



The Health Care Exchange Cookbook

Recipes for consumer advocates to build consumer-friendly health care exchanges at the state level



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The 2010 Affordable Care Act (ACA) mandated that states create health insurance exchanges. These marketplaces allow consumers and small businesses to choose from private health insurance plans that meet certain criteria. Consumers are also able to determine whether they qualify for Medicaid, the Children’s Health Insurance Program (CHIP), or tax credits for private insurance.

The ACA allows states to create boards to establish and govern these exchanges. If states do not set up their own exchanges, the federal government will manage them.^{i ii}

The characteristics of these exchanges at the state level will play a significant role in determining the quality of health care coverage for millions of consumers. What follows are recommendations that can be used by advocates to improve exchange governance and the quality and value of the products offered.

The following topics are covered in this report:

- Excluding insurance interests from boards
- Avoiding other conflicts of interest
- Active purchaser: consumer protection through negotiation
- Regulating excessive price hikes through rate reviews
- Keeping choices presented to consumers transparent
- Streamlining administration of health plans for consumers and businesses
- Spreading out governance fees among all insurers
- Avoiding adverse selection
- Language access vital to an equitable exchange
- States consider offering the Basic Health Option
- Public option still a viable choice for states

While this document focuses on state exchanges, an additional paper explains how advocates can use changes in the health care system as an opportunity to improve and reform health care offerings in each state.

Some of the policies proposed here can be adopted by the governing boards of the exchanges, but others must be enacted by legislatures to be effective. Where available, examples of legislative language from other states and laws are provided.

Excluding Insurance Interests from Boards

It is up to individual states to establish boards that will govern health care exchanges. The primary function of these boards involves buying insurance for consumers and small businesses. Persons representing consumer interests should control the governing structures of the exchanges. Boards dominated by insurance interests will prevent them from getting fair deals for consumers in terms of price and quality, and turn the exchanges into just one more way for insurance companies to profit.

States should not appoint to these boards representatives of insurance companies or others with a direct financial interest in board decisions (such as representatives of hospitals or pharmaceutical companies), with the exception of consumers. Here are some examples of legislation explicitly addressing conflicts of interest:

Washington: “No board member may be appointed if his or her participation in the decisions of the board could benefit his or her own financial interests or the financial interests of an entity he or she represents. A board member who develops such a conflict of interest shall resign or be removed from the board.”

Vermont: “No board member shall, during his or her term or terms on the board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the board; provided that for a health care practitioner, the employment restriction in this subdivision shall apply only to administrative or managerial employment or affiliation with a hospital or other health care facility [as defined in another section] and shall not be construed to limit generally the ability of the health care practitioner to practice his or her profession.”

Avoiding Other Conflicts of Interest

Even if boards are consumer-driven, there will be occasions when the various members of the boards will face conflicts that could lead to decisions that are not in the best interests of consumers and small businesses. States can avoid or lessen the impact of these conflicts by establishing the following policies:

1. **Full Disclosure.** Board members should divulge their financial interests to shed light on potential conflicts of interest. An example:

Maryland: “(1) A member of the board shall disclose to the board and to the public any relationship not addressed in the required financial disclosure that the member has with a carrier, insurance producer, third-party administrator, managed care organization or any entity in an industry involved in matters likely to come before the board.

(2) On all matters that come before the board, the member shall:

(I) Adhere strictly to the conflict of interest provisions under [other sections defining conflict of interest].”

2. **Recusal.** Prohibit board members from participating in any board decision in which they or a family member has a financial interest.

Vermont: “No board member shall participate in creating or applying any law, rule, or policy or in making any other determination if the board member, individually or as a fiduciary, or the board member’s spouse, parent, or child wherever residing or any other member of the board member’s family residing in his or her household has an economic interest in the matter before the board or has any more than a de minimus interest that could be substantially affected by the proceeding.”

3. **No Revolving Door.** For a determined period, bar board members from later being employed by an entity with a direct financial interest in board decisions. This policy should also apply to senior members of exchange staff.

Adaptation from another bill: **RESTRICTIONS ON EMPLOYMENT.** No board member, officer or employee of the exchange shall, within 2 years after his employment with the exchange has ceased, act as agent or attorney for or otherwise represent any other person, entity or organization in any formal or

informal appearance before the exchange with the intent to influence the decisions of the exchange or make any oral or written communication on behalf of any other person in connection with any proceeding, application, regulation or other determination involving a specific party or parties in which the exchange is a party or has a direct and substantial interest or which was actually pending under the person's official responsibility as a board member, officer or employee of the exchange, or accept employment or compensation, during the two-year period beginning on the date on which board membership or employment with the exchange has ceased, from any person that has a direct and substantial interest in any matter that was pending under the official responsibility of the board member or employee of the exchange or in which the board member or employee participated personally and substantially as an officer or employee of the exchange.

4. Apply Rules to the Navigator Program. Conflict of interest requirements should apply to entities participating in the navigator program, which involve entities that are appointed to help guide consumers through the exchanges,ⁱⁱⁱ established by the exchange.

Vermont: "Consistent with Section 1311(i)(4) of the Affordable Care Act, health insurers shall not serve as navigators, and no navigator shall receive any compensation from a health insurer in connection with enrolling individuals or employees in qualified health benefit plans."

5. Apply Rules to Senior Staff. Conflict of interest requirements should apply to senior exchange staff, in addition to exchange board members.

6. Regulate Third-Party Contracts. Contracts to operate part of the business of the exchange with third party administrators or insurers that have a financial interest in exchange business should be regulated to prevent conflicts of interest. This issue might arise, for example, in the case of a health insurance company hired to administer the exchange or where contracts are let with third party administrators who otherwise do business with insurance companies in other states or circumstances.

Active Purchaser: Consumer Protection through Negotiation

Exchanges should not just passively accept whatever products the insurance plans bring their way — they should actively negotiate the best deal possible for consumers before letting insurance companies get this business. Here are some examples:

California: "[The board shall] determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."

Vermont: “Prior to contracting with a health insurer to offer a qualified health benefit plan, the commissioner shall determine that making the plan available through the...health benefit exchange is in the best interest of individuals and qualified employers in this state. In determining the best interest, the commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state’s health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate.”

Regulating Excessive Price Hikes through Rate Reviews

In some states, government regulators routinely review the rates that insurance companies want to charge their customers and can deny rates deemed excessive or unfair. However, in a majority of states, the review of rates is weak or non-existent. The provisions of the ACA provide only limited review of rates when annual increases exceed 10 percent, and it provides no clear power to deny these rates if they appear unjustified. State laws can and should provide stronger rate review systems, which should be applied to proposed rates both within and outside the exchanges. Here are some examples:

Maryland: “To be certified as a qualified health plan, a health benefit plan shall ... obtain prior approval of premium rates and contract language from the commissioner.”

Vermont: “Submit a justification for any premium increase prior to implementation of the increase. The plans shall prominently post that information on their Internet Web sites. The board shall take this information, and the information and the recommendations provided to the board by the [Department of Insurance] under paragraph (1) of subdivision (b) of Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange. The board shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the [Department of Insurance].”

Some states add a public hearing to their rate review process — usually requiring hearings on premium increase requests that exceed a certain threshold. Such a provision can have a deterrent effect on rate increases in that the insurance companies, seeking to avoid a public hearing, will keep rate increase requests under the threshold. Here is an example:

Oregon: “The director may conduct a public meeting, in accordance with the provisions of ORS 192.610 to 192.690, on any filing with respect to an individual or small employer health benefit plan submitted under subsection (1) of this section.

(3)(a) The director shall conduct a public meeting, in accordance with the provisions of ORS 192.610 to 192.690, on any filing with respect to an individual or small employer health benefit plan submitted under subsection (1) of this section if:

(A) The filing proposes an average annual increase to the premium rates charged by the insurer of seven percent or greater; and

(B) The rate increase affects 1,000 or more policyholders.

(b) The purpose of a public meeting conducted under this subsection is to obtain additional information necessary for the director to determine if the proposed premium rates meet the requirements of ORS 743.018 (4) and that there are no grounds for disapproval under ORS 742.005. An actuary for the insurer or other representative of the insurer who is knowledgeable about the details of the filing must appear at the public meeting to answer questions.”

Keeping Choices Presented to Consumers Transparent

Even if there are strong rate review systems and the exchanges are active purchasers, consumers are going to have a lot of choices to make. The consumers should have as much information as possible when making their choices. Here is some appropriate language that fairly closely parallels the provisions of the ACA:

Vermont: *“(A) Make available to the public and submit to the board, the United States Secretary of Health and Human Services, and the [Insurance Commissioner], as applicable, accurate and timely disclosure of the following information:*

- (i) Claims payment policies and practices.*
- (ii) Periodic financial disclosures.*
- (iii) Data on enrollment.*
- (iv) Data on disenrollment.*
- (v) Data on the number of claims that are denied.*
- (vi) Data on rating practices.*
- (vii) Information on cost sharing and payments with respect to any out-of-network coverage.*
- (viii) Information on enrollee and participant rights under Title I of the federal act.*
- (ix) Other information as determined appropriate by the United States Secretary of Health and Human Services.*

(B) The information required under subparagraph (A) shall be provided in plain language, as defined in subparagraph (B) of paragraph (3) of subdivision (e) of Section 1311 of the federal act.”

Streamlining Administration of Health Plans for Consumers and Businesses

Administrative Burdens

One of the barriers that small businesses face in providing health care to their employees is the day-to-day costs and hassles of administering the plan. The same is true for individuals. The exchanges can ease this burden. Here is an example:

California: *“With respect to individual coverage made available in the Exchange, collect premiums and assist in the administration of subsidies. ... With respect to the SHOP Program, collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers.”*

Paperwork

Paperwork burdens imposed on consumers and small businesses should be limited to things absolutely necessary to administer the exchange, and added verification processes should be avoided. An example:

California: “The Exchange shall only collect information from individuals or designees of individuals necessary to administer the Exchange and consistent with the federal act.”

Spreading Out Governance Fees among All Insurers

Under the ACA, a state may impose fees to cover the cost of the operation of the exchanges. Unfortunately, in most states, governance fees are being assessed only on health carriers that participate in the exchanges. This policy effectively makes products inside the exchange more expensive than those outside. States have the power to require all health carriers selling products in any market to pay this fee, and it should be an objective of good governance to assess these fees on all of them.

Furthermore, the HHS rules provide that states may use “broad-based funding,” which may include general state revenues or provider taxes, among other funding mechanisms. Here is an example:

Maryland: “(A) ... The Exchange may:

(1) Impose user fees, licensing or other regulatory fees, or other assessments that do not exceed reasonable projections regarding the amount necessary to support the operations of the Exchange under this title; or

(2) Otherwise generate funding necessary to support its operations under this title.

(B) Any fees, assessments, or other funding mechanisms shall be imposed or implemented, to the maximum extent possible, in a manner that is transparent and broad-based.

(C) Before imposing or altering any fee or assessment established by law, the Exchange shall adopt regulations that specify:

(1) The persons subject to the fee or assessment;

(2) The amount of the fee or assessment; and

(3) The manner in which the fee or assessment will be collected.

(D) Funds collected through any fees, assessments, or other funding mechanisms:

(1) Shall be deposited in the Fund;

(2) Shall be used only for the purposes authorized under this title; and

(3) May not be used for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory actions.

(E) The exchange may not impose fees or assessments authorized under this section in a manner that would provide a competitive disadvantage to health benefit plans operating outside of the Exchange.”

Avoiding Adverse Selection

There is a policy concern that those who end up buying insurance through the exchanges will be statistically more likely to have medical costs than those who buy outside the exchanges. If this phenomenon, called “adverse selection,” occurs, the price of insurance will go up for those least likely to be able to afford it, subsidies available through exchanges will become more costly, and exchanges will attract fewer customers, thus diminishing its purchasing power. There are a number of provisions in various statutes designed to protect against this phenomenon:

Level the Playing Field

The intent here is to prevent insurance companies from “gaming” the system by providing different price and marketing practices when they sell products both inside and outside of the exchanges.

California: “Require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.”

Risk Adjustment

The ACA permits states to establish “risk adjustment” systems, which typically conduct annual reviews to determine if any insurance plans are attracting more “risky” customers than are proportionately being attracted by other comparable plans. In such an event, regulators can adjust premiums to level out costs and keep plans that are attracting more risk from failing. This is often very important to low-income consumers who may get trapped into a plan that fails.

New Jersey: “The board shall establish procedures necessary to avoid risk selection between qualified health benefits plans offered through the exchange and health benefits plans offered outside the exchange and among qualified health benefits plans offered within the exchange, including, but not limited to, such mechanisms as the board determines appropriate for adjusting payments to qualified health benefits plans to account for risk selection and assure market stability.”

Vermont: The board should study “whether it is necessary or advisable to implement a financial reserve requirement or reinsurance mechanism to reduce the state’s exposure to financial risk in the operation of [the exchange]; if so, how to accomplish such implementation; and the impact, if any, on the state’s bond rating.”

Community Rating

Some states have systems of sharing risk called “community rating.” These systems pool risk and prevent undue costs from falling on older or otherwise riskier populations. They

also protect small businesses that may have experienced unusual medical costs among their employees. The usual pools include all the customers of an insurance plan. A community rating of these pools, including consumers both inside and outside of the exchanges, will reduce the possibility of adverse selection inside the exchange.

Adapted from Washington law, which only requires a study: “The Insurance Commissioner shall by (a date) establish rules that merge the risk pools for rating the individual and small group markets in the exchange and the private health insurance markets.”

Language Access Vital to Equitable Health Care

Communicating with Consumers

About 20 million health care consumers in the U.S. speak English less than very well. These consumers will struggle to understand complicated insurance policies and communication with exchanges. Wherever appropriate, linguistically sensitive communication should be required. Here are some examples:

California: “Require, as a condition of participation in the Exchange, carriers to ... undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.”

New Jersey: “Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the exchange, and undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as persons with disabilities and those with limited English language proficiency.”

Vermont: “[Navigators shall] provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the ... health benefit exchange.”

California: “Ensure that the Exchange provides oral interpretation services in any language for individuals seeking coverage through the Exchange and makes available a toll-free telephone number for the hearing and speech impaired. The board shall ensure that written information made available by the Exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages.”

Similar standards should be applied to telephone hotlines and web portals that provide information about exchanges and access to insurance.

Interpretation in the Medical Setting

In addition to communication with the exchange and insurance companies, those with limited English proficiency will experience difficulty communicating with physicians and other health professionals. Many will be deterred from even approaching health care providers, knowing that their language will not be understood. While federal standards, through the Culturally and Linguistically Appropriate Services policy, require interpretation in medical settings for those who receive federal health funding, there is no requirement regarding the rest of the health care system. A requirement to provide interpretation in the medical setting should be established.

Imposing this cost only on exchange products would have the effect of driving up costs for products inside the exchange and make their prices less attractive than products outside of the exchange. California has a system requiring insurers to provide interpretation in medical settings. In other states, where such requirements do not exist, legislative language should establish this requirement for all products sold in the state. An example:

California: The State Department of [Medicaid/SCHIP] shall adopt regulations to ensure that all enrollees have access to language assistance and culturally competent health care services and the State Insurance Commissioner shall promulgate regulations applicable to health insurers that require that the insured have access to translated materials, language assistance in medical settings, and culturally competent health care services.

An alternative would be to require that the exchange provide this service, that the fees assessed for the operation of the exchange be sufficient to pay for the services, and that the fees be imposed both inside and outside of the exchange.

States Consider Offering the Basic Health Option

The ACA give states the option to offer special “Basic Health” insurance plans to low- to moderate-income consumers. The plans must, at a minimum, include essential health benefits.^{iv}

Under the ACA, affordability credits are available for those whose incomes range from 133 percent to 400 percent of the Federal Poverty Level (FPL). (Those below the 133 percent threshold are eligible for Medicaid.) States may choose to exercise a Basic Health option for those whose incomes fall between 133 percent and 200 percent FPL.

If a state exercises this option, it will receive 95 percent of the dollars projected to go to this group as subsidies, and will be charged with negotiating a health care program for those in this eligibility category. Those individuals who then become eligible for this new program will not buy their health insurance through the exchange.

To date, no state has exercised this option, but many of them are studying it. These studies should be encouraged and the results carefully assessed.

Some possible advantages of states adopting this option:

- Better benefits and less cost;
- Greater ease of access, especially for immigrant populations;
- Easier movement from Medicaid to subsidies as income changes;
- Reduced risk, which should reduce the price of exchange products.

Some risks:

- Enrolling consumers in a Basic Health Plan could reduce membership in the exchange, which may lessen its purchasing power;
- State negotiation of benefits and costs may not be aggressive enough.

Sample language from a proposal currently under debate:

Washington: “The Legislature finds that the federal Basic Health option under section 1331 of the patient protection and affordable care act of 2010 offers a promising way to provide affordable, quality health coverage to the residents of Washington State... . However, there is still a need for additional information to ensure that the option can be operationalized successfully. The state’s continued planning for implementation of the Affordable Care Act shall include the federal Basic Health Option. Implementation of the option shall proceed unless it is determined by credible, objective, unchallenged findings of an independent, nationally-recognized consultant that provider rates would not be sufficient to guarantee network adequacy, considering options for innovative payment models; or that reducing premiums below Exchange levels would not be feasible within the allocated funds. If such findings have been made but have been challenged, an evaluation of the feasibility of the BHO shall be made on or before June 30, 2012 by the Governor, and a decision made whether to continue to pursue a federal Basic Health program.”

Public Option Is Still a Viable Choice for States

While the public option was not included in the ACA, nothing prevents a state from developing a public option of its own. The option, which was hotly debated leading up to the passage of the ACA, would compete with private insurance options and help drive down the growing cost of the entire health care system. A public option benefits from lower administrative costs than private insurance, does not amass profit or excess accumulations of capital, avoids bureaucracies designed to deny claims and avoid risk, and does not offer lucrative executive pay. A couple of states have worked on establishing a public option. Here is language used in one bill:

Vermont: “§ 1821. PURPOSE

The purpose of Green Mountain Care is to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless and equitable manner regardless of income, assets, health status, or availability of other health coverage. Green Mountain Care shall contain costs by:

- (1) providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits;*
- (2) establishing innovative payment mechanisms to health care professionals, such as global payments;*

- (3) encouraging the management of health services through the Blueprint for Health; and*
- (4) reducing unnecessary administrative expenditures.*

§ 1822. IMPLEMENTATION; WAIVER

(a) Green Mountain Care shall be implemented 90 days following the last to occur of:

(1) Receipt of a waiver under Section 1332 of the Affordable Care Act

pursuant to subsection (b) of this section.

(2) Enactment of a law establishing the financing for Green Mountain Care.

(3) Approval by the Green Mountain Care board of the initial Green Mountain Care benefit package pursuant to 18 V.S.A. § 9375.

(4) Enactment of the appropriations for the initial Green Mountain Care benefit package proposed by the Green Mountain Care board pursuant to 18 V.S.A. § 9375.

(5) A determination by the Green Mountain Care Board that each of the following conditions will be met:

(A) Each Vermont resident covered by Green Mountain Care will receive benefits with an actuarial value of 80 percent or greater.

(B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy.

(C) The financing for Green Mountain Care is sustainable.

(D) Administrative expenses will be reduced.

(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending.

(F) Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.

(b) As soon as allowed under federal law, the secretary of administration shall seek a waiver to allow the state to suspend operation of the Vermont health benefit exchange and to enable Vermont to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing subsidies, and small business tax credits provided in the Affordable Care Act. The secretary may seek a waiver from other provisions of the Affordable Care Act as necessary to ensure the operation of Green Mountain Care.”

Another approach to a public option from a bill under consideration:

Washington: *“If the commissioner finds the consumers in the exchange do not have an adequate choice of health plan options among the actuarial value tiers specified in section 1302 of P.L. 111-148 in the exchange, the commissioner in consultation with the exchange board, may authorize the offering of a public plan and pursue the opportunity for a waiver under section 1332 of P.L. 111-148 of 2010, as amended.”*

Here is an example of another approach:

Connecticut: “(1) Notwithstanding the provisions of title 38a of the general statutes, the Comptroller shall offer coverage under the state employee plan to nonstate public employers, municipal-related employers, small employers and nonprofit employers and their respective retirees, if applicable, in accordance with subdivision (2) of this subsection, provided the Comptroller receives an application from any such employer and the application is approved in accordance with sections 3 and 4 of this act.

(2) The Comptroller shall offer coverage under the state employee plan to: (A) Nonstate public employers beginning July 1, 2011; (B) municipal-related employers and nonprofit employers beginning July 1, 2012; and (C) small employers beginning July 1, 2012.

(b) (1) The Comptroller shall offer participation in such plan to nonstate public employers, municipal-related employers, small employers and nonprofit employers for not less than two-year intervals. An employer may apply for renewal prior to the expiration of each interval.

(2) The Comptroller shall develop procedures by which:

(A) Such employers may apply to participate in the state plan, including procedures for nonstate public employers that are currently self-insured and procedures for nonstate public employers that are currently fully-insured; and

(B) Employers receiving coverage for their employees pursuant to the state plan may (i) apply for renewal, or (ii) withdraw from such coverage, including, but not limited to, the terms and conditions under which such employers may withdraw prior to the expiration of the interval and the procedure by which any premium payments such employers may be entitled to shall be refunded. Any such procedures shall provide that nonstate public employees covered by collective bargaining shall withdraw from such coverage in accordance with chapters 113 and 166 of the general statutes.

(c) (1) The initial open enrollment for nonstate public employers shall be for coverage beginning July 1, 2011. Thereafter, open enrollment for nonstate public employers shall be for coverage periods beginning July first.

(2) Open enrollment for municipal-related employers, small employers and nonprofit employers shall be for coverage periods beginning January first and July first.

Conclusion: Much at Stake at State Level

The passage of the ACA was a landmark moment for the health care reform movement. However, much remains at stake, and the battleground for fair, equitable implementation of this new sweeping policy largely lies at the state level. It will be up to advocates in each of the states to ensure consumer interests are served as these exchanges are established and governed.

Endnotes

ⁱ “Affordable Insurance Exchanges,” HealthCare.gov, accessed Feb. 15, 2012, viewed at: <http://www.healthcare.gov/law/features/choices/exchanges/>.

ⁱⁱ “A Health Care Marketplace to Help You Find Insurance,” HealthCare.gov, accessed Feb. 15, 2012, viewed at: <http://www.healthcare.gov/blog/2011/08/exchanges08122011a.html>.

ⁱⁱⁱ <http://www.healthreformgps.org/resources/state-health-insurance-exchange-navigators/>

^{iv} “The Basic Health Option: Considerations for States Implementing Federal Health Reform,” National Health Law Program, Dec. 6, 2010, viewable at: <http://www.familiesusa.org/conference/health-action-2011/speaker-materials/NHELP-Paper-Basic-Health-Option.pdf>, p. 1.