Children's Health Insurance Program (CHIP) or any applicable state or local program and enrollment in these programs, if an individual is determined eligible through screening by the exchange.
- Provide an economic calculator for consumers to determine the actual cost of coverage after application of any premium tax credit or cost-sharing reduction.
- Grant certification to individuals relating to hardship or other exemptions.
- Establish a "navigator" program to facilitate enrollment and refer consumers' questions and complaints to the appropriate agencies.

PART II: STATE GRANT APPLICATION FOR STATE PLANNING AND ESTABLISHMENT GRANT

The Wisconsin Department of Health Services (DHS) submitted a grant proposal for the Wisconsin Exchange Planning Project on September 1, 2010. The DHS requested $999,873 to fund 12 months of activities relating to planning for the establishment of a state-based health insurance exchange. The Project Abstract Summary (Enclosure 2) indicates the activities that will be conducted within the Executive Branch over the 12-month period which include:

- Establish a project team comprised of staff from all impacted state agencies: DHS, Office of the Commissioner of Insurance (OCI), Department of Administration, Department of Revenue, and the Department of Employee Trust Funds (ETF).

- Maintain exchange resource information on the OHCR website to allow stakeholders to stay informed and provide input.

- Conduct surveys of the individual, small group, and large group markets, and model and analyze insurance reform impacts to assure clear understanding of Wisconsin's current and future health insurance landscape.

- Create a blueprint for the Wisconsin exchange and obtain stakeholder feedback to allow consumers, brokers, insurers, advocates, coalitions, national experts, and state and federal agencies to have a voice in the design of the exchange.

- Complete the necessary policy analysis and produce options papers with pros, cons, and recommendations for strategic decisions.

- Draft and recommend enabling legislation required to provide the regulatory authority and enforcement to establish and operate an exchange.

- Develop a functional model that clearly shows each entity that will interact with the exchange, the entity's specific roles, and the frequency of their interaction.

- Develop a technical model that clearly shows the technical interaction for the entities documented in the functional model.

The Project Abstract Summary envisions an exchange with the following characteristics:

- An easy-to-use, consumer-friendly website where small business owners and individuals can find an "apples-to-apples" comparison of insurance policies: what they offer and how much they cost.

- A single point of access for all eligible residents and businesses to choose their insurance.

- Promotion of consumer choice by providing easy comparability of health plans and lower health care premium costs by creating a large pool of employees to increase consumer purchasing and bargaining power.

- A health insurance purchasing exchange structure that rewards the highest quality and most cost-effective health care providers and insurers.

PART III: EXCHANGE DEVELOPMENT ACTIVITIES IN SELECTED STATES

This part describes exchanges that have been created in Massachusetts, Utah, California, Florida, and Washington State. The California exchange is the only exchange to have been created subsequent to passage of PPACA.

Massachusetts

Program summary. The Massachusetts health exchange, known as the Connector, serves as an intermediary to assist individuals in acquiring health coverage by managing two insurance programs: Commonwealth Care and Commonwealth Choice. Commonwealth Care is a subsidized insurance program available to Massachusetts adults earning up to 300% of the federal poverty level who do not have access to employer-sponsored insurance or other subsidized insurance and who meet certain eligibility guidelines. Commonwealth Choice is a commercial insurance program available to individuals not eligible for subsidized coverage and to small employers.

Governance. The Connector has been described as a semi-independent public authority. It is a self-governing entity separate from the State of Massachusetts and has features of both a public agency and a private organization. The Connector is governed by a 10-member board, composed of both public and private representatives. Chaired by the Secretary of Administration and Finance, the board also includes the following individuals:

- Director of Medicaid.
- Commissioner of Insurance.
- Executive Director of the Group Insurance Commission.

Additionally, the Governor appoints the following representatives to the board:

- Member in good standing of the American Academy of Actuaries.
- Health economist.
- Representative of interests of small businesses.

The Attorney General appoints the remaining three members, one from each of the following categories:

- Employee health benefits plan specialist.
- Representative from health consumer organization.
- Representative of organized labor.

All appointees serve for a three-year term. Six members of the board constitute a quorum. Members are not paid a salary, but are reimbursed for their expenses. No appointee may be an employee of a licensed carrier authorized to do business in the state. The board meets on a monthly basis in a public forum.

Board powers and duties. The Connector is charged with developing policy and regulatory components of the state health reform measure, including establishment of the benefits packages and premium contributions schedules, development of regulations defining what constitutes minimum creditable coverage, and construction of an affordability schedule. The Connector is also responsible for outreach and education regarding the programs.

In carrying out its responsibilities, the Connector contracts with many state agencies and private businesses. Below is a list of some of the entities and the services they provide:

- Massachusetts Health and Human Services (MassHealth): conducts eligibility screening and much of the enrollment process for CommCare applicants.
- Division of Insurance: assists with health insurance regulatory issues.
- Department of Revenue: enforces mandatory insurance requirements.
- Outside Vendor: makes eligibility determinations with data-matching.

Staff. The Connector is led by an executive director and employs approximately 50 people. After an initial infusion of $25 million from state appropriations for the development of infrastructure and operations, the Connector has been funded by the revenues obtained through retention of a percentage of premiums collected on both the subsidized and unsubsidized insurance products.

Utah

Program summary. Utah enacted legislation in 2008 and 2009 that creates the Utah NetCare Plan, a low-cost health benefit plan. The legislation also created the Office of Consumer Health Care Services, which was directed to create an Internet portal (the Utah Health Exchange) through which insurance products are offered. The bill allows insurers to offer lower-cost health insurance products that do not include certain state mandates in the individual market, the small employer group market, and in the conversion market. The Risk Adjuster Board, appointed by the Governor and confirmed by the Senate, oversees the risk adjustment mechanisms of insurers participating in the exchange. The board is in the Insurance Department.

The legislation establishes a defined contribution arrangement market, available through the Utah Health Exchange, that offers insurance products that were available as of January 1, 2010 to small employer groups. These products will be available in 2012 to larger employer groups. A "defined contribution arrangement" (DCA) is a group health benefit plan that meets the requirements in the bill and is sold through the exchange. An employer that chooses to participate may not offer a major medical health benefit plan that is not a part of the DCA. However, an employer may offer supplemental or limited benefit policies. An employee individually selects the DCA plan among those

that are available through the exchange. If the employee does not select one of the DCA plans through the exchange, the employer may enroll the employee in a "default" health benefit plan.

Governance. The legislation created the Utah Defined Contribution Risk Adjuster, an entity within the Utah Insurance Department. The Risk Adjuster is under the direction of a board of directors. The role of the Risk Adjuster is to create a risk adjustment mechanism to apportion risk among the insurers who participate in the exchange.

The Risk Adjuster Governing Board is comprised of up to nine members, appointed by the Governor with the consent of the Senate, as follows:

- At least three, but up to five, directors with actuarial experience who represent insurance carriers that are participating or have committed to participate in the DCA market, and including at least one and up to two directors who represent a carrier that has a small percentage of lives in the DCA market.

- One director who represents either an individual employee or employer participant in the DCA market.

- One director appointed by the Governor to represent the Office of Consumer Health Services within the Governor's Office of Economic Development.

- One director representing the Public Employee's Health Benefit Program with actuarial experience, chosen by the director of the Public Employee's Health Benefit Program, who serves as an ex officio member.

- The Insurance Commissioner or a representative from the Insurance Department with actuarial experience appointed by the Commissioner. This member has voting privileges only in the event of a tie vote.

The legislation also created the Office of Consumer Health Services within the Governor's Office of Economic Development. The Office is cooperating with the Insurance Department, the Department of Health, and the Department of Workforce Services, to create the exchange that is capable of providing access to private and governmental insurance websites, and their electronic application forms and submission procedures.

Board and office powers and duties. The Board has a number of duties with respect to the operation of the exchange. The Board must submit a plan of operation for the Risk Adjuster to the Insurance Commissioner. The plan must have the following components:

- The methodology for implementing the DCA market.

- Regular times and places for meetings of the Board.

- Procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner.

- Additional provisions necessary and proper for the execution of the powers and duties of the risk adjuster.

- Procedures in compliance with the Utah Administrative Services Code, to pay for administrative expenses incurred.

The Board has the power to:

- Enter into contracts to carry out the provisions and purposes of the program, including, with the approval of the Commissioner, contracts with persons or other organizations for the performance of administrative functions.

- Sue or be sued, including taking legal action necessary to implement and enforce the plan for risk adjustment.

- Establish appropriate rate adjustments, underwriting policies, and other actuarial functions appropriate to the operation of the DCA market.

The Board must prepare and submit an annual report to the Insurance Department for inclusion in the department's annual market report. The law outlines the various required items for the report, including the budget for the operation of the Risk Adjuster, which is subject to the Board's approval. The Board is also required to report to the Health Reform Task Force (created in 2008) regarding progress in developing the exchange.

The Office of Consumer Health Services is required to create the exchange. The exchange must provide a consumer comparison of health benefit plans for small employer group, individual, and DCA markets. It must also contain information on premium assistance and other governmental programs. It must facilitate a private sector method for the collection of health insurance premium payments. The Office must adopt administrative rules that establish uniform electronic standards for a health insurer using the exchange; designate the level of detail that would be helpful for consumers to compare plans; and assist the Board created and carriers participating in the DCA market in determining employer eligibility to participate in the DCA market.

California

Program summary. California enacted Senate Bill 900 and Assembly Bill 1602 on August 24 and 25, 2010. Senate Bill 900 establishes the California Health Benefit Exchange. Assembly Bill 1602 creates the California Patient Protection and Affordable Care Act. Included in this Act is a specification of the powers and duties of the board governing the California Health Benefit Exchange.

Governance. The exchange is governed by a five-member California Health Benefit Exchange Board consisting of five residents of California. The Board is an independent public entity not affiliated with any state agency. Two of the members are appointed by the Governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly. The Secretary of California Health and Human Services or his or her designee is a voting, ex officio member of the board.

Members of the board, other than the ex officio member, are appointed for four-year terms. The initial appointment by the Senate Committee on Rules is for a term of five years, and the initial appointment by the Speaker of the Assembly is for a term of two years. Appointments by the Governor made after January 2, 2011 are subject to Senate confirmation. Each year, the Board must elect a chairperson.

Each person appointed to the Board must have demonstrated and acknowledged expertise in at least two of the following areas:

- Individual health care coverage.
- Small employer health care coverage.
- Health benefits plan administration.
- Health care finance.
- Administering a public or private health care delivery system.
- Purchasing health plan coverage.

There are conflict of interest provisions that prohibit a member of the Board, or the staff of the exchange, from being employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier or other insurer, an agent or broker, a health care provider, or a health care facility or health clinic while serving on the Board or on the staff of the exchange. In addition, exchange Board members and staff may not be a member, a board member, or an employee of a trade association of carriers, health facilities, health clinics, or health care providers while serving on the Board or on the staff of the exchange. A member of the Board or of the staff of the exchange must not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

Board members receive a per diem and travel expense reimbursement, but do not receive any other compensation.

Board members are prohibited from using their positions to influence decisions that will financially benefit the Board member or his or her immediate family. There are also provisions that limit the private liability the Board or any of its members, officers, or employees, for acts performed in their official capacity, in good faith, without intent to defraud, and in connection with the operation of the Board.

The Board is subject to the Open Meetings Act of California.

Board powers and duties. Assembly Bill 1602 sets out in detail the powers and duties of the California Health Benefit Exchange.

The Board is required to hire an executive director to manage the exchange's operations, who is exempt from civil service, and serves at the Board's pleasure.

The Board is directed to apply for exchange planning grants available under federal law. The California Health and Human Services Agency submitted the initial application, since the Board was not appointed in time to submit the application.

The Board may adopt bylaws for regulation of its affairs and the conduct of its business; adopt an official seal; sue and be sued; receive gifts, grants, and donations of moneys to carry out it purposes; engage private consultants; and exercise other extensive powers.

The Board must implement procedures for the certification, recertification, and decertification, consistent with guidelines established by the federal government, of health plans as qualified health plans. The Board has powers and duties relative to determining eligibility for enrollment in the exchange and arranging for coverage under qualified health plans. The Board is required to facilitate the purchase of qualified health plans through the exchange by qualified individuals and qualified small employers by January 1, 2014.

This bill authorizes the California Health Facilities Authority to provide a working capital loan of up to $5 million to assist in the establishment and operation of the California Health Benefit Exchange.

Washington

Program summary. In 2007, Washington created the Health Insurance Partnership (HIP), which is available to small employers with at least half of their employees earning under 200% of the federal poverty level. HIP has received a $1.2 million implementation grant from the federal Department of Health and Human Services Health Resources and Services Administration (HRSA) in 2009. A subsequent HRSA grant for $2.8 million will help pay for program costs and subsidies for approximately 650 low-income enrollees. Over the next three years, the program will be eligible for similar grants amounting to approximately $10 million annually.

The program, characterized as an exchange, began enrolling businesses into the HIP at the beginning of September 2010, and will provide coverage beginning January 1, 2011.

In a separate effort, the Joint Select Committee on Health Reform Implementation was created by the Legislature and began working on PPACA implementation issues in May 2010, including creation of the health insurance exchange required under federal law.

Governance. The HIP is part of the Washington State Health Care Authority, an executive branch agency. The HIP is administered by the Washington State Health Insurance Partnership Board. The seven board members are appointed by the Governor and must have expertise in health insurance market and benefit design. The Board is chaired by the Authority administrator. Board members are compensated and reimbursed for their travel expenses.

Board powers and duties. The Board prescribes its own rules for conducting business and has established a technical advisory committee.

The Board must:

- Develop policies for enrolling small employers in the HIP, including minimum participation rule for small employer groups. The small employer determines criteria for eligibility and enrollment in the employer's plan and the amount they will contribute to the plan.

- Designate up to five health benefit plans, ranging from comprehensive to catastrophic coverage, that are currently offered in the small group market, that will be offered to participating small employers.

- Determine plans that will qualify for premium subsidy payments. A mid-range benefit plan is selected to be used as a benchmark plan for calculating premium subsidies.

- Determine whether there should be a minimum employer premium contribution

- Develop policies related to partnership participant enrollment.

- Determine appropriate health benefit plan rating methodologies.

The Board and employees have immunity from civil or criminal liability for actions or inactions done in good faith in performing their powers and duties prescribed under law.

Florida

Program summary. The Florida Health Choices program, created in 2008, is intended to provide a single, centralized exchange for purchase of health insurance and health services. These products include health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program must be made available both through printed material and an interactive Internet website. A participant needing personal assistance to select products and services must be referred to a participating agent in the person's geographical area.

The program is voluntary and is intended to be available to employers, individuals, vendors, and health insurance agents. Entities eligible to enroll in the program include: employers that have one to 50 employees; fiscally constrained counties, as defined in statute; municipalities having populations of fewer than 50,000 residents; and school districts in fiscally constrained counties. Individuals eligible to participate in the program include: individual employees of enrolled employers; state employees not eligible for state employee health benefits; state retirees; certain Medicaid participants; and rural hospitals.

Governance. The governing body for Florida Health Choices is Florida Health Choices, Inc. Florida health choices is a nonprofit corporation governed by a 15-member board of directors, composed of the following:

- The Secretary of Health Care Administration or a designee with expertise in health care services.

- The Secretary of Management Services or a designee with expertise in state employee benefits.

- The Commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

- Four members appointed by and serving at the pleasure of the Governor.

- Four members appointed by and serving at the pleasure of the President of the Senate.

- Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

The three department heads are nonvoting members. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate, or subsidiary of eligible vendors.

Members are appointed for terms of up to three years. Any member is eligible for reappointment. Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses. Board members have immunity from liability for any action taken by them in the performance of their powers and duties under this section.

Board powers and duties. The board is required to develop and adopt bylaws and other corporate procedures as necessary for the operation of the corporation. The bylaws must:

- Specify procedures for selection of officers and qualifications for reappointment.

- Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

- Specify policies and procedures regarding conflicts of interest, including provisions that would prohibit a member from participating in any decision that would result in a benefit to the member or the organization that employs the member. The policies and procedures shall also require public disclosure of an interest that prevents the member from participating in a decision on a particular matter.

The Board must select a chief executive officer for the corporation. The CEO is responsible for hiring staff as authorized by the corporation.

The corporation may exercise all powers granted to it under Florida's nonprofit corporation statutes that are necessary to carry out the purposes of the program, including the power to accept grants, loans, or advances of funds from any public or private agency and to accept other contributions for the program.

The corporation may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

The corporation must:

- Determine eligibility of employers, vendors, individuals, and agents to participate in the program.

- Establish procedures necessary for the operation of the program, including procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

- Arrange for collection of contributions from participating employers and individuals.

- Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

- Establish criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

- Develop and implement a plan for promoting public awareness of and participation in the program.

- Secure necessary staff and consultant services.

- Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.

- Develop a plan, in coordination with the Department of Revenue, to establish tax credits or refunds for employers that participate in the program.

- Report each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives, documenting the corporation's activities in compliance with its statutory responsibilities.

To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

PART IV: ISSUES RELATING TO ESTABLISHING A WISCONSIN HEALTH INSURANCE EXCHANGE

Initial questions. Although the federal PPACA requires states to establish or participate in an insurance exchange by 2014, PPACA does not provide extensive guidance to states in setting up its exchange, if it decides to do so. As discussed in Part I, the federal DHHS is currently soliciting comments from stakeholders in preparation for issuing guidance to states in establishing their exchanges.

The state OHCR has proceeded with a plan that anticipates that Wisconsin will operate its own exchange. As described in Part II, it has applied for grant funds and developed a project narrative that keeps a major planning function for exchange development within the Executive Branch.

This committee may wish to coordinate its activities with the OHCR's activities that are anticipated to take place if the exchange planning grant is approved.

However, if this committee proceeds with its own proposal for exchange development, this committee may wish to first consider the threshold questions posed by the federal legislation, as follows:

- Should Wisconsin establish a state exchange, or should it opt to have the federal government operate its exchange? The federal law provides that the federal government will operate a state's exchange if a state does not establish its exchange by 2014, or if that state elects for the federal government to operate its exchange.

- If Wisconsin operates an exchange, should it consider a multi-state, or interstate exchange? The federal law allows an exchange to operate in more than one state, if each state where the exchange will operate permits such operation, and the Secretary of DHHS approves the regional or interstate exchange.

- If Wisconsin operates an exchange, should there be regional or other types of sub-exchanges within the state? The federal law permits a state to establish or more subsidiary exchanges if each exchange serves a geographically distinct area, and the area served by each such exchange is at least as large as a rating area designated in the Public Health Service Act.

Governance structure options. If Wisconsin decides to operate its own exchange, the federal law requires the state to determine how the exchange will be administered. The federal law provides that an exchange shall be a governmental agency or a nonprofit entity that is established by a state. Examples of some eligible entities include:

- A state agency: An existing state agency such as DHS, OCI, or ETF could be designated to operate the exchange. Alternatively, a new state agency could be created to operate the exchange. OCI would offer expertise in commercial insurance but may lack experience operating insurance programs. DHS has experience operating publicly subsidized programs and conducting outreach, eligibility determinations, enrollment, plan contracting, and other functions but may not have expertise regarding commercial insurance. ETF could offer in-depth knowledge of commercial insurance and experience operating an insurance program but may not have expertise in the individual and small group markets. In addition, if an agency within the Executive Branch is selected to run the exchange, there is a possibility that the continuity of operations and the mission of the exchange may change if a new Governor is elected.

- A board attached for limited purposes to an existing state agency under s. 15.03, Stats.: A board attached to a department is a distinct unit of that department and exercises its powers, duties, and functions prescribed by law independently of the head of the department or independent agency. Budgeting, program coordination, and related management functions are performed under the direction and supervision of the head of the department. Examples

of such boards include the Board for People with Developmental Disabilities, attached to the Department of Administration and the Labor and Industry Review Commission, attached to the Department of Workforce Development.

Some of the issues to address when creating such a board include the number of members; which constituencies the membership will represent; who will appoint the members; whether the board director shall be inside or outside the classified service; what the roles and responsibilities of the board will be; what the budget for the board will be.

While this option would allow access to the state agency and its resources, it may face some of the same challenges existing state agencies would face.

- A quasi-public authority which would be independent of, but accountable to, state government: Authorities that have been established in Wisconsin are the Health Insurance Risk Sharing Plan (HIRSP) Authority; the Wisconsin Aerospace Authority; the Quality Home Care Authority; the Wisconsin Health and Educational Facilities Authority; the Bradley Center Sports and Entertainment Corporation; the University of Wisconsin Hospitals and Clinics Authority; the Wisconsin Housing and Economic Development Authority; the World Dairy Center Authority; the Fox River Navigational System Authority; and the Lower Fox River Remediation Authority. A quasi-public authority may allow the exchange to be more insulated from political influence and have more access to business expertise but may require additional start-up costs, encounter challenges in communicating with agencies and policy-makers.

Some of the issues that would need to be addressed when creating an authority include the same issues when establishing a board attached to an agency, including membership; representation; appointing authorities; and budgets. However, additional issues must be addressed, including the applicability of state laws relating to purchasing and contracting; open records and meetings; tax treatment of property and income; limitations on liability of board members and staff; and other operational issues.

- A private, non-profit corporation. This option may allow the governing body and its employees to focus their time and attention to the exchange. Like the quasi-public authority, it would be more insulated from political influence.

Some of the issues that would need to be addressed when designating a private, nonprofit corporation to operate the exchange would include designating certain requirements for the membership of the corporation's board of directors to ensure public accountability; ensuring that the corporation's articles of incorporation and bylaws specify the purpose of the exchange; and specifying the functions that the corporation would have to fulfill in operating the exchange.

A private, non-profit board may face the challenges that the quasi-public authority may face in regard to start-up costs, and communication with agencies and policy-makers.

Subsequent issues to consider. If the committee determines that the state will operate the exchange, and identifies the governance structure for operating exchange, and it then may proceed to

define the exchange's roles and responsibilities. Some of these subsequent implementation issues could include the following:

- What will be the powers and duties of the exchange governing body? How much of these powers and duties will be delineated in statute, and which will be left to board policymaking and rule-making?
- What will be role of various state agencies in interacting with the exchange?
- How will the exchange be staffed?
- What will be the level of transparency and accountability of the exchange governing body?
- What role will the exchange play? Will it operate as a market organizer, be a selective purchaser of plans, or something in between?
- Will separate exchanges be established for individuals and small employer group plans?
- How will an exchange certify qualified health plans?
- How many and what type of products will be offered through the exchange?
- What selection criteria will be used to select health plans?
- What risk-sharing model will be utilized and what level of risk adjustment will be necessary to ensure a fully functioning system?

These subsequent implementation issues may be explored in detail in additional memoranda to the committee.

LR:HJF:jal;ksm

Enclosures