



IU Center for Health Policy Proposal for a “Hoosier Health Insurance Exchange”

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Department of Public Health, IU School of Medicine
Indiana University–Purdue University Indianapolis (IUPUI)
410 W. 10th Street, Suite 3100
Indianapolis, Indiana 46202



INDIANA UNIVERSITY

CENTER FOR HEALTH POLICY

Department of Public Health



The Center for Health Policy

The mission of the Center for Health Policy is to collaborate with state and local government and public and private healthcare organizations in policy and program development, program evaluation, and applied research on critical health policy-related issues. Faculty and staff aspire to serve as a bridge between academic health researchers and government, healthcare organizations, and community leaders. The Center for Health Policy has established working partnerships through a variety of projects with government and foundation support.

This proposal was prepared as a public service for the State of Indiana to promote discussion on various options regarding the future of state-level health reform in Indiana. The views expressed are those of the authors and do not necessarily reflect the positions of Indiana University and the Center's partner organizations or funders. Please direct all correspondence and questions to Eric R. Wright, PhD, Director, Center for Health Policy, Department of Public Health, Indiana University School of Medicine, 410 W 10th Street, HS3119, Indianapolis, IN 46202; Email: ewright@iupui.edu; Phone: (317)274-3161.



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Authors

Eric R. Wright, PhD, Director, Center for Health Policy; Professor and Division Director for Health Policy and Management, Department of Public Health, IU School of Medicine; Co-Director, Consortium for Health Policy, Law and Bioethics, Indiana University - Purdue University Indianapolis (IUPUI)

Michael Cook

Ann Marie Judson-Patrick

The federal Patient Protection and Affordable Care Act (PPACA) requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and small employers. This proposal provides recommendations to initiate the creation of the Exchange with an emphasis on improving the general health of Hoosiers and encouraging personal and social responsibility for individuals' health. This proposal also recommends establishment of the Hoosier Health Commission, which will manage both the Exchange and Indiana's overall healthcare system.

What type of Exchange: State, Federal, or Regional?

One of the most important and earliest decisions Indiana must make with regard to healthcare reform is the decision to either establish its own health insurance Exchange or allow the federal government to establish and operate the Exchange for the state. California, which is the only state thus far that has taken legislative action on its insurance Exchange following PPACA's passage has pursued the creation of its own Exchange. There are strong reasons why Indiana would also wish to create its own Exchange, including the following:

- A state-created Exchange would give Indiana the ability to regulate the insurance policies offered within the Exchange.
- Indiana would have control over risk selection rules for the market inside the Exchange and the market outside the Exchange.
- Indiana would use the state-created Exchange to promote alternative goals, including improvement of the state population's health.

- It would allow greater coordination of benefits and eligibility rules across health programs, including Hoosier Healthwise, Healthy Indiana Plan, and policies sold through the Exchange.

While there are positives to a state-created Exchange, there are also potential drawbacks to be considered:

- Funding the creation of the Exchange may pose a financial challenge; the state is already facing budget constraints due to the recent economic downturn.
- Indiana only has until January 2013 to present a detailed proposal for a state-based Exchange.
- Once the state-based Exchange has been implemented, it must have a steady revenue stream by January 2015. No additional federal funding will be made available after this date.¹

In addition to creating its own Exchange, Indiana may also elect to collaborate with surrounding states to create a regional Exchange. A regional Exchange might improve administrative efficiency, streamline processes for enrollment and customer service, allow for a regional website, and generate lower premium rates for those seeking coverage within the Exchange.¹ A regional Exchange would also substantially increase the risk pool for enrollees thereby reducing the potential for adverse selection within the Exchange.

There are several issues to be considered before pursuing a regional Exchange:

- Surrounding states may have differences in consumer protections and insurance regulations. Before a regional Exchange is created, the participating states would need to standardize consumer protections and insurance regulations to prevent unfair advantages in the market.



- Surrounding states must have state governments that are willing to collaborate to pursue the most effective regional Exchange.
- States sharing a regional Exchange must also be mindful of the population health and overall insurance markets of the participating states.

Governance and Management

Indiana must decide who will govern the Exchange and how it will be managed. The main examples Indiana can use as models are Massachusetts, Utah, and California.

Massachusetts established a quasi-independent state agency called the Massachusetts Health Connector to administer its Exchange, and it is governed by the Board of the Commonwealth Health Insurance Connector Authority (the Board) and chaired by the Secretary of Administration and Finance.

- The Board contains 11 members: Secretary of Administration and Finance (chairperson), Director of Medicaid, Commissioner of Insurance, Director of the Group Insurance Commission, three members appointed by the Governor (one member must be in good standing of the American Academy of Actuaries, one must be a health economist, and one must represent small businesses), three members appointed by the State Attorney General (one must be an employee health benefits plan specialist, one must represent a health consumer organization, and one must represent organized labor), and an Executive Director.
- These members serve three-year terms. None can be a licensed insurance carrier authorized to do business in the Commonwealth.²

Recommendation 1:

Indiana should pursue a state-based Exchange (Hoosier Health Insurance Exchange) by 2014. However, considering the potential strengths of the regional model, Indiana should establish a goal of forming a regional Exchange by 2020. A federally-based Exchange model should be avoided because it would not allow Indiana to address the state's unique needs.

California is also creating an independent state agency to administer the California Health Benefit Exchange. However, California has taken a different approach in determining the Board of Directors and the size of the Board:

- Its Board contains five members: Two appointed by the Governor, one from the Senate Committee on Rules, one from the Speaker of the General Assembly, and the Secretary of California's Health and Human Services.
- Board members must be "experts" in two of the following fields: Individual healthcare coverage, small employer healthcare coverage, health benefits plan administration, health finance, administering a public or private health delivery system, or purchasing plan coverage.
- The Director of the Department of Managed Care and the Insurance Commissioner are given roles with the Secretary of HHS, but they are not mandated positions on the Board of Directors.

In contrast, Utah has chosen a much smaller structure for its current Exchange. Currently, the Utah Health Insurance Exchange operates with two employees and is located within the Governor's Office of Economic Development instead of working as an independent state



Recommendation 2:

Indiana should establish a new quasi-independent state agency.

2.a. This new agency should be governed and managed by a newly created agency, the Hoosier Health Commission.

2.b. The Hoosier Health Commission should consist of 15 members with specialized knowledge of Indiana's health insurance and health policy issues. Members should include:

- Indiana Insurance Commissioner
- Secretary of Family and Social Services Administration
- One health economist or health policy expert with knowledge about the health insurance industry
- Three representatives of organized labor as well as small and large business
- Three representatives from the healthcare delivery system, including hospitals, physicians, nurses or other allied healthcare providers
- Three healthcare consumers and/or leaders of major healthcare consumer advocacy organizations
- Three representatives from Indiana's health insurance industry

2.c. Members of the Hoosier Health Commission should be appointed by the Governor with the consent of the Indiana State Legislature's Health Finance Commission.

2.d. The Hoosier Health Commission should be given permanent staff led by an Executive Director to fulfill the administrative work necessary to manage the Hoosier Health Insurance Exchange.

agency.³ However, Utah's system may change over the course of the next several years because the Exchange was created prior to PPACA's passage.

Using an existing state agency for Indiana's Exchange is problematic because most of Indiana's state agencies are not equipped to handle the numerous responsibilities of the Exchange. Utah's decision to use its Office of Economic Development weakens its authority because the agency is not designed to "administer premium subsidies, process eligibility for lower-income individuals, administer requests for exemptions from the individual mandate, or pursue other provisions of the healthcare reform law."¹

Recommendation 3:

The Hoosier Health Insurance Exchange and its Hoosier Health Commission should have a broad scope of oversight authority. In addition to the regulation of the Hoosier Health Insurance Exchange, the Commission should work to increase the efficiency and effectiveness of Indiana's healthcare system and to improve the overall health status of Hoosiers.



ISSUES AND RECOMMENDATIONS FOR IMMEDIATE AND LONG-TERM ACTION BY THE HOOSIER HEALTH COMMISSION

To achieve these broad goals, the Hoosier Health Commission should consider the following issues pertaining to Indiana's Exchange and healthcare system:

Who enters the risk pools, and how many pools/Exchanges should the state have?

The Commission has several risk issues it must address when implementing the Hoosier Health Insurance Exchange. The PPACA mandates the creation of not only an Exchange for the individual insurance market but also a Small Business Health Option Plan, or SHOP, Exchange. The Commission can choose to keep these Exchanges separate or combine them.

Massachusetts has combined the individual and small business insurance markets into one risk pool. Meanwhile, Utah operates one risk pool, which is limited to small group policies. Finally, California has decided to keep a separate SHOP Exchange, but the state has the option to combine the individual Exchange and individual risk pool by December 2018.

Administratively, it would be better for Indiana to operate (or outsource to a nonprofit) one Exchange instead of two separate Exchanges. Combining the individual pool and small business pool of enrollees should decrease premiums for small businesses since small business enrollees would enjoy higher economies of scale (more members, lower premiums). However, the Commission will need to analyze Massachusetts's experience merging the two markets before making a decision.

Massachusetts' Risk Pool Merger

In 2006, an actuarial consulting firm for Massachusetts estimated the impact of

merging the two risk pools. The firm estimated that non-group (individual) premiums would decrease by 2% to 50% depending upon carrier, while small group (small business) premium rates would increase anywhere from 1% to 4%.⁴ From 2007 to 2008, premiums for small businesses in Massachusetts grew by 5.8%.⁵ However, Massachusetts has not updated premium trends since 2008, so evaluating long-term gains from combining the pools is unknown. It appears that individual policy holders are benefiting financially from the larger risk pool at the expense of small businesses.

Subsidies

Subsidies are another factor to consider. Keeping the risk pools separate may be important because subsidies are only available for those without employer coverage within the individual market. Consequently, the two groups could be combined under one Exchange, with Indiana retaining the option of separating the pools to ensure subsidies are allocated appropriately.

Small Business Size

Another question the Commission will encounter is the size qualification for a "small business." After 2016, the PPACA requires all businesses with fewer than 100 employees to be considered "small." Until 2016, however, states may define a "small business" as one with fewer than 50 employees or one with fewer than 100 employees. Since the federal reform defines small business as having 100 employees or less in 2016, it would be in the best interest of Indiana to allow businesses with fewer than 100 employees to utilize the Exchange immediately to avoid access issues after the Exchange's launch.



Large Businesses

An additional question pertains to large businesses utilization of the Exchange. The federal legislation allows states to open Exchanges to businesses with more than 100 employees after 2017 however it is unclear if states can allow large businesses to access the health Exchanges prior to that date. California has chosen not to address this question in their recent legislation.

The Application Process and Connection with Public Programs

The PPACA provides easier enrollment into health insurance coverage by mandating states create a “coordinated, simple, and technology-supported process by which individuals may obtain coverage through Medicaid, CHIP [Children’s Health Insurance Program], and the new Exchanges.”⁶ Specific requirements include: web portals for comparing information about health insurance policy options; a single application form across programs; “no wrong door” for coverage (people are correctly screened and enrolled in the appropriate program regardless of where they start); income rules using Modified Gross Income; and the usage of electronic data exchange.⁶

The integrated system should allow a person to complete a short application either online, in person, or by phone. The information is verified and screened to determine eligibility for government assistance programs, in addition to qualifying for the Exchange. After the initial enrollment and verification, the individual is notified of eligibility for programs and enrolled in the appropriate program.

Recommendation 4:

The Hoosier Health Commission should combine the small business and individual Exchanges into one. The risk pools, however, should be separated until 2018. This will allow the Commission to know how many small businesses and individuals will participate in the Hoosier Health Insurance Exchange.

Recommendation 5:

During the initial year of operation, the Hoosier Health Commission should consider broadening the definition of a small business to include all firms with fewer than 100 employees. In 2018, the Commission should consider the possibility of opening the Exchange to businesses with larger numbers of workers.

Eligibility Systems

The Commission must prepare to implement an eligibility system that can be integrated with all forms of health insurance. One option is to consider how a federally created Exchange handles eligibility and adopt that process for the Hoosier Health Insurance Exchange. However, this option hinders Indiana’s ability to adopt an eligibility system unique to Hoosier needs.

Indiana currently uses the Indiana Client Eligibility System (ICES) to determine eligibility for Hoosier Healthwise and Medicaid. In August 2010, a letter written by the Secretary of the Family and Social Services Administration (FSSA), Anne Murphy, and Insurance Commissioner Stephen Robertson



indicated that Indiana is currently evaluating possible vendors to assist in the implementation of a new eligibility system. However, the new eligibility system will not be operational until 2015.⁷

Premium Billing and Collection

The Commission must decide whether or not to empower the Exchange to control the premium billing and collection process. The Hoosier Health Insurance Exchange will already have a number of federally-mandated responsibilities, but assuming the role of the billing agency may put some employers at ease:

- Mandating individual carriers to bill and collect premiums may be very costly considering the number of subsidized individuals the carriers will monitor.
- Depending upon the establishment of the small business Exchange (along with the number of participating carriers), business owners may need to pay multiple insurance carriers to insure their employees, which could add to administrative costs.
- More administrative hassles would occur for employers who have mid-year changes to employment demographics. Without a central billing entity, employers may be forced to spend time and resources communicating with multiple insurance carriers.

Navigators

The reform emphasizes the importance of “navigators,” or organizations/people that help consumers and small businesses understand their insurance options, in addition to educating the public about the Exchange. Navigators could be nonprofit organizations, insurance brokers, or any other group that the Commission identifies to adequately educate the

Recommendation 6:

The Hoosier Health Commission should use this opportunity to improve the state’s overall eligibility and application system. The Commission’s goal would be to simplify and streamline the application process for government programs as well as for coverage through the Hoosier Health Insurance Exchange. This improvement should enable one completed form to identify the correct insurance coverage and government assistance (if applicable) for applicants.

Recommendation 7:

While not an immediate necessity, the Hoosier Health Commission should decide by 2018 whether or not to allow the Hoosier Health Insurance Exchange to become the sole premium biller and collector for participating insurance carriers.

Recommendation 8:

The Hoosier Health Commission should utilize any willing organization (with the exception of insurance companies) that has the capacity to advertise the features of the Hoosier Health Insurance Exchange to fulfill the role of navigators.

general public. Currently, Oregon is recommending using insurance brokers to help individuals purchase coverage in their Exchange.⁸ The Commission could encourage Hoosier insurance brokers to become experts in the Exchange, as well as establish guidelines for reimbursement. However, other organizations may fulfill that role as well.



The key for successful navigators will be to disseminate enrollment and subsidy information about the Exchange in a fair and impartial manner to a range of consumers and businesses. Navigators will need to design a “multi-pronged outreach, education, and enrollment campaign” that could include “school-based advocacy organizations, private employers, business groups, hospitals, community health centers, physicians, paid media, and public service announcements.”¹

Funding

Federal grants will be available through 2014 to support the planning, establishment, and initial operations of the Hoosier Health Insurance Exchange. However, federal grants are not renewable after December 31, 2014 (one year after the Exchange is operating). Therefore, the Exchange will need to be self-financed by 2015. Similar to the payment model for insurance brokers (paid from policymaker's premiums), the Exchange could generate operating revenues by retaining a portion of the insurance premiums or through direct payments from the participating carriers.

The financing required to operate the Exchange will depend on a number of factors, including, but not limited to:

- The ability of the Exchange to leverage existing infrastructure for its operations;
- The manner by which eligibility for premium subsidies will be processed;
- The need to establish interfaces between the Exchange and health insurers for functions such as rate development, transfer of enrollment information, and eligibility for premium subsidies;
- Whether the Exchange will handle premium billing, collection, and reconciliation;
- The extent of outreach and marketing undertaken by the Exchange;
- The development and maintenance of a website capable of providing decision-support tools used by consumers to evaluate their health insurance options;
- Whether brokers will be paid from Exchange revenues or by the carriers;
- The amount of consumer support that will be provided by the Exchange; and
- The level and type of reporting required by the federal government.

These and other issues, along with the number of people expected to be served by the Exchange, will determine the revenues required to support the Exchange operations. Tension between keeping administrative fees low and providing consumers with high-quality service will arise. To achieve economies of scale and minimize per-member cost, the Exchange will likely need to spend money to attract and retain consumers by offering value-added services. Achieving a balance between these two competing – although not mutually exclusive – factors will be an ongoing challenge faced by the Commission.

Options for funding the creation and establishment of the Hoosier Health Insurance Exchange and the Hoosier Health Commission include: 1) securing a working capital loan through the State and creating a Health Trust Fund, similar to California; 2) leveraging federal money to initiate the Exchange; 3) generating new funds by imposing fees on insurance companies that participate in the Exchange; and 4) increasing taxes.

Option 1: Capital Loan and Health Trust Fund

This option provides a working capital loan of up to \$5,000,000 for the creation and establishment of the Hoosier Health Insurance Exchange (but only if federal money is shown to be insufficient for its creation).

Option 2: Federal Sources

Securing federal funds to initiate the Exchange may be a strong option for policymakers in the beginning, but it is unlikely that federal funds will be able to support the Exchange long-term. The most immediate source of additional



funding involves leveraging federal dollars available for establishing Exchanges and soliciting other federal sources. Three areas that might offer funding: 1) current Medicaid enrollees who were eligible for, but not enrolled in, additional federal programs; 2) school programs that were eligible for Medicaid support (and matching federal dollars) but had not applied for such support; and 3) welfare programs that were similarly eligible for Medicaid support but had not applied for support. Barriers to obtaining funding from these sources include the administrative burden, such as lack of a grant writer, and lack of knowledge.

Option 3: Exchange Charges and Fees

The Commission may assess a charge on qualified plans that is “reasonable and necessary to support the development, operations, and prudent cash management of the Exchange.”⁹

Option 4: Increase taxes (e.g., property; sales, including “sin taxes”; income; corporate income and payroll).

After evaluating different tax bases, the Commission should consider the impact on economic competitiveness, the distribution of the burden, and the complexity of administering such taxes. In contrast to the other fundraising strategies, taxation can readily support public health and other community-

Recommendation 9:

The Hoosier Health Commission should fund the Hoosier Health Insurance Exchange, while improving Hoosiers’ health, by increasing taxes on tobacco products, sugar beverages, and alcohol. The tax increases should be supplemented by a tax assessment on participating insurance providers.

based initiatives. While a single tax base would reduce complexity, other considerations support drawing upon multiple sources. Possible options, with select examples of implementation, include:

- *Property tax (e.g., used within Marion county to support the health safety net);*
- *Sales tax (e.g., the “sin tax” on sugar beverages, fast food, and processed foods);*
- *Income tax (e.g., contributions to general revenues support Medicaid);*
- *Payroll tax (e.g., used to finance Medicare);*
- *Corporate tax (e.g., as proposed for the Illinois Covered Program;¹⁰*
- *Tax on providers (e.g., a tax on private specialty hospitals’ revenue of 3.5%, as adopted in New Jersey.¹¹*



The Selection of Participating Plans

The Commission must also determine how many insurance plans will be allowed to operate within the Exchange. For consideration, Massachusetts and Utah provide two dominant yet vastly different models for the selection and pricing of health insurance policies available on the Exchange.

In 2006, Massachusetts created the Connector, which has become the basis for national healthcare reform. The Connector functions as an active purchaser of health insurance, which allows it to negotiate pricing and benefit packages that can be offered to consumers. In this capacity, the Connector can guarantee consumers the lowest possible price on policies while being selective on which plans get into the Exchange. An active purchaser model may work if the Hoosier Health Insurance Exchange can secure the majority of the individual and small group insurance market. Consequently, insurance providers would be more likely to bargain for higher value and lower premiums.¹²

An alternative to the active purchaser model is the market organizer, or clearinghouse model, such as that employed by the Utah Health Exchange. Rather than selective contracting with insurance providers and bargaining for lower premiums, the Exchange acts as a clearinghouse, which allows any insurance company that meets the minimum defined benefit package to sell a policy within the Exchange.¹³ This allows competition among different policies, rather than selective intervention by the Exchange, lowering prices and keeping insurers competitive.

Deciding which model to use will depend upon several key issues:

- The number of insurance providers within the state – The Hoosier Health

Exchange's success depends upon the participation of insurance providers. If the insurance market is controlled by a select few providers, there will be little bargaining power to encourage an insurance provider to provide benefits beyond the federally-mandated minimal benefits package. Unless preventative action is taken, the insurance companies may decline the Exchange altogether and provide coverage outside the market.

Conversely, a market with many smaller insurance companies may diminish over time as small insurers consolidate to provide coverage at the mandated minimum level.

- The consumers within the Exchange – Another factor contributing to the success of the Hoosier Health Insurance Exchange is the number of enrollees that participate. A smaller risk pool that fails to capture most of the individual or small group market will provide less incentive for insurance providers to enter the Exchange in a clearinghouse model. Under the active purchaser model insurance companies will not want to become one of the selectively bargained providers without a vibrant risk pool.
- The overall goal of the Exchange – The competing goals of cost containment or consumer choice impact the participation model. A market organizer model that allows all insurance companies meeting a minimum threshold to enter the Exchange would give consumers the maximum amount of choice for coverage. However, too many insurance options may become burdensome for consumers and stop consumers from shopping around for the best option. Instead, an active purchaser model would allow the state to select a limited number of companies to provide coverage and raise competition for the lowest premiums. Consumers would sacrifice choice for heightened competition among providers.



The Market Outside of the Exchange

When designing the Hoosier Health Insurance Exchange, the Commission will need to remember that a market for insurance still exists outside of the Exchange. A major problem could arise if Indiana is not consistent with its consumer protections and restrictions for the market inside and outside the Exchange. A less restrictive outside market could lead to adverse selection if individuals and small businesses desiring cheaper or less comprehensive coverage go to the outside market and leave the sicker, or less protected groups, within the Exchange. Another issue to consider is young individuals seeking catastrophic coverage. If insurance companies were allowed to sell low-cost catastrophic coverage outside of the Exchange, healthier individuals would stay out of the Exchange and force sicker individuals to bear more of the risk within the Exchange. This adverse selection could lead to high premiums for Exchange participants, and it might also lead to a collapse of the Exchange model.

Recommendation 10:

The Hoosier Health Commission should selectively contract with the highest valued insurance policies within the Hoosier Health Insurance Exchange. Additionally, the Commission should construct a ranking system for participating carriers to indicate higher quality plans.

Recommendation 11:

For both the Hoosier Health Insurance Exchange and the outside insurance market to work together, the Hoosier Health Commission must apply state insurance regulations to both the Exchange and the outside insurance market. This includes requiring catastrophic insurance policies to be sold within the Hoosier Health Insurance Exchange.



**CONCLUDING
THOUGHTS**

Indiana has an opportunity to transform both its healthcare system and its population's health. The Hoosier Health Insurance Exchange will be a powerful tool that can control costs, increase access to care, and improve its overall insurance market. Additionally, the Hoosier Health Commission will provide direction as it

implements changes to strengthen Indiana's overall healthcare system. While it will require time and sacrifice to be effective, we believe the Hoosier Health Commission and the Hoosier Health Insurance Exchange will become a national role model for future health policy decisions.

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