Lieberthal, Robert, Sikirica, Slaven, Farquhar, Marybeth, Saheba, Lisa, Legnini, 2013, "Examples of How Health Insurance Exchanges Can Create Greater Value for Consumers: Lessons from Three Other Marketplaces" *Health Management, Policy and Innovation*, 1 (4): 49-60

Examples of How Health Insurance Exchanges Can Create Greater Value for Consumers: Lessons from Three Other Marketplaces

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Acknowledgement: Funding for this research was provided through a grant from URAC. The Novartis/Jefferson School of Population Health Health Economics and Outcomes Research Fellowship supported Mr. Sikirica's effort. All funds were paid to the Jefferson School of Population Health.

Abstract

Health insurance exchanges or HIXs (otherwise known as "marketplaces") have characteristics and strategic options similar to those of organized marketplaces for other goods and services. By examining how other markets provide greater value for consumers we can anticipate certain choices that HIXs can make to provide higher-value insurance plans to buyers, as well as certain pitfalls they should avoid. The most important choice might be whether to function only as a clearinghouse for all qualified health plans (QHPs) that want to sell through the exchange, or to adopt an 'active purchaser' model that limits the choices available through the exchange. Since all offered plans must be accredited, the role of designated accrediting agencies will expand not only as 'gatekeepers' but also with regard to providing feedback for HIX operations and policy making as well as consumer information to aid in plan choice. We use specific examples of states to illustrate the choices available to HIXs. These choices will ultimately drive the success of HIXs, which we define in terms of enrollment and quality of care.

1 Introduction

The 2010 Patient Protection and Affordable Care Act (ACA) will provide access to health insurance for millions of consumers through federal or state health insurance exchanges (HIXs). The U.S. Department of Health & Human Services (HHS) guidance to states on creating these exchanges defines the HIX as "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" (U.S. Department of Health & Human Services (HHS) 2013). HIXs will be sources of subsidies for low-income buyers, markets with a quality 'floor' (that is, offering only Qualified Health Plans or QHPs) and sources of information to make individuals better-informed consumers. They also will be a place for those who are self-employed or in the individual insured market to purchase insurance —not everyone in the HIX will be using a subsidy. In some states, they will be the sole source of insurance for small businesses and individuals.

Supporters of the ACA hope HIXs will increase value for consumers of health insurance and medical care by lowering cost and increasing quality. Michael Porter has defined value in healthcare as "...the health outcomes achieved per dollar spent." (Porter 2010). High value insurance maximizes health outcomes while minimizing financial burdens, balancing trade-offs between these two objectives.

2 Objectives of This Paper

Our two main objectives are to determine how HIXs can deliver value to consumers and what role accreditation will play in that process. To do this we examine the experiences of other, similar marketplaces; what lessons can we draw from their successes or failures? This paper identifies specific strategies, taken from several marketplace models, which would allow HIXs to offer and promote higher value QHPs. We focus on the role of accreditation in certifying QHPs and offer relevant examples from three existing types of marketplaces: financial exchanges; a state-run public employees' exchange (CalPERS); and actuarial monitoring of existing health plans. We then discuss how strategies to deliver value in health insurance depend on the willingness of HIX management to consider active purchasing strategies and to manage their interaction with suppliers and competitors to maximize the value of insurance for consumers.

3 Background

3.1 Institutional features of HIX

The HIX is a marketplace designed for the uninsured and others in need of higher quality health insurance. The intent of the ACA was to allow states to tailor their marketplace design to the needs of their population and existing insurance marketplace. There currently are three types

of HIXs—state-based, federally facilitated, and "partnership" exchanges where states will take a limited role. Many states chose to "default" to the federally facilitated HIX model. As a result of continued regulatory guidance and exploration by different states, there is now a continuum of options for states, from a fully state run exchange, to a fully federally facilitated exchange. States with federally facilitated HIXs also can choose to take responsibility for certain roles such as plan management, consumer assistance, outreach, and education functions (Dash, Monahan, and Lucia 2013).

Those states that choose to take full responsibility for running and managing their HIX can be further distinguished based on how they choose to select and monitor plans that are allowed onto the exchange. In a state-based exchange, the main choice that states have is whether to run an "active purchaser" vs. "clearinghouse" exchange. The experiences of two states with existing, pre-ACA health insurance exchanges, Massachusetts and Utah, provide examples of this important distinction in strategies to deliver value to marketplace customers. Massachusetts pioneered the 'active purchaser' approach wherein states "choose(s) to have the exchange contract with selected health plans and/or negotiate premium prices with health plans (active purchaser)." (Kaiser Family Foundation 2013). The exchange assures quality and value for plans offered by approved insurers (Jost 2010). In Utah, the health insurance exchange employed a 'clearinghouse' model. Clearinghouse exchanges "...have the exchange contract with all qualified health plans", will not limit the number of firms, and will allow as many QHPs into the market as desire entry (Kaiser Family Foundation 2013a). There is a continuum of strategic choices for state-based HIXs under the ACA between the existing Massachusetts and Utah models; HIXs may be more active than clearinghouse exchanges without being as selective as a fully 'active' purchaser.

3.2 Accreditation

Federal rules set common standards and practices for QHPs offered by any HIX (Federal Register 2012a), including mandatory accreditation of the QHP issuer (Goodell and Robert Wood Johnson Foundation 2013). Additionally, HHS and state-based exchanges are required under the law to establish performance ratings of health plans (Federal Register 2012b). Existing models for rating health plans include the "five star" ratings of health plans such as those available for Medicare Advantage plans (available at http://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/five-star-enrollment/5-star-enrollment-period.html) and HMO and PPO report cards offered by the California Office of the Patient Advocate (available at http://reportcard.opa.ca.gov/rc2013/). California's HIX's (Covered California™) plan to use existing ratings to help consumers choose between health plans was dropped due to concerns that the data are not current and will not reflect QHPs that will be offered through the HIX (Terhune 2013).

Mandatory accreditation is a critical component for ensuring the quality of QHPs and will apply consistently across all HIXs (Federal Register 2012a). Accrediting bodies can play a key role in implementing performance measurement, setting standards, and providing information to consumers as well as to federal and state policymakers (URAC 2013). In 2012 the Secretary of

HHS formally approved URAC (formerly the Utilization Review Accreditation Commission) and NCQA (the National Committee for Quality Assurance) as accrediting entities for QHP issuers. While URAC and NCQA currently are designated, additional accrediting bodies may apply to be recognized by HHS (NAIC Health Insurance and Managed Care (B) Committee 2012). It remains to be seen how HIXs, HHS, and other policymakers will evaluate accrediting bodies' performance.

3.3 Quality reporting systems

Under the ACA, the Secretary of Health and Human Services (HHS) will develop and administer a quality rating system and enrollee satisfaction survey system. Additionally, HHS must develop a methodology for calculating the value and quality of health plans participating on the HIX. HHS must promulgate the new quality and enrollee satisfaction survey ranking methodology by 2016, for use in all HIX, both state and federally run. The subsequent quality and enrollee satisfaction survey rankings will be displayed on all HIX websites so that consumers have a clear and consistent view of QHP performance (Federal Register 2012b). This information will be accessible to consumers shopping for a health plan and will provide them with a platform to assess and evaluate health plans based on quality and enrollee satisfaction.

While no mandatory quality reporting requirements are in effect until 2016, many states plan to display quality measures and ratings prior to the release of the federal regulations. In July 2013, *The Commonwealth Fund* reported nine states plan to display quality data and ten states will display quality ratings by 2014. States that elect to display quality data will require QHP issuers to report on selected measures. States may opt to develop a measure set, implement quality measures endorsed by the National Quality Forum (NQF), or use measures currently required for their state's quality reporting. In states requiring display of quality ratings, QHP issuers are required to display state selected quality ratings or ratings from previous years (Dash, Lucia, Keith, and Monahan 2013).

3.4 Value in health insurance

The ACA categorizes QHPs through 'medal levels' of actuarial value: bronze, silver, gold, and platinum plans carry different cost sharing burdens for subscribers (catastrophic plans also will be offered to certain individuals under age 30). Under the ACA, silver plans are the basis for the premium affordability test that determines the amount of subsidy consumers are entitled to. Bronze plans have lower upfront premiums and higher out-of-pocket costs, while gold plans have higher upfront premiums and lower out-of pocket-costs. Platinum plans have the highest premiums, and the lowest burden in terms of out-of-pocket costs (Kaiser Family Foundation 2011). These levels are only financial measures, however—two plans in the same medal category could provide different levels of value. Nonfinancial aspects of value are difficult for HIXs to identify and communicate to their members. If one 'silver' plan is more valuable than another is because it delivers higher quality care for the same amount of money, then that distinction will not be easy for HIXs to identify or advertise to members.

It is important to distinguish the role HIXs can play in providing *affordable* insurance from the role they can play in providing *high value* insurance. To the extent that HIXs facilitate the availability of subsidies so that premiums and out-of-pocket costs are lower, consumers will value exchanges as pass-through vehicles for the subsidy and sources of more affordable coverage. Affordability will contribute to the success of HIX to a certain extent, since one major goal for HIX is coverage expansion, meaning getting previously uninsured individuals health insurance. HIXs can provide additional value through strategies for: selecting which QHPs they offer; providing consumers with information to assist in plan choice; and monitoring plan performance. Ensuring that there is a competitive, affordable market for health insurance and that plans offer high quality care are two ways to promote high value health insurance. HIXs that can do both will enhance the efficiency of health insurance delivery.

HIXs' unique position in the market gives them access to enormous bargaining power. Currently, the small group and non-group health insurance markets (target populations for the exchanges) do not have the scale of the large employer market. In a 'managed competition' model, HIXs could use their power to benefit consumers by "(overcoming) attempts by insurers to avoid price competition." (Enthoven 1993) The goal would be to have existing uninsured consumers, as well as those currently served by non-group and small group markets, find similar or superior choices on HIXs when compared to their current alternatives.

4 Lessons from other exchange models

We looked at other markets in order to identify strategies that would result in higher consumer value in health insurance under the HIX model. Our selection of strategies was guided by an assessment of the evolution of exchange models in other industries. We also considered choices that HIXs and state policymakers have to make: whether the HIX will act as an active purchaser versus a clearinghouse; and whether it will pursue a state-based, partnership, or federally facilitated status. Ultimately, we chose three markets to look at relevant strategies: financial exchanges, an existing, state-run public employees' exchange (the California Public Employees Retirement System—CalPERS), and the actuarial monitoring of health plans.

4.1 Financial exchanges

Two important aspects of financial exchanges are that they offer highly standardized products and a central point to facilitate transactions. A standardized product, e.g., stocks for sale on an exchange, implies that one share of a particular stock is no different from another share of the same stock. A centralized point to facilitate transactions means that financial exchange members, or 'brokers', sell to the end user, the consumer, via a formalized physical or electronic transaction system (Hasan, Malkamäki, and Schmiedel 2003). Centralization could result in lower costs to consumers, but financial exchanges also could strategically select their membership or transaction system in order to generate higher profits (known as 'economic rents') that would be unobtainable under perfect competition (Pirrong 1999). In other words, a stock exchange could restrict the number of stocks it offers in order to profit from high listing

fees from companies that wish to be on the exchange, instead of being run to maximize returns for consumers. This is one danger that HIXs must guard against.

4.2 Active purchaser exchanges

We focused on CalPERS as an active purchaser to identify strategies that could potentially affect all QHPs on an exchange rather than single out individual QHPs. Active purchasing orients the entire marketplace towards value for the consumer. Under active purchasing, health plan benefit packages often are standardized. In this model, the purchaser dictates plan design to insurers rather than selecting from plan designs chosen by the insurer. Insurers are asked to bid on providing a pre-determined level of coverage, submitting prices to cover the purchaser's standard benefit packages (Carlson 2001). CalPERS first pursued this strategy by mandating a standard benefit package for all contracting HMOs in the 1990s (Robinson 1995). The exchange's actions allow for potentially greater value, both through the reductions in financial costs and in the improved comparability of plans, which allows consumers to make easier comparisons to select the plan that suits them best. As with financial exchanges, restricting choices is one cost of standardization, and could limit value if the limited range of plan designs is not selected carefully. Thus, active purchasing also places a greater burden on the marketplace to select plan designs that work for consumers.

California was the first state to create a health benefit exchange following the passage of the ACA. In the tradition of that state's health care marketplace for the last several decades, its HIX follows an active purchaser model and might be expected, because of its size and legacy, to be the most prominent example of that approach. As stated on the California exchange's website, Covered California™'s mission is to increase health insurance coverage, improve the quality health care, reduce costs, and ensure fair and equal access to quality health care—not simply to establish a clearinghouse for insurance plans (Covered California 2013a). Thus, as an active purchaser, Covered California™ defines success in terms of how many consumers purchase insurance through the HIX and whether the choices they make are as good as, or superior to, alternative choices available both on and off the exchange. It does not define success in terms of having plans be tailored specifically to the demands of individual consumers.

4.3 Actuarial models for monitoring performance

Active purchasers will need new strategies for continuous monitoring of plan performance. We found a close analogue to ways that HIXs and accrediting bodies could monitor health plan performance in actuarial practice. To ensure the financial performance of health insurance products, actuaries use a process called the 'Actuarial Control Cycle' for continuous monitoring of a health insurance policy (Bluhm 2007). This system is a 'life cycle' analysis to assess and improve health plan performance because illnesses and episodes of care do not fit neatly into 12-month periods. Actuaries also have a set of models and techniques that they use for forecasting and managing the populations in their plan, called "managing antiselection." (Bluhm 2007). In other words, actuaries try to forecast who will be attracted to a particular health plan, developing tools to limit plan membership to specific populations, and managing changes

in premiums and benefit designs in order to ensure a stable population for a given health plan policy. Successful plans deliver financial performance (profits) over an annual period for a health plan, as well as for a longer period representing the lifetime of a health plan policy. Insurers can also more quickly identify unsuccessful plans, and alter or stop offering those plans in order to ensure financial performance of the entire organization.

5 Lessons for HIXs

5.1 HIXs will succeed if their benefits exceed their costs

Exchanges that have survived and thrived have done so by offering a valuable service to buyers and sellers. For example, stock exchanges (e.g., NYSE, NASDAQ) do not offer their own financial products directly to consumers, but they do serve as real or virtual meeting places where buyers and sellers of stocks can meet, subject to certain rules. Stock exchanges and other financial exchanges must offer a valuable service; otherwise, buyers and sellers would trade stocks directly ("over-the-counter" or OTC) without paying the cost of an intermediary (Kroszner 1999). Stock exchanges are also constantly adjusting their strategies in order to respond to competitors, keep their existing customers happy, and to grow their customer base. In a somewhat different example, CalPERS has demonstrated cost reductions by employing an active purchasing strategy. These cost reductions have had to exceed the additional cost of implementing the active purchasing model because the alternative—smaller, clearinghouse purchasers—would be cheaper to implement.

5.2 Organized marketplaces restrict supplier and consumer choice in order to provide other benefits to buyers and sellers

Like other organized markets, HIXs will restrict choice for consumers and suppliers in order to create a market. However—successful marketplaces must provide advantages for consumers that outweigh their restrictions on choice. Managers of marketplaces decide who can sell what types of products within their boundaries, and how and when consumers can make purchases. In the case of CalPERS, the marketplace actively chooses a small set of plan designs, and does not provide its members (consumers) access to additional plan designs. The consumer benefit in terms of more comprehensible choices (and enhanced purchasing power) has to exceed the loss of choice in order for the intermediary to be successful.

One lesson for HIXs is that influencing how insurers sell, and consumers buy, insurance can provide as much value, or more, than simply keeping prices low. It is important to note that, because of the variety of exchanges, there will be fewer than fifty data points for any given HIX model. For example, the Kaiser Family Foundation notes that there are currently seventeen state-based, seven partnership, and twenty-seven federally facilitated exchanges. Of the seventeen state-based exchanges, six intend to be active purchasers, nine intend to be clearinghouses, and two have "not yet addressed" this choice (Kaiser Family Foundation 2013b). As a result, lessons learned will need to be derived from the success of individual health plans, as well as the quality

measures that they collect, in order to gather sufficient data to make credible conclusions about the features of HIX that succeed.

5.3 Markets must be carefully designed to avoid benefiting intermediaries or suppliers at the consumers' expense

CalPERS's purchasing strategy was designed primarily to benefit the consumer. However, CalPERS also recognized the importance of maintaining the goodwill of suppliers, because they had to ensure a minimum level of supplier participation—they were only the intermediary, so they needed suppliers to provide health plans. HIXs will face similar strategic challenges, and should consider the types of consumer protections they want to implement. HIXs also should consider how accrediting bodies should function as outside consumer advocates on the exchange. The need to benefit consumers rather than suppliers is a principal motivation for the use of quality metrics. In an exchange that is focused solely on financial outcomes, the incentive for insurers would be to deliver low quality care, or utilize inadequately "narrow" provider networks, in order to maximize profits.

5.4 Successful marketplaces consider and respond to competitors, suppliers, and consumers

Successful HIXs will need to demonstrate why consumers and insurers are better off participating in the exchange than opting out. Consumers will have alternatives, including other sources of insurance or deciding to remain uninsured. Insurers will have other markets for their products. While scale could make HIXs attractive to insurers, exchanges also will have to ensure that insurers earn an adequate return to make participation worthwhile. For example, Aetna, a large health insurance company, will not offer plans through the Maryland HIX due to concerns about premiums being too low to cover costs, nor will it offer plans through the Georgia or California HIXs (Dance 2013). HIXs will have to consider the tradeoff between giving insurers enough flexibility to assure their participation, while still achieving the goal of high value insurance for consumers.

6 Factors determining the success of HIX

6.1 Enrollment as a measure of success

Successful HIXs will be those that can attract, and retain, a large proportion of the eligible population over time, including many currently uninsured individuals. Thus, HIXs will want to understand who in a state is eligible for HIX coverage. Attracting individuals through

plan pricing, design, and network construction will be key to success. Other issues, such as marketing, outreach, and other "soft" aspects of implementation also will be important aspects of success that are less technical in nature but no less actuarial[1]. For example, "...Covered California™ will be working with a number of different partner groups to help with these educational efforts." (Covered California 2013a). The consumer orientation of this active purchaser model is Covered California's *raison d'être*. Covered California's website explains to consumers that, "The advantage of purchasing insurance from Covered California is that you can easily compare different plans. For the first time ever, you can make 'apples-to-apples' comparisons across different health plans, thanks to new standard benefits that were designed to work for consumers—not for insurance companies." (Covered California 2013b) Premium variation in Covered California is now proving to be quite low, in part because of the choice to standardize benefits in this way (Ario, Block, and Spatz 2013).

6.2 Choices for exchanges will mean opportunity and challenges for accrediting bodies

A national quality strategy from HHS will open the doors for health care quality improvement, transparency, and informed decision making for consumers. To advance performance measurement in the United States, it is important HHS builds off its recommendations from current and previous national efforts put forth by consensus organizations, such as the National Quality Forum. Furthermore, standardization of measuring quality will provide a systematic data collection methodology that, in turn, can allow for accurate and precise state-to-state comparisons. HHS' guidance on quality data and ratings in 2016 will be imperative to providing a standardized snapshot across populations (e.g., Medicaid, commercial) on quality of health care delivered in the United States.

Accreditation is not the final stamp of approval for QHPs but it is an important element in allowing plans onto an exchange. Those managing HIXs will have many choices to make their local market function efficiently, and those choices will differ by locale. Accrediting bodies will have to choose how to measure plans and report performance, and which measurement and reporting strategies facilitate the choices faced by each HIX. Accrediting bodies could take on a key consultative role for HIXs and policymakers, especially given their unique national experience. That would give them an important part to play in developing HIXs that promote value in health insurance.

[1] We thank an anonymous referee for clarifying this point.

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