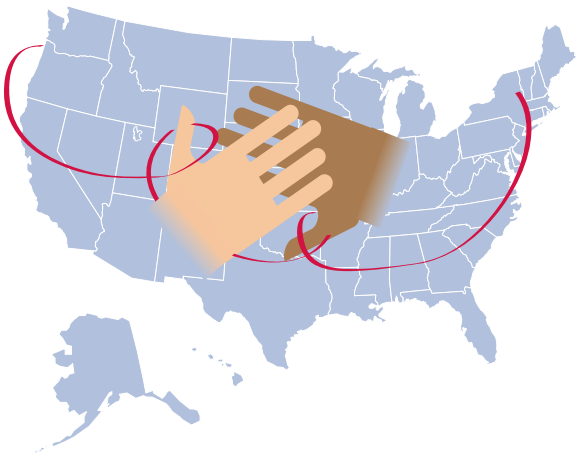

Implementing Exchanges

Part of a Families USA series on implementing state health insurance exchanges

Families USA • February 2011

Selecting Plans to Participate in an Exchange

The Affordable Care Act authorizes states to establish health insurance marketplaces, or "exchanges," to sell plans to individuals and small businesses. Although the federal government will set minimum standards for the plans that may be sold through these exchanges, states will have great latitude in selecting which plans can participate. The Affordable Care Act allows states to certify health plans as "qualified" to be sold through an exchange if the plans meet federal standards and "the Exchange determines that making available such health plan through such Exchange *is in the interest* [emphasis added] of qualified individuals and qualified employers." Thus, states are free to set additional minimum requirements that go beyond the federal minimum standards.

In the long run, the success of these exchanges will depend chiefly on how well they serve the interests of consumers. In particular, will the plans that are sold through the exchanges be reasonably priced, and will they offer good coverage with good customer service? Because states will determine which plans can participate, they now have an opportunity to ensure that state residents get good value for their health care dollars.

This guide is intended to help stakeholders understand what's involved in selecting plans and how the process can be structured in the best interests of state residents. We review the outlines of the federal minimum standards, then we discuss additional elements that states might consider incorporating into the selection process. We also offer specific examples, drawn from the states, of how these issues have played out at the state level. These examples show that states have experience from prior state-run exchanges, state employee plans, Medicaid plans, and privately run purchasing pools that can provide insight for how to best select plans for an exchange.

How Active Will Your State Be in Selecting Plans?

One of the earliest decisions a state must make is how active it wants to be in the process of selecting plans to participate in the exchange. Will the state use its new power vigorously, to encourage high quality and to negotiate lower prices? Or will the state simply verify that plans meet the specified standards?

States have a range of options for how they can select plans to participate in an exchange. At one end of the continuum, a state may allow all plans that meet federal qualifications to participate. In this case, the state exchange would serve only as a clearinghouse, organizing the marketplace a bit by providing consumers with information about their plan choices, and helping them enroll. (Utah's exchange is sometimes cited as an example of an exchange that takes all willing health plans and provides consumers with information about their options. However, it does not yet provide information about comparable plan choices, as will be required in 2014.)

Moving along the continuum toward playing a more active role, a state could establish additional criteria beyond the standards that are required by the federal government (described on page 3) but still allow any insurer to sell its plans in the exchange if it meets the state criteria and federal standards. Moving further still, the state could establish a bidding process and select from among the bidders only those plans that it thinks are the best value for consumers. (Most states are used to this type of bidding to select employee plans and/or Medicaid managed care plans. Massachusetts uses a scoring system to choose plans for its Connector. See "The Massachusetts Connector: An Active Negotiator" on page 9.) This could create some competition for a place in the exchange: plans could bid lower prices or offer more attractive provider networks and quality innovations, hoping to get a spot on the exchange. Finally, a state could actually negotiate with plans and refuse to accept them unless they bid at a certain price point, much as a large employer negotiates with health plans.

Gary Claxton, Vice President of the Kaiser Family Foundation, notes that there are several good reasons for an exchange to actively negotiate with health plans instead of taking all comers:

> *"In markets with a few dominant competitors, for example, negotiation and the threat of exclusion may be necessary to get the lowest prices from insurers. Exchanges also are in a good position to identify and represent consumer preferences in areas where buyers have little experience. By communicating with consumers and surveying the experiences of all types of plan users, exchanges can identify unexpected traps and difficulties that consumers face and negotiate plan terms and arrangements that better protect consumers with differing health care needs."*[1]

But even if your state is not yet ready to be an active negotiator, it can help consumers by taking additional steps to ensure that health plans in the exchange work well for consumers.

For example, your state can further standardize benefit choices; and your state can take seriously its responsibility to certify that plans meet federal standards, have not unreasonably increased premiums, and are operating in consumers' interests.[2]

What federal standards must plans meet to participate in an exchange?

The Secretary of the Department of Health and Human Services (HHS) is charged with setting the minimum standards for qualified health plans through regulation. HHS will probably publish proposed regulations in the spring of 2011 and further regulations later in 2011 and 2012. HHS's initial guidance to states is available online at http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html.

The statute requires federal standards for plans to address the following issues:

- **Marketing requirements**: Plans cannot use marketing practices that would discourage enrollment by people with significant health needs.
- **Network adequacy**: Plans must provide a "sufficient" choice of providers and must include essential community providers (where available) that serve low-income, medically underserved individuals (such as Federally Qualified Health Centers).
- **Accreditation**: Plans must be accredited or achieve accreditation within a defined time period, based on a review of their clinical quality, patient experience, access, utilization management, quality assurance, provider credentialing, complaints and appeals processes, network adequacy and access, and patient information programs.
- **Quality improvement**: Plans must have a quality improvement strategy.
- **Uniform enrollment form**: Plans must use a uniform enrollment form for individuals and small employers.
- **Standard format**: Plans must use a standard format for presenting plan options.
- **Performance information**: Plans must provide information about their performance on certain standardized quality measures to enrollees and prospective enrollees.
- **Fulfill reporting requirements on pediatric quality**: Plans must report annually to the federal government on the quality of their pediatric care.

The statute also requires qualified health plans to provide the essential benefits package. Qualified plans must be transparent, providing data to the public about their claims, finances, enrollment, rating practices (that is, how they vary premiums by age, geography, or other factors), cost-sharing and payments for out-of-network providers, as well as information about enrollee rights. In addition, as part of the certification process, exchanges must require health plans to justify any planned premium increases, and plans with unreasonable premium increases can be excluded from participating in an exchange. However, exchanges cannot directly impose premium price controls.

Insurers that offer qualified plans must do the following:

- be licensed in the state(s) where they are doing business;
- agree to offer at least one silver level plan and one gold level plan in an exchange;
- charge the same premium for the same health plan regardless of whether the insurer is selling the plan through an exchange, selling directly to individuals or employers outside the exchange, or selling through an agent; and
- comply with regulations established by HHS and any other requirements established by the exchange.

Insurers that participate in an exchange can also offer bronze and platinum level plans, and they can offer catastrophic plans to individuals aged 30 and under and to those who are exempt from the Affordable Care Act's individual responsibility requirements (this is voluntary—they are not required to offer this coverage under the federal law). The various levels of coverage are defined according to their "actuarial value"—that is, the amount that the plan would typically pay for covered benefits as compared to the amount that enrollees would pay out of pocket for the benefits covered by the plan. The bronze, silver, gold, and platinum level plans would cover 60, 70, 80, or 90 percent of costs, respectively.

What other elements might states want to consider in certifying and selecting plans?

In addition to making sure that plans in an exchange meet federal standards, states may want to consider a number of other factors as they select plans for their exchanges. Overall, states should ask themselves the question: "Will this plan provide a good value for consumers?" States should also take steps to make sure that plans inside and outside the exchange take on a fair balance of risks, work to make sure that people who lose Medicaid eligibility can still get continuous care, consider further requirements concerning benefits and cost-sharing structures, and work to ensure that enrollees will have access to high-quality service.

- ### Providing Value

  Ultimately, the plans that participate in an exchange should provide good value for consumers–that is, the prices charged should be reasonable in relationship to the benefits provided. Under the Affordable Care Act, insurers must charge the same price for a plan sold both in an exchange and outside an exchange. In addition, there are new tools, such as medical loss ratio (MLR) limits and premium review, that are designed to ensure value in all health plans. However, states can further evaluate the value of plans that will be offered in an exchange, then exclude those that have a history of high premium increases, or ask plans to "sharpen their pencils" and lower their prices if they want to sell in the exchange.

- ## Preventing Adverse Selection

  If sicker people tend to enroll in plans sold in an exchange and healthier people tend to enroll in plans that are offered outside an exchange, premium prices in the exchange may escalate in a phenomenon known as "adverse selection." The Affordable Care Act provides some mechanisms states can use to redistribute high costs more equitably among plans (such as risk adjustment and reinsurance), but states can take further action. For example, they can require insurers that sell in the exchange to offer plans in each of the possible coverage levels. Since people who buy the most comprehensive coverage (the platinum level) may be sicker than those who buy more limited coverage, offering the full array of coverage levels will help assure that carriers get a mix of enrollees. (California has addressed this in its exchange law—see "California's Exchange Legislation" on page 11.)

  States can make the rules for plans that sell outside of the exchange as similar as possible to the rules for plans that sell inside the exchange, and states can require that plans that sell silver and gold coverage in the exchange also offer that coverage outside of the exchange. For more details, see the Center on Budget and Policy Priorities paper, *States Should Structure Insurance Exchanges to Minimize Adverse Selection*, available online at http://www.cbpp.org/cms/index.cfm?fa=view&id=3267.

- ## Ensuring Continuity of Coverage for Enrollees Whose Incomes Fluctuate

  Low-income families and adults may experience frequent fluctuations in their incomes that cause them to move between Medicaid and private plans that provide premium assistance. If plans that provide Medicaid managed care also participate in an exchange, these families may not have to switch plans and providers each time their incomes change.

  One association that represents not-for-profit safety net health plans says that many Medicaid managed care plans would be interested in also accepting exchange enrollees if participation requirements between the two systems were not too different.[3] For example, Medicaid managed care contracts now typically set standards for provider networks, reporting on health delivery, telephone customer service, quality assurance, and other aspects of coverage. Exchanges might consider whether they can use similar standards, or whether plans that have met the state Medicaid agency's contractual standards might automatically meet some of the exchange's standards.

  Even if Medicaid managed care plans do not participate in an exchange and former Medicaid enrollees end up changing plans, rules for exchange plans should ensure that patients can continue seeing the same providers, or at least have a reasonable

process for transitioning to new providers when their incomes fluctuate.[4] For instance, states could consider requiring qualified health plans to contract with any provider that was serving a patient under Medicaid and that wanted to continue serving that patient, or they could consider requiring payment to a former provider for a set time period or until the patient had concluded his or her course of treatment.

• Defining a Good Benefits Package

The federal government will define a list of "essential health benefits" that all qualified health plans must provide. States will have additional flexibility to ensure that health plans in their exchange have benefit packages that meet residents' needs. For example, states could do one or more of the following:

- Each state should examine the list of items that are now "benefit mandates" for licensed insurers in the state. Hopefully, many of these will be incorporated into the federal definition of essential benefits. For those that are not, states can still require plans in their exchange to cover those benefits, but the state will have to pay any increased cost in premiums that results from the additional benefits. In such instances, consumer advocates recommend that states calculate the *net* increase in premiums after subtracting any resulting savings—for example, the cost of providing a particular benefit might be offset if it prevents a patient from needing a different covered service, so that should be factored into the equation. Further, if most plans would provide a given benefit even without a mandate, and the mandate mainly serves to bring a recalcitrant plan up to the typical standard, the true cost may be slight.[5]

  Thus, states should study whether there would be more than a marginal cost to any benefit mandate, whether coverage of the benefit might be offset by a reduction in use of another covered service, the importance of the services to consumers, and whether there would be costs elsewhere in the state's health system (for example, in public health services or uncompensated care) if the benefits were not covered. If the state exchange requires plans to offer any benefits beyond the federal package, it will need to specify that in the contract.

- Your state might want plans and providers to focus on particular populations and use state-designated tools for improving care or coordination of care for those populations. For example, as states have contracted with Medicaid managed care plans and with Children's Health Insurance Program (CHIP) plans, they have sometimes required use of common tools for developmental assessments, required coordination with school-based health services, identified diseases that were of special concern in their states as a focus for case management and disease management, and specified language access requirements. Are there elements in your state's Medicaid or CHIP contracts that you want to bring into exchange contracts?

In the Massachusetts Connector, Commonwealth Care plans, which are subsidized and available to people with incomes below 300 percent of the federal poverty level, have contracts that are fairly similar to the state's Medicaid managed care plans, and the same plans serve both populations. People with higher incomes that purchase coverage without premium assistance in the Connector use a different set of plans that are not subject to such detailed requirements.

- Your state may want to assure that various reproductive health services are available in exchange plans and that consumers have clear information about which plans offer which family planning services. Federal funding cannot be used for abortion coverage (except in cases of rape, incest, or endangerment of the mother's life), so people will not receive premium assistance or cost-sharing reductions for abortion services except in those instances. However, qualified plans can still cover abortion services unless this is prohibited under state law. If an insurer wants to cover abortion services, it must collect separate payments from all enrollees for this portion of the coverage; that is, the enrollees would send one premium payment for other services and a separate premium for abortion services. (Enrollees of all ages and sexes would be charged for this, not just women of child-bearing age.) Further, the insurer must segregate the funding that is related to abortions, establishing a separate account for the abortion-related premiums and services. Other reproductive services that could vary from plan to plan include coverage of contraception, counseling, and fertility services.

- ## Standardizing Cost-Sharing Options

Health insurance plans that are offered in an exchange must provide one of four levels of coverage for essential benefits (platinum, gold, silver, or bronze) or provide catastrophic coverage for people under age 30. As noted on page 4, the four levels of coverage are defined according to the actuarial value of coverage that they provide. All plans at the silver level, for example, will pay for about 70 percent of average enrollees' costs for covered benefits, and enrollees will pay the remaining amount in the form of deductibles, copayments, and co-insurance.

While consumers will thus be able to choose among plans that offer comparable levels of coverage, the federal requirements still leave lots of room for plans to establish different combinations of deductibles, copayments, and co-insurance that would achieve a given actuarial value. To make the process of comparing plans easier for consumers, states could require further standardization of these cost-sharing structures. Research suggests that having too many health plan options can bewilder consumers. For example, many Medicare consumers have found Medicare Part D plan choices to be confusing and have not chosen the plans that best matched their needs for drug coverage.[6] Medicare is therefore gradually moving to more standardization of plan choices.

Even before health reform, states and private associations have often standardized plan choices to make it easier for consumers to compare and select plans. For example, the Connecticut Business and Industry Association, a large association of employers, offers a range of health plans and allows employees to choose among several standardized options (see "Connecticut Business and Industries Association Offers Clear Cost-Sharing Options for Comparable Benefits" on page 12). Kansas is among several states that offer standardized benefit options to state employees (see "Kansas Offers Standardized Plans to State Employees" on page 13). Massachusetts took the step of standardizing benefit designs for health plans in its exchange, the Connector, in 2009 to make it easier for consumers to compare plans (see "The Massachusetts Connector: An Active Negotiator" on page 9).

Does your state want to further standardize benefit designs that are offered in the exchange to make comparison shopping easier? A state could do this, for example, by proscribing a couple of different deductible levels and co-insurance or copayment structures that would be offered by all competing plans. States might also consider whether particular services should have lower cost-sharing based on consumer needs (for example, a state might insist that at least generic drugs have low copayments, or that outpatient mental health services be available with limited copayments in all plans). Or they may want to ensure that people have a choice between a low-deductible and a high-deductible plan, for example, or between an HMO network and a PPO network.

- ### Ensuring Quality and Access

  Although HHS will be setting minimum standards for qualified plans, your state can further evaluate which plans have been the best performers and can hold plans to additional standards to ensure that they provide quality and value for consumers. For instance, HHS will set minimum network standards, but you may want to go further to give preference to plans that have a history of good performance, that have centers of excellence in their networks, or that do a good job of creating medical homes. HHS will also set some quality standards, but you may want to consider information that your state collects about consumer complaints or customer satisfaction. Or you may want to encourage plans to innovate in an area where price and cost increases have been problematic and reward those that succeed.[7] Many states already have experience with encouraging state employee plans or Medicaid or CHIP plans to provide high-quality services. (See "Wisconsin Chooses State Employees' Plans to Provide Quality and Value" on page 13. Also, see the Center for Health Care Strategies online at www.chcs.org. They provide information about state best practices for improving quality in Medicaid and other publicly financed plans.)

How can states set up a framework now for plan selection?

In 2011, many states will pass laws that give a state agency or another entity authority to establish the state's exchange. These laws may not provide much detail about standards for participating plans, but they can at least set a framework that allows the exchange to contract with selected plans rather than taking all comers. California enacted such a law in 2010 (see "California's Exchange Legislation" on page 11).

State contracting and procurement processes vary, so there may be differences in when states will have to begin the process of procuring qualified health plans in order to have an exchange operational by 2014. One timeline suggests that states should develop specifications and a request for proposals for qualified health plans by January 2013. However, some states may need to do this even earlier depending on how long it will take to prepare requests for proposals, accept and review bids, and make a selection. Even if a state does not use a bidding process to select qualified health plans, as part of its exchange planning process, it should think about how it will determine whether plans that want to participate in the exchange will serve the interests of individuals and employers.

State Examples

Massachusetts

The Massachusetts Connector: An Active Negotiator

The Massachusetts Connector, which began operating in 2006 under a state law, is quite similar to the exchanges that are envisioned under the Affordable Care Act. The Connector's board sets high standards for plans that will participate and uses a bidding process to select plans. Currently, the Connector includes two types of plans:

1. Commonwealth Care plans serve adults with incomes up to 300 percent of poverty ($55,590 for a family of three in 2011), and enrollees in these plans pay sliding scale premiums and copayments based on their incomes. Commonwealth Care contracts are fairly similar to the state's Medicaid managed care contracts. In fact, all but one of the five Commonwealth Care plans also serve Medicaid managed care enrollees. This helps ensure continuity for families whose incomes fluctuate between Medicaid and Commonwealth Care guidelines.
2. Commonwealth Choice plans serve higher-income people and small businesses. Insurers bid to receive the "seal of approval" and participate in the Connector. The Connector's procurement process does not predetermine a specific number

of Commonwealth Choice carriers that will participate in the Connector. Instead, the procurement sets some minimum criteria for participation and then selects plans that both exceed that minimum and that would seem to best serve members. Commonwealth Choice plans are scored and selected based on the following criteria:

- Cost, including the amount people would pay in premiums and in typical out-of-pocket costs. Under state law, prices for plans in the Connector are the same as those charged in the general market. In 2008, when carriers initially submitted bids with premiums that seemed too high, the governor asked carriers to "sharpen their pencils" and offer lower premiums, and they did so.
- An evaluation of the carrier's overall offering and plan design, including the following preferred features: use of a select, high-performance network; centers of excellence for complex conditions or procedures; innovative pharmacy management; consumer engagement; wellness incentives and management; and preventive and flex benefits for chronic conditions.
- Whether the plan had a good marketing strategy, understood the role of the Connector, and offered products that seemed marketable. For example, a carrier that had a multilingual community outreach strategy and a proposed media campaign that also targeted nontraditional media scored well.
- Network access and geographic coverage: plans with broad networks that operated in all geographic areas scored best.
- Whether the plan could confirm its compliance with various program rules and reporting requirements.

In 2009, the Connector board also told plans how to structure deductibles, co-insurance, and cost-sharing for each plan level. Previously, plans had to provide the same value of benefits but could use differing cost-sharing structures. The board found that this confused enrollees and determined that more standardization of benefit design would help consumers choose plans.

Sources: Personal communication between Cheryl Fish-Parcham, Deputy Director of Health Policy, Families USA, and Patrick Holland, Managing Director, Wakely Consulting Group (previously Chief Financial Officer for the Commonwealth Health Insurance Connector Authority), on November 24, 2010; Presentation of Patrick Holland, Commonwealth Choice Chief Financial Officer, to Board of Directors, *Commonwealth Choice CY 2010 Seal of Approval*, April 9, 2009; Memorandum from Jon Kingsdale, Executive Director, and Bob Carey, Director of Planning and Development, to Commonwealth Health Insurance Connector Authority, *Staff Recommendations for Health Insurance Carriers for Commonwealth Choice*, March 3, 2007. Documents are available online at www.mahealthconnector.org.

California

California's Exchange Legislation

California is the first state to enact legislation that will establish an exchange pursuant to the Affordable Care Act. Its law broadly sets a framework for how the exchange board will select plans. The legislation a) requires that the exchange board selectively contract with plans that provide an optimal combination of choice, value, and quality; b) requires carriers to offer products in all five levels of coverage (platinum, gold, silver, bronze, and catastrophic), avoiding the kind of adverse selection that would occur if some carriers did not offer the most comprehensive options that are often used by sicker enrollees; and c) requires carriers that sell in the exchange to also offer the same products outside of the exchange. The following excerpt from California's law explains this framework:

> [The board of the exchange shall...]
>
> (c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.
>
> (d) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal act.
>
> (e) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal act. The board may require carriers to offer additional products within each of those five levels of coverage. This subdivision shall not apply to a carrier that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504.
>
> (f) (1) Require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to do both of the following:

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

Source: Title 22, California Government Code, Section 100503 (enacted as AB 1602 in 2010).

Connecticut

Connecticut Business and Industry Association Offers Clear Cost-Sharing Options for Comparable Benefits

The Connecticut Business and Industry Association (CBIA) is a private association of Connecticut employers that began offering health insurance policies in the early 1980s. It established an exchange-like program, Health Connections, in 1995. Its operations are very similar to those of a SHOP (Small Business Health Options Program) exchange under the Affordable Care Act, so it can provide lessons to states in how to structure a state-run exchange for businesses.

CBIA has been highly successful in attracting employers: About 6,000 small and mid-sized employers now purchase health insurance through CBIA, and 87,000 people are covered by its health insurance plans. Once an employer decides to offer coverage through CBIA, its employees can choose from among the participating health plans and choose a benefit level.

Employers purchase coverage through CBIA because it offers their employees easily understandable plan choices, and because CBIA delivers good service. Besides providing employers with consolidated bills, collecting premiums, and paying insurers, CBIA also offers help with administering COBRA benefits and health reimbursement accounts, help with Section 125 plan documentation, and it sells other types of insurance products.

When CBIA first began offering health insurance, it solicited participation from all insurers in Connecticut's small group market. To participate, insurers must agree to CBIA's terms, which include offering standardized, comparable plans. CBIA also requires participating insurers to offer certain standardized plans that cover a common set of benefits and that use the same cost-sharing structures. In addition, under Connecticut law, small group insurers must charge the same price for premiums no matter how they sell the policies, so premiums for a given plan will be the same whether an employer purchases a plan through CBIA or directly from an insurer or a broker in the outside market.

Since its inception, the program has operated with four insurers, but the insurance industry in the state has consolidated, so only two insurers will be offering small group plans through CBIA in 2011. Currently, there are 12 plan options for small business employees that are offered by the two participating insurers. The range of plan options includes HMO and point-of-service plans that have copayments of $20, $30, or $45 for most services. Some of the plans have no deductible for in-network services, and other plans have deductibles for hospital-based services only or are high-deductible plans that are compatible with health savings accounts (HSAs). The standardization of out-of-pocket costs helps employees choose plans and helps prevent adverse selection: Since participating insurers must offer the same products, they are likely to attract similar groups of enrollees.

Sources: Personal communication between Cheryl Fish-Parcham, Deputy Director of Health Policy, Families USA, and Ken Comeau, Vice President, CBIA Health Connections, on December 3, 2010, as well as information on CBIA's website, www.cbia.com.

Kansas

Kansas Offers Standardized Plans to State Employees

The Kansas Health Authority administers Medicaid, CHIP, and the state employee plan. For state employees, it sets three schedules of benefits (Plans A, B, and C) so that employees can easily compare their choices. The three plans all provide coverage for the same set of benefits, but they differ in their deductibles, co-insurance, and copayments. Four insurance carriers administer the plans. (The state self-funds the plans, but the carriers administer benefits and contract with provider networks.) Employees are able to choose both the cost-sharing structure and the provider network and administrator that they prefer.

Source: Personal communication between Cheryl Fish-Parcham, Deputy Director of Health Policy, Families USA, and Peter Hancock, Director of Public Relations, Kansas Health Policy Authority, on December 3, 2010.

Wisconsin

Wisconsin Chooses State Employees' Plans to Provide Quality and Value

Wisconsin offers state employees a choice of plans that are grouped in three tiers, which all have different premiums. Plans in the first tier, which cost employees the least, are chosen by Wisconsin's Group Insurance Board as delivering the most cost-effective care and meeting quality standards. Wisconsin is considering building on this type of rating system to select plans for its exchange.

The board begins the process of choosing these plans by collecting cost and utilization data, as well as HEDIS scores (health care performance measures) from plans that wish to offer coverage to state employees. An actuary evaluates the data after adjusting for the risks (the demographics and health conditions) of enrollees in each plan. When the board and actuary identify an area where a plan is not as cost-effective as other plans, they discuss this with plan representatives. For example, they note when plans have particularly high provider reimbursement rates, or when they have longer than average hospital stays. They then allow plans to reduce their premium bids in order to be placed in a lower tier of cost-sharing.

While the negotiating tools will be somewhat different in an exchange, advocates are urging Wisconsin to similarly consider quality and cost-effectiveness when it negotiates with plans that want to sell in the exchange.

Sources: *WI State Employee Health Insurance Program* (PowerPoint presentation), submitted by Dave Stella, Secretary, Lisa Ellinger, Division of Insurance Services, and Bill Kox, Director of Health Benefits and Insurance Plans, Wisconsin Department of Employee Trust Funds (September 21, 2010), available online at http://legis.wisconsin.gov/lc/committees/study/2010/REFORM/files/detf_presentation.ppt; draft bill to establish a Wisconsin Health Insurance Exchange, December 28, 2010, available on the website of the Special Committee on Health Care Reform Implementation at http://legis.wisconsin.gov/lc/committees/study/2010/REFORM/index.html; Wisconsin Department of Human Services, *Early Innovator Grant Application to HHS Secretary Sebelius*, December 22, 2010, available online at http://www.healthcarereform.wi.gov/docview.asp?docid=20944&locid=173.

Endnotes

[1] *Statement of Gary Claxton, Kaiser Family Foundation*, NAIC Exchange Subgroup Hearing, July 22, 2010, available online at www.kff.org/healthreform/upload/Statement-of-Gary-Claxton-to-NIAC-Exchanges-B-Subgroup.pdf.

[2] Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues* (New York: The Commonwealth Fund, September 2010), available online at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.

[3] Letter from Margaret Murray, CEO, Association for Community Affiliated Plans, to Jay Angoff, Director, Office of Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services, October 4, 2010. For example, in many states, Medicaid plans are not now required to be accredited by the National Committee for Quality Assurance, but they are instead subject to review by state-contracted external quality review organizations.

[4] See letter from Thomas Johnson, President and CEO, Medicaid Health Plans of America, to Jay Angoff, Director, Office of Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services, October 4, 2010, available online at http://www.mhpa.org/_upload/10-4-10%20MHPA%20Exchange%20Comments%20(2).pdf.

[5] Maryland is an example of a state that thoughtfully determines the cost of benefit mandates, taking into account both cost offsets and the number of employer-based plans that would cover a given benefit even without a mandate. Personal communication between Cheryl Fish-Parcham, Deputy Director of Health Policy, Families USA, and Rex Cowrdy, M.D., Executive Director, Maryland Health Care Commission, on December 3, 2010.

[6] Jason Abaluck and Jonathan Gruber, *Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program* (Cambridge, MA: National Bureau of Economics, February 2009), available online at http://econ-www.mit.edu/files/6008.

[7] The Oregon Health Policy Board is considering ways that it can improve the quality of health care through its exchange, the state employees' plan, and publicly financed coverage programs. Meeting notes are available online at http://www.oregon.gov/OHA/OHPB/meetings/index.shtml.

Acknowledgments

This guide was written by:

Cheryl Fish-Parcham
Deputy Director, Health Policy
Families USA

The following Families USA staff assisted in the preparation of this guide:

Kathleen Stoll, Deputy Executive Director, Director of Health Policy

Peggy Denker, Director of Publications

Ingrid VanTuinen, Senior Editor

Nancy Magill, Senior Graphic Designer

1201 New York Avenue NW, Suite 1100 • Washington, DC 20005
Phone: 202-628-3030 • Fax: 202-347-2417 • Email: info@familiesusa.org
www.familiesusa.org