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Plan Management: Issues for State, Partnership and Federally Facilitated Health Insurance Exchanges

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Glossary of Abbreviations

ACA	Patient Protection and Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
COA	Certificate of Authority
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
DFS	Department of Financial Services
DOH	Department of Health
DOI	Department of Insurance
FFE	Federally facilitated exchange
HHS	U.S. Department of Health and Human Services
HEDIS®	Health Effectiveness Data and Information Set
HMO	Health Maintenance Organization
MCC	Managed Care Company
MCO	Managed Care Organization
MAO	Medicare Advantage Organization
NASI	National Academy of Social Insurance
NAIC	National Association of Insurance Commissioners
NOIA	Notice of Intent to Apply
PPO	Preferred Provider Organizations
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
SERFF	System for Electronic Rate and Form Filing
UTPA	Unfair Trade Practices Act

Executive Summary

Health insurance exchanges as established under the Patient Protection and Affordable Care Act (ACA) must engage in five core functions: determine eligibility for federal subsidies or public coverage, enroll consumers and employees into qualified health coverage (or connect eligible individuals with Medicaid and CHIP), conduct plan management, provide consumer assistance, and perform financial management. This paper focuses on just one of these core functions: the series of oversight activities that federal officials have called “plan management.”

States face three choices: establish their own exchange and exercise control over plan management functions, allow the federal government to establish a federally facilitated exchange (FFE) but enter into a partnership arrangement to perform plan management, or cede all plan management functions to the FFE. With the latter two approaches, the state will essentially turn over to the federal government some of its traditional authority to regulate its private health insurance markets. However, through a partnership arrangement, state regulators can recapture that authority and oversight.

The U.S. Department of Health and Human Services (HHS) has defined plan management to encompass a broad range of functions, including certifying qualified health plans (QHPs), collecting and reviewing rate and benefit information, managing contracts with QHPs, monitoring ongoing compliance issues, recertifying and decertifying QHPs, and running an open enrollment process. Certifying QHPs involves reviewing plans’ adherence to a set of criteria related to provider networks, marketing practices, quality, and transparency. In addition, to protect exchanges from adverse selection, states will need to conduct ongoing market analysis of the products and prices carriers offer inside and outside the exchange.

In order to better understand the capacity for plan management in the states, we review their current regulation of plans in their commercial marketplaces and Medicaid programs. To help inform our review, we evaluate the regulatory structure in six states: Arizona, Minnesota, New York, Tennessee, Washington, and Wisconsin. In addition, because the Centers for Medicare and Medicaid Services (CMS) may be responsible for

plan management for some FFEs, we assess CMS’ experience running Medicare Advantage, a federal program providing Medicare beneficiaries with private health plan choices. This paper is not, however, a comprehensive evaluation of all the plan management functions defined by HHS. Instead, we focus on a subset of plan management activities most closely analogous to what state and federal regulators are currently doing: granting licenses and ensuring solvency, assessing network adequacy, reviewing rates and policy forms, regulating marketing practices, improving plan quality, and conducting ongoing oversight.

Based on our findings, we conclude that exchanges’ plan management responsibilities represent a considerable expansion of states’ oversight of insurers. The law requires oversight that in some cases expands on what states currently do and in other cases represents a wholly new activity. However, to fulfill their responsibilities, state exchanges can leverage the authority and skills of multiple state agencies, including departments of insurance, departments of health, and Medicaid agencies.

In addition, the entity ultimately responsible for plan management, whether at the state or federal level, will need to balance the ACA’s requirements for greater front-end review of carriers and plans with the need to develop a management process that supports and sustains an adequate mix of quality carriers to serve consumers in the exchange. This will be particularly true for the small business exchange (SHOP), in which there are limited incentives for health plans to participate. For the individual market exchange, the incentives to participate are stronger and plans will be less deterred by a robust review and approval process.

Key Findings

- **Confirming licensure and solvency.** QHPs must be state-licensed and “in good standing” with state departments of insurance (DOI). While the status of insurers’ licenses is public information, exchanges, including FFEs, will either need the cooperation of the DOI to determine whether an insurer is subject to any enforcement actions by the state or require insurers to attest to their good standing.
- **Network adequacy.** While some states have network adequacy requirements for commercial insurers, many

do not. And those that do have standards generally apply them only to health maintenance organizations (HMOs). Medicaid and Medicare Advantage plans must submit to up front scrutiny on network adequacy, as well as ongoing oversight. Where a state does not currently have a network adequacy standard for commercial health plans, the exchange could rely on a general standard HHS has prescribed through regulation, or they could import some or all of the standards used for Medicaid plans. For a FFE run by CMS, the agency could require carriers to attest to network adequacy, rely on the state DOI to certify compliance, or leverage the standards and process used in Medicare Advantage.

- **Benefit and rate review.** The ACA includes sweeping insurance reforms that affect all new individual and small group plans, not just exchange plans. Most DOIs have experience reviewing health insurance policies to assess whether they include a required set of benefits, but they generally do not have experience reviewing benefit packages for actuarial equivalence against a benchmark, or determining whether a particular benefit design discriminates against higher risk individuals. They also do not currently assess plans' actuarial value. Many states will need to build this capacity in order to meet ACA requirements. While CMS has much of this kind of experience in Medicare Advantage, to perform this activity for FFEs it would have to expand capacity, rely on attestations from insurers, or obtain cooperation from state DOIs.
- **Marketing regulation.** Of the six states we reviewed, none have a comprehensive prior assessment and approval process for commercial plans' marketing materials before they are used. Conversely, state Medicaid agencies must conduct prior approval of all marketing materials and activities, while CMS requires Medicare Advantage plans to file all marketing materials with the agency and conducts extensive post-market surveillance to ensure plans are not using improper sales techniques. State exchanges will need to coordinate with their DOI to determine a common marketing standard for QHPs, and decide the process by which they will review materials for certification. CMS, in operating a FFE, will need to establish an appropriate marketing standard and process for reviewing materials, but will need to be cognizant of each state's regulatory environment.
- **Quality improvement.** Very few states have imposed

quality improvement, care coordination, or performance reporting requirements on private health insurance plans, although some have imposed quality-related obligations on HMOs. Expectations for plans' efforts to improve quality are far more entrenched in Medicaid and Medicare Advantage. As a result, state exchanges will likely find their Medicaid agency to be a source of expertise, while CMS can look to Medicare Advantage for experience setting quality standards, collecting and evaluating quality data, and rating plan performance.

- **Ongoing oversight.** State exchanges will likely want to rely on their DOI for at least some ongoing oversight of QHPs. Most DOIs have a built-in infrastructure – consumer complaint hotlines and databases, an ability to identify and analyze trends, and staff to conduct market conduct exams, all of which an exchange could leverage in order to meet its oversight obligations. However, DOIs may be understaffed and underfunded, and the exchange may need to help finance a QHP oversight program. CMS, in operating a FFE, will want to rely on DOIs as well, particularly for information relating to consumer complaints about QHPs and the results of any market conduct exams of carriers offering QHPs. However, if the state is unwilling or unable to assist CMS in its oversight responsibilities, the agency will need to build the necessary capacity.

The above activities represent only a portion of the plan management responsibilities for exchanges. However, exchange officials do not need to build a plan management infrastructure from scratch. Within the state, whether at the DOI, department of health (DOH), or Medicaid agency, there likely resides an existing infrastructure for communicating with insurers, setting state standards for consumer protection, and collecting and evaluating data to perform oversight.

While CMS, in its operation of plan management for FFEs, has an existing infrastructure it can draw upon, there are dramatic differences in the regulatory approach taken by the agency and that of state insurance regulators working with private health insurers. CMS will likely want to rely on state regulators to help the FFE engage directly with insurers, share information and data about insurers' status within a state and, at a minimum, perform their conventional state role of oversight and consumer assistance to ensure that all insurers, whether inside or outside an exchange, are meeting consumers' needs.

Introduction

Health insurance exchanges are often called the lynchpin of the Patient Protection and Affordable Care Act's (ACA) provisions to expand access to quality, affordable coverage.¹ As the gateways for people to find and purchase federally subsidized commercial coverage, exchanges must engage in five core functions: determine eligibility for federal subsidies or public coverage, enroll consumers and employees into qualified health coverage (or connect eligible individuals with Medicaid and the Children's Health Insurance Program (CHIP)), conduct plan management, provide consumer assistance, and perform financial management. This paper focuses on just one of those core areas – the series of oversight functions that federal regulators refer to as “plan management.”² This concept encompasses a wide range of activities, such as setting standards for plan participation in the exchange; communicating those standards to insurance carriers; reviewing data from the insurance carriers to assess adherence to the relevant standards and plans' eligibility for the exchanges; determining plans' continued compliance with exchange standards; and conducting market analysis of prices and products inside and outside the exchanges, in order to recognize and respond to potential adverse selection.

An exchange's development and execution of a plan management strategy will depend on a number of factors, not the least of which is whether the exchange is run by the state or run by the federal government through a federally facilitated exchange (FFE). Under an FFE arrangement, states can choose to have the U.S. Department of Health and Human Services (HHS) operate plan management for the FFE, or the state can perform the plan management functions under a partnership arrangement.³ States thus have three options regarding plan management: establish and run their own exchange and exercise control over plan management functions, allow the federal government to establish an FFE but enter into a partnership agreement to perform plan management, or cede all plan management functions to the FFE.

With the latter two approaches the state will essentially cede to the federal government some of its traditional authority to regulate its private health insurance markets.

Whichever approach is chosen will have significant consequences for the relationship between the state and federal government. With the latter two approaches, the state will essentially cede to the federal government some of its traditional authority to regulate its private health insurance markets.⁴ However, through a partnership arrangement, state regulators can recapture that authority and oversight. Whichever option a state chooses, there will need to be a minimum level of coordination between state and federal regulators. And for states that choose to take on the plan management responsibilities themselves, there will also need to be an unprecedented amount of coordination among state agencies, including the exchange, the department of insurance (DOI), and, in some cases, the state Medicaid agency or a separate department responsible for regulating closed network plans like health maintenance organizations (HMOs).

This paper evaluates the plan management functions for exchanges, as prescribed by the ACA, and reviews current systems of plan management at the state and federal levels. It builds on an earlier report for the National Academy of Social Insurance (NASI) by Deborah Bachrach and Patti Boozang, which evaluated the full range of exchange functions under FFE and partnership arrangements.⁵

In order to better understand the capacity for plan management in the states, we first introduce the new requirements ushered in under the ACA and review how states currently regulate plans in their commercial marketplaces and in their Medicaid programs. We then evaluate what existing skills and resources exchanges can use to perform plan management activities, and discuss where capacity may need to be built or expanded. This analysis focuses on how the exchange plan management functions can be supported by states' existing regulatory infrastructure, as well as areas in which states may need to build capacity to perform the necessary oversight. Because it is likely that a significant number of states will not partner with the federal government on plan management, we also identify how plan management could be shaped by the Centers for Medicare and Medicaid Services' (CMS) experience in managing plans in Medicare Part C (the Medicare Advantage program) and the implications of having CMS conduct what traditionally has been the role of state regulators.⁶

To help inform our review, we have examined private insurance regulation and interviewed insurance regulators

in six states: Arizona, Minnesota, New York, Tennessee, Washington, and Wisconsin. These states were chosen for two primary reasons. First, we were able to benefit from Bachrach and colleagues’ extensive review of Medicaid managed care contracts in each of these states and her

report analyzing their oversight of Medicaid plans.⁷ Second, these states take diverse approaches to their regulatory oversight of commercial carriers, allowing us to gain a better understanding of the wide range of authority and tools available to state insurance regulators.

Exchange Plan Management: “Not Your Grandma’s Rate Review”⁸

HHS’ guidance to states has defined plan management as encompassing a broad range of functions, including certifying QHPs, collecting and reviewing rate and benefit information, managing contracts with QHPs, monitoring ongoing compliance issues, recertifying and decertifying QHPs, and running an open enrollment process.⁹ In addition, to protect exchanges from adverse

selection, states will need to conduct ongoing market analysis of the products and prices carriers offer inside and outside of the exchange (see Exhibit 1).

Many of the activities listed in Exhibit 1 relate to the exchange’s determination of whether a particular insurer meets all of the requirements for participation.

Exhibit 1: Plan Management Activities for Health Insurance Exchanges

Plan Management Activity	Description
Confirm state licensure and solvency	The exchange must confirm that QHPs are licensed and “in good standing” in the state in which they are offering coverage.
Certify QHPs	The exchange must certify that QHPs meet a minimum set of criteria related to provider network, marketing practices, quality, and transparency.
Review justifications of rate increases	The exchange must review QHPs’ justifications for rate increases before any rate increases are implemented. The exchange must also take into consideration any recommendations from its state DOI regarding such rate increases, and take the information into account before approving a QHP for participation.
Manage a selective contracting process (where applicable)	The exchange must ensure that each QHP’s participation is “in the interests of” consumers and small businesses. Some may engage in a selective contracting process in order to meet that goal.
Monitor premium growth in and outside of the exchange	The exchange must track and assess premium growth among participating and non-participating plans.
Review rating and benefits	The exchange must ensure that QHPs are complying with the ACA’s rating restrictions and requirements for the value and scope of benefits (often referred to as the “precious metal” tiers and essential health benefits package).
Assign plan ratings	The exchange must assign QHPs a rating based on price and quality, according to a rating methodology devised by HHS. The exchange will need to post that rating on its web portal. ¹⁰
Recertify QHPs	The exchange must have a process in place for renewing QHPs that wish to continue participating.
Monitor QHPs	In addition to an annual or multi-year recertification process, the exchange must engage in ongoing oversight of QHPs to ensure ongoing compliance with exchange requirements.
Decertify QHPs	The exchange will have the authority to decertify a QHP that is no longer meeting exchange standards. HHS has also clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification.
Manage an appeals process for QHPs	The exchange will need to manage an appeals process for decertified QHPs.
Promote transparency	QHPs must report a wide range of data to the exchange, including financial disclosures, enrollment and disenrollment figures, and number of denied claims. The exchange must provide consumers with a web portal that enables comparisons based on plans’ benefits and cost-sharing, performance on consumer satisfaction surveys, medical loss ratio, and provider networks.

Sources: Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (hereinafter “ACA”) §§ 1302(b), 1311(d), (e); 45 CFR §§ 155.1000, 155.1020, 155.205, 155.1075, 155.1010, 155.1080, 155.1040, 156.220.

Others focus on the ongoing oversight and consumer protection that exchanges must provide to ensure that plans, once initially certified, continue to serve the interests of enrollees. For purposes of this report, we focus primarily on those activities most closely aligned with what regulators do today to determine whether insurers and their products are compliant with state and federal standards. Specifically, we evaluate the following functions, as performed by DOIs, state Medicaid agencies or Departments of Health, and CMS, for Medicare Advantage plans:

- Licensing and solvency
- Network adequacy
- Benefit and rate review
- Marketing
- Quality improvement
- Ongoing oversight

HHS, in its final rule on the establishment of exchanges, recognizes that states have experience in performing such functions and gives states flexibility to draw on existing

Exhibit 2: Minimum Certification Requirements for QHPs

Certification Standard	Description
State licensed	QHPs must be licensed and “in good standing” in each state in which they’re offering coverage. This means the insurer cannot be subject to any outstanding sanctions from the state’s DOI.
Accredited	QHPs must be accredited with respect to local performance on clinical quality measures such as HEDIS®, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by a third party accrediting entity, as designated by the Secretary. QHPs that are not accredited at the time of certification must become accredited within a timeframe established by the exchange.
Adequate network	QHPs must provide enrollees with a sufficient choice of providers and make their provider directory available to consumers. QHPs must further ensure services are available without “unreasonable delay.”
Access to essential community providers	QHPs must include within their network community providers that serve predominantly low-income, medically underserved individuals.
Fair marketing practices	QHPs must meet marketing requirements, as determined by the exchange. They cannot employ marketing practices or benefit designs that effectively discourage enrollment by individuals with significant health care needs.
Quality improvement strategy	QHPs must implement a quality improvement strategy that uses provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety and implement wellness programs.
Report on rates and benefits	QHPs must submit rate and benefit information to the exchange, and provide a justification for a rate increase prior to the implementation of the increase. The justification must also be posted prominently on the QHP’s website.
Data reporting	QHPs must report to HHS, exchanges, state DOIs, and the public data on: <ul style="list-style-type: none"> • Claims payment policies and practices; • Financial disclosures; • Enrollment and disenrollment; • Number of denied claims; • Rating practices; • Cost-sharing and payments for any out-of-network coverage; • New enrollee rights under the ACA; and • Cost-sharing information for a particular item or service, upon the request of an enrollee.
Offer minimum essential health benefits and meet Bronze, Silver, Gold or Platinum actuarial value targets	All new plans in the individual and small group markets, including QHPs, must abide by the ACA’s rating restrictions and requirements for the value and scope of benefits, often referred to as the “precious metal” tiers and essential health benefits package. Participating carriers must offer at least one silver level and one gold level QHP in the exchange.

Sources: ACA §§ 1301, 1311(c), 1311(g); 45 C.F.R. §§ 155.1040, 155.1045, 155.405, 156.200 156.210, 156.220, 156.230

standards and procedures. This is particularly true for the minimum certification requirements for QHPs (see Exhibit 2). As HHS notes, “we continue to believe that States are best equipped to adapt the minimum Exchange functions to their local markets...States already have significant experience performing many of the key functions.”¹¹

Though true for many states, such experience may not exist within a single agency or apply across all markets, entities, or products. For example, at least 20 states impose network adequacy requirements on managed care plans such as HMOs.¹² Others require commercial plans to implement quality assurance programs and report on health plan quality metrics, such as the Healthcare Effectiveness Data and Information Set (HEDIS[®]) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]). However, in a number of states these requirements are regulated not by the DOI but by a separate agency, such as a DOH or department of managed care.¹³ And most states limit these requirements to closed network plans or HMOs.

To address these limitations, states may want the exchange to partner with other agencies such as the DOI, DOH, or Medicaid agency. Plan management activities do not need to be performed exclusively by a state’s exchange. In its final rule, HHS makes clear that exchanges can enter into agreements with other state agencies to perform plan management so long as the exchange retains “ultimate accountability” for certification and review of QHPs.¹⁴ At a minimum, the DOI can confirm that a QHP is licensed and in good standing. In addition, most state DOIs have existing authority to review and approve (or disapprove) health insurance policy forms before they are marketed, as well as authority to review insurers’ rates. And regardless of how an exchange is organized in a state, the DOI will retain key oversight functions for plans inside and outside of exchanges. In addition, as noted by Bachrach and colleagues in their recent paper, state exchanges could leverage the plan management experience of their state Medicaid agencies, many of whom have been setting eligibility and reporting standards and managing contracts with Medicaid managed care organizations (MCOs) for decades.¹⁵

The ACA’s requirements for initial QHP certification will also require the exchange or a delegated entity like the DOI to collect and evaluate an unprecedented amount of plan data (see Exhibit 2). To collect, manage and use this data to make appropriate decisions about plans’ ability to participate in exchanges, state officials responsible for plan management will need to rely on IT-based data

management and sharing programs. Efforts to build such programs are already underway, such as the National Association of Insurance Commissioner’s (NAIC) System for Electronic Rate and Form Filing (SERFF) project to upgrade their centralized filing system to meet the expanded data collection and review requirements of exchange plan management.¹⁶

In recognition of this need for interagency partnership, some state exchanges have already entered into or are exploring agreements that delineate the functions to be performed by the insurance department.

Effective collaboration across state agencies, some of whom may have no past history of working together, will likely require the commitment and leadership of top political officials within the state. In recognition of this need for interagency partnership, some state exchanges have already entered into or are exploring agreements that delineate the functions to be performed by the insurance department and the flow of information among carriers, the DOI, and the exchange. For example, New Mexico’s exchange planners have delegated to the DOI the certification of QHPs, monitoring ongoing compliance, data collection to meet the ACA’s transparency requirements, review of essential health benefits, and determination of actuarial value. The DOI will also be responsible for assessing the market to evaluate the potential for adverse selection.¹⁷ Presumably, however, New Mexico’s exchange leadership must have the final say on a QHP’s participation and ongoing suitability in order to comply with HHS’ rule that it maintain “ultimate accountability” for plan management.

Yet, even when done in partnership with other state agencies, exchanges’ plan management responsibilities represent a considerable expansion of states’ regulatory oversight over insurers. As one commentator put it, “This isn’t your grandma’s rate review any more.”¹⁸ The new oversight requirements could require states to enact expanded regulatory authority for the agency responsible, and allocate the necessary resources to expand their IT and staff capacity. For example, many states do not currently have network adequacy standards for private health insurers in their state codes. Fewer still require private health insurers to implement and report on quality improvement activities. And, with the exception of Massachusetts, we could find no state that currently sets minimum requirements for a plan’s actuarial value.

Furthermore, much of the current state regulation of commercial insurers is done post-market, in response to complaints or as part of an auditing process (often called “market conduct” examinations). Going forward, the entity ultimately responsible for plan management will need to balance requirements for greater front-end review of carriers and plans with the need to develop an oversight process that attracts an adequate mix of carriers to the exchange. This will be particularly true for the SHOP exchange, in which there are limited incentives for health plans to participate. For the individual market exchange, which is the only avenue through which plans can access federal premium subsidies, the incentives to participate are stronger and plans will be less deterred by a robust review and approval process.

For states with an FFE in which CMS is responsible for plan management, there may need to be an accommodation between regulation and oversight as it has traditionally been done in the private market, and

the standards and processes CMS has had in place to manage commercial plans in Medicare Advantage. This is in part for pragmatic reasons: in designing and building an FFE, CMS will likely not have the resources to tailor plan management to suit each state’s regulatory standards and culture. However, the agency has fifteen years of experience and a well-developed infrastructure to assess and oversee the performance of commercial health plans in the Medicare program.

Plan management in exchanges, whether or not done in coordination with other State regulatory agencies, or performed exclusively by federal regulators, will face heightened public scrutiny, and an overall shift in the level of accountability. In many respects, the success and long term viability of exchanges rests on the effective execution of plan management. And because federal premium subsidies are at stake, taxpayers will expect value for the dollars spent.

Current State and Federal Experience with Plan Management

Federal and state regulators take a range of approaches to their interactions with health insurance carriers, from hands-on contract management to more limited regulatory oversight. The regulatory approach chosen by the state or federal entity stems largely from their mission and statutory mandate, as well as the political environment in which they operate. In the Medicare program, for example, CMS acts as a steward of federal tax dollars by managing contracts with Medicare Advantage plans in order to protect beneficiaries, improve quality and ensure compliance with applicable guidance, regulations, and statutes. Similarly, state Medicaid agencies must act as stewards of federal and state tax dollars by managing contracts with managed care plans to increase access to care, improve quality and reduce costs in the Medicaid program.¹⁹

The role and approach of the state agencies responsible for regulating commercial health insurance tends to be very different. Unlike their sister Medicaid agencies, DOIs are not stewards of tax subsidies, and do not enter into contractual relationships with the health plans they regulate. And while the DOI’s mission statements generally encompass consumer protection, most of the DOI mission statements we reviewed require them to also “ensure a competitive insurance environment”

(Wisconsin), “encourage economic development,” (Arizona), or provide “efficient” oversight (Tennessee).²⁰ State insurance regulators must balance two jobs: first, to protect the public and second, to help insurance companies bring products to market in a timely and efficient manner.

In many respects, “plan management” is just not what DOIs do. Yet the ACA envisions a considerable expansion of state regulatory oversight of health insurers, particularly QHPs participating in insurance exchanges. Thus, the law requires exchanges to engage in oversight that in some cases expands on what many state DOIs already do but in other cases represents a wholly new activity.

Below we discuss generally how state DOIs oversee insurance companies, and discuss how six states (Arizona, Minnesota, New York, Tennessee, Washington, and Wisconsin) perform oversight on five key areas related to exchange plan management: network adequacy, marketing, quality improvement, rate and benefit review, and ongoing oversight.

We then compare the DOIs’ regulatory activities to the plan management activities performed by state Medicaid agency officials, as described by Bachrach and colleagues,

and our review of CMS' oversight of plans participating in the Medicare Advantage program.

DOIs are responsible for regulating the business of health insurance, with the exception of self-insured group health insurance. As noted above, they don't enter into contracts with insurers or "manage" them in any way. Fundamentally, state regulators are responsible for ensuring the financial solvency of insurance companies, enforcing minimum state standards for competition, and protecting consumers against fraud.²¹ DOIs execute this responsibility by licensing entities that bear insurance risk and reviewing and approving the rates and policy forms for health plan products. They are often under very tight timelines for conducting the reviews. For example, most DOIs must make a determination on rates and policy forms within 30 to 60 days or the filing is "deemed" approved.²² Once products are being sold to individuals and groups, DOIs review companies' behavior to assess compliance with state laws and provide assistance to consumers or employers that have complaints about their coverage.

In Medicaid, state agencies have expanded their oversight role as Medicaid managed care programs have grown in scope and size. As of October 2010, 36 states were contracting with risk-based managed care organizations to provide health care services to Medicaid beneficiaries.²³ Plans seeking to participate in Medicaid managed care must meet both federal and state requirements. Federal requirements set minimum standards for all plans and state rules and contracting standards can build on those.²⁴ As a result, states vary considerably in their approach to contracting and the ongoing oversight of plans.

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For plans seeking to participate in Medicare Advantage, they can expect a formal application, review and approval process that takes place over a timeframe of over a year.²⁵ For example, in order to enroll beneficiaries by January 2013, a health insurance company would have had to submit its Notice of Intent to Apply (NOIA) to CMS by November of 2011.²⁶ While CMS provides detailed application instructions for plans, and encourages them to take advantage of opportunities to obtain training on CMS systems and procedures, companies that submit an incomplete or noncompliant application may have their applications denied. Unlike state DOIs, CMS officials

face no statutory "deemer" provision that deems a plan approved for participation if they don't act within a statutory time frame.

Licensing and solvency. For private health insurance, at the licensing stage, companies must apply for a "certificate of authority" (COA) from the state. As part of that process, they must submit information on the company's officers and business plan, as well as detailed financial information. Analysts within the DOI review the financial and governance information about the company and conduct background checks. All states require health insurance companies to be financially solvent and capable of paying claims. If a company is approved, it receives a COA to conduct business in the state.²⁷ While there is often no formal renewal process for a COA, companies are required to file financial information with the DOI on a regular basis. Although information about which companies have COAs to operate in a state is public information, ongoing investigations or penalties imposed on an insurer may not be made public.

Medicaid MCOs are generally required by federal regulation to meet state solvency standards for commercial, non-Medicaid HMOs or be licensed or certified by the state as a risk-bearing entity (with some exceptions). In a recent survey, the majority of states indicated they require Medicaid MCOs to be licensed as HMOs, with a few exceptions. For example, two states (Arizona and Maryland) indicated they have no licensing requirements, and six states allow exemptions from solvency requirements.²⁸

For Medicare Advantage plans, CMS generally relies on state insurance regulators to determine financial solvency.²⁹ Medicare Advantage Organizations (MAOs) must be state licensed and meet state financial solvency standards.³⁰

Discussion. To participate in the insurance exchanges under the ACA, QHPs must be licensed and "in good standing" with state insurance departments. HHS has interpreted "good standing" to mean the insurer is not subject to any outstanding sanctions from the state DOI. While the final rule does not define what it means for a carrier to be sanctioned, states use a range of enforcement tools, such as letters that raise concerns, corrective action plans, civil monetary penalties, and rescinding a carrier's COA.³¹ It is unclear whether each of these actions would constitute a sanction that would erase a plan's "good standing" with a state. Also, while carriers' COAs are public information, other enforcement actions

are often not publicly disclosed. Exchanges could collect information on plans’ status from the DOI, or they could require carriers to attest to their status as part of their QHP applications. Without further detail from HHS, exchanges can presumably decide for themselves what enforcement actions constitute a “sanction.” For FFEs operated by CMS, the agency can check public databases for companies’ COA status, but will either need the cooperation of the state DOI to determine whether an insurer is subject to any enforcement actions or require carriers to attest to their good standing.

Network adequacy. A number of states require private health insurance carriers to meet network adequacy requirements as a condition of receiving an HMO license. Seven states have adopted the NAIC’s Managed Care Network Adequacy Model Act, which requires managed care plans to “maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.”³² Another 13 states have adopted similar laws establishing an adequacy standard for network-based plans.³³ Of the states we reviewed, only Washington requires all carriers to meet network adequacy requirements. Regulators review plans based on both quantitative and subjective standards to ensure networks are broad and deep enough to provide for timely services.³⁴ Arizona, Minnesota, Tennessee, and Wisconsin apply their network adequacy standards only to HMOs or closed network plans; in Minnesota and Tennessee it is the DOH’s responsibility, not the DOI’s, to ensure compliance with such standards.³⁵ All five states review network adequacy when the carrier is seeking their HMO license.

New York has also bifurcated its regulation of network-based health plans. The DOH reviews network adequacy for HMOs, while the Department of Financial Services (DFS) sets and enforces standards for traditional insurers with network-based products (such as preferred provider organizations, or PPOs).³⁶ In general, while the DOH reviews network adequacy at the time a carrier seeks an HMO license or a geographic area expansion, the DFS’ review of network adequacy takes place at the product level, when a carrier is seeking approval to market a network-based product. During the review process, New York’s DFS and DOH discuss any problems or concerns about the adequacy of the network with the company and the company is allowed to make changes. Because the agencies’ concerns are usually resolved during this process, it is rare for an HMO or PPO product to have its application formally rejected because of a network adequacy problem.³⁷

However, the DOH continues to monitor the adequacy of HMO networks through annual reviews.

Medicaid MCOs must meet a mix of federal and state requirements. Federal regulations provide detailed definitions of broad statutory protections that ensure all covered services are available and accessible to enrollees. Federal rules interpret those protections to ensure services are always available when medically necessary. State contracts build on the federal rules with more detailed standards for availability and access, including enrollee-to-provider ratios, travel time and distance to providers, appointment availability standards, and, in some cases, in-office wait times for appointments. For example, Tennessee prohibits travel time and distance to primary care providers exceeding 30 miles or 30 minutes in rural areas and 20 miles or 30 minutes in urban areas. New York has similar time/distance standards and requires plans to assign no more than 1,500 enrollees to each physician.³⁸

In Medicare Advantage, all MAOs must maintain adequate networks of providers to serve beneficiaries.³⁹ Before their plan bid can be accepted, MAOs must attest that they have a network of contracted providers and facilities that meets the required access standards (which, similar to Medicaid, include enrollee to provider ratios and time/distance standards) and submit a “Health Service Delivery Table” to CMS.⁴⁰ CMS then reviews the network against specific provider types, as well as time and distance standards based on specific geographic criteria of the county.⁴¹ The standard varies depending on the MAO’s proposed service area (i.e., rural vs. urban), and MAOs can seek exceptions if their network in a specific county for specific provider types receives a failing grade. In addition, MAOs must submit a sample of their actual provider contracts to CMS. While the agency reviews a subset of the contracts at the time of application, they monitor beneficiary access to care on an ongoing basis and may audit contracts to ensure networks are adequate.⁴²

	State Private Health Insurance Regulation	State-Federal Medicaid MCO Regulation	Medicare Advantage
Review Network Adequacy Prior to Approval?	Varies; generally applies only to HMOs	Yes	Yes

Discussion. Under the ACA, QHPs must meet network adequacy standards to be eligible to participate in an exchange. While HHS has set a standard requiring QHPs to provide access to services “without unreasonable delay,” states may expand on this general standard.⁴³ Whether responsibility rests with the exchange, a state DOI or DOH, or CMS, the assessment of network adequacy will need to be done before an insurer can be certified as a QHP.

Where a state does not currently have a network adequacy standard for commercial plans, the exchange could rely on the general “unreasonable delay” standard proposed by HHS, or they could import some or all of the standards used for Medicaid MCOs. At a minimum, however, state officials should consider aligning network adequacy standards so that they apply equally to plans both inside and outside the exchange in order to limit the potential for adverse selection.⁴⁴

For an FFE run by CMS, the agency could require carriers to attest that their networks meet the state standard, or if none exists, the “without unreasonable delay” standard articulated by HHS. For a more proactive review, they could leverage the process used in Medicare Advantage, in which plans must submit their networks to a system that checks against a default standard and delivers a pass or fail grade for each provider/facility type in each specific county. Further, if CMS’ Medicare Advantage system is upgraded to allow for network adequacy submissions from QHP applicants, CMS may want to make the system available for use by states that are performing plan management functions under a partnership arrangement. CMS would, however, need to account for the fact that Medicare Advantage standards for time and distance reflect the needs of an over-65 population, which may be different than the needs of enrollees in the exchanges.

Beyond network adequacy, an exchange will want to assess whether its participating QHPs, taken together, can provide adequate service to all of the exchange’s potential enrollees, regardless of where they reside in the state. In other words, assuming the exchange serves residents statewide, it will need to attract and retain a sufficient mix of plans to ensure that all eligible enrollees in the state are served by at least one QHP.

Benefit and rate review. Most, but not all, state DOIs review and approve insurers’ policy forms before a product can be sold. A policy form is the representative document that defines the contractual relationship between the insurer and its enrollees and typically lists the policy’s benefits and restrictions.⁴⁵ DOI reviewers check to ensure the form complies with state and federal standards,

including notice provisions and any required benefit mandates. In most states a form cannot be used unless it has been approved by the DOI.⁴⁶ Of the six states we reviewed, all review insurers’ forms to ensure they include required state benefit mandates. In addition, New York’s form review includes an assessment of whether HMOs are meeting guidelines for maximum enrollee cost sharing.⁴⁷

In roughly two-thirds of states, DOIs also have the authority to review and approve premium rates before they are implemented.⁴⁸ Under the ACA, in order to have an “effective” rate review process, the DOI must receive sufficient data from health insurers to adequately examine whether a proposed rate increase is reasonable. The examination must consider medical cost trends, changes in utilization, benefits and cost sharing, changes in the risk profile of enrollees, reserves, administrative costs, taxes and fees, medical loss ratio, and the insurer’s capital and surplus.⁴⁹ The state must have a standard for determining whether a proposed rate is reasonable, and the DOI must post either rate filings or justifications on its website (or post to the preliminary justifications that appear on the CMS website). States must also provide for a public process to review and comment on proposed rate increases. CMS has determined that forty-four states and the District of Columbia have effective rate review programs in at least one insurance market.⁵⁰ Conversely, a small number of state DOIs do not currently have any authority to require certain insurers to submit a rate filing, or can only review filings in one insurance market.⁵¹

Of the six states we reviewed, only Arizona’s rate review program was deemed “not effective” by HHS. Since that designation, the Arizona DOI had begun a rulemaking process intended to bring Arizona into compliance with HHS’ effective rate review standards.⁵² Washington and Wisconsin’s rate review programs were deemed only partially effective because they do not fully review coverage sold through associations.⁵³ HHS is thus reviewing proposed rate increases for all of Arizona’s individual and small group markets and for a number of policies sold through associations in Washington and Wisconsin.

In general, most state DOIs attempt to resolve concerns about insurers’ rate and policy form filings before having to issue a formal disapproval.

For states that have adopted rate restrictions in the individual and or small group markets, the rate review process can also include an assessment of whether a plan’s

rate is in compliance with those restrictions. For example, small group insurers in Wisconsin are subject to rate bands, such that rates cannot vary more than 30 percent above or below the midpoint rate.⁵⁴ As part of Wisconsin’s rate review process, the Office of the Insurance Commissioner will typically check the carrier’s filing to confirm that it meets this statutory requirement.⁵⁵ Under the ACA, DOIs will need to review rate filings in the individual and small group markets to ensure they are in compliance with the new rating restrictions in the law, which prohibit health status underwriting and allow rates to vary only based on age, tobacco use, family status, and geography.⁵⁶

In general, most state DOIs attempt to resolve concerns about insurers’ rate and policy form filings before having to issue a formal disapproval. This can be an iterative process, involving written and oral communications between the regulator and the insurer. Often, the statutory review deadlines are tolled while insurers respond to the DOI’s questions or requests.

For Medicaid MCOs, rates are set through a procurement process that is governed by both federal and state rules. States generally use two different approaches to setting rates for Medicaid MCOs: administrative pricing, in which the state sets the capitation rate and plans decide whether or not to apply for participation in the program, and competitive bidding, in which states issue a request for proposals and judge plan bids based on their proposed rates and services.⁵⁷ After rates are set, an actuary must certify the rates as actuarially sound. States must then submit their rates and rate-setting methodology to CMS for review and approval in order to receive federal funding for their Medicaid managed care program.⁵⁸

In addition, Medicaid MCO contracts stipulate the benefits that must be covered by the plan. If a benefit is

covered by Medicaid but not listed in the contract, then it must be covered by the Medicaid agency, outside the capitated rate paid to the plans.⁵⁹

CMS uses a formal bidding process for plans offered by MAOs. Once a MAO is approved for participation, it must then submit bids for any plans it intends to offer. One goal of the bid review process is to conserve taxpayer resources by ensuring that any payments above plan costs are returned to beneficiaries in the form of lower out-of-pocket costs or better benefits. A second key goal is to protect beneficiaries against health status discrimination through plan benefit design.⁶⁰ The contracting and oversight process for MAOs is dictated in large part by Congress, which has laid out numerous requirements for participating plans.

The bids must include a description of the plan’s benefits (including any supplemental benefits beyond those offered in traditional Medicare) as well as the amount of the proposed premium and any beneficiary cost sharing.⁶¹ CMS reviews the plan bids for appropriateness of pricing as well as benefit design.⁶² In recent years, CMS has discouraged the proliferation of “look alike” products that made beneficiaries’ selection of plans unnecessarily complicated.⁶³ If a MAO’s offerings are not “meaningfully different” in a particular geographic areas, CMS will encourage the MAO to modify their offerings or consolidate into fewer plans. This policy grew out of complaints from beneficiaries that they were confused by the profusion of products, many very similar to each other, offered by the same insurer.

CMS also reviews both the overall benefit package to assess actuarial equivalence of cost sharing with the traditional Medicare benefit package and actuarial equivalence within specific benefit categories, including

	State Private Health Insurance Regulation	State-Federal Medicaid MCO Regulation	Medicare Advantage
Review and approve benefits and cost-sharing offered in plan or product?	Varies	Yes	Yes
Review and approve premium rates?	Varies	N/A	Yes
Review number of products offered for “meaningful differences”?	No	N/A	Yes
Review actuarial equivalence within and across benefit categories?	No	N/A	Yes

renal dialysis, skilled nursing facility care, chemotherapy, durable medical equipment and Medicare Part B drugs.⁶⁴ To perform this review, CMS has authority to examine detailed information about the plans' benefits and cost sharing, but also relies on signed actuarial certifications submitted by the MAO. If CMS does find problems, MAOs are typically given an opportunity to negotiate or modify their original submissions.

Discussion. The ACA includes sweeping reforms that address the adequacy and affordability of coverage, including requirements that new individual and small group plans provide a minimum benefit package, meet prescribed targets for the actuarial value of the plan (Bronze, Silver, Gold, Platinum), and eliminate rating that discriminates based on health status. These reforms apply to individual and small group plans, regardless of whether they participate in state exchanges. However, exchange officials are ultimately responsible for ensuring that participating QHPs have met all federal and state requirements for essential benefits, actuarial value, and rates.

In the majority of states, DOIs have experience reviewing policy forms for compliance with state benefit mandates, and exchange officials can look to them for expertise on whether QHPs' offerings include a required set of benefits. However, state DOIs will also need to assess whether plans – inside and outside of exchanges – are complying with actuarial equivalence standards within or across benefit categories,⁶⁵ as well as the ACA's provisions barring plans from using benefit design to discriminate against high risk individuals.⁶⁶ Generally, state DOIs do not have experience reviewing benefit packages for actuarial equivalence against a benchmark, or determining whether a particular benefit design discriminates against higher risk individuals. Also new to state DOIs will be the determination of whether plans are meeting the actuarial value tiers prescribed in the ACA. Many states will need to build this capacity, by, for example, hiring or contracting with health actuaries. A review and approval process that is more onerous for QHPs than for non-participating plans may result in higher premiums inside the exchange or reduce carriers' incentive to participate.

CMS has experience assessing MAO bids to determine the scope of benefits, as well as whether the benefits covered in specified categories are actuarially equivalent to coverage under traditional Medicare. Further, the agency reviews bids to guard against the use of benefit design to discriminate against high risk beneficiaries. However, CMS does not currently have the resources and staff to

perform this kind of review in states with FFEs and may need, at least to some extent, to rely either on attestations by plans or cooperation with state DOIs.

...state DOIs will also need to assess whether plans – inside and outside of exchanges – are complying with actuarial equivalence standards within or across benefit categories, as well as the ACA's provisions barring plans from using benefit design to discriminate against high risk individuals.

The ACA also requires exchanges to review QHPs' justifications for rate increases before such increases are implemented. The exchange must take into consideration any recommendations from its DOI regarding rate increases. Most state exchanges will likely rely on the findings of their DOI regarding carriers' rates, in order to leverage the existing staff and expertise within those agencies, and avoid duplication of effort. However, for states that do not currently have authority to collect and review rate filings for certain carriers or certain markets, it is unclear how their exchange will fulfill the ACA requirement. Ideally, the state will confer on the DOI the necessary authority to review filings of all carriers in the individual and small group markets, whether inside or outside the exchange. If CMS is performing the plan management function for the exchange, it will either have to review rate increase justifications itself or rely on DOIs. It is currently conducting rate review in eighteen states for at least one market or for association products, but would have to expand its capacity to perform the necessary review for FFEs.

Marketing regulation. Virtually all states have enacted a version of the NAIC's model Unfair Trade Practices Act (UTPA).⁶⁷ The law confers upon the DOI the authority to regulate private health insurers' marketing materials and practices to protect consumers against "unfair" and "deceptive" acts and the false advertising of insurance policies. In addition, 48 states have enacted the NAIC's model state regulation to constrain health insurers' advertising practices.⁶⁸ The regulation establishes specific parameters for the "clear and truthful disclosure of the benefits, limitations and exclusions" of individual and group health insurance policies. While all states also set standards for the conduct of insurance producers (health plan agents and brokers), we did not include this element of marketing regulation in our review.

Of the six states we reviewed, none conduct a comprehensive prior assessment of plans’ marketing materials before they are used. While Arizona reviews some marketing materials for compliance with the UTPA and the advertising regulation if the insurers submit the materials to the DOI at least 15 days before they’re used, the Department does not currently have staff in place to perform this review for more than about half of the advertising filings it receives. Arizona also assesses compliance in response to complaints or as part of a market conduct exam.⁶⁹ Tennessee and Wisconsin generally do not conduct any prior review or approval of marketing materials, but will assess compliance in response to complaints or as part of a market conduct exam.⁷⁰ New York’s DOH does review marketing materials of commercial HMOs, but this is typically limited to ensuring that the materials are accurate and factual.⁷¹ Both Washington and Minnesota review marketing materials under the UTPA but apply more detailed standards to HMOs.⁷²

Medicaid managed care companies’ (MMC) marketing materials and activities are governed by a mix of federal regulations, state regulation and contracting requirements. The rules are an outgrowth of the marketing abuses seen in the early stages of MMC implementation and in some cases are highly prescriptive. Federal rules require prior approval of all marketing materials and address both the content of the materials and the method of distribution. Marketing materials cannot contain false or misleading information and must provide individuals with information in a format and language that is easily understood. Federal rules also prohibit unsolicited personal contact (i.e., door-to-door marketing and cold calls), and require marketing materials be distributed throughout the plan’s service area.⁷³

As recently documented by Bachrach and colleagues, state rules further define how and to whom plans can market and set more detailed rules for marketing material

and permissible activities. For example, Arizona requires materials to be reapproved every two years or after any modification. New York requires MMCs to submit a detailed plan for all proposed activities during the contract period, and Minnesota requires materials to be understandable to a person who reads at a 7th grade level and printed in at least 10-point-font. Some states go beyond the federal requirement that all materials be distributed throughout the plan’s service area to stipulate permitted locations for distribution. New York rules include a full list of allowable locations, including schools and community centers. Wisconsin allows materials to be distributed in participating provider offices as long as all plans with which the provider contracts are allowed to distribute their materials.⁷⁴

For Medicare Advantage, CMS’ review of plans’ communications with enrollees and prospective enrollees has evolved, and Congress has enacted new standards and enforcement authority in response to concerns about marketing abuses in the program. The Social Security Act and implementing regulations take a broad view of what constitutes “marketing” for purposes of Medicare Advantage.⁷⁵ Essentially, marketing materials are any informational materials or activities directed at Medicare beneficiaries. And, as with Medicaid, certain marketing activities, such as unsolicited personal contacts, are prohibited. CMS reviews everything from written communications to radio or television advertising to face-to-face sales. MAOs must file all marketing materials with CMS, and some may be subject to “prior approval” before they can be used. Most materials, however, fall into a “file and use” category, meaning that CMS does not need to formally approve them before MAOs can use them although the agency can disapprove them retroactively. CMS is moving increasingly towards the file and use approach and staff are doing fewer front-end reviews of marketing materials.⁷⁶ The agency also provides plans with template language they can use in

	State Private Health Insurance Regulation	State-Federal Medicaid MCO Regulation	Medicare Advantage
Review and prior approve marketing materials?	Varies	Yes	Yes, but not all
Prohibit specified conduct or language?	Yes	Yes	Yes
Ongoing oversight of marketing materials or activities after plan approval?	Yes	Yes	Yes

their communications with beneficiaries. If they do so, the language is deemed approved.

CMS has also implemented a “secret shopper” program, in which CMS personnel conduct surveillance of plans’ marketing activities. Plans are required to submit an advance schedule of all their marketing events to CMS, but agency personnel will also review local newspapers and media outlets for any announcements of sales events that plans did not report in advance. Staff will then attend these events undercover to monitor and report any improper sales techniques.⁷⁷

Discussion. Under the ACA, exchanges must certify that QHPs meet marketing standards, and do not employ marketing practices that discriminate against high risk individuals.⁷⁸ HHS’ final rule for exchange certification indicates deference to states’ own marketing standards, and expressly rejects requests to import standards from Medicare Advantage.⁷⁹

State exchanges will likely need to coordinate with their state DOI to determine a common marketing standard, and the existing state standard may need to be modified to include the prohibition against discrimination against high risk individuals. In addition, because few state DOIs appear to review and pre-approve marketing materials, exchanges will need to decide whether they will conduct this kind of review as part of the QHP certification process. If they do, this could be done by exchange staff or through a contract with the state DOI or Medicaid agency. Based on our review of state practices, it is likely that the Medicaid agency has an existing process and infrastructure for reviewing and approving marketing materials, unlike many state DOIs.

CMS, in operating a FFE, will need to strike a balance between establishing meaningful consumer marketing protections and encouraging carrier participation in the exchange. Unlike Medicare, which is the only viable market for individuals over 65, the FFE will not be the exclusive market for individual and small group coverage in a state. Thus, as CMS officials consider appropriate marketing standards and a review process for the FFE, they will want to consider each state’s regulatory environment, to the extent they have the resources and capacity to do so. While the review of marketing materials and activities is but one factor for an insurer to consider in deciding whether to participate in the FFE, insurers will be more likely to do so if CMS can offer them a level playing field compared to insurers who choose not to participate.

Exchanges, whether state- or federally run, could use a range of approaches for determining compliance with marketing standards, from relying solely on plans’ self-attestation to requiring plans to undergo a full prior approval process for all marketing materials and activities.

Exchanges, whether state- or federally run, could use a range of approaches for determining compliance with marketing standards, from relying solely on plans’ self-attestation to requiring plans to undergo a full prior approval process for all marketing materials and activities. As noted above, both federal and state regulators are increasingly moving towards post-marketing enforcement of standards as opposed to up front reviews. However, reliance on self-attestation alone would likely require more robust ongoing oversight, particularly because the ACA’s prohibition on health status underwriting could lead some carriers to increase their use of marketing as a risk selection tool.

Quality improvement. Very few states have imposed quality improvement, care coordination, or performance reporting requirements on private health insurance plans, although some have imposed quality-related obligations on HMOs. Only two states have adopted NAIC’s Quality Assessment and Improvement Model Act, but many more (26) have adopted other, related quality improvement requirements for HMOs. Of the states we reviewed, Arizona, New York and Wisconsin require HMOs to have a quality improvement plan in place when they apply for licensure.⁸⁰ Wisconsin and New York require HMOs to report annually on quality metrics, including HEDIS® and CAHPS®, and New York ranks commercial HMOs and Medicaid plans based on their performance. Minnesota requires all plans to submit encounter and pricing data to a third party entity, using standardized measures, and must establish health care homes. In addition, all plans in the individual and small group market must develop products that encourage consumers to use high-quality, low-cost providers.⁸¹ In contrast, Washington imposes no quality standards on private health insurance plans.⁸²

For MMCs, federal rules require a quality assessment and improvement strategy that incorporates standards of access to and quality of care, procedures for monitoring, evaluating, and reporting on the quality of care, clinical practice guidelines, and standards for care coordination for those with special needs. State rules and contracting standards further define and in many cases go beyond those federal rules.⁸³

All states require MMC plans to measure and report their performance on key measures, with the majority of states relying on HEDIS® and CAHPS®, and all states requiring that performance measurement data be validated. In addition, state contracts may require quality assessment and improvement activities to include minimum plan performance benchmarks and performance improvement goals such as improving care for those with chronic conditions. Bachrach’s research found that several states offer incentives to plans that meet performance goals and penalties or sanctions for those that fail to do so. For example, Minnesota provides incentive payments to plans that meet performance goals for well-child primary care, developmental and mental health screenings for children, and certain types of preventive health screenings. New York has a program to reward high performing plans with incentive payments and to disqualify poor performers from auto enrollment for members who do not choose a plan.⁸⁴ And Michigan assigns MMC plans with a quality rating that beneficiaries can use when selecting a plan.⁸⁵

In addition, all states require MMC plans to implement case management, care coordination or some type of treatment plan for enrollees with special health needs. For example, Wisconsin requires plans to identify women at high risk for poor birth outcomes and provide them with coordinated and continuous care. Tennessee requires disease management for ten specified conditions.⁸⁶

In the Medicare Advantage program, all MAOs must have a quality improvement program that measures and demonstrates improvements in clinical outcomes and beneficiary satisfaction. The plans must also maintain a chronic care improvement program that helps beneficiaries manage chronic conditions.⁸⁷ CMS requires MAOs to have adequate health information systems enabling them to collect, analyze, and report quality performance data, including data from HEDIS® and CAHPS®. In addition, CMS rates plans based on a 5-star scale reflecting their performance on quality and

consumer satisfaction metrics. According to observers, CMS has evolved from simply requiring plans to report on their quality activities to being fairly prescriptive about what those quality activities should be. In addition, while CMS has been providing reports to MAOs on their performance relative to their competitors, Congress has recently enacted a “pay for performance” program, in which plans’ payments depend in part on their performance on selected quality and customer service metrics, as measured by their star ratings.⁸⁸ Low performing plans face the risk of having their contracts terminated. Observers note that this “raises the stakes” for the plans, and that plans have increased their emphasis on the activities being measured.

Discussion. While the ACA requires QHPs to implement and report on quality improvement strategies, HHS has delayed rulemaking that details specific standards and the information insurers will be required to report.

Few state DOIs have experience setting standards for quality improvement, and only a few require plans (primarily HMOs) to report on quality metrics. State exchanges may find that their Medicaid agency has more experience in this area. In addition, state employee benefit purchasing agencies often have experience working with health plans on quality improvement strategies.⁸⁹

For FFEs operated by CMS, agency officials can look to Medicare Advantage for experience setting standards for plans, rating plans, and conducting ongoing oversight of plan performance. However, CMS will likely want to ensure that any requirements are comparable to what is required of them in the market outside the exchange.

Ongoing oversight. Once health insurance products are in the marketplace, DOIs have the authority to assess insurers’ conduct and ensure they remain in compliance with state laws. This assessment is generally done through market conduct exams, which include a comprehensive, on-site examination of the company’s policies and

	State Private Health Insurance Regulation	State-Federal Medicaid MCO Regulation	Medicare Advantage
Require quality improvement plan?	Varies; HMOs only	Yes	Yes
Require reporting on quality metrics?	Varies; HMOs only	Yes	Yes
Rate plans based on quality rankings?	Varies; HMOs only	Varies	Yes
Pay for performance?	None known	Varies	Yes

procedures. While some states conduct the exams on a multi-year cycle (i.e., every three years), others carry out targeted market conduct exams in response to consumer complaints or other evidence of problems at the company.

DOIs also use their consumer information and complaints systems to monitor insurer compliance with state and federal laws. In addition to addressing particular consumer complaints, state regulators use these systems to identify trends or problem areas for companies and products. For DOIs that do not conduct form or rate review before products are marketed, receiving complaints may be the only mechanism to trigger a comprehensive examination of the policy form or rate filings. And even for those DOIs that do a pre-market review, the consumer complaint system is an essential mechanism for regulators to learn about non-compliant policies and marketing practices.

When problems are found, DOIs have a range of tools available to them. In most cases, problems can be resolved informally, by notifying the company of a potential violation and working with them on a remedial action plan. Less frequently, the DOI may impose civil penalties on the company, issue a cease and desist order, or seek an injunction to stop a company from marketing a product. And, more rarely, a DOI may take the drastic step of rescinding a company's COA.

State DOIs play another critically important function – they help insurers comply with the law through interpretive regulations and sub-regulatory guidance (i.e., bulletins, memoranda, notices, and instruction manuals). And generally, the Commissioner or senior regulators will communicate frequently – through in person meetings, telephone and e-mail – with the companies they regulate in order to field questions, solicit input and provide guidance.

State Medicaid agencies use a range of tools to monitor access to care and quality in MMC plans, including complaints and data collected from plans. At a minimum, to monitor quality, states must meet federal rules under the Balanced Budget Act of 1997 and the regulations that followed, but have flexibility in what they must report to CMS.⁹⁰ For example, states must contract with external quality review organizations to monitor quality of care, and all beneficiaries are entitled to an internal appeal with the plan and a fair hearing with the state. In addition, Medicaid MCO contracts require collection and reporting of data such as HEDIS® and CAHPS®, which assess plans on measures such as controlling blood pressure, use of appropriate medications for people with asthma, wait times and appointment scheduling.⁹¹

For Medicare Advantage plans, the primary responsibility for oversight rests with an account manager. He or she draws on a range of resources to assess how the contract is being implemented, including complaints from enrollees and data from the plans' own submissions to a centralized CMS database, called the Health Plan Management System (HPMS). Examples of the kind of data plans must annually report include:

- Frequency of procedures (i.e., number of enrollees receiving specified products each year)
- Serious adverse events (i.e., number of catheter-associated infections, numbers of in-hospital fractures, etc.)
- Number of grievances
- Provider payment dispute resolution process (i.e., number of provider payment complaints, number of provider complaints resolved, etc.)
- Agent oversight (i.e., number of agents, number of agents under investigation, etc.)
- Enrollment and disenrollment data⁹²

The account managers review this data for trends and outliers. To the extent problems are found, CMS may conduct a formal audit of a company.⁹³

CMS has a range of enforcement tools at its disposal if an MAO is not performing under its contract. It can impose intermediate sanctions to suspend marketing and enrollment activities, impose civil money penalties, or choose not to renew a contract. If there's a matter of grave concern, CMS can terminate a plan immediately.⁹⁴

Discussion. State exchanges will likely want to rely extensively on their DOI for at least some ongoing oversight of QHPs. Most DOIs have a built-in infrastructure – consumer complaint hotlines and databases, an ability to identify and analyze trends, and staff to carry out market conduct exams, all of which an exchange could leverage in order to meet its required oversight obligations. However, not all DOIs will have sufficient staff and funding to conduct the robust data collection and oversight that will be required. The exchange may need to help finance a QHP oversight program within the DOI or build its own. At the same time, exchange leadership will want to assess the expertise and capacity of their Medicaid agency to conduct plan oversight, and determine areas in which they could benefit from collaboration. Ideally, exchange officials, DOI and Medicaid staff will work together to develop a coordinated, effective, and robust system to ensure all

plans, whether inside or outside exchanges, are meeting state standards and meeting consumers' needs.

CMS, in its operation of an FFE, will want to rely on DOIs as well, particularly for information relating to

consumer complaints about QHPs and the results of any market conduct exams of carriers offering QHPs. However, if the state is unwilling or unable to assist CMS in its oversight responsibilities, it will need to build the necessary capacity.

Conclusion

State officials developing the plan management function for health insurance exchanges will need to tackle a wide range of activities, both in terms of the up front review of insurers seeking QHP status and the ongoing oversight necessary to ensure that QHPs continue to meet exchange standards. However, exchange officials do not need to build a plan management infrastructure on their own. Within the state, whether at the DOI, DOH, or Medicaid agency, there likely resides an existing infrastructure for communicating with insurers, setting state standards for consumer protection, and collecting and evaluating data to perform oversight responsibilities. Exchanges can and should leverage the infrastructure and expertise that already exists in these agencies in order to execute the plan management function most efficiently.

However, plan management as contemplated under the ACA also represents an expansion of the regulatory role most state insurance regulators currently perform. Whether it's assessing actuarial value, determining whether a particular benefit design is discriminatory, or establishing a network adequacy standard for plans other than HMOs, most state regulators will be entering new territory. Exchanges will have the ultimate accountability for delivering a high-value product to participating consumers and small businesses, but to do so, they may need to help build necessary capacity at the relevant state agencies, if they don't do it themselves.

CMS, in its operation of plan management for the FFEs, will have an existing infrastructure it can draw upon – Medicare Advantage. However, there are dramatic differences in the regulatory approach taken by the agency towards the review and approval of MAOs and that of state insurance regulators working with private health insurers. While there may be efficiencies associated with the use of Medicare's standards, procedures, and systems, CMS must balance that with the need to attract a sufficient number and mix of insurers to the FFE, particularly for the unsubsidized SHOP exchange and in states with concentrated insurance markets. If carriers perceive the process of applying for and maintaining QHP status to be overly burdensome, and there is sufficient uncertainty about the FFE's ability to attract and retain a sizeable and healthy pool of enrollees, they may choose not to participate.

Thus, CMS will likely want to rely on state regulators to help the FFE engage directly with insurers interested in participating in the exchange, share information and data about insurers' status within a state, and, at a minimum, perform their conventional state role of ongoing oversight and consumer assistance to ensure that all insurers, whether inside or outside of an exchange, are meeting consumers' needs.

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