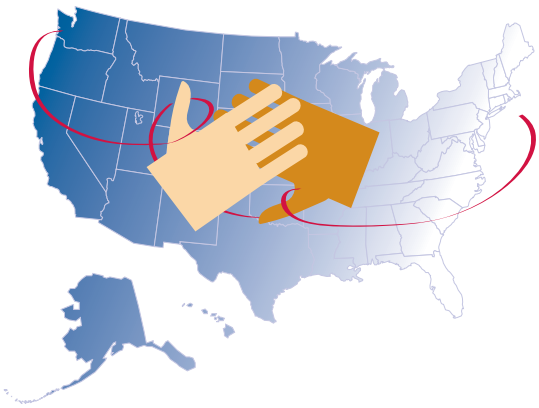

Implementing Exchanges

A series of briefs from Families USA on implementing health insurance exchanges

January 2013

Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States

Starting in 2014, the Affordable Care Act establishes a minimum set of consumer protection and quality standards that all health plans sold in the new insurance exchanges must meet. However, when a state runs its own exchange (a state-based exchange), or when the federal government and a state run an exchange together (a partnership exchange), states have considerable flexibility in how they implement the standards for health plans that can be sold through exchanges, called "qualified health plans" (QHPs). The way an exchange implements QHP standards will have a significant impact on the ability of these health plans to meet the needs of consumers and small businesses.

This piece outlines the minimum QHP standards required by the Affordable Care Act. It then provides examples from eight state-based exchanges (California, Connecticut, the District of Columbia, Maryland, Minnesota, Oregon, Vermont, and Washington) and one partnership exchange state (Delaware) on how to implement those standards in a consumer-friendly way, based on their plans for QHP standards as of January 2013. The QHP standards discussed in this piece cover the following areas:

We urge officials and stakeholders who are working on exchange implementation to consider the examples in this piece when determining the QHP standards that will best meet the needs of residents and businesses that will be seeking exchange coverage. The examples featured in this piece could be incorporated into state-based, partnership, and federally facilitated exchanges alike.

QHP Standard: Plan Design Standardization

The Issue

The Affordable Care Act prescribes a set of minimum standards for the benefits and the cost-sharing requirements of QHPs. However, these standards still allow for a great deal of variation in the QHP designs that may be offered in an exchange. Therefore, further standardization of QHP designs may be needed to ensure that consumers can find exchange plans that meet their needs. For example, exchanges may want to create a standard QHP design that all insurers in the exchange must offer to ensure that there are plans with lower deductibles available in the exchange. In addition, exchanges may want to enact requirements to ensure that the number of plans offered is reasonable so that consumers can make well-informed selections and do not face an overwhelming number of options that are hard to distinguish.

Affordable Care Act Requirements

QHPs must comply with all Affordable Care Act requirements regarding plan design, including the following: (1) the essential health benefits, as described in section 1302(b) of the Affordable Care Act; (2) cost-sharing limits, as described in section 1302(c) of the Affordable Care Act; and (3) [requirements that the plans meet] a bronze, silver, gold, or platinum level of coverage, as described in section 1302(d) of the Affordable Care Act, or that a plan be a catastrophic plan, as described in section 1302(e) of the Affordable Care Act.[1]

State Implementation Examples

The following states are instituting policies to further standardize QHP designs:

- **California**

  The California Health Benefit Exchange requires QHP issuers to offer standardized benefit plans, which have either a copayment or a co-insurance design, at all four coverage levels (bronze, silver, gold, and platinum). QHP issuers must also offer a standardized catastrophic plan. QHP issuers may elect to offer both copayment standardized plans and co-insurance standardized plans, but they are not required to do so. QHP issuers may also offer a standardized Health Savings Account-eligible plan. In addition, each issuer may propose one nonstandardized plan design.[2]

- **Connecticut**
  In the Connecticut Health Insurance Exchange, insurers will be required to offer one standard bronze plan, one standard silver plan, and one standard gold plan. The exchange plans to prescribe the mix of deductibles, copayments, and co-insurance in these standard plans.[3] Stand-alone dental plans will also be standardized. Insurers may also submit one standard platinum plan and/or one nonstandard platinum plan, along with one nonstandard gold, one nonstandard silver, and one nonstandard bronze plan. The QHPs offered by a carrier must be *meaningfully different*. Connecticut's examples of meaningful differences include plans using copayments instead of co-insurance, varying the amount of cost-sharing by at least 10 percent, varying the deductible by $250 or more, and varying care management practices (through gatekeeper models, patient-centered medical homes, etc.).[4]

- **Oregon**
  The Oregon Health Insurance Exchange requires insurers to offer standard plans designed by the Oregon Insurance Division in the bronze, silver, and gold levels in each service area in which they participate. Beyond that, each carrier can offer two additional, nonstandard plans per tier (including the platinum tier) per service area and, with exchange approval, two additional plans that demonstrate innovation through the use of networks or other variations that do not include premiums or benefits. Finally, each carrier in the Oregon individual market exchange may offer up to one catastrophic plan.[5]

- **Vermont**
  All QHPs must sell six standard plans in the Vermont exchange, which is called Vermont Health Connect: one platinum plan, one gold plan, two silver plans, and two bronze plans. The designs of these plans are outlined in the *Vermont Health Connect Request for Proposals*.[6] In addition, insurers may submit two nonstandardized gold, two nonstandardized silver, and two nonstandardized bronze plans for QHP certification. The state will approve nonstandardized plans based on the plans' capacity to achieve the exchange's goals of promoting wellness, prevention, preventive health, and payment reform, and whether the plans integrate and promote mental health and substance abuse services within the plan design. Nonstandardized plans must also demonstrate meaningful difference in design from the standardized plans. Vermont's examples of meaningful difference include using a copayment versus a co-insurance structure, applying a different deductible, varying co-insurance by at least 10 percent, or varying copayments for provider office visits by at least $10. The exchange discourages insurers from offering nonstandardized high-deductible health plans.[7]

QHP Standard: Provider Network Adequacy

The Issue

In order for an insurance plan to make affordable care accessible to consumers, it must have a robust network of different types of health care providers. These providers must be able to see plan enrollees in a timely manner and must be located within a reasonable distance of where enrollees live. The Affordable Care Act sets general standards for QHP provider networks, but exchanges should further define these standards to ensure that QHP provider networks are adequate.

Affordable Care Act Requirements

All QHPs must have a network that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.[8]

State Implementation Examples

The following states have further defined what constitutes a sufficient provider network:

- **California**
  - QHPs in California must meet the existing network adequacy requirements that were established by the applicable regulatory agency (the Department of Managed Health Care for managed care plans, the Department of Insurance for other health plans).[9] These include the following:
    - Appointment wait-time standards specific to the type of care, including mental health care, for HMOs.
    - Standards for PPOs that include requirements designed to ensure that enrollees have adequate access to basic, non-emergency health care in terms of hours of operation (ensuring that provider networks offer access to care at least 40 hours per week and until 10:00 pm on at least one week day or at least four hours on one weekend day) and requirements that providers be "reasonably accessible" by public transportation.
    - For both HMOs and PPOs, requirements for the specific types of providers that must be included in plans' networks, including physician, hospital, specialist, ancillary, home health, emergency, and mental health providers. [10]
  - QHP issuers must use the same provider network across all tiers of coverage.
  - QHPs are expected to "hold enrollees harmless," making sure they don't have to pay any extra costs if they receive care from an out-of-network provider (such as an anesthesiologist, pathologist, radiologist, etc.) while in an in-network hospital.[11]

- **Delaware**
  - QHP issuers in the Delaware partnership exchange must meet time, distance, and provider-to-enrollee ratio standards for access to primary care providers. Primary care providers must be available to enrollees within 20 miles or no more than 30 minutes of driving time from an enrollee's residence, and a QHP's network must have at least one full-time-equivalent primary care provider for every 2,000 patients.
  - QHP issuers must provide for reimbursement of licensed nurse midwives for covered services that fall within their scope of practice under state law.[12]
- **Maryland**
  - Starting in July 2013, QHP issuers will be required to provide the Maryland Health Benefit Exchange with quarterly reports that demonstrate the adequacy of their networks.
  - The Maryland Health Benefit Exchange will use specialized computer software to monitor insurer networks, compare networks across insurers, and publicly report on the accessibility of providers.[13]
- **Minnesota**

  The Minnesota Health Insurance Exchange's Advisory Task Force has proposed extending existing network adequacy requirements for HMOs in the state to all QHPs. This means that QHPs would have to comply with the following requirements:
  - Geographic access standards (access to primary care within 30 miles or 30 minutes of travel time; access to specialty care within 60 miles or 60 minutes, with some exceptions in more sparsely populated regions of the state) and timeliness standards (primary and specialty physician services and emergency and urgent care shall be available 24 hours a day within a plan's service area).
  - Contract with or provide enrollees with sufficient and appropriate resources to meet anticipated needs for health services and implement guidelines to assess the capacity of each network to provide timely access to care.
  - Make available a full range of licensed mental health and chemical dependency providers.

  The Advisory Task Force also recommends applying the existing rules for when an HMO fails to meet network adequacy requirements to all QHPs. Under these rules, if QHPs do not meet network adequacy standards, state regulators may institute a corrective action plan, including requiring the insurer to pay non-network providers for care, reducing the insurer's service area, or limiting new enrollment in the health plan to areas with sufficient provider availability.[14]

- **Vermont**
  QHP issuers must comply with Vermont Rule H-2009-03, which includes distance and wait-time standards for obtaining several types of care. For example, enrollees must have access to a primary care provider and office-based mental health and substance abuse services within 30 minutes of driving time and must able to receive non-emergency, non-urgent care within two weeks.[15]

QHP Standard: Provider Directories

The Issue

In order for consumers to get affordable care in a timely manner, they need accurate, up-to-date information about which health care providers accept their insurance and are available to see new patients. If health plan provider directories are not updated regularly, consumers may find that the providers they contact for care no longer accept their insurance or are no longer practicing. The Affordable Care Act sets general standards for QHP provider directories, but exchanges should further define directory requirements to ensure that enrollees have the information they need to receive care in a timely manner.

Affordable Care Act Requirements

A QHP issuer must make its provider directory available to the exchange for publication online and to potential enrollees in hard copy upon request. In its directory, the QHP issuer must identify providers that are not accepting new patients.[16]

State Implementation Examples

The following states have enacted more specific standards to ensure that QHPs have accurate, up-to-date provider directories:

- **California**
  QHP issuers must provide information on network providers to the exchange so that the exchange can create a centralized provider directory for consumers.[17]
- **Connecticut**
  QHPs must update their provider directories every 15 days.[18]
- **Maryland**
  QHP issuers will be required to submit provider data to a centralized repository, the State Health Information Exchange, which is managed by the Chesapeake Regional Information System for Our Patients (CRISP). The information in this repository will be validated by the state to ensure accuracy.[19]

- **Minnesota**
  The Minnesota Health Insurance Exchange's Advisory Task Force has recommended extending Minnesota's existing HMO provider directory requirements to all QHPs. These requirements include a mandate that insurers report to state regulators within 10 business days information about providers leaving a network due to a lost license or death.[20]

- **Washington**
  Washington requires insurers to submit monthly electronic reports of participating providers.[21] The exchange will adopt this requirement and create a centralized provider directory for QHPs.[22]

QHP Standard: Essential Community Providers

The Issue

Essential community providers (ECPs) are providers that serve predominantly low-income and underserved people. They may be based at hospitals or not, and they are an essential source of care for many individuals, especially those with special health care needs.[23] Therefore, including them in health plan networks is crucial to ensuring that consumers can get the care they need. The Affordable Care Act creates general standards for the inclusion of essential community providers in QHP provider networks, and exchanges should further define these requirements to ensure sufficient access to essential community providers.

Affordable Care Act Requirements

A QHP issuer must have a sufficient number and geographic distribution (where available) of essential community providers. These providers include clinics, health centers, and hospitals that are eligible for reduced-price prescription drugs under section 340B of the Public Health Service Act.[24] A QHP must ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved consumers in the QHP's service area. (Staff model HMOs and other insurers that have similarly integrated, and therefore narrower, provider networks must comply with an alternative standard.)[25]

State Implementation Examples

The following states have further defined what is considered a sufficient number and distribution of essential community providers:

- **California**
  QHPs must demonstrate a reasonable geographic distribution of essential community providers with a balance of hospital and non-hospital providers. QHPs must also contract with at least 15 percent of the 340B entities in their service area and contract with at least one essential community provider hospital in

each geographic service area. More extensive contracting may be required in areas with high concentrations of low-income people. Insurers that are seeking QHP certification must submit maps that show non-hospital essential community providers plotted relative to low-income populations and hospital-based essential community providers plotted relative to low-income populations. Organizations that are exempt from the essential community provider standards due to their structure as a staff model or integrated delivery system must explain how they will ensure access for low-income, medically underserved consumers and must map their non-hospital and hospital providers relative to low-income populations.[26]

- **Connecticut**
  QHPs must contract with at least 75 percent of the essential community providers in any county and at least 90 percent of the federally qualified health centers (FQHCs) or "look-alike" health centers in Connecticut. (A plan that fails to meet these standards may still be eligible for QHP certification if it can show a good faith effort to contract with essential community providers by, for example, providing contract terms accepted by comparable providers and offered to, but rejected by, an essential community provider.) QHPs will be required to provide the exchange with a list of participating hospital and non-hospital essential community providers that is updated within seven days of any change to the list.[27]

- **Minnesota**
  The Minnesota exchange's Advisory Task force has recommended applying to QHPs existing Minnesota standards requiring all health plans to offer contracts to any essential community providers within their service area.[28]

QHP Standard: Marketing Requirements

The Issue

How health insurance marketing materials are written and displayed can have a significant effect on the choices that consumers make about health coverage. Past experience with programs like Medicare Advantage demonstrates that without strong standards, health insurance marketing materials can be deceptive or misleading and can be used as a tool to steer consumers into health plans for reasons other than what is in their best interests. The Affordable Care Act creates general standards for QHP marketing, but it defers to exchanges to enact sufficient QHP marketing standards.

Affordable Care Act Requirements

A QHP insurer and its officials, employees, agents, and representatives must comply with any applicable state laws and regulations regarding marketing by health insurers. In addition, they may not use marketing practices or create benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.[29]

State Implementation Examples

The following states have enacted more protective standards for QHP marketing:

- **Maryland**
  QHP insurers will be required to include standardized text on all communications and advertisements aimed at existing and potential enrollees.[30]

- **Minnesota**
  The Minnesota exchange's Advisory Taskforce recommends requiring QHP issuers to follow existing state law that prohibits the use of marketing materials that misrepresent the terms of any insurance policy or that make any misrepresentation to policyholders with the purpose of inducing the policyholders to drop coverage. Advertisements or representations must not omit information or use words, phrases, statements, references, or illustrations if doing so has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of the insurance policy. HMOs are further required to disclose exclusions and limitations, including referral requirements and restrictions on covered services.[31]

- **Vermont**
  - QHPs must abide by Title 8, Section 4084 of the Vermont statutes, which prevents insurance companies, agents, and brokers from using misleading and deceptive marketing materials. This statute also requires the state to issue a cease and desist order if misleading or deceptive marketing materials are used, after providing 10 days' advance notice and a hearing to the company, agent, or broker affected. If the company, agent, or broker violates a cease and desist order, the state may revoke its license.[32]
  - The Vermont exchange has created a logo to designate the certification of QHPs, which QHP insurers may use on their marketing materials. The exchange will review and approve the use of this logo on insurers' marketing materials. QHP insurers may not claim that the exchange's certification of a QHP implies any form of further endorsement or support of the QHP.[33]

- **Washington**
  The Washington Health Benefit Exchange has created a logo to designate the certification of QHPs, which insurers may use on their marketing materials and websites. The exchange will review and approve the use of this logo by insurers. QHP insurers may not claim that the exchange's certification of a QHP implies any form of further endorsement or support of the QHP.[34]

QHP Standard: Tobacco Rating

The Issue

Tobacco use is one personal factor that insurers in the individual and small group markets may still use as a basis for varying individual health insurance premiums under the Affordable Care Act. Charging people who use tobacco more for health insurance (a practice known as "tobacco rating") can make coverage unaffordable for them, making it harder for this higher-risk group to get the health care they need. To ensure that all residents have access to affordable coverage and care, states can further limit or prohibit the use of tobacco rating for insurance premiums.

Affordable Care Act Requirements

Individual and small group health plans may not vary premiums by more than 1.5 to 1 based on tobacco usage. Nothing prevents a state from requiring the use of a premium pricing ratio narrower than 1.5 to 1 in connection with tobacco usage.[35]

State Implementation Examples

The following states are taking action to prohibit tobacco rating:

- **California**
  Legislation that is expected to pass in California's special legislative session in January 2013 will forbid the use of tobacco rating for all insurance premiums.[36]
- **Connecticut**
  Connecticut will prohibit insurers from employing tobacco use as a rating factor in the individual market exchange.[37] State law already prohibits tobacco rating in the small group market, and this prohibition will remain in effect in the Small Business Health Options Program (SHOP) exchange.[38]

QHP Standard: Accreditation

The Issue

Accreditation is a tool for ensuring that a health plan is operating in compliance with recognized standards of doing business as an insurer. In the accreditation process, a third-party entity examines the policies, procedures, and quality of a health plan to assess whether it meets benchmarks required for accreditation. Under the Affordable Care Act, QHPs must be accredited by one of two federally recognized accreditors, the National Committee for Quality Assurance (NCQA) and URAC. Although the Affordable Care Act sets general requirements for QHP accreditation, exchanges have flexibility to set the timelines under which QHPs must become accredited.

Affordable Care Act Requirements

Each exchange must set a timeline by which all QHPs must be accredited by a federally recognized accreditor based on local performance in areas such as clinical quality measures, patient experience ratings, consumer access, and other factors. QHPs must allow accreditors to release the results of their accreditation surveys and other related information to the exchange and to the Department of Health and Human Services (HHS).[39]

State Implementation Examples

The following jurisdictions have created timelines to ensure that QHPs are accredited soon after their exchanges are established:

- **District of Columbia**
  The District of Columbia has proposed a one-year grace period for plans that are not accredited at the time of their application for QHP certification. Plans that fall within the grace period must attest that the plan has applied for accreditation and must submit updates on their application status.[40]

- **Maryland**
  For the 2014 plan year only, the Maryland Health Benefit Exchange will provide non-accredited insurers with a one-year grace period to become accredited. Insurers must demonstrate that they have applied for accreditation by July 1, 2013, to be eligible for this grace period.[41]

- **Oregon**
  The Oregon Health Insurance Exchange will require that, at a minimum, insurers be accredited by a federally recognized entity by April 2014 (18 months from the release of the exchange's QHP application). Insurers that receive full accreditation by January 1, 2014, will receive extra recognition in the form of an icon next to their plans on the exchange website to let consumers know that they are accredited.[42]

QHP Standard: Quality Reporting

The Issue

The Affordable Care Act requires QHPs to perform transparent reporting of quality measures. However, implementation of this requirement has been delayed until 2016. Despite this permissible delay, exchanges may want to require QHP quality reporting earlier so that consumers and other stakeholders have access to quality information about exchange coverage as soon as possible.

Affordable Care Act Requirements

QHPs must disclose and report on health care quality and outcomes.[43] HHS plans to fully implement this requirement in 2016.[44]

State Implementation Examples

The following states are moving forward with quality reporting requirements for QHPs for the 2014 plan year:

- **California**
  QHPs will be required to participate in the eValue8 survey (described online at http://www.nbch.org/evalu8) to assess "prevention and health promotion, adoption of health information technology, member and provider support, disease management, provider performance measurement and rewards, patient safety, pharmaceutical management, and behavioral health."[45]

- **Connecticut**
  Insurers must provide the exchange with Consumer Assessment of Health Providers and Systems (CAPHS) data for the product that is most comparable to the submitted QHP, along with National Committee for Quality Assurance (NCQA) star ratings in the five core areas (Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living with Illness) for the NCQA-accredited product that is most comparable to the submitted QHP.[46]

- **Maryland**
  - During the 2014 plan year, the Maryland Health Benefit Exchange will use the NCQA Health Effectiveness Data and Information Set (HEDIS) and CAHPS data as a proxy for QHP quality and performance data. These data will be posted on the exchange's consumer website during open enrollment in 2013.[47]
  - For the 2015 plan year, a supplemental process will be developed to collect and report quality data for stand-alone dental and vision plans.[48]
  - All QHP issuers will be required to participate in Maryland's system to report data on race, ethnicity, language, interpreters, and cultural competency (RELICC) so that "health care disparities can be analyzed and addressed in future years."[49]

- **Washington**
  Although the Washington Health Benefit Exchange does not plan to post QHP quality reports for the 2014 plan year, it will require QHPs to begin collecting quality data during the 2014 plan year. Quality reports based on these data will be displayed to consumers during 2015 open enrollment for the 2016 plan year.[50]

QHP Standard: Quality Improvement Strategies

The Issue

The Affordable Care Act requires all QHPs to have in place quality improvement strategies designed to improve the health of enrollees and make health care safer and more efficient for patients. However, the mandatory implementation of this requirement has been delayed until 2016. Despite this permissible delay, exchanges may want to implement quality improvement requirements earlier to address problems in the health care system as soon as possible.

Affordable Care Act Requirements

QHPs must implement and report on quality improvement strategies to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and reduce disparities in health and health care.[51]

State Implementation Examples

The following states are moving forward with implementing quality improvement strategies for QHPs:

- **Delaware**
  QHP insurers in Delaware's partnership exchange will be required to participate in state quality improvement workgroups. These groups will work to standardize QHP quality improvement strategies, activities, metrics, and operations, including payment structures designed to improve health outcomes, medical home models, and technology and data analytics, to support coordination and improved quality and outcomes.[52]

- **Washington**
  QHP insurers must submit quality improvement strategies on a form provided by the Washington Health Benefit Exchange. These quality improvement strategies will be posted on the exchange website. If a QHP insurer modifies its quality improvement strategy, it must resubmit the form with updated information within 30 days.[53]

QHP Standard: Continuity of Care

The Issue

People who are enrolled in QHPs and Medicaid may transition back and forth between these two types of coverage as their income levels change. If a patient is undergoing a course of treatment or awaiting a medical service during such a transition, his or her care may be interrupted unless policies are in place to ensure that patients can continue to receive scheduled treatments despite any changes in coverage. Therefore,

exchanges should consider whether to enact policies to ensure continuity of care for consumers whose coverage source changes.

Affordable Care Act Requirements

The Affordable Care Act does not prescribe continuity of care standards to ensure that individuals have continued access to care when their coverage source changes, but states may enact standards to ensure continuity of care for consumers.

State Implementation Examples

The following states are implementing QHP standards to ensure that care is not interrupted for consumers whose eligibility status changes:

- **Delaware**
  In Delaware's partnership exchange, "A QHP issuer must have a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs."
  - For medical treatment that is in progress or that has been preauthorized, the enrollee's new plan must cover the service for 90 days or until the treating provider releases the patient from care, whichever is less.
  - For prescription medications, a continuity period of at least 60 days must be provided, and for prescriptions for a mental health diagnosis, the continuity period must be at least 90 days. If the new plan uses a tiered formulary, the medication must be covered at the tier comparable to that in the plan from which the individual was transitioned.[54]

- **Maryland**
  The Maryland Health Benefit Exchange Act of 2012 required the exchange to study and make recommendations on requirements for continuity of care in the state's health insurance markets. After completing its study, the Maryland Health Benefit Exchange recommended that the state do the following:
  - Data collection, beginning during open enrollment in 2013 for the 2014 plan year, to evaluate continuity issues. This will focus on the newly eligible population and trends in disparities.
  - Starting in 2015, institute requirements that all individual and small group health plans in Maryland accept prior authorizations for care from relinquishing health plans for all covered services for the lesser of the course of the treatment or 60-90 days (or through delivery and postpartum visits for pregnant women). In addition, the exchange recommends considering whether these requirements should also apply to the large group market.

- Starting in 2015, institute requirements that all individual and small group health plans in Maryland allow new enrollees undergoing specific courses of treatment to receive care from out-of-network providers for 90 days, or through delivery and postpartum visits for pregnant women. (Applicable courses of treatment include care for pregnancy, mental health issues, pediatric dental problems, bone fractures, recent heart attacks, other acute traumas or surgeries, joint replacements, and newly diagnosed cancers.) The exchange also recommends considering whether these requirements should apply to the large group market.[55]

QHP Standard: QHP Selection

The Issue

There are a variety of ways that an exchange can select health plans for QHP certification. On one end of the continuum is a more passive approach, where an exchange certifies any health plan that seeks certification as long as the plan meets all QHP requirements. On the other end of the continuum is a very active approach, where the exchange certifies only the plans that provide the best quality and value to consumers. The Affordable Care Act grants exchanges the flexibility to decide how to select their QHPs. Exchanges should consider whether a more active approach to QHP selection would enhance their ability to bring consumers high-quality health plan choices at an affordable cost.

Affordable Care Act Requirements

To receive QHP certification, a health plan must meet the criteria outlined in Section 1311(c) of the Affordable Care Act (and described throughout this piece). An exchange may certify a health plan that meets these criteria as a QHP if the exchange determines that making the plan available in the exchange is in the interest of individuals and employers that are eligible to purchase exchange coverage.[56]

State Implementation Examples

The following states have more specific policies regarding QHP selection:

- **California**
  California's exchange legislation authorized active purchasing of QHPs. This means that insurers interested in offering QHPs will have to submit bids to the exchange, and the exchange "reserves the right to select or reject" any bid. Insurers' proposed QHPs will be assessed based on measures of quality and value, provision of care in geographically underserved areas, service to low-income individuals and areas, and implementation of innovative delivery reforms. The California Health Benefit Exchange is also looking at capping profits for QHPs in multi-year contracts.[57]

- **Connecticut**
  The exchange may selectively contract and may elect not to offer for sale one or more otherwise certified QHPs on the basis of price if there is an adequate number of QHPs available to allow for sufficient consumer choice.[58]

- **Maryland**
  Beginning on January 1, 2016, the Maryland Health Benefit Exchange Act of 2012 authorizes the exchange to "use alternative contracting options and active purchasing strategies to increase affordability and quality of care for consumers and lower costs in the health care system overall." The legislation specifies that such options and strategies may include competitive bidding; negotiating with insurers to achieve optimal participation and plan offerings in the exchange; and partnering with insurers to promote choice and affordability among health plans offering high-value, patient-centered, team-based care, value-based insurance design, and other high-quality and affordable options. Before implementing a more active option for QHP selection, the exchange must submit its selection strategy to certain legislative committees for review and comment.[59]

- **Vermont**
  The Vermont exchange does not have to accept all insurers that meet QHP criteria. It may reject a QHP proposal based on what is deemed to be in the best interest of individuals and qualified employers.[60]

As exchange planning in your state moves forward, please let us know if your state enacts consumer-friendly QHP standards that you believe would be a good model for other states. Please contact Families USA at stateinfo@familiesusa.org.

For more information on selecting and certifying qualified health plans for exchanges, see the Families USA brief *Selecting Plans to Participate in an Exchange*, available online at http://www.familiesusa2.org/assets/pdfs/health-reform/Selecting-Plans-for-Exchanges.pdf.

Endnotes

[1] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule and Interim Final Rule, *Federal Register*, 45 CFR 156.20, March 27, 2012.

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[3] Connecticut Health Insurance Exchange, *Joint Advisory Committees' Recommendations for "Issues for Review" Identified in Draft of "Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges* (Hartford: State of Connecticut, November 27, 2012), available online at www.ct.gov/hix/lib/hix/11272012_Joint_AC_Committee_Recommendations.pdf.

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[6] Department of Vermont Health Access, *Vermont Health Connect Request for Proposals* (Williston: State of Vermont, amended December 21, 2012), available online at http://www.statereforum.org/sites/default/files/vermont_qhp_rfp_amend_12_21_12.pdf.

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[8] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule and Interim Final Rule, *Federal Register*, 45 CFR 156.2301(a)(2), March 27, 2012.

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